

Study Inclusion / Cohort Assignment: C1

Study ID

(C1-XXXXX-X)

Study ID should begin with "C1-", and be in the format "C1-XXXXX-X".
Please review and correct the ID for this participant.

Research Team

Name of RA?

- ☐ Anthony Chesang
- ☐ Caroline Kerich
- ☐ Benedine Kokwon
- ☐ Winnie Matelong
- ☐ Anthoney Opon
- ☐ Washington Rotich
- ☐ Marsha Alera
- ☐ Fred Kaemba
- ☐ Gladys Jeptoo
- ☐ Calvin Oginga
- ☐ Lindah Muli
- ☐ Justine Kipsang

Date of screening for C1?

Inclusion Criteria (all must be YES to be eligible)

Is the woman currently pregnant?

- ☐ Yes
- ☐ No

Has the woman enrolled in ANC at the study site?

- ☐ Yes
- ☐ No

Does the woman understand English or Swahili?

- ☐ Yes
- ☐ No

Comments on inclusion criteria:

Exclusion Criteria (all must be NO to be eligible)

Does the woman have any physical or mental disability that prevents her from giving informed consent?

- ☐ Yes
- ☐ No

Does the woman plan to transfer out?

- ☐ Yes
- ☐ No

Additional comments on exclusion criteria:

Based on the responses above, this woman is ELIGIBLE for study enrollment.

Based on the responses above, this woman is INELIGIBLE for enrollment.
DO NOT PROCEED PAST THIS FORM

Consent

Date of Consent?

Does the woman consent to be in the study?

- ☐ Yes
☐ No

Reason for refusal to consent:

Does the woman consent to PHONE / Text follow-up?

- ☐ Yes
☐ No

Does the woman consent to HOME / Field follow-up?

- ☐ Yes
☐ No

Does the woman consent to PICTURES/VIDEOS of the infant to classify any potential birth defect?

- ☐ Yes
☐ No

Does the woman consent for use of her / her baby's data in future research?

- ☐ Yes
☐ No

Does the woman agree to be contacted for future research?

- ☐ Yes
☐ No

Additional Characteristics

What is the woman's age in years?

(Years (Integer Only))

What is the woman's current gestational age in weeks?

(Weeks (Integer Only))

Is this woman HIV positive?

- ☐ Yes, Positive
☐ No, Negative

If HIV Negative, please enter the Study ID of the matched HIV Positive woman:

Consent was refused, DO NOT PROCEED PAST THIS FORM

Delivery Plan

Where does the woman plan to deliver?

☐ MTRH
☐ Home
☐ Not yet decided
☐ Other

If other plan to deliver, please specify:

Repeat Study Enrollments

If this woman has already been enrolled in MANGO C1 previously under a different Study ID, please enter the prior Study ID below:

Prior MANGO C1Study ID:

Identifiers

Identity of Participant (Woman)

Name (First Middle Last)

Date of Birth

Are any parts of the Date of Birth unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

The Date of Birth entered above indicates the woman is < 10 years old, please review and make any corrections necessary

Medical Record Numbers

MFL Number:

ANC Number:

PNC Number:

Hospital Number:

Linda Mama Number:

Other medical record number 1:

Other Medical Record Number (1) Type:

Other medical record number 2:

Other Medical Record Number (2) Type:

Is client known to be HIV positive?

- ☐ Yes
☐ No

The HIV Status recorded above does not match the HIV status indicated on the Study Inclusion/Enrollment Form, please review and make any corrections necessary

AMRS number (HIV+ women only)

CCC number (HIV+ women only):

Comments

Additional Comments

Contact Information

Current Address

County:

- ☐ Uasin Gishu
- ☐ Trans-Nzoia
- ☐ Elgeyo-Marakwet Rift Valley
- ☐ Baringo
- ☐ Bomet
- ☐ Bungoma
- ☐ Busia
- ☐ Embu
- ☐ Garissa
- ☐ Homa Bay
- ☐ Isiolo
- ☐ Kajiado
- ☐ Kakamega
- ☐ Kericho
- ☐ Kiambu
- ☐ Kilifi
- ☐ Kirinyaga
- ☐ Kisii
- ☐ Kisumu
- ☐ Kitui
- ☐ Kwale
- ☐ Laikipia
- ☐ Lamu
- ☐ Machakos
- ☐ Makueni
- ☐ Mandera
- ☐ Marsabit
- ☐ Meru
- ☐ Migori
- ☐ Mombasa
- ☐ Murang'a
- ☐ Nairobi
- ☐ Nakuru
- ☐ Nandi Rift Valley
- ☐ Narok
- ☐ Nyamira
- ☐ Nyandarua
- ☐ Nyeri
- ☐ Samburu
- ☐ Siaya
- ☐ Taita Taveta
- ☐ Tana River
- ☐ Tharaka Nithi
- ☐ Turkana
- ☐ Vihiga
- ☐ Wajir
- ☐ West Pokot

Sub-county:

Please use all caps in response

Ward:

Please use all caps in response

Estate:

Please use all caps in response

Text description of residence location, including nearby landmarks:

Locator Map:

Updated Locator Map (if applicable):

Rural Home Locator Map (if applicable):

Comments on Current Address:

Phone Information

Phone 1:

(9-digit Number Only)

Who does Phone 1 belong to?

- ☐ Woman (Participant)
- ☐ Partner
- ☐ Participant's Parent
- ☐ Child
- ☐ Other

If Other relationship, please specify:

Is there another phone number?

- ☐ Yes
- ☐ No

Phone 2:

(9-digit Number Only)

Who does Phone 2 belong to?

- ☐ Woman (Participant)
- ☐ Partner
- ☐ Participant's Parent
- ☐ Child
- ☐ Other

If Other relationship, please specify:

Is there another phone number?

- ☐ Yes
- ☐ No

Phone 3:

(9-digit Number Only)

Who does Phone 3 belong to?	<input type="radio"/> Woman (Participant) <input type="radio"/> Partner <input type="radio"/> Participant's Parent <input type="radio"/> Child <input type="radio"/> Other
-----------------------------	--

If Other relationship, please specify:	<div></div>
--	-------------

Preferred method(s) of communication? Please select all that apply	<input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message
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If someone else other than you answers the phone, can we leave a message with whoever answers the phone?	<input type="radio"/> Yes <input type="radio"/> No
--	---

Comments:	<div></div>
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SUB-STUDY ENROLLMENT

Is this participant co-enrolled in a MANGO sub-study?

- ☐ Yes
☐ No
☐ Approached but not enrolled

Sub-study participant is enrolled in:

- ☐ JOZI
☐ Tabiri / DAPP

Date of consent and enrollment in sub-study:

(DD-MM-YYYY)

Comments:

Demographics

Demographics

Relationship status at enrollment in ANC at the study site?

- ☐ Single
☐ Cohabiting / Married
☐ Separated / Divorced
☐ Widowed

Employment status at enrollment in ANC at the study site?

- ☐ Employed
☐ Self-employed
☐ Casual worker
☐ Farmer
☐ Student
☐ Other
☐ Not Employed

If other employment status, please specify:

Highest level of education completed?

- ☐ None
☐ Primary
☐ Secondary
☐ Tertiary

Total number of people living in the household (other than the participant) at enrollment in ANC at the study site?

- ☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 or more

Partner HIV status (for all women)

Is your partner (i.e. the father of the baby) HIV positive?

- ☐ He is positive
☐ He is negative
☐ Do not know

Have you disclosed your HIV status to anyone?

- ☐ Yes
☐ No

Have you disclosed your HIV status to your partner?

- ☐ Yes
☐ No

Comments

Additional Comments:

Past Medical History

History of any of the following obstetric or newborn conditions?

- ☐ None
- ☐ C-section
- ☐ Preterm delivery (≤ 36 weeks)
- ☐ Stillbirth (fresh or macerated)
- ☐ Neonatal death (≤ 28 days after birth)
- ☐ Infant with a neural tube defect
- ☐ Infant with any birth defect
- ☐ Other adverse birth outcome

If birth defect, please specify:

If adverse birth outcome, please specify:

History of any of the following non-communicable diseases?

- ☐ None
- ☐ Anaemia
- ☐ Asthma
- ☐ Breast lump
- ☐ Diabetes
- ☐ Fibroids
- ☐ High blood pressure (includes hypertension, gestational hypertension, and pregnancy induced hypertension)
- ☐ Pre-eclampsia or eclampsia
- ☐ Warts, genital warts, or vulvar warts
- ☐ Other NCD

Date of diagnosis of Anemia?

Are any parts of the Date of diagnosis of Anemia unknown?

