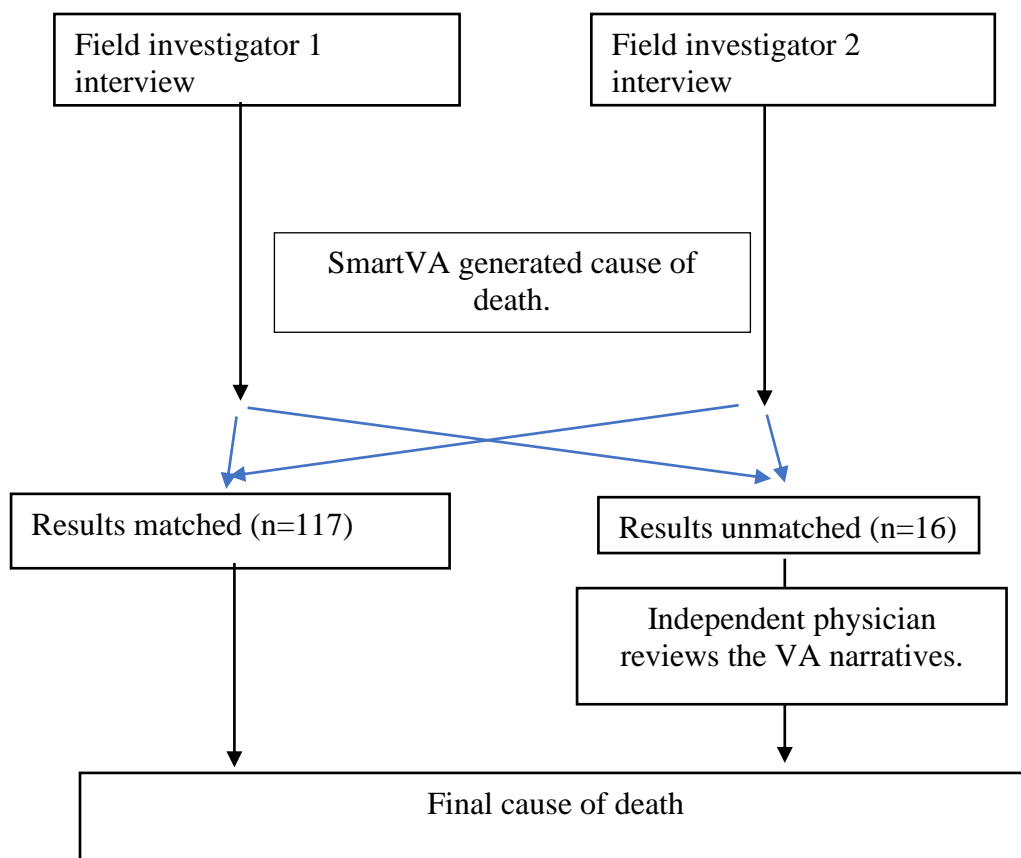


Supplementary Figure 1: Data collection flow



Supplementary table S1: Age and sex disaggregated mortality data of Andhra Pradesh and STOP CKDu study.

Variables	Gender (deceased population) n=133		Age specific death rate per 1000 population
	Male (n=100), n (%)	Female (n=33), n (%)	
Age			
18-30	2 (2)	Nil	6.15
31-40	3 (3)	3 (9.1)	10.56
41-50	19 (19)	8 (24.2)	40.84
51-60	25 (25)	11 (33.3)	70.45
>60	51 (51)	11 (33.3)	175.1

**POPULATION HEALTH METRICS RESEARCH CONSORTIUM
SHORTENED VERBAL AUTOPSY QUESTIONNAIRE
GENERAL INFORMATION MODULE**

INTERVIEW BEGINS

Instructions to interviewer: Introduce yourself and explain the purpose of your visit. Ask to speak to the mother or to another adult who was the deceased's main caretaker during the illness that led to death. If this is not possible, arrange a time to revisit the household when the caretaker will be home. (see example below).

