

SOCIAL AUTOPSY TOOL FOR NEWBORN DEATHS (0-28 DAYS) AN INDEPTH TOOL

OPEN HISTORY QUESTION

Instructions to interviewer - Allow the respondent to tell you about the illness in his or her own words. Do not prompt except for asking whether there was anything else after the respondent finishes. Keep prompting until the respondent says there was nothing else. While recording, underline any unfamiliar terms.

PROBE FOR:

Recognition in the home (*first symptoms recognised, other symptoms, when did they realise it was severe, who recognized the first and severe symptoms*)

Timing (*how long it took from first symptoms to realising it was severe*)

Actions taken in home and outside the home (*how long after first symptom and severe symptoms, what actions, what treatment, who made the decision, reason for this action, if not going outside for care – why?*)

Provider behaviour (*advice given, treatment given, referral, referral experience, timing of referral, reasons for not going or delaying referral*)

ASK :

Could you tell me about the illness that led to the child's death?

Is there anything that you or anyone else could have done differently to prevent this death? Why?

1. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS			
1.1. DID THE MOTHER RECEIVE ANTENATAL CARE?	YES1 NO2 DON'T KNOW8	→1.4 →1.4	ANC
1.2. HOW MANY TIMES DID THE MOTHER ATTEND ANC?	TIMES <input type="text"/> <input type="text"/> DON'T KNOW99		TANC
1.3. HOW OLD WAS THE PREGNANCY AT THE FIRST ANC VISIT?	WEEKS <input type="text"/> <input type="text"/> MONTHS <input type="text"/> <input type="text"/> DON'T KNOW99		OANC
1.4. DID THE MOTHER TAKE ANY MALARIA PROPHYLAXIS DURING THE PREGNANCY (IPTP)?	YES1 NO2 DON'T KNOW99		IPTP
1.5. DID THE MOTHER SLEEP UNDER A BED NET DURING THE PREGNANCY?	YES1 NO2 DON'T KNOW99		MBED
1.6. WAS THE MOTHER TESTED FOR HIV?	YES1 NO2 DON'T KNOW99		HIVT
1.7. WAS THE MOTHER GIVEN FOLATE AND IRON SUPPLEMENTS?	YES1 NO2 DON'T KNOW99		FOLIR
1.8. WAS THE MOTHER GIVEN DEWORMING TABLETS?	YES1 NO2 DON'T KNOW99		WORM
1.9. DID THE BABY SLEEP UNDER A BED NET?	YES1 NO2 DON'T KNOW99		BBED
1.10. HOW SOON AFTER LABOUR STARTED DID THE MOTHER REACH DELIVERY CARE?	HOURS <input type="text"/> <input type="text"/> DON'T KNOW99		REACH
1.11. WHAT MATERIAL WAS USED FOR CUTTING THE CORD?	NEW RAZOR BLADE1 USED RAZOR BLADE2 SCISSORS3 OTHER (SPECIFY)4 DON'T KNOW99		CCORD
1.12. WHAT MATERIAL WAS USED FOR TYING THE CORD?	CLEAN PIECE OF THREAD1 UNCLEAN PIECE OF THREAD2 CORD CLAMP3 OTHER (SPECIFY)4 DON'T KNOW99		TCORD
1.13. ON WHAT SURFACE DID THE MOTHER DELIVER?	MATRASS1 FLOOR WITH MACKINTOSH/COVER2 DIRECTLY ON THE FLOOR3 OTHER (SPECIFY)4 DON'T KNOW99		SURF
1.14. DID THE BIRTH ATTENDANT USE GLOVES?	YES1 NO2 DON'T KNOW99		GLOV
1.15. DID THE BIRTH ATTENDANT WASH HIS/HER HANDS?	YES1 NO2 DON'T KNOW99		WASH