- ☐ No, Date is Exact
- ☐ Day is Unknown
- ☐ Month is Unknown
- ☐ Day and Month are Unknown

Date of diagnosis of Asthma?

Are any parts of the Date of diagnosis of Asthma unknown?

- ☐ No, Date is Exact
- ☐ Day is Unknown
- ☐ Month is Unknown
- ☐ Day and Month are Unknown

Date of diagnosis of Breast lump?

Are any parts of the Date of diagnosis of Breast lump unknown?

- ☐ No, Date is Exact
- ☐ Day is Unknown
- ☐ Month is Unknown
- ☐ Day and Month are Unknown

Date of diagnosis of Diabetes?

Are any parts of the Date of diagnosis of Diabetes unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Fibroids?

Are any parts of the Date of diagnosis of Fibroids unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of High blood pressure?

Are any parts of the Date of diagnosis of High blood pressure unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Pre-eclampsia or eclampsia?

Are any parts of the Date of diagnosis of Pre-eclampsia or eclampsia unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Warts?

Are any parts of the Date of diagnosis of Warts unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

If Other non-communicable disease(s), please specify:

Date of diagnosis of Other NCDs?

Are any parts of the Date of diagnosis of Other NCD unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

History of any of the following communicable diseases?

- ☐ None
☐ Abscess
☐ Candida/Candidiasis
☐ Cervicitis/STD/Vaginal Discharge Syndrome (VDS)
☐ Covid-19
☐ Herpes (HSV)
☐ Malaria
☐ PID (pelvic inflammatory disease)
☐ Pneumonia
☐ Rubella
☐ Syphilis
☐ Toxoplasmosis
☐ Tuberculosis
☐ Varicella (chicken pox or zoster)
☐ Other Communicable Disease
-

Date of diagnosis of Abscess?

Are any parts of the Date of diagnosis of Abscess unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Candida/Candidiasis?

Are any parts of the Date of diagnosis of Candida/Candidiasis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Cervicitis/STD/VDS?

Are any parts of the Date of diagnosis of Cervicitis/STD/VDS unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Covid-19?

Are any parts of the Date of diagnosis of Covid-19 unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of HSV?

Are any parts of the Date of diagnosis of HSV unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Malaria?

Are any parts of the Date of diagnosis of Malaria unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of PID?

Are any parts of the Date of diagnosis of PID unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Pneumonia?

Are any parts of the Date of diagnosis of Pneumonia unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Rubella?

Are any parts of the Date of diagnosis of Rubella unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Syphilis?

Are any parts of the Date of diagnosis of Syphilis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Toxoplasmosis?

Are any parts of the Date of diagnosis of Toxoplasmosis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Tuberculosis?

Are any parts of the Date of diagnosis of Tuberculosis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Varicella?

Are any parts of the Date of diagnosis of Varicella unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

If Other communicable disease(s), please specify:

Date of diagnosis of Other communicable disease(s)?

Are any parts of the Date of diagnosis of Other communicable disease unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Family history of any of the following conditions?
(includes other biologically related individuals except infants born to the woman/participant)

- ☐ None
☐ Infant with a neural tube defect
☐ Infant with any birth defect
☐ Other adverse birth outcome

If birth defect, please specify:

If adverse birth outcome, please specify:

Is the woman (participant) related to the father of the baby
(i.e. consanguineous; second cousin or closer)?

- ☐ Yes
☐ No

Comments

Additional Comments:

Current Pregnancy History

Obstetric Data (in relation to current pregnancy)

Gravida?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ >=10

Para?

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ >=10

Last menstrual period (LMP)?

Are any parts of the Date of LMP unknown?

☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Estimated date of delivery (EDD)?

The Estimated Date of Delivery entered above is prior to the Date of Enrollment or greater than 9 months from enrollment, please review and make any corrections necessary

Are any parts of the Date of EDD unknown?

☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Transfer History

Did the woman transfer in from another facility during pregnancy?

☐ Yes
☐ No

What was the reason for transferring in?
Select all that apply

- ☐ Referred for management of complications during pregnancy or delivery, specify
☐ Change of residence
☐ Other reason, specify

If other reason, please specify?

Specify Complication(s):
Please select all that apply

- ☐ Primigravid and age >30
- ☐ Primigravid (age not >30)
- ☐ Age < 18
- ☐ Age >35
- ☐ Hypertension, Pre-eclampsia or Eclampsia (High BP, high blood pressure, elevated BP, PIH, Pregnancy Induced Hypertension, gestational hypertension)
- ☐ Scheduled C-section
- ☐ Prior C-section
- ☐ Other medical problem with the mother (such as heart problem, kidney problem, etc.)
- ☐ Infection
- ☐ Problem with the baby noted during antenatal care (but NOT a congenital abnormality)
- ☐ Congenital abnormality of infant noted during antenatal care
- ☐ Concern for the baby (fetal distress)
- ☐ PPROM (Preterm Premature rupture of membranes)
- ☐ PROM/SROM
- ☐ Premature Labor
- ☐ Anemia
- ☐ Antepartum hemorrhage (APH)/PV bleeding
- ☐ Bad Obstetric History (BOH)
- ☐ IUFD (fetal demise)
- ☐ CPD/Big baby (cephalo-pelvic disproportion)
- ☐ Presentation of the baby (e.g breech, footling, transverse)
- ☐ Failed induction
- ☐ Multiparous/grand multip
- ☐ Failure to progress/stalled labor/prolonged labor
- ☐ Placenta previa
- ☐ Twin (or triplet) pregnancy
- ☐ Labor Pains/ for Delivery
- ☐ Unknown
- ☐ Other

If Other reason for referral, please specify:

History of any of the following non-communicable diseases during the current pregnancy?

- ☐ None
- ☐ Anaemia
- ☐ Asthma
- ☐ Breast lump
- ☐ Diabetes
- ☐ Fibroids
- ☐ High blood pressure (includes hypertension, gestational hypertension, and pregnancy induced hypertension)
- ☐ Pre-eclampsia or eclampsia
- ☐ Warts, genital warts, or vulvar warts
- ☐ Rash
- ☐ Other NCD

Date of diagnosis of Anemia?

Are any parts of the Date of diagnosis of Anemia unknown?

- ☐ No, Date is Exact
- ☐ Day is Unknown
- ☐ Month is Unknown
- ☐ Day and Month are Unknown

Date of diagnosis of Asthma?

Are any parts of the Date of diagnosis of Asthma unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Breast lump?

Are any parts of the Date of diagnosis of Breast lump unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Diabetes?

Are any parts of the Date of diagnosis of Diabetes unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Fibroids?

Are any parts of the Date of diagnosis of Fibroids unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of High blood pressure?

Are any parts of the Date of diagnosis of High blood pressure unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Pre-eclampsia or eclampsia?

Are any parts of the Date of diagnosis of Pre-eclampsia or eclampsia unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Warts?

Are any parts of the Date of diagnosis of Warts unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Rash?

Are any parts of the Date of diagnosis of Rash unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

If Other non-communicable disease(s), please specify:

Date of diagnosis of Other non-communicable disease(s)?

Are any parts of the Date of diagnosis of Other NCD unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

History of any of the following communicable diseases during the current pregnancy?

- ☐ None
☐ Abscess
☐ Candida/Candidiasis
☐ Cervicitis/STD/Vaginal Discharge Syndrome (VDS)
☐ Covid-19
☐ Diarrhoea, gastroenteritis
☐ Ear infection
☐ Eye infection
☐ Fever (unknown cause)
☐ Herpes (HSV)
☐ Malaria
☐ PID (pelvic inflammatory disease)
☐ Pneumonia
☐ Rubella
☐ Sore throat/tonsillitis
☐ Syphilis
☐ Toxoplasmosis
☐ Tuberculosis
☐ Urinary track infection (UTI)
☐ Varicella (chicken pox or zoster)
☐ Other communicable disease

Date of diagnosis of Abscess?

Are any parts of the Date of diagnosis of Abscess unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Candida/Candidiasis?

Are any parts of the Date of diagnosis of Candida/Candidiasis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Cervicitis/STD/Vaginal Discharge Syndrome (VDS)?

Are any parts of the Date of diagnosis of Cervicitis/STD/VDS unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Covid-19?

Are any parts of the Date of diagnosis of Covid-19 unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Diarrhoea, gastroenteritis?

Are any parts of the Date of diagnosis of Diarrhoea unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Ear infection?

Are any parts of the Date of diagnosis of Ear infection unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Eye infection?

Are any parts of the Date of diagnosis of Eye infection unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Fever?

Are any parts of the Date of diagnosis of Fever unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Herpes (HSV)?