"My name is [your name]. I am an interviewer with the Population Health Metrics Research Consortium project. I have been informed that a death has occurred in your household. I am very sorry to hear that a member of your household has passed away. Please accept my sympathies. For the purpose of improving health care, we are collecting information on all recent deaths in this area. I would like to talk to the mother or main caretaker of [the deceased's name] and ask some questions about the events and any symptoms that [the deceased's name] had during her/his illness before death."

SECTION 1 QUESTIONS ON THE DECEASED

1.1	Address of/directions to household	
-----	------------------------------------	--

SECTION 2: CONSENT

<i>INTERVIEWER: Read the consent form to the respondent. Ask the respondent if he or she has any questions. Once any questions are answered, ask the respondent if he or she is willing to take part in the study.</i>			
2.1	Did respondent give consent?	1. Yes 2. No	<input type="checkbox"/> <input type="checkbox"/>
<i>If answer is "Yes" proceed to 3.1. If answer is "No" then thank respondent for their time and end the interview.</i>			

SECTION 3 QUESTIONS ON THE DECEASED

3.1	What was the name of the deceased?	[_____]
3.2	What year was the deceased born?	[][][][] <i>Enter 9999 if unknown</i> Year must be between 1880 and this year.
3.3	What month was the deceased born?	[][] <i>Enter 99 if unknown</i> Month must be between 1 and 12.

3.4	What day of the month was the deceased born?	[][] Enter 99 if unknown Day must be between 1 and 31.	
3.5	What was the sex of the deceased?	1. Male 2. Female	<input type="checkbox"/> <input type="checkbox"/>
3.6	What year did the deceased die?	[][][][] Enter 9999 if unknown Year must be between 1880 and this year.	
3.7	What month did the deceased die?	[][] Enter 99 if unknown Month must be between 1 and 12.	
3.8	What day of the month did the deceased die?	[][] Enter 99 if unknown Day must be between 1 and 31.	
3.9	What was the last known age of the deceased? (Less than 24 hours = 00 days. Enter age in days up to 27 days. Enter 28 days as 1 month. From 1-11 months enter age in months. Enter 12 months as 1 year. From 1 year enter age in years.)	1. ___ __ days Enter 99 if unknown 2. ___ __ months Enter 99 if unknown 3. ___ __ years Enter 99 if unknown 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
If "Refused to answer" or "Don't know", go to 3.10			
3.10	What age group does the deceased's last known age fall into?	1. Less than 28 days 2. 28 days – 11 years 3. Older than 12 years 8. Refused to answer 9. Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If age and age group are both "Don't know" or "Refused to answer", thank respondent for their time and end the interview.			
3.11	Where did the deceased die?	1. Hospital 2. Other health facility 3. On route to hospital or other health facility 4. Home 5. Other (specify _____) 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

SECTION 4 QUESTIONS ON THE NOTIFICATION OF DEATH

4.1	Has this death been registered? <i>(refer to local registration process, e.g. with the civil registry office)</i>	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No", "Refused to answer" or "Don't know", go to 4.4</i>			
4.2	Record the date of registration <i>Enter 9999 if unknown</i>	<u> </u> / <u> </u> / <u> </u> dd mm yyyy	
4.3	Record the registration number:		
4.4	<i>Has this death been notified?</i> <i>(question for the interviewer)</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No", "Refused to answer" or "Don't know", go to 4.6</i>			
4.5	Record notification number:		
4.6	Did the decedent have a National ID number?	1. Yes 2. No 3. Too young for a National ID number 4. Not relevant 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "Yes", go to 4.7</i> <i>If "Too young for a National ID number", go to 4.8</i> <i>If "No", "Not Relevant", "Refused to answer" or "Don't know", go to specific age group VA module</i>			
4.7	Record the National ID number:		
<i>Go to specific age group VA module</i>			
4.8	Does one of the parents have a National ID number?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No", "Refused to answer" or "Don't know", go to specific age group VA module</i>			

4.9	Which parent will we record?	1. Mother 2. Father	<input type="checkbox"/> <input type="checkbox"/>
4.10	Record the parent's National ID number:		

If deceased was 12 years or older, begin Adult VA module.
If deceased was 28 days or older and younger than 12 years, begin the Child VA module.
If deceased was less than 28 days old, go to the Neonate VA module.