1.16. DID THE BIRTH ATTENDANT CLEAN THE PERINEUM OF THE MOTHER?	YES.....1 NO.....2 DON'T KNOW.....99		PERI
1.17. HOW WAS THE BABY CLEANED ON THE FIRST DAY AFTER BIRTH?	BATHING WITH COLD WATER.....1 BATHING WITH WARM WATER.....2 WIPING WITH FABRIC.....3 NOT CLEANED.....4 OTHER (SPECIFY).....5 DON'T KNOW.....99		CLEAN
1.18. HOW WAS THE BABY KEPT WARM ON THE FIRST DAY AFTER BIRTH?	WRAPPING.....1 SKIN-TO-SKIN.....2 INCUBATOR.....3 OTHER (SPECIFY).....4 DON'T KNOW.....99		WARM
1.19. WAS THE CHILD EVER BREASTFED?	YES.....1 NO.....2 DON'T KNOW.....99	→1.22 →1.22	BFED
1.20. HOW SOON AFTER BIRTH WAS BREAST FEEDING INITIATED?	HOURS..... <input type="text"/> <input type="text"/> DON'T KNOW.....99		HBFE
1.21. WAS ANY OTHER FEEDS ADMINISTERED BEFORE BREAST MILK FLOW STARTED?	YES (SPECIFY).....1 NO.....2 DON'T KNOW.....99		OFEED
1.22. HOW SOON AFTER BIRTH WAS THE BABY DISCHARGED?	HOURS..... <input type="text"/> <input type="text"/> DAYS..... <input type="text"/> <input type="text"/> DON'T KNOW.....99		BDIS
1.23. WAS THE BABY EXAMINED BY A HEALTH WORKER PRIOR TO DISCHARGE?	YES.....1 NO.....2 DON'T KNOW.....99		BEXAM
1.24. DID YOU RECEIVE ANY COUNSELLING BY A HEALTH WORKER PRIOR TO DISCHARGE?	YES.....1 NO.....2 DON'T KNOW.....99		COUNS
1.25. WHAT WERE YOU COUNSELLED ON?	BREAST FEEDING.....1 IMMUNIZATION.....2 POST-NATAL CARE ATTENDANCE.....3 DANGER SIGNS.....4 OTHER (SPECIFY).....5 DON'T KNOW.....99		COUND
1.26. WAS THE CHILD GIVEN ANY OF THE FOLLOWING VACCINES IN THE FIRST WEEK OF LIFE?	BCG (TB).....1 OPV (POLIO).....2 DON'T KNOW.....99		VACC
1.27. WAS THE MOTHER GIVEN ANY VITAMIN A JUST BEFORE OR AFTER DELIVERY?	YES.....1 NO.....2 DON'T KNOW.....99		VITA
1.28. WHEN DID THE BABY FIRST COME IN CONTACT WITH A HEALTH FACILITY?	DAYS..... <input type="text"/> <input type="text"/> DON'T KNOW.....99		CONT
1.29. SYMPTOMS IN CHRONOLOGICAL ORDER (DAYS AFTER BIRTH)	SYMPTOM 1: _____ 2: _____ 3: _____ 4: _____ 5: _____	DAY AFTER BIRTH DAY: DAY: DAY: DAY: DAY:	S1/D1 S2/D2 S3/D3 S4/D4 S5/D5
1.30. HOW LONG AFTER YOU RECOGNISED THE FIRST SYMPTOM DID THE BABY DIE?	DAYS..... <input type="text"/> <input type="text"/> DON'T KNOW.....99		DITI

1.31. DID S/HE RECEIVE ANY TREATMENT BEFORE S/HE DIED?	YES.....1 NO.....2 DONT KNOW.....99	→1.33 →END	ANYT
1.32. WHY DID THE BABY NOT RECEIVE ANY TREATMENT?	_____ _____ _____	→END	NTRE
1.33. HOW WAS S/HE TREATED AT HOME?	NO HOME TREATMENT.....1 WITH DRUGS.....2 WITH HERBS.....3 OTHER (SPECIFY).....4 DONT KNOW.....99	→1.36 →1.36	HOTR
1.34. WHAT TYPE OF TREATMENT WAS GIVEN TO THE BABY?	MALARIA DRUG (SPECIFY).....1 ANTIBIOTIC (SPECIFY).....2 PARACETAMOL.....3 OTHER (SPECIFY).....4 DONT KNOW.....99		TYTRH
1.35. HOW MUCH TIME AFTER ILLNESS STARTED WAS CARE INITIALIZED AT HOME?	DAYS..... <input type="text"/> <input type="text"/> DONT KNOW.....99		DCAH
1.36. WAS THE BABY BROUGHT OUTSIDE THE HOME FOR CARE WHILE SHE HAD THIS ILLNESS?	YES.....1 NO.....2 DONT KNOW.....99	→1.38 →1.52	CSLOC
1.37. WHY DID YOU NOT TAKE THE CHILD FOR OUTSIDE CARE?	_____ _____ _____	→1.52	NOUT
1.38. ON WHICH DAY AFTER BIRTH WAS THE BABY BROUGHT OUTSIDE THE HOME FOR CARE?	DAYS..... <input type="text"/> <input type="text"/> DONT KNOW.....99		DCARS
1.39. WHERE DID YOU GO TO SEEK TREATMENT? (CIRCLE ALL THAT APPLY – PROBE BY SAYING “ANYWHERE ELSE”)	HOSPITAL.....1 HEALTH CENTRE.....2 PRIVATE CLINIC.....3 DRUG SHOP.....4 TRADITIONAL HEALER.....5 OTHER (SPECIFY).....6 DONT KNOW.....99		WHITR
1.40. CARE SOUGHT IN CHRONOLOGICAL ORDER			
TYPE OF PROVIDER: 1: _____ 2: _____ 3: _____ 4: _____	WHEN? DAY: _____ DAY: _____ DAY: _____ DAY: _____	FACILITY NAME: _____ _____ _____	VILLAGE: _____ _____ _____
		DISTRICT: _____ _____ _____	P1/W1 P2/W2 P3/W3 P4/W4
1.41. HOW DID YOU TAKE THE BABY TO THE FIRST AND LAST CARE PROVIDER?	PRIVATE CAR.....1 BICYCLE.....2 MOTORCYCLE.....3 TAXI.....4 ON FOOT.....5 OTHER (SPECIFY).....6 DONT KNOW.....99	1ST SOURCE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	LAST SOURCE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1.43. HOW MUCH TIME DID IT TAKE TO GO TO THE FIRST AND LAST PROVIDER?	HOURS.....1 DONT KNOW.....99	<input type="text"/> <input type="text"/> <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="checkbox"/>
			TIPR1 TIPR2