Are any parts of the Date of diagnosis of HSV unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Malaria?

Are any parts of the Date of diagnosis of Malaria unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of PID?

Are any parts of the Date of diagnosis of PID unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Pneumonia?

Are any parts of the Date of diagnosis of Pneumonia unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Rubella?

Are any parts of the Date of diagnosis of Rubella unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Sore throat/tonsillitis?

Are any parts of the Date of diagnosis of Sore throat/tonsillitis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Syphilis?

Are any parts of the Date of diagnosis of Syphilis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Date of diagnosis of Toxoplasmosis?

Are any parts of the Date of diagnosis of Toxoplasmosis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Tuberculosis?

Are any parts of the Date of diagnosis of Tuberculosis unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Urinary track infection (UTI)?

Are any parts of the Date of diagnosis of UTI unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of diagnosis of Varicella?

Are any parts of the Date of diagnosis of Varicella unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

If Other communicable disease(s), please specify:

Date of diagnosis of Other communicable disease(s)?

Are any parts of the Date of diagnosis of Other communicable disease unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

COVID 19 SUBSTUDY

Is this woman part of the Covid-19 sub-study?

- ☐ Yes
☐ No

Patient Name

Phone Number

Patient Email

National ID number

MTRH Patient Number?

County of residence in the last 14 days?

- ☐ Baringo
- ☐ Bomet
- ☐ Bungoma
- ☐ Busia
- ☐ Elgeyo Marakwet
- ☐ Embu
- ☐ Garissa
- ☐ Homabay
- ☐ Isiolo
- ☐ Kajiado
- ☐ Kakamega
- ☐ Kericho
- ☐ Kiambu
- ☐ Kilifi
- ☐ Kirinyaga
- ☐ Kisii
- ☐ Kisumu
- ☐ Kitui
- ☐ Kwale
- ☐ Laikipia
- ☐ Lamu
- ☐ Machakos
- ☐ Makueni
- ☐ Mandera
- ☐ Marsabit
- ☐ Meru
- ☐ Migori
- ☐ Mombasa
- ☐ Murang'a
- ☐ Nairobi
- ☐ Nakuru
- ☐ Nandi
- ☐ Narok
- ☐ Nyamira
- ☐ Nyandarua
- ☐ Nyeri
- ☐ Samburu
- ☐ Siaya
- ☐ Taita Taveta
- ☐ Tana River
- ☐ Trans Nzoia
- ☐ Tharaka Nithi
- ☐ Turkana
- ☐ Uasin Gishu
- ☐ Vihiga
- ☐ Wajir
- ☐ West Pokot

Sub-County

Village/Estate

Physical home address in the last 14 days since onset of symptoms or presentation to hospital (If asymptomatic)?

Occupation

Work location

How many persons, including children, have lived with the case in the 14 days prior to symptom onset or presentation to hospital (if asymptomatic)?

Number of adults living with case in the last 14 days prior to onset of symptoms or presentation to hospital?

Children aged < 13 years living in the house in the last 14 days?

Next of kin name?

Next of kin contacts?

1.1 Sex at Birth:

- ☐ Male
☐ Female
☐ Not specified

Age/Estimated age Unit

- ☐ Months
☐ Years

1.2 Age/Estimated age

(If patient is a child less than one year age, include age in months)

1.3 Ethnic group (check all that apply)

- ☐ Black
☐ White
☐ Asian
☐ Others

If Other: Specify

1.4 Employed as a healthcare worker?

- ☐ YES
☐ NO
☐ N/A

1.4 Employed in a microbiology laboratory?

- ☐ YES
☐ NO
☐ N/A

1.5 Pregnant ?

- ☐ YES
☐ NO
☐ Unknown
☐ N/A

If YES: Gestational weeks assessment:

(weeks)

1.6 Post Partum	<input type="radio"/> Yes <input type="radio"/> No
1.6.1 Pregnancy Outcome	<input type="radio"/> Live birth <input type="radio"/> Still birth
1.6.2 Delivery date	<input type="text"/>
1.6.3 Baby tested for mother's ARI infection	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
If YES	<input type="radio"/> Positive <input type="radio"/> Negative
1.6.4 Method	<input type="radio"/> PCR <input type="radio"/> Other
If OTHER method; Specify	<input type="text"/>
1.7 INFANT - Less than 1 year old?	<input type="radio"/> Yes <input type="radio"/> No
1.7.1 Birth weight	<input type="text"/>
Birth weight unit	<input type="radio"/> kg <input type="radio"/> lbs
1.7.2 Gestational outcome	<input type="radio"/> Term birth (\geq 37wk GA) <input type="radio"/> Preterm birth (< 37wk GA) <input type="radio"/> N/A
1.7.3 Breastfed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
If YES	<input type="radio"/> Currently breastfed <input type="radio"/> Breastfeeding discontinued <input type="radio"/> N/A
Discontinued breastfeeding at	<input type="text"/> (weeks)
1.7.4 Appropriate development for age?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
1.7.5 Vaccinations appropriate for age/country?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> N/A

Comorbidities present? ☐ Yes
☐ No

5.1 Was pathogen testing done during this illness episode? ☐ YES
☐ NO
☐ N/A

Does the patient have:

5.3 Influenza: ☐ YES - Confirmed
☐ YES - Probable
☐ NO

5.3.1 If Yes ☐ A/H3N2
☐ A/H1N1pdm09
☐ A/H7N9
☐ A/H5N1
☐ A - not typed
☐ B
☐ Other

Other influenza, specify:

5.3 Coronavirus: ☐ YES - Confirmed
☐ YES - Probable
☐ NO

5.3.1 If Yes: ☐ Novel-CoV
☐ MERS-CoV
☐ Other CoV

IF Other coronavirus; Specify:

5.4 RSV ☐ YES - Confirmed
☐ YES - Probable
☐ NO

5.5 Adenovirus ☐ YES - Confirmed
☐ YES - Probable
☐ NO

5.6 Bacteria ☐ YES-Confirmed
☐ NO

5.7 Other Infectious Respiratory Diagnosis: ☐ YES - Confirmed
☐ YES - Probable
☐ NO

If YES: Other infectious respiratory diagnosis, specify:

5.8 Clinical pneumonia: ☐ YES
☐ NO
☐ Unknown

5.9 IF NONE OF THE ABOVE: Suspected Non-infective:

- ☐ Yes
☐ N/A

COVID-19 TESTING

COVID-19 testing done?

- ☐ Yes ☐ No

Laboratory specimen type?

- ☐ Initial
☐ 1st Follow up
☐ 2nd Follow up
☐ Other follow up

Collection Date

Bio specimen type

- ☐ Nasal / NP swab
☐ Throat swab
☐ Combined nasal / NP + throat swab
☐ Sputum
☐ Bronchoalveolar Lavage (BAL)
☐ Exotoxin A (ETA)
☐ Urine
☐ Feces / rectal swab
☐ Blood
☐ Other

If OTHER; Specify

Laboratory Test Method

- ☐ PCR
☐ Culture
☐ Other

If Other Laboratory test method; Specify

Result

- ☐ Positive
☐ Negative
☐ N/A

Pathogen Tested / Detected

Justification

- ☐ Meets case definition
☐ Travel to Country/County with presumed widespread COVID-19
☐ Contact with confirmed case
☐ Basis of MOH guidelines
☐ Basis of Public Health Act
☐ Acute severe respiratory illness
☐ Before medical/surgical procedure
☐ Occupational exposure
☐ Others (specify)

Specify

Specify medical/surgical procedure

HIV Status

Is the woman HIV positive?

☐ Yes
☐ No

The HIV Status recorded above does not match the HIV status indicated on the Enrollment Form, please review and make any corrections necessary

Have you disclosed your HIV status to anyone?

☐ Yes
☐ No

Have you disclosed your HIV status to your partner?

☐ Yes
☐ No

Timing of HIV diagnosis?

☐ Prior to current pregnancy (known positive)
☐ During current pregnancy (new positive)

Was the woman an AMPATH client prior to enrolling in ANC?

☐ Yes
☐ No
☐ Unknown

Date of HIV diagnosis?

Are any parts of the Date of HIV diagnosis unknown?

☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Date of ART Initiation?

Are any parts of the Date of ART initiation unknown?

☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

WHO stage at ART initiation

☐ 1
☐ 2
☐ 3
☐ 4

Lowest CD4 count prior to pregnancy?

Date of lowest CD4 count?

Are any parts of the Date of Lowest CD4 count unknown?

☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Most recent CD4 count?

Date of most recent CD4 count?