**POPULATION HEALTH METRICS RESEARCH CONSORTIUM
SHORTENED VERBAL AUTOPSY QUESTIONNAIRE
ADULT AND ADOLESCENT VERBAL AUTOPSY MODULE**

SECTION 1: INJURIES AND ACCIDENT

1.1	Did _____ suffer from an injury or accident that led to his/her death?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No", refused to answer or don't know is checked, go to Section 2.</i>			
1.2	What kind of injury or accident did _____ suffer from? <i>Ask respondent each in sequence and mark all to which the respondent indicated "Yes."</i>	1. Road traffic crash/injury 2. Fall 3. Drowning 4. Poisoning 5. Bite or sting by venomous animal 6. Burn/fire 7. Violence (suicide, homicide, abuse) 11. Other injury, specify _____ 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1.3	Was the injury or accident self-inflicted?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1.4	Was the injury or accident intentionally inflicted by someone else?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Go to Section 6: HEALTH RECORDS			

SECTION 2: HISTORY OF CHRONIC CONDITIONS OF THE DECEASED

2.1	Was _____ ever told by a health professional that he or she ever suffered from one of the following?		
2.2	Asthma	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.3	Cancer	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

2.4	COPD (Chronic Obstructive Pulmonary Disease)	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.5	Diabetes	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.6	Epilepsy	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.7	Heart Disease	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.8	Tuberculosis	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.9	Stroke	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.10	AIDS	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

SECTION 3: SYMPTOM CHECKLIST

3.1	Did _____ have a fever?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.4</i>			
3.2	How severe was the fever?	1. Mild 2. Moderate 3. Severe 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

3.3	What was the pattern of the fever?	1. Continuous 2. On and off 3. Only at night 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.4	Did _____ have a rash?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.6</i>			
3.5	Where was the rash located?	1. Face 2. Trunk 3. Extremities 4. Everywhere 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.6	Did _____ have sores?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.8</i>			
3.7	Did the sores have clear fluid or pus?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.8	Did _____ have an ulcer (pit) on the foot?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.11</i>			
3.9	Did the ulcer ooze pus?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.11</i>			
3.10	For how many days did the ulcer ooze pus?	1. ___ days <i>Enter 99 if unknown</i> 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
3.11	Did _____ have yellow discoloration of the eyes?	1. Yes 2. No 8. Refused to answer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

		9. Don't know	<input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.13</i>			
3.12	For how long did _____ have the yellow discoloration?	1. ___ days <i>Enter 99 if unknown</i> 2. ___ months <i>Enter 99 if unknown</i> 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
3.13	Did _____ have puffiness of the face?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.15</i>			
3.14	For how long did _____ have puffiness of the face?	1. ___ days <i>Enter 99 if unknown</i> 2. ___ months <i>Enter 99 if unknown</i> 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
3.15	Did _____ have general puffiness all over his/her body?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.16	Did _____ have a lump in the neck?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.17	Did _____ have a lump in the armpit?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.18	Did _____ have a lump in the groin?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.19	Did _____ have a cough?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	<i>If "No" or "Don't know" or "Refused to answer" go to 3.22</i>		
3.20	Did the cough produce sputum?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.21	Did _____ cough blood?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.22	Did _____ have difficulty breathing?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.23	Did _____ experience pain in the chest in the month preceding death?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Don't know" or "Refused to answer" go to 3.25</i>		
3.24	How long did the pain last?	1. Less than 30 minutes 2. 30 minutes to 24 hours 3. More than 24 hours 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.25	Did _____ have more frequent loose or liquid stools than usual?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.26	Was there blood in the stool?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Don't know" or "Refused to answer" go to 3.28</i>		
3.27	Was there blood in the stool up until death?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.28	Did _____ stop urinating?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.29	Did _____ vomit in the week preceding the death?	1. Yes 2. No	<input type="checkbox"/> <input type="checkbox"/>