1.44. WHAT KIND OF TREATMENT WAS GIVEN TO THE BABY AT THE FIRST AND LAST CARE PROVIDER?	TABLETS (SPECIFY)1 <input type="checkbox"/> <input type="checkbox"/> SYRUP (SPECIFY)2 <input type="checkbox"/> <input type="checkbox"/> BLOOD TRANSFUSION3 <input type="checkbox"/> <input type="checkbox"/> IV FLUID/ORS/INJECTION4 <input type="checkbox"/> <input type="checkbox"/> OXYGEN5 <input type="checkbox"/> <input type="checkbox"/> NO TREATMENT6 <input type="checkbox"/> <input type="checkbox"/> OTHER (SPECIFY)7 <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW99 <input type="checkbox"/> <input type="checkbox"/>		TRE1 TRE2
1.45. HOW LONG AFTER YOU ARRIVED AT THE CARE PROVIDER WAS TREATMENT OBTAINED?	IMMEDIATELY1 <input type="checkbox"/> <input type="checkbox"/> HOURS2 <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW99 <input type="checkbox"/> <input type="checkbox"/>		TITRE1 TITRE2
1.46. DID YOU HAVE TO PAY FOR THE TREATMENT THAT WAS GIVEN TO YOU?	YES1 NO2 DON'T KNOW99		PATRE
1.47. WAS THE BABY EVER HOSPITALIZED DURING THE FINAL ILLNESS?	YES1 NO2 DON'T KNOW99		HOSPI
1.48. WAS THE BABY EVER REFERRED TO ANOTHER PLACE OF CARE DURING THE FINAL ILLNESS?	YES1 NO2 DON'T KNOW99	→1.52 →1.52	REF
1.49. WHERE DID THE PROVIDER TELL YOU TO TAKE THE BABY FOR REFERRAL?	HOSPITAL1 HEALTH CENTRE2 PRIVATE CLINIC3 DRUG SHOP4 TRADITIONAL HEALER5 OTHER (SPECIFY)6 DON'T KNOW99		WHRE
1.50. WHAT WAS THE REASON FOR THE REFERRAL?	LACK OF EQUIPMENT1 FOR BETTER CARE2 LACK OF BLOOD3 LACK OF DRUGS4 LACK OF OXYGEN5 OTHER (SPECIFY)6 DON'T KNOW99		RERE
1.51. WAS THE BABY TAKEN TO THE PLACE WHERE SHE/HE WAS REFERRED?	YES1 NO2 DON'T KNOW99	→1.52	TARE
1.52. WHY DID YOU NOT TAKE THE BABY FOR REFERRAL CARE?	CHILD DIED BEFORE REACHING1 THOUGHT IT WASN'T NECESSARY2 HOPED/WAITED FOR IMPROVEMENT3 LACK OF MONEY4 LACK OF TRANSPORT5 OTHER (SPECIFY)6 DON'T KNOW99		REFNO
1.53. HOW MUCH DID YOU PAY FOR TRANSPORT DURING THE FINAL ILLNESS EPISODE?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> UGS		COSTR
1.54. HOW MUCH DID YOU PAY FOR TREATMENT AND OTHER COSTS RELATED TO CARE OF THE BABY (INCL. FEES FOR ADMISSION, CONSULTATION, LAB TESTS, CONSUMABLES ETC)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> UGS		COSTP
1.55. HOW MUCH DID YOU PAY FOR OTHER COSTS (INCL. ACCOMODATION, FEEDING ETC)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> UGS		COSTO