Are any parts of the Date of most recent CD4 count unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Most recent HIV viral load result:
If undetectable, enter 0

(copies/mL)

Date of viral load measurement?

Are any parts of the Date of most recent VL measurement unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Current ART regimen:

- ☐ TDF / 3TC / EFV
☐ TDF / 3TC / NVP
☐ TDF / 3TC / LPV/r
☐ TDF / 3TC / ATV/r
☐ TDF / 3TC / DTG
☐ Other

If other regimen, please specify:
Select all antiretroviral drugs that the woman is currently taking

- ☐ abacavir (ABC)
☐ atazanavir (ATV)
☐ darunavir (DRV)
☐ dolutegravir (DTG)
☐ efavirenz (EFV)
☐ etravirine (ETR)
☐ lamivudine (3TC)
☐ lopinavir (LPV)
☐ nevirapine (NVP)
☐ raltegravir (RAL)
☐ tenofovir (TDF)
☐ zidovudine (AZT or ZDV)

Start date of current regimen:

Are any parts of the Start Date of current regimen unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Is this the woman's first ART regimen?

- ☐ Yes
☐ No

What ART regimen was the woman given immediately prior to this regimen?

- ☐ TDF / 3TC / EFV
☐ TDF / 3TC / NVP
☐ TDF / 3TC / LPV/r
☐ TDF / 3TC / ATV/r
☐ TDF / 3TC / DTG
☐ Other

If other regimen, please specify:
Select all antiretroviral drugs that the woman was taking immediately prior to the current regimen

- ☐ abacavir (ABC)
☐ atazanavir (ATV)
☐ darunavir (DRV)
☐ dolutegravir (DTG)
☐ efavirenz (EFV)
☐ etravirine (ETR)
☐ lamivudine (3TC)
☐ lopinavir (LPV)
☐ nevirapine (NVP)
☐ raltegravir (RAL)
☐ tenofovir (TDF)
☐ zidovudine (AZT or ZDV)

Start date of prior ART regimen:

Are any parts of the Start Date of prior regimen unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Reason for regimen switch?

Baseline breastfeeding intention (Msingi wa nia ya kunyonyesha)

How do you intend to feed your baby for the first six months of your baby's life?

Una nia ya kumnyonyesha mtoto vipi kwa muda wa miezi sita baada ya kuzaliwa?

- ☐ Exclusive breastfeeding (Kunyonyesha pekee)
☐ Exclusive formula feeding (Maziwa maalum ya watoto wachanga pekee)
☐ Combination of breastfeeding and formula feeding (Mchanganyiko ya kunyonyesha na maziwa maalum ya watoto wachanga)

1a. How long (months) do you plan to exclusively breastfeed?
(Unapanga kumnyonyesha mtoto (kunyonyesha pekee) kwa muda gani (Miezi)?

- ☐ Less than 1 month (Chini ya mwezi mmoja)
☐ 1 or more months but less than 3 months (Mwezi mmoja ama zaidi lakini chini ya miezi mitatu)
☐ 3 or more months but less than 6 months (Miezi tatu ama zaidi lakini chini ya miezi sita)
☐ 6 or more months but less than 9 months (Miezi sita ama zaidi lakini chini ya miezi tisa)
☐ 9 or more months but less than 12 months (1 year) (Miezi tisa ama zaidi lakini chini ya mwaka mmoja)
☐ 12 or more months but less than 18 months (1.5 years) (Mwaka mmoja ama zaidi lakini chini ya mwaka mmoja na nusu)
☐ 18 or more months but less than 24 months (2 years) (Mwaka mmoja na nusu ama zaidi lakini chini ya miaka miwili)
☐ More than 2 years (Zaidi ya miaka miwili)

1b. How long (months) do you plan to breastfeed?
(Unapanga kumnyonyesha mtoto (kunyonyesha pekee) kwa muda gani (Miezi)?

- ☐ Less than 1 month (Chini ya mwezi mmoja)
- ☐ 1 or more months but less than 3 months (Mwezi mmoja ama zaidi lakini chini ya miezi mitatu)
- ☐ 3 or more months but less than 6 months (Miezi tatu ama zaidi lakini chini ya miezi sita)
- ☐ 6 or more months but less than 9 months (Miezi sita ama zaidi lakini chini ya miezi tisa)
- ☐ 9 or more months but less than 12 months (1 year) (Miezi tisa ama zidi lakini chini ya mwaka mmoja)
- ☐ 12 or more months but less than 18 months (1.5 years) (Mwaka mmoja ama zaidi lakini chini ya mwaka mmoja na nusu)
- ☐ 18 or more months but less than 24 months (2 years) (Mwaka mmoja na nusu ama zaidi lakini chini ya miaka miwili)
- ☐ More than 2 years (Zaidi ya miaka miwili)

Comments

Additional Comments

Exposures

Key Exposures

HIV and PMTCT:
for HIV+ women only

- ☐ None
☐ ART (If YES, enter ART in the Current Pregnancy History form)
☐ CTX prophylaxis

Start Date of ART?

Are any parts of the Date of ART start unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Start Date of CTX Prophylaxis?

Are any parts of the Start Date of CTX unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of CTX Prophylaxis?

Are any parts of the End Date of CTX unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

HIV and PMTCT:
for HIV- women only

- ☐ None
☐ HIV pre-exposure prophylaxis (PrEP)

Start Date of PREP?

Are any parts of the Start Date of PREP unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of PREP?

Are any parts of the End Date of PREP unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

TB:

- ☐ IPT (isoniazid preventive therapy / TB prophylaxis)
☐ TB Treatment
☐ None

Start Date of IPT?

Are any parts of the Start Date of IPT unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

EndDate of IPT?

Are any parts of the End Date of IPT unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Start Date of TB Treatment?

Are any parts of the Start Date of TB Treatment unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of TB Treatment?

Are any parts of the End Date of TB Treatment unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

If Yes to anti-TB medication, please select all that apply:

- ☐ Rifampin (Rif, the "R" in RHZE)
☐ INH (Isoniazid, the "H" in RHZE)
☐ Pyrazinamide (PZA, the "Z" in RHZE)
☐ Ethambutol (the "E" in RHZE)
☐ Streptomycin (this is given as an IV or IM)
☐ Rifabutin
☐ Amikacin
☐ Levofloxacin
☐ Unknown

Vitamins

- ☐ Antenatal vitamin
☐ Folate (folic acid) supplement
☐ Iron supplement
☐ Vitamin C
☐ None

Start Date of Antenatal vitamins?

Are any parts of the Start Date of Antenatal vitamins unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of Antenatal vitamins?

Are any parts of the End Date of Antenatal vitamins unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Start Date of Folate supplement?

Are any parts of the Start Date of Folate supplement unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of Folate supplement?

Are any parts of the End Date of Folate supplement unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Start Date of Iron supplement?

Are any parts of the Start Date of Iron supplement unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of Iron supplement?

Are any parts of the End Date of Iron supplement unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Start Date of Vitamin C?

Are any parts of the Start Date of Vitamin C unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of Vitamin C?

Are any parts of the End Date of Vitamin C unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Anti-infectives

- ☐ Anti-malarial (either for treatment or prevention)
☐ Antibiotic
☐ Deworming
☐ None

Start Date of Anti-malarial?

Are any parts of the Start Date of Anti-malarial unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of Anti-malarial?

Are any parts of the End Date of Anti-malarial unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

If Yes to anti-malarial, please select all that apply:

- ☐ Chloroquine
☐ Atovaquone/Proguanil (Malarone)
☐ Coartem (artemether lumefantrine)
☐ Quinidine
☐ Other

If Other anti-malarial, please specify:

Start Date of Antibiotic?

Are any parts of the Start Date of Antibiotic unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of Antibiotic?

Are any parts of the End Date of Antibiotic unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

If Yes to antibiotic, please select all that apply:

- ☐ Amoxicillin
☐ Ceftriaxone
☐ Cloxacillin
☐ Cotrimoxazole (CTX)
☐ Doxycycline
☐ Erythromycin
☐ Metronidazole
☐ Penicillin
☐ Other

If Other antibiotic, please specify:

Start Date of Deworming medicine?

Are any parts of the Start Date of De-worming medicine unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of Deworming medicine?

Are any parts of the End Date of De-worming medicine unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Deworming medication name(s):

- ☐ Mebendazole
☐ Other

If Other deworming medication, please specify:

Substance Use During Pregnancy:

- ☐ Alcohol
☐ Tobacco
☐ Other illicit drug
☐ None

If other illicit drug, please specify:

(e.g. methamphetamine, cannabis, cocaine, heroin)

Other Therapeutic Exposures During Pregnancy

Other Medication 1:

Start Date of [othermed1]?