		8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Don't know" or "Refused to answer" go to 3.32</i>		
3.30	Was there blood in the vomit?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.31	Was the vomit black?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.32	Did _____ have difficulty swallowing?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Don't know" or "Refused to answer" go to 3.35</i>		
3.33	For how long before death did _____ have difficulty swallowing?	1. ___ days <i>Enter 99 if unknown</i> 2. ___ months <i>Enter 99 if unknown</i> 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
3.34	Was the difficulty with swallowing with solids, liquids, or both?	1. Solids 2. Liquids 3. Both 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.35	Did _____ have pain upon swallowing?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.36	Did _____ have belly pain?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Don't know" or "Refused to answer" go to 3.39</i>		
3.37	For how long before death did _____ have belly pain?	1. ___ hours <i>Enter 99 if unknown</i> 2. ___ days <i>Enter 99 if unknown</i> 3. ___ months	

		<p><i>Enter 99 if unknown</i></p> <p>8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/>
3.38	Was the pain in the upper or lower belly?	<p>1. Upper belly 2. Lower belly 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.39	Did _____ have a more than usual protruding belly?	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 3.42</i>			
3.40	For how long before death did _____ have a protruding belly?	<p>1. ___ ___ days <i>Enter 99 if unknown</i></p> <p>2. ___ ___ months <i>Enter 99 if unknown</i></p> <p>8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/>
3.41	How rapidly did _____ develop the protruding belly?	<p>1. Rapidly 2. Slowly 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.42	Did _____ have any mass in the belly?	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Refused to answer" or "Don't know", go to question 3.44</i>			
3.43	For how long before death did _____ have a mass in the belly?	<p>1. ___ ___ days <i>Enter 99 if unknown</i></p> <p>2. ___ ___ months <i>Enter 99 if unknown</i></p> <p>8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/>
3.44	Did _____ have a stiff neck?	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Refused to answer" or "Don't know" go to question 3.46</i>			
3.45	For how long before death did _____ have stiff neck	1. ___ ___ days	

		<p><i>Enter 99 if unknown</i></p> <p>2. ___ months <i>Enter 99 if unknown</i></p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/>
3.46	Did _____ experience a period of loss of consciousness?	<p>1. Yes</p> <p>2. No</p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Refused to answer" or "Don't know" go to question 3.49</i>			
3.47	Did the period of loss of consciousness start suddenly or slowly?	<p>1. Suddenly</p> <p>2. Slowly</p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.48	Did it continue until death?	<p>1. Yes</p> <p>2. No</p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.49	Did _____ have convulsions? <i>(Demonstrate)</i>	<p>1. Yes</p> <p>2. No</p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Refused to answer" or "Don't know" go to question 3.52</i>			
3.50	For how long before death did the convulsions last?	<p>1. ___ minutes <i>Enter 99 if unknown</i></p> <p>2. ___ hours <i>Enter 99 if unknown</i></p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/>
3.51	Did the person become unconscious immediately after the convulsions?	<p>1. Yes</p> <p>2. No</p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.52	Was _____ in any way paralyzed?	<p>1. Yes</p> <p>2. No</p> <p>8. Refused to answer</p> <p>9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Refused to answer" or "Don't know", if the deceased was female, then go to section 4: Questions for Women; if the deceased was male, then go to section 5: Tobacco Use.</i>			

3.53	<p>Which were the limbs or body parts paralyzed?</p> <p><i>Read through the list in sequence and MARK ALL THAT APPLY</i></p>	<p>1. Right side (arm and leg) 2. Left side (arm and leg) 3. Lower part of the body 4. Upper part of the body 5. One leg only 6. One arm only 7. Whole body 11. Other (specify _____) 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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If the deceased was female, then continue to Section 4: Questions for Women.