Are any parts of the Start Date of [othermed1] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of [othermed1]?

Are any parts of the End Date of [othermed1] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Medication 2:

Start Date of [othermed2]?

Are any parts of the Start Date of [othermed2] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of [othermed2]?

Are any parts of the End Date of [othermed2] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Medication 3:

Start Date of [othermed3]?

Are any parts of the Start Date of [othermed3] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of [othermed3]?

Are any parts of the End Date of [othermed3] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Medication 4:

Start Date of [othermed4]?

Are any parts of the Start Date of [othermed4] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of [othermed4]?

Are any parts of the End Date of [othermed4] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Medication 5:

Start Date of [othermed5]?

Are any parts of the Start Date of [othermed5] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of [othermed5]?

Are any parts of the End Date of [othermed5] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Medication 6:

Start Date of [othermed6]?

Are any parts of the Start Date of [othermed6] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of [othermed6]?

Are any parts of the End Date of [othermed6] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Medication 7:

Start Date of [othermed7]?

Are any parts of the Start Date of [othermed7] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

End Date of [othermed7]?

Are any parts of the End Date of [othermed7] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Medication 8:

Start Date of [othermed8]?

Are any parts of the Start Date of [othermed8] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

End Date of [othermed8]?

Are any parts of the End Date of [othermed8] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Other Medication 9:

Start Date of [othermed9]?

Are any parts of the Start Date of [othermed9] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

End Date of [othermed9]?

Are any parts of the End Date of [othermed9] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

Other Medication 10:

Start Date of [othermed10]?

Are any parts of the Start Date of [othermed10] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown
-

End Date of [othermed10]?

Are any parts of the End Date of [othermed10] unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Other Exposures During Pregnancy

Please specify any other exposures during pregnancy:

Comments

Additional Comments:

ANC Profile

Date of Data Extraction:

Haemoglobin (Hb):

(g/dl (with 1 decimal))

Date of Haemoglobin (Hb):

Are any parts of the Date of Haemoglobin unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Blood Group:

- ☐ A
☐ B
☐ O
☐ AB

Rhesus (Rh):

- ☐ Positive
☐ Negative

Serology (VDRL/RPR)

- ☐ Positive
☐ Negative

Date of Serology (VDRL/RPR):

Are any parts of the Date of Serology unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

HIV Test Result:

- ☐ Positive (reactive)
☐ Negative (non-reactive)
☐ Indeterminate
☐ Not tested
☐ Not applicable (known positive)

Date of HIV test:

Are any parts of the Date of HIV Test unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Couple HIV counselling and testing done:

- ☐ Yes
☐ No

Urine protein result:

- ☐ No urine protein documented
☐ Trace Protein
☐ 1+ Protein
☐ 2+ Protein
☐ 3+ Protein

Date of urine protein:

Are any parts of the Date of Urine Protein unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

Comments

Comments:

Visits

Research Team

Name of RA:

- ☐ Anthony Chesang
- ☐ Caroline Kerich
- ☐ Benedine Kokwon
- ☐ Winnie Matelong
- ☐ Anthoney Opon
- ☐ Washington Rotich
- ☐ Marsha Alera
- ☐ Fred Kaemba
- ☐ Gladys Jeptoo
- ☐ Calvin Oginga
- ☐ Linda Muli
- ☐ Justine Kipsang

Was the woman encountered by the RA on this visit?

- ☐ Yes
- ☐ No

Patient Visits

Date of ANC visit?

ANC clinic name?

- ☐ MTRH
- ☐ Other

If Other, please specify clinic name:

Weight (kg)?

(kg (MUST include 1 decimal))

Haemoglobin (Hb)

((MUST include 1 decimal))

Blood Pressure

Systolic (top) number?

Diastolic (bottom) number?

Date of Next Visit

Date of next scheduled visit:

Return Visit Date is not after current visit date, please review and make any changes necessary

Comments

Additional Comments:

Pregnancy Imaging Results

Research Team

Name of RA:

- ☐ Anthony Chesang
- ☐ Caroline Kerich
- ☐ Benedine Kokwon
- ☐ Winnie Matelong
- ☐ Anthoney Opon
- ☐ Washington Rotich
- ☐ Marsha Alera
- ☐ Fred Kaemba
- ☐ Gladys Jeptoo
- ☐ Calvin Oginga
- ☐ Linda Muli
- ☐ Justine Kipsang

Imaging

Type of Imaging:

- ☐ Ultrasound
- ☐ X ray
- ☐ CT scan
- ☐ ECHO
- ☐ Other
- ☐ None

Please specify other imaging study?

Date of study?

Are any parts of the Date of study unknown?

- ☐ No, Date is Exact
- ☐ Day is Unknown
- ☐ Month is Unknown
- ☐ Day and Month are Unknown

Report Upload:

Please upload file/image of report if available:

Report Upload:

Additional space to upload imaging report

Report Upload:

Additional space to upload imaging report

Comments:

Labor and Delivery

Research Team

Name of RA:

- ☐ Anthony Chesang
- ☐ Caroline Kerich
- ☐ Benedine Kokwon
- ☐ Winnie Matelong
- ☐ Anthoney Opon
- ☐ Washington Rotich
- ☐ Marsha Alera
- ☐ Fred Kaemba
- ☐ Gladys Jeptoo
- ☐ Calvin Oginga
- ☐ Linda Muli
- ☐ Justine Kipsang

Delivery Details

Delivery Location?

- ☐ MTRH
- ☐ Woman's Home
- ☐ Other Location

If Other delivery location, please specify:

Pregnancy Outcome?

- ☐ Live birth
- ☐ Stillbirth (≥ 24 weeks gestation)
- ☐ Miscarriage (< 24 weeks gestation)
- ☐ Termination of Pregnancy
- ☐ Ectopic Pregnancy
- ☐ Molar pregnancy
- ☐ Not pregnant
- ☐ Other

If Other pregnancy outcome, please specify:

Duration of labor?

(hours)

Was labor induced?

- ☐ Yes
- ☐ No

Date of pregnancy outcome?

Time of pregnancy outcome?

Mode of delivery?

- ☐ SVD (spontaneous vaginal delivery)
- ☐ SBD (spontaneous breech delivery)
- ☐ Elective CS (c-section)
- ☐ Emergency CS (c-section)
- ☐ AVD (assisted vaginal delivery)

How many children were delivered?

- ☐ 1
☐ 2 or more

Peripartum HIV testing and treatment

HIV test result

- ☐ Positive (reactive)
☐ Negative (non-reactive)
☐ Indeterminate
☐ Not tested
☐ Not applicable (known positive)

Date of HIV test:

After Delivery

Did the mother receive IV zidovudine (AZT) during labor (HIV+ women only)?

- ☐ Yes
☐ No

Blood Loss (mls)?

_____ (mls)

Other delivery complications?

Umbilical cord appearance?

- ☐ Normal
☐ Abnormal

Umbilical cord comments:

Placenta appearance?

- ☐ Normal
☐ Abnormal

Placenta comments:

Peripartum complications:
Please select all that apply

* Note: enter conditions diagnosed during pregnancy under the Current Pregnancy History section and not in this field

- ☐ Gestational hypertension
☐ Pre-eclampsia (PET)
☐ Eclampsia
☐ Antepartum hemorrhage (APH)
☐ Postpartum hemorrhage (PPH)
☐ Prolonged labor
☐ Cardiomyopathy / Cardiac disease
☐ Psychosis
☐ Puerperal sepsis, Endometritis or Postpartum metritis
☐ None of the above

Mother alive at discharge?

- ☐ Yes
☐ No

If mother not alive, please enter date of death:

If mother not alive, please enter cause of death:

Comments

Additional Comments

Phone Contact

Research Team

Name of RA?

- ☐ Anthony Chesang
- ☐ Caroline Kerich
- ☐ Benedine Kokwon
- ☐ Winnie Matelong
- ☐ Anthoney Opon
- ☐ Washington Rotich
- ☐ Marsha Alera
- ☐ Fred Kaemba
- ☐ Gladys Jeptoo
- ☐ Calvin Oginga
- ☐ Lindah Muli
- ☐ Justine Kipsang

Contact Details

Date and time of call?

Phone contact outcome?

- ☐ Reached client
- ☐ No answer
- ☐ Phone temporarily off
- ☐ Phone temporarily out of service
- ☐ Asked to call back later
- ☐ Someone else answered, wrong number
- ☐ Someone else answered, contact client at number provided

Phone number used to successfully contact client?

(9-digit Number Only)

Maternal Vital Status?

- ☐ Alive
- ☐ Deceased or absent

Maternal Vital Status Questions

Individual being interviewed?