If the deceased was male, then go to Section 5: Tobacco Use

SECTION 4: QUESTIONS FOR WOMEN

4.1	<p>Did _____ have any swelling or lump in the breast?</p>	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.2	<p>Did _____ have any ulcers (pits) in the breast? <i>Show photo</i></p>	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p><i>Refer to General Module Question 3.9: last known age of the deceased</i> <i>If the decedent is under 18 years old go to question 4.3</i> <i>If the decedent is 18-39 years old go to question 4.6</i> <i>If the decedent is over 40 years old go to question 4.4</i></p>			
4.3	<p>Did _____ ever have a period or menstruate?</p>	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p><i>If "Yes", "Don't know" or "Refused to answer" skip to 4.6</i> <i>If "No" skip to Section 5: Tobacco Use</i></p>			
4.4	<p>Had _____'s periods stopped naturally because of menopause?</p>	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p><i>If "No" skip to 4.6</i></p>			
4.5	<p>Did _____ have vaginal bleeding after cessation of menstruation? (post-menopausal)</p>	<p>1. Yes 2. No 8. Refused to answer 9. Don't know</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	<i>Skip to Section 5: Tobacco Use</i>		
4.6	Did _____ have vaginal bleeding other than her period? (intermenstrual)	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.7	Was there excessive vaginal bleeding in the week prior to death?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.8	At the time of death was her period overdue?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Refused to answer" or "Don't know" go to question 4.10</i>			
4.9	For how many weeks was her period overdue?	1. ____ weeks <i>Enter 99 if unknown</i> 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
4.10	Did she have a sharp pain in the belly shortly before death?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.11	Was she pregnant at the time of death?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Refused to answer" or "Don't know", question 4.18</i>			
4.12	For how many months was she pregnant?	1. ____ months <i>Enter 99 if unknown</i> 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
4.13	Did _____ die during an abortion?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	<i>If "Yes", skip to 4.20</i>		
4.14	Did bleeding occur while she was pregnant?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.15	Did she have excessive bleeding during labour or delivery?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.16	Did she die during labor or delivery? <i>("Labor" is the period of time by which contractions are less than 10 minutes apart.)</i>	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.17	For how long was she in labor?	1. ___ hours <i>Enter 99 if unknown</i> 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>
	<i>If answer to 4.16 is "Yes", skip to Section 5: Tobacco Use</i>		
4.18	Did she die within 6 weeks of having an abortion?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "Yes", skip to 4.20</i>		
4.19	Did she die within 6 weeks of childbirth?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Refused to answer" or "Don't know", skip to Section 5: Tobacco Use</i>		
4.20	Did she have excessive bleeding after delivery or abortion?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

SECTION 5: TOBACCO USE

5.1	Did _____ use tobacco?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Refused to answer" or "Don't know" go to Section 6: Health Records</i>		
5.2	What kind of tobacco did _____ use?	1. Cigarettes 2. Pipe 3. Chewing Tobacco	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

		4. Local form of Tobacco 5. Other (specify _____) 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "Yes" to cigarettes, continue to 5.3. If "No" to cigarettes, go to Section 6: Health Records</i>			
5.3	How many cigarettes did _____ smoke daily?	1. Number ____ ____ 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/>

SECTION 6: HEALTH RECORDS

6.1	Was care sought outside the home while the deceased had this illness?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 6.4</i>			
6.2	Where or from whom did you seek care? (CHECK ALL THAT APPLY)	1. Traditional Healer 2. Homeopath 3. Religious leader 4. Government Hospital 5. Governmental health center or clinic 6. Private Hospital 7. Community-based practitioner associated with health system 8. Trained birth attendant 9. Private physician 10. Pharmacy, drug seller, store, market 11. Other provider 12. Relative, friend (outside household) 88. Refused to answer 99. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6.3	<i>Record the name and address of the hospital, health center or clinic where the care was sought. :</i>		
6.4	Did a health care worker tell you the cause of death?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>If "No" or "Don't know" or "Refused to answer" go to 6.6</i>			
6.5	What did the health care worker say?		
6.6	Do you have any health records that belonged to the deceased?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	<i>If "No" or "Don't know" or "Refused to answer" go to 6.11</i>		
6.7	Can I see the health records?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Don't know" or "Refused to answer" go to 6.11. If "Yes", and respondent allows you to see the records, transcribe entries below</i>		
6.8	Record the dates of the two most recent visits from the health record <i>If not listed, mark 9999</i>	1. __/__/____ dd mm yyyy 2. __/__/____ dd mm yyyy	
6.9	Record the date of the last note <i>Enter 9999 if unknown</i>	__/__/____ dd mm yyyy	
6.10	<i>Transcribe the note:</i>		
6.11	Was a death certificate issued?	1. Yes 2. No 8. Refused to answer 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" or "Don't know" or "Refused to answer" go to Section 7: Open Ended Response</i>		
6.12	Can I see the death certificate?	1. Yes 2. No 8. Refused to answer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<i>If "No" go to Section 7: Open Ended Response</i>		
6.13	<i>Record the immediate cause of death from the certificate.</i>		
6.14	<i>Record the first underlying cause of death from the certificate.</i>		

6.15	<i>Record the second underlying cause of death from the certificate.</i>		
6.16	<i>Record the third underlying cause of death from the certificate.</i>		
6.17	<i>Record the contributing cause(s) of death from the certificate.</i>		
END OF HEALTH RECORDS SECTION GO TO SECTION 7: OPEN ENDED RESPONSE AND INTERVIEWER COMMENTS/OBSERVATIONS			

Section 7: Open Ended Response and Interviewer Comments/Observations Section

Instructions to the interviewer: Say to the respondent: "Thank you for the patient responses to this exhaustive set of questions. Could you please summarize, or tell us in your own words, any additional information about the illness and/or death of your loved one?"

To the interviewer: Listen to what the respondent tells you in his/her own words. Do not prompt except for asking whether there was anything else after the respondent finishes. If the respondent mentions any of the following words, mark "mentioned". Tell the respondent to stop and start again if they mention a word of interest, so you have time to mark it down.

Adult Checklist

	Key words	Mentioned
7.1	Chronic Kidney Disease	<input type="checkbox"/>
	Dialysis	<input type="checkbox"/>
	Fever	<input type="checkbox"/>
	Heart Attack (AMI)	<input type="checkbox"/>
	Heart Problems	<input type="checkbox"/>
	Jaundice	<input type="checkbox"/>
	Liver Failure	<input type="checkbox"/>
	Malaria	<input type="checkbox"/>
	Pneumonia	<input type="checkbox"/>
	Renal (Kidney) Failure	<input type="checkbox"/>
	Suicide	<input type="checkbox"/>
	7.2	Confirm that no words of interest were used during the open response.

**END OF INTERVIEW.
THANK RESPONDENT FOR PARTICIPATION**

MODIFIED KUPPU SWAMI SCALE

1	Education	Professional Degree	7	<input type="checkbox"/>
		Graduate or Post graduate	6	
		Intermediate or diploma	5	
		High school (9 to 10)	4	
		Middle school (6 to 8)	3	
		Primary school or literate (1 to 5)	2	
		illiterate	1	
2	Occupation	Professional	10	<input type="checkbox"/>
		Semi professional	6	
		Clerical, shop owner/farm	5	
		Skilled worker	4	
		Semi-skilled worker	3	
		Unskilled worker	2	
		Unemployed	1	
3	Income	≥52,734	12	Income in INR/ month <input type="checkbox"/>
		26,355-52,734	10	
		19,759-26,355	6	
		13,161-19,759	4	
		7887-13,161	3	
		2,641-7,886	2	
		≤2,641	1	