- ☐ Father
- ☐ Other individual

If Other individual, please specify:

Where is the woman now?

- ☐ Deceased
- ☐ Admitted to a hospital
- ☐ Unknown
- ☐ Other location

If Other location, please specify:

If Deceased, please enter date of death:

Reason for death?

☐ Suicide
☐ Accident
☐ Murder
☐ Illness
☐ Unknown
☐ Other reason

If Other reason, please specify:

Can you describe what illness she died from?

Was the woman still pregnant at the time that she died or became absent (whichever is known to have occurred)?

☐ Yes
☐ No
☐ Unknown

Maternal Status

Is the woman still pregnant?

☐ Yes
☐ No

How many babies were delivered?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9

The number of babies delivered recorded above does not match the number of babies delivered reported on the Labor and Delivery form, please review and make any corrections necessary

Which baby is this interview about?
(add a new instance of the Phone Contact form for each additional baby)

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9

Outcome at birth?

☐ Live birth
☐ Fresh stillbirth
☐ Macerated stillbirth

Have any of the babies passed away?

☐ Yes
☐ No

Does the participant agree to be encountered with the infant by the study team?

☐ Yes
☐ No

Where does the participant agree to be encountered?

☐ Home (verify address and locator details)
☐ MTRH
☐ Other location

If Other location agreed upon for encounter, please specify:

WHO Verbal Autopsy Tool

Please record the start time of the interview:

General Information

Sex of respondent?

- ☐ Female
☐ Male

What is your relationship to the infant?

- ☐ Father
☐ Mother
☐ Sibling
☐ Other relative
☐ No relation

Did you live with the infant in the period leading to her/his death?

- ☐ Yes
☐ No

Information on the infant and date/place of death

Was the baby female or male?

- ☐ Female
☐ Male

When was the baby born?

How old was the baby when s/he died?

(Age in Days)

When did s/he die?

(Age in Days)

Where did s/he die?

- ☐ Hospital
☐ Other health facility
☐ Home
☐ Other
☐ Do not know

If Other location, please specify:

Could you tell me about the illness/events that led to his/her death?

Pregnancy History

How many births, including stillbirths, did the mother have before this baby?

- ☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10

How many months was the pregnancy when the baby was born?

- ☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9

Did the pregnancy end earlier than expected?

- ☐ Yes
☐ No
☐ Do not know

How many weeks before the expected date of delivery?

During the pregnancy did the mother suffer from any of the following known illnesses?

	Yes	No
High blood pressure	<input type="radio"/>	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Epilepsy/convulsion	<input type="radio"/>	<input type="radio"/>
Did she suffer from any other medically diagnosed illness?	<input type="radio"/>	<input type="radio"/>

During the last 3 months of pregnancy did the mother suffer from any of the following illnesses?

	Yes	No
Vaginal bleeding	<input type="radio"/>	<input type="radio"/>
Smelly vaginal discharge	<input type="radio"/>	<input type="radio"/>
Puffy face	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>
Blurred vision	<input type="radio"/>	<input type="radio"/>
Convulsion	<input type="radio"/>	<input type="radio"/>
Febrile illness	<input type="radio"/>	<input type="radio"/>

Severe abdominal pain that was not labor pain	<input type="radio"/>	<input type="radio"/>
Pallor and shortness of breath (both present)	<input type="radio"/>	<input type="radio"/>
Did she suffer from any other illness?	<input type="radio"/>	<input type="radio"/>

Was the child a single or multiple birth?	<input type="radio"/> Singleton <input type="radio"/> Twin <input type="radio"/> Triplet or more <input type="radio"/> Do not know
---	---

What was the birth order of the child that died?	<input type="radio"/> First <input type="radio"/> Second <input type="radio"/> Third or higher <input type="radio"/> Do not know
--	---

Delivery History

Where was the child born?	<input type="radio"/> Hospital <input type="radio"/> Other health facility <input type="radio"/> Home <input type="radio"/> Other <input type="radio"/> Do not know
---------------------------	---

If Other, please specify:

Who assisted with the delivery?	<input type="radio"/> Doctor <input type="radio"/> Nurse/midwife <input type="radio"/> Traditional birth attendant <input type="radio"/> Relative <input type="radio"/> Mother by herself <input type="radio"/> Do not know
---------------------------------	--

When did the water break?	<input type="radio"/> Before labor Started <input type="radio"/> During labor <input type="radio"/> Do not know
---------------------------	---

How many hours after the water broke was the baby born?	<input type="radio"/> Less than 24 hours <input type="radio"/> 24 hours or more <input type="radio"/> Do not know
---	---

Was the water foul smelling?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know
------------------------------	--

Did the baby stop moving in the womb?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know
---------------------------------------	--

If Yes, when did the baby stop moving in the womb?	<input type="radio"/> Before Labor Started <input type="radio"/> During Labor <input type="radio"/> Don't Know
--	--

Did a birth attendant listen to the fetal heart sounds during labor?

- ☐ Yes
☐ No
☐ Do not know
-

If Yes, were the fetal heart sounds present?

- ☐ Yes
☐ No
☐ Don't Know
-

Was there excessive bleeding on the day labor started?

- ☐ Yes
☐ No
☐ Do not know
-

Did the mother have a fever on the day labor started?

- ☐ Yes
☐ No
☐ Do not know
-

How long did labor pains last?

- ☐ Less than 12 hours
☐ 12 - 23 hours
☐ 24 hours or more
☐ Do not know
-

Was it a normal vaginal delivery?

- ☐ Yes
☐ No
☐ Do not know
-

If No, what type of delivery was it?

- ☐ Forceps/Vacuum
☐ Caesarian Section
☐ Other
☐ Don't Know
-

If Other, please specify:

Which part of the baby came out first?

- ☐ Head
☐ Bottom
☐ Feet
☐ Arm/Hand
☐ Other
☐ Do not know
-

If Other, please specify:

Did the umbilical cord come out before the baby was born?

- ☐ Yes
☐ No
☐ Don't Know

Condition of the baby soon after birth

After birth, what was the size of the baby?

- ☐ Smaller than normal
☐ Normal
☐ Larger than normal
☐ Don't Know

Was the baby premature?

- ☐ Yes
☐ No
☐ Don't Know

Do you know the birth weight of the baby?

- ☐ Yes
☐ No
☐ Don't Know

Birth weight (in Kg)

(kg (with 1 decimal point))

Was there anything applied to the umbilical cord stump after birth?

- ☐ Yes
☐ No
☐ Don't Know

What was it?

Were there any signs of injury or broken bones?

- ☐ Yes
☐ No
☐ Don't Know

What were the marks or signs of injury?

Was there any sign of paralysis?

- ☐ Yes
☐ No
☐ Don't Know

Did the baby have any abnormal physical appearance (i.e. birth defect or malformations)?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, what kind of malformation or birth defect?

- ☐ Swelling/Defect on the back
☐ Very large head
☐ Very small head
☐ Defect of the lip or palate
☐ Other abnormal appearance
☐ Don't Know

If other abnormal appearance, please describe:

What was the color of the baby at birth?

- ☐ Normal
☐ Pale
☐ Blue
☐ Don't Know

Did the baby breathe after birth, even a little?

☐ Yes
☐ No
☐ Don't Know

Was the baby given assistance to breathe?

☐ Yes
☐ No
☐ Don't Know

Did the baby ever cry after birth, even a little?

☐ Yes
☐ No
☐ Don't Know

Did the baby ever move, even a little?

☐ Yes
☐ No
☐ Don't Know

If the baby did not cry, breathe or move, was it born dead?

☐ Yes
☐ No
☐ Don't Know

Was the baby macerated, that is, showed signs of decay?

☐ Yes
☐ No
☐ Don't Know

History of Injuries/Accidents

Did the baby suffer from any injury or accident that lead to his/her death?

☐ Yes
☐ No
☐ Don't Know

What kind of injury or accident did the baby suffer?

☐ Road traffic accident
☐ Fall
☐ Drowning
☐ Poisoning
☐ Burns
☐ Violence/Assault
☐ Other
☐ Don't Know

Was the injury or accident intentionally by someone else?

☐ Yes
☐ No
☐ Don't Know

Did the baby suffer from any animal/insect bite that lead to his/her death?

☐ Yes
☐ No
☐ Don't Know

If Yes, what type of animal/insect?

☐ Dog
☐ Snake
☐ Insect
☐ Other
☐ Don't Know

If Other, please specify:

Neonatal Illness History

Was the baby ever able to suckle or bottle-feed?

- ☐ Yes
☐ No
☐ Don't Know

How soon after birth did the baby suckle or bottle-feed?

- ☐ < 2 hours after birth
☐ 2 or more hours after birth
☐ Don't Know

Did the baby stop suckling or bottle-feeding?

- ☐ Yes
☐ No
☐ Don't Know

How many days after birth did the baby stop suckling or bottle-feeding?

Was the breastfeeding exclusive?

- ☐ Yes
☐ No
☐ Don't Know

Did the baby have convulsions?

- ☐ Yes
☐ No
☐ Don't Know

How many days after birth did the convulsions start?

Did the baby become stiff and arched backwards?

- ☐ Yes
☐ No
☐ Don't Know

Did the child have bulging fontanelle?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, how many days after birth did the baby have the bulging?

Did the baby become unresponsive or unconscious?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, how many days after birth did the baby become unresponsive or unconscious?

Did the baby have a fever?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, how many days after birth did the baby have a fever?

Did the baby become cold to the touch?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, how many days after birth did the baby become cold to the touch?

Did the baby have a cough?

- ☐ Yes
☐ No
☐ Don't Know
-

If Yes, how many days after birth did the baby start to cough?

Did the baby have fast breathing?

- ☐ Yes
☐ No
☐ Don't Know
-

If Yes, how many days after birth did the baby have fast breathing?

Did the baby have difficulty in breathing?

- ☐ Yes
☐ No
☐ Don't Know
-

If Yes, how many days after birth did the baby have difficulty in breathing?

Did the baby have chest indrawing?

- ☐ Yes
☐ No
☐ Don't Know
-

If Yes, how many days after birth did the baby have chest indrawing?

Did the baby have grunting?

(Interviewer to demonstrate sound of grunting)

- ☐ Yes
☐ No
☐ Don't Know
-

Did the baby have flaring of the nostrils?

- ☐ Yes
☐ No
☐ Don't Know
-

Did the baby have diarrhea?

- ☐ Yes
☐ No
☐ Don't Know
-

If Yes, how many days after birth did the baby have diarrhea?

When the diarrhea was most severe, how many times did the baby pass stools in a day?

(Enter 99 in Unknown)

Did the baby have abdominal distension?

- ☐ Yes
☐ No
☐ Don't Know

How many times after birth did the baby have abdominal distension?

(Enter 99 in Unknown)

Did the baby have redness or discharge from the umbilical cord stump?

- ☐ Yes
☐ No
☐ Don't Know

Did the baby have a pustular skin rash?

- ☐ Yes
☐ No
☐ Don't Know

Did the baby have yellow palms or soles?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, how many days after birth did the yellow palms or soles begin

For how many days did the baby have yellow palms or soles?

(Enter 99 in Unknown)

Mother's Health and Contextual Factors

What was the age of the mother at the time the baby died?

(Years (enter 99 if Unknown))

Did the mother receive antenatal care?

- ☐ Yes
☐ No
☐ Don't Know

Did the mother receive tetanus toxoid (TT) vaccine?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, how many doses?

How is the mother's health now?

- ☐ Healthy
☐ Ill
☐ Not Alive
☐ Don't Know

Treatment and Health Sciences use for the Final Illness

Did the baby receive any treatment for the illness that led to death?

- ☐ Yes
☐ No
☐ Don't Know

Can you please list the treatment the baby was given for the illness that lead to death?

Please tell me at which of the following places or facilities the baby received treatment during the illness

	Yes	No	Don't Know
Home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Traditional healer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Government clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Government hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Private clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Private hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pharmacy, drug seller, store	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Any other place or facility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the month before death, how many contacts with formal health services did the baby have?

Did a health care worker tell you the cause of death?

- ☐ Yes
☐ No
☐ Don't Know

If Yes, what did the health care worker say?

Data Abstracted from Death Certificate

Do you have a death certificate for the baby?

- ☐ Yes
☐ No
☐ Don't Know

What is the documented date of death on the certificate?

Record the cause of death from the first (top) line of the death certificate

Record the cause of death from the second line of the death certificate (If Any)

Record the cause of death from the third line of the death certificate (If Any)

Record the cause of death from the fourth line of the death certificate (If Any)

Data abstracted from Other Medical Records

Other health record(s) available?

☐ Yes

☐ No

If Yes, for each type of health record summarize details for last 2 visits (if more than 2) and record date issue.
(Record information about mother and stillborn deceased child)

Burial permit (Cause of Death):

Postmortem results (cause of death):

MCH/ANC Card (Relevant Information):

Hospital prescription (Relevant information):

Treatment cards (Relevant information):

Hospital discharge (Relevant Information):

Laboratory results (Relevant Information):

Other hospital documents:

Record time at the end of the interview:

Verbal autopsy interview stop date/time is before starting date/time, please review and make any changes necessary

Interviewers Observations

Comments on specific questions:

Additional Comments:

In-Person Contact

Research Team

Name of RA:

- ☐ Anthony Chesang
- ☐ Caroline Kerich
- ☐ Benedine Kokwon
- ☐ Winnie Matelong
- ☐ Anthoney Opon
- ☐ Washington Rotich
- ☐ Marsha Alera
- ☐ Fred Kaemba
- ☐ Gladys Jeptoo
- ☐ Calvin Oginga
- ☐ Linda Muli
- ☐ Justine Kipsang

Contact Details

Date of attempted in-person contact?

Was the subject successfully contacted by phone prior to field follow-up?

- ☐ Yes
- ☐ No

Where was the in-person contact attempt made?

- ☐ Home
- ☐ MTRH
- ☐ Other

If other encounter location, please specify:

Who accompanied the RA at any point during field follow-up?

Select all that apply

- ☐ Community Health Worker
- ☐ Mentor Mother
- ☐ AMPATH defaulter tracking team member
- ☐ Peer parent
- ☐ None
- ☐ Other, specify below

If other person accompanied RA, please specify:

Was the subject successfully encountered in person?

- ☐ Yes
- ☐ No

Reason for unsuccessful attempt?

Where was the subject successfully encountered?

- ☐ Home
- ☐ MTRH
- ☐ Other

If Other location, please specify:

Comments

Comments:

Newborn Birth Details

Research Team

Name of RA:

- ☐ Anthony Chesang
- ☐ Caroline Kerich
- ☐ Benedine Kokwon
- ☐ Winnie Matelong
- ☐ Anthoney Opon
- ☐ Washington Rotich
- ☐ Marsha Alera
- ☐ Fred Kaemba
- ☐ Gladys Jeptoo
- ☐ Calvin Oginga
- ☐ Linda Muli
- ☐ Justine Kipsang

Birth Details

Infant Number?

Infant ID (auto-generated):

Date of delivery?

The maternal date of delivery specified on a previous form was
[maternal_delivery_arm_1][deliv_d]

Gestational age (completed weeks)?

Mode of gestational age assessment?

- ☐ LMP
- ☐ Ultrasound
- ☐ SFH (symphysial fundal height)

Outcome at birth?

- ☐ Live birth
- ☐ Fresh stillbirth
- ☐ Macerated stillbirth

If stillbirth, please specify all causes:

Sex?

- ☐ Male
- ☐ Female
- ☐ Ambiguous

Birth Weight?

(kg (MUST include 1 decimal))

Date of weight measurement?

Birth Length?

(cm)

Date of length measurement?

Head circumference?

(cm)

Date of head circumference measurement?

Foot Length?

(cm)

Date of foot length measurement?

APGAR at 1 minute?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

APGAR at 5 minutes?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

Documentation of any congenital abnormality?

- ☐ Yes
- ☐ No

Comments

Additional Comments:

Congenital Abnormalities

Presence of any potential congenital abnormality?

- ☐ Yes
☐ No

Was a surface exam done by the study team?

- ☐ Yes
☐ No

Date of surface exam?

Where was surface exam performed?

- ☐ Postnatal WARD
☐ Postnatal clinic
☐ Community
☐ Other

If Other surface exam location, please specify:

Congenital anomaly details

Description of abnormality (please include as much detail as possible)

Abnormality is an extra digit

- ☐ Yes
☐ No
☐ Unknown

Position of extra digits

- ☐ Left hand
☐ Right hand
☐ Left foot
☐ Right foot

Left hand - location of extra digit

- ☐ Near 5th digit (little finger)
☐ Near thumb
☐ Other place

Left hand - appearance of extra digit

- ☐ Fully formed extra digit (looks like a finger and has a bone in it)
☐ Soft, without a bone (sometimes hanging by a stalk)

Right hand - location of extra digit

- ☐ Near 5th digit (little finger)
☐ Near thumb
☐ Other place

Right hand - appearance of extra digit

- ☐ Fully formed extra digit (looks like a finger and has a bone in it)
☐ Soft, without a bone (sometimes hanging by a stalk)

Left foot - location of extra digit

- ☐ Near 5th digit (little toe)
☐ Near big toe
☐ Other place

Left foot - appearance of extra digit	<input type="radio"/> Fully formed extra digit (looks like a finger and has a bone in it) <input type="radio"/> Soft, without a bone (sometimes hanging by a stalk)
Right foot - location of extra digit	<input type="radio"/> Near 5th digit (little toe) <input type="radio"/> Near big toe <input type="radio"/> Other place
Right foot - appearance of extra digit	<input type="radio"/> Fully formed extra digit (looks like a finger and has a bone in it) <input type="radio"/> Soft, without a bone (sometimes hanging by a stalk)
Head and neck exam abnormal (includes skull, fontanelles, eyes, ears, nose, jaw)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Describe abnormality (please include as much detail as possible)	_____
Evidence of hydrocephalus (swollen head)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Defect in the skull	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Description of skull defect	<input type="radio"/> Completely covered by skin <input type="radio"/> Partly covered by skin <input type="radio"/> Covered by a thin sac/membrane <input type="radio"/> Not covered by skin (brain tissue visible) <input type="radio"/> Unknown
Mouth, lip and palate exam abnormal	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Describe abnormality (please include as much detail as possible)	_____
Chest exam abnormal (including shape and respiratory movements)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Describe abnormality (please include as much detail as possible)	_____
Abdominal and anal exam abnormal (including any masses, umbilical hernia, and abdominal wall defects)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Describe abnormality (please include as much detail as possible)	_____
Arms and legs abnormal (including length, shape, missing parts)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Describe abnormality (please include as much detail as possible)

Fingers and toes abnormal (including nails, number, dangling, shape, missing parts, abnormally large or small)

- ☐ No
☐ Yes
☐ Unknown

Describe abnormality (please include as much detail as possible)

Spine exam abnormal (including lumps, cysts, tufts of hair, bulging at back of neck, thorax or lumbar area)

- ☐ No
☐ Yes
☐ Unknown

Describe abnormality (please include as much detail as possible)

Location of spine defect

- ☐ Cervical
☐ Thoracic
☐ Lumbosacral
☐ Unknown

Description of spine defect

- ☐ Covered in hair and NOT bulging out
☐ Covered in hair and bulging out
☐ Bulging out and completely covered with skin
☐ Bulging out and partly covered with skin
☐ Bulging out and covered with only a sac/thin membrane
☐ Open - can see the spine/spinal cord
☐ Unknown

Hips and genitalia abnormal (including urethra, testes, penile shaft, vagina, labia)

- ☐ No
☐ Yes
☐ Unknown

Describe abnormality (please include as much detail as possible)

Skin exam abnormal (including pale, blue, birth marks, large very red areas)

- ☐ No
☐ Yes
☐ Unknown

Describe abnormality (please include as much detail as possible)

Describe any other abnormality, unusual finding or comment about the abnormality

Congenital anomaly assessment

Diagnosis documented

- ☐ No
☐ Yes
☐ Unknown

Diagnosis made by

- ☐ Registered Nurse
☐ Medical Officer
☐ Pediatrician
☐ Obstetrician
☐ Geneticist

Specify diagnosis

Congenital abnormality reviewed by geneticist

- ☐ No
☐ Yes
☐ Unknown

Final diagnosis by geneticist

ICD 10 code for diagnosis 1

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

ICD 10 code for diagnosis 2

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

ICD 10 code for diagnosis 3

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

ICD 10 code for diagnosis 4

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

ICD 10 code for diagnosis 5

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

ICD 10 code for diagnosis 6

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

ICD 10 code for diagnosis 7

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

ICD 10 code for diagnosis 8

Certainty of diagnosis:

- ☐ Definite
☐ Probable
☐ Possible
☐ Uncertain

Date of geneticist diagnosis

(if date unknown 11/11/1911)

Name of geneticist

Classification of abnormality (check all that apply)

- ☐ Unknown
- ☐ Absent radius, bilateral
- ☐ Albino
- ☐ Ambiguous genitalia
- ☐ Amniotic band syndrome
- ☐ Anencephaly
- ☐ Ascites
- ☐ Bifid digit
- ☐ Birth injury
- ☐ Blue-black patch
- ☐ Cebocephaly
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cryptophthalmus
- ☐ Cystic hygroma
- ☐ Dental cyst
- ☐ Disseminated hairy nevus
- ☐ Downs syndrom (T21)
- ☐ Dysmorphic facial features
- ☐ Encephalocele
- ☐ Foreskin defect
- ☐ Hydrocephalus
- ☐ Hyperextended limb
- ☐ Hypospadias, glandular
- ☐ Hypospadias, perineal
- ☐ Hypospadias, penile
- ☐ Imperforate anus
- ☐ Isolated bowed tibia
- ☐ Limb-body wall defect
- ☐ Multiple abnormalities of unknown origin
- ☐ Myelomeningocele, lumbo-sacral
- ☐ Natal teeth
- ☐ Omphalocele
- ☐ Phimosis
- ☐ Postaxial polydactyly, unilateral hand
- ☐ Postaxial polydactyly, bilateral hand
- ☐ Postaxial polydactyly, unilateral foot
- ☐ Postaxial polydactyly, bilateral foot
- ☐ Preaxial polydactyly, unilateral hand
- ☐ Preaxial polydactyly, bilateral hand
- ☐ Preaxial polydactyly, unilateral foot
- ☐ Preaxial polydactyly, bilateral foot
- ☐ Preauricular skin tag
- ☐ Short limbs
- ☐ Skeletal dysplasia
- ☐ Calcaneovalgus deformity
- ☐ Talipes varus, unilateral (clubfoot)
- ☐ Talipes varus, bilateral (clubfoot)
- ☐ Tongue tie
- ☐ Umbilical hernia
- ☐ Vaginal tag

Neural tube defect

- ☐ Yes (photo available)
- ☐ Probable (no photo available)
- ☐ No
- ☐ Unknown

Major abnormality

- ☐ Yes (photo available)
- ☐ Probable (no photo available)
- ☐ No (photo available)
- ☐ Unlikely (no photo available)
- ☐ Unknown
- ☐ Not an abnormality

Comments

Additional Comments:

Newborn Imaging Results

Type of Imaging?

- ☐ None
- ☐ Ultrasound
- ☐ ECHO
- ☐ X-ray
- ☐ CT scan

Date of Imaging?

Are any parts of the Date of Imaging unknown?

- ☐ No, Date is Exact
- ☐ Day is Unknown
- ☐ Month is Unknown
- ☐ Day and Month are Unknown

Imaging Report:

Please upload file/image if available

Imaging Comments:

Enter Additional Imaging Below

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Imaging Report:

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Imaging Comments:

Newborn Follow-Up

Date of documentation?

Was the newborn delivered at a health facility?

- ☐ Yes
☐ No

Date of discharge after delivery?

Newborn alive at discharge?

- ☐ Yes
☐ No

Has the newborn passed away?

- ☐ No
☐ Yes

Date of death?

Fetal autopsy completed?

- ☐ Yes
☐ No

Fetal autopsy findings:

Was the umbilical cord wrapped around the newborn's neck at delivery?

- ☐ Yes
☐ No

Is there documentation of neonatal jaundice?

- ☐ Yes
☐ No

Was the baby given supportive care measures during the first 24 hours of life?
Please select all that apply

- ☐ None
☐ Oxygen
☐ Intubation

Newborn required NBU admission prior to discharge?

- ☐ Yes
☐ No

If yes, please specify all reasons neonate required NBU:

Current feeding method?

- ☐ Exclusive breastfeeding (EBF)
☐ Exclusive replacement feeding (ERF)
☐ Mixed feeding (MF)

Was the baby ever taken to a health facility after delivery?

- ☐ Yes
☐ No

What facility was the baby taken to?

- ☐ MTRH
☐ Other Health Facility

If Other facility, please specify:

Date of health facility visit?

Was the baby given an HIV test any time after delivery?

- ☐ Yes
☐ No

Date of HIV test?

Are any parts of the Date of HIV test unknown?

- ☐ No, Date is Exact
☐ Day is Unknown
☐ Month is Unknown
☐ Day and Month are Unknown

HIV test result?

- ☐ Positive
☐ Negative

ARV Medication given after birth?
Select all that apply

- ☐ None
☐ Kaletra (KTL)
☐ Nevirapine (NVP)
☐ Zidovudine (AZT)
☐ Lamivudine (3TC)
☐ Unknown

Comments

Additional Comments:
