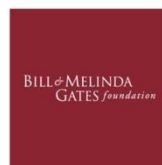


# Verbal autopsy standards:

## The 2016 WHO verbal autopsy instrument

V1.5.3



World Health  
Organization

## WHO Library Cataloguing-in-Publication Data

Verbal autopsy standards: the 2016 WHO verbal autopsy instrument.

1.Autopsy – methods. 2.Autopsy – standards. 3.Cause of Death. 4.Death Certificates.  
5.Data Collection. 6.Mortality. I. World Health Organization.

(NLM classification: WA 900)

**© World Health Organization 2016**

All rights reserved. Publications of the World Health Organization are available on [the WHO website \(www.who.int\)](http://www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: [bookorders@who.int](mailto:bookorders@who.int)).

Requests for permission to reproduce or translate WHO publications –whether for sale or for non-commercial distribution– should be [addressed to WHO Press through the WHO website \(www.who.int/about/licensing/copyright\\_form/en/index.html\)](http://www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The mark "CDC" is owned by the US Dept. of Health and Human Services and is used with permission. Use of this logo is not an endorsement by HHS or CDC of any particular product, service, or enterprise.

## Acknowledgements

The production of this manual would not have been possible without the collaboration and support of numerous organizations, institutions and individuals. The organizations contributing to this work include World Health Organization (WHO), Bill & Melinda Gates Foundation, Bloomberg Philanthropies Data for Health (D4H), Health Metrics Network (HMN), INDEPTH Network, Institute for Health Metrics and Evaluation (IHME), All India Institute of Medical Sciences, Australian National University, India National Institute of Medical Statistics, International Centre for Diarrhoeal Disease Research (ICDDR), US Centres for Disease Control and Prevention (CDC), Federal University of Minas Gerais, Ghana Health Service, Ifakara Health Institute, London School of Hygiene & Tropical Medicine (LSHTM), Johns Hopkins Bloomberg School of Public Health, National Institute of Health Research Indonesia, National Institute of Medical Statistics of India; Norwegian Institute of Public Health, Swiss Tropical and Public Health Institute, Ohio State University, Thailand Ministry of Public Health, The University of Queensland, UCL Centre for International Health and Development, Umeå University, United Nations Population Fund (UNFPA), Office of the United Nations High Commissioner for Refugees (UNHCR), University of Alexandria, University of the Witwatersrand, Uttar Pradesh Center for Maternal, Neonatal and Child Health

For the 2014 and 2016 version of the VA instrument, acknowledgement is given to the WHO working group on Verbal Autopsy, including Shams El Arifeen, International Centre for Diarrhoeal Disease Research; Daniel Chandramohan, London School of Hygiene & Tropical Medicine; Samuel Clark, University of Washington; Lalit Dandona, Public Health Foundation of India; Abraham Flaxman, IHME; Bernardo Hernandez Prado, IHME; Robert Jakob, WHO; Henry Kalter, Johns Hopkins Bloomberg School of Public Health; Soewarta Kosen, National Institute of Health Research Indonesia; Jordana Leitao, Angola; Erin Nichols, CDC; Arvind Pandey, National Institute of Medical Statistics, India; Chalapati Rao, Australian National University; Ian Riley, Professor Emeritus, University of Queensland; Philip Setel, Vital Strategies, D4H

This verbal autopsy instrument was produced and reviewed in collaboration with a WHO led-expert group including Shams El Arifeen, International Centre for Diarrhoeal Disease Research; Kanitta Bundhamcharoen, Thailand Ministry of Public Health; Peter Byass, Umeå University Centre for Global Health; Daniel Chandramohan, London School of Hygiene & Tropical Medicine; Chanpen Choprapawon, Health Policy and Strategic Bureau; Samuel Clark, University of Washington; Don de Savigny, Swiss Tropical and Public Health Institute; Dr Abraham Flaxman, IHME; Edward Fottrell, UCL Centre for International Health and Development; Elizabeth França, Federal University of Minas Gerais; Frederik Frøen, Norwegian Institute of Public Health; Gihan Gewaifel, University of Alexandria; Bernardo Hernandez, IHME; Abraham Hodgson, Ghana Health Service; Sennen Hounton, UNFPA; Kathleen Kahn, University of the Witwatersrand; Henry Kalter, Johns Hopkins Bloomberg School of Public Health; Soewarta Kosen, National Institute of Health Research Indonesia; Anand Krishnan, All India Institute of Medical Sciences; Vishwajeet Kumar, Uttar Pradesh Center for Maternal, Neonatal and Child Health; Jordana Leitao, London School of Hygiene & Tropical Medicine; Alan Lopez, The University of Queensland; Rafael Lozano, IHME; Honorati Masanja, Ifakara Health Institute; Lene Mikkelsen, University of Queensland; Dean Yergens, University of Calgary; Thorkild Tylleskär, University of

Bergen; Jørn Ivar Klungsøyr, University of Bergen; Carlos Navarro-Colorado, Centers for Disease Control and Prevention (CDC); Erin Nichols, CDC; Sam Notzon, CDC; Arvind Pandey, National Institute of Medical Statistics of India; National Institute of Health Research Indonesia; Mohammad Hafiz; Chalapati Rao, The University of Queensland; Rasooly, Afghanistan Ministry of Public Health; Ian Riley, The University of Queensland; Osman Sankoh, INDEPTH Network; Paul Spiegel, UNHCR; Carla Abou-Zahr; Derege Kebede, WHO; William Soumbey Alley, WHO; Fatima Marinho, WHO; Mohamed Ali, WHO; Enrique Loyola, WHO; Jyotsna Chikersal, WHO; Jun Gao, WHO; Robert Jakob, WHO; Giuseppe Annunziata, WHO; Rajiv Bahl, WHO; Kidist Bartolomeus, WHO; Ties Boerma, WHO; Bedirhan Ustun, WHO; Doris Chou, WHO; Lulu Muhe, WHO; Matthews Mathai; Marc Amexo, HMN.

For technical support in the design and production of the XLS forms and review of the skip logic, acknowledgement is given to Carolyn Gulas and Matt Berg, ONA; and Aurelio Di Pasquale, Rajib Mitra, Vinit Mishra, Nicolas Maire, Swiss Tropical and Public Health Institute; and Anuraj Shankar, Alisa Pedrana, Mandri Apriatni, Harvard School of Public Health.

For technical support in the design of the paper forms and related reviews, acknowledgement is given to Do Yoon Kwon; Kyung Mok Ko; Jinsung Jung; Eunji Jo; Sangbin Han; Junseong Kim; Youngseok Kim; Eunyong Cho; Yoon Joo Cho; Inah Kim; Sehee Kim; Kwansoo Lee; Young Jae Chun; Soojin Moon, Chalapati Rao, Matthew Kelly.

# Table of Contents

|   |  |           |
|---|--|-----------|
| <b>1</b>  | <b>Purpose and content .....</b>   | <b>1</b>  |
| <b>2</b>  | <b>Introduction to verbal autopsy .....</b>  | <b>3</b>  |
| 2.1   | Historical background.....   | 3         |
| 2.2   | Uses and users of VA data.....   | 4         |
| <b>3</b>  | <b>The development of the 2016_WHO verbal autopsy instrument .....</b>                           | <b>7</b>  |
| 3.1   | 2016 List of causes of death for VA.....   | 7         |
| 3.2   | List of indicators and their definitions, relevant age and sex groups and sample questions ..... | 8         |
| <b>4</b>  | <b>Application and implementation of the 2016 WHO verbal autopsy instrument .....</b>            | <b>10</b> |
| 4.1   | Sections of the 2016 WHO VA instrument.....  | 12        |
| 4.2   | Technical description of the Table of Indicators (ODK XLS).....                                  | 13        |
| 4.3   | Sample questionnaires.....   | 15        |
| 4.3.1   | <i>Sample VA questionnaire 1: death of a child aged under four weeks .....</i>                   | <i>15</i> |
| 4.3.2   | <i>Sample VA questionnaire 2: death of a child aged four weeks to 11 years .....</i>             | <i>15</i> |
| 4.3.3   | <i>Sample VA questionnaire 3: death of a person aged 12 years and above.....</i>                 | <i>15</i> |
| 4.4   | Guidelines on augmentation and local adaptation.....   | 15        |
| 4.5   | Translation.....   | 16        |
| 4.6   | Vital registration.....  | 17        |
| 4.7   | Age categories of death.....   | 17        |
| 4.8   | Infrastructure .....   | 17        |
| 4.8.1   | <i>Interviewers .....</i>  | <i>18</i> |
| 4.8.2   | <i>Data collection software, database, technology and staff.....</i>                             | <i>19</i> |
| 4.8.3   | <i>Methods for determining causes of death .....</i>   | <i>20</i> |
| 4.8.4   | <i>Legal requirements, privacy, confidentiality, informed consent .....</i>                      | <i>22</i> |
| 4.9   | Appropriate respondents and recall period .....  | 22        |
| 4.10  | Use of verbal autopsy-generated data.....  | 22        |
| <b>5</b>  | <b>Bibliography .....</b>  | <b>24</b> |
| <b>Appendix 1: 2016 cause of death list for verbal autopsy with corresponding ICD-10 codes (identical with 2014).....</b> |  | <b>1</b>  |
| <b>Appendix 2: Considerations for the use of verbal autopsy in the identification of COVID-19 deaths .....</b>            |  | <b>3</b>  |
| Background .....  |  | 3         |
| Questions to identify suspected COVID-19 deaths .....   |  | 4         |
| Considerations for VA implementation in the context of the COVID-19 pandemic .....  |  | 5         |



## 1 Purpose and content

The 2016 version of the WHO verbal autopsy instrument is suitable for routine use. Based on the 2012 instrument, experiences with the interim 2014 version, and in collaboration with the authors of the different analytical software for assigning the cause of death, questions have been added or edited to facilitate the use of the publicly available analytical software (InterVA, SmartVA previously known as Tariff – simplified PHMRC, and InsilicoVA). Also, the skip pattern has been edited based on the information obtained from field testing and cognitive reviews of the 2012 instrument, and the 2014 interim version.

**All materials (questionnaires, table of indicators with skip patterns, crosswalks, and this manual) are available separately for download at <http://www.who.int/healthinfo/statistics/verbalautopsystandards>.**

The questions allow for responses with a simple yes or no answer, multiple choice, or a duration in some instances. This approach makes the instrument usable with analytical software that assigns causes of death. Some very few free text fields are included to allow adding information that may be used in reviews, but they are not used by the analytical software.

The instrument is designed for all age groups, including maternal and perinatal deaths, and also deaths caused by injuries. A set of paper forms by age group shows the design of the instrument. It is however recommended to use electronic data collection methods, based on the electronic format of the published instrument.

Sets of questions address information relevant to vital registration and information relevant to assessment of the cause of death and the context.

The 2016 instrument is based on the 2012 version of the WHO verbal autopsy instrument that had been designed to become suitable for routine use. Compared to the 2007 instrument, numbers of conditions and questions had been reduced, based on evidence from the field and expert reviews. This document contains some references to the development of the 2012 instrument, because its development is the basis for this new version of the WHO instrument.

This manual informs users on how to use the 2016 WHO verbal autopsy (VA) instrument. The components of this manual include:

- Background on VA;
- The full matrix of questions, definitions and related skip patterns;
- Instructions on how to use the matrix of questions;
- ODK compatible form for all ages, including skip patterns and calculated fields
- Paper forms for illustration and data collection - where necessary
- Information about available analytical software for assigning cause of death, including crosswalks for publicly available analytical software: InterVA5, Smart VA (IHME) and InsilicoVA (Washington University);
- Criteria for setting up a data collection infrastructure and the related databases;
- Instructions on how to adapt questionnaires for local use;

## Purpose and content

- General cause of death certification and coding guidelines for applying the International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10)<sup>1</sup> to VA; and
- A simplified cause of death list for VA with corresponding ICD-10 codes.
- Crosswalks for InterVA4 and SmartVA are available for download separately

This manual and its resources are the products of the first one-year effort by an expert group led by the World Health Organization (WHO), consisting of researchers, data users, and government agencies, for the 2012 VA instrument, and an additional year of work of the WHO Working Group on Verbal Autopsy (subgroup of the WHO Reference Group for Health Statistics). The 2016 WHO VA instrument is intended to allow for simple and inexpensive identification of causes of death in places where no other routine system is in place and will serve the needs of countries' civil registration and vital statistics (CRVS) systems. Independently, this instrument can also be used in research and disease specific programmes. All materials are easily and widely accessible on the WHO web site, in print, and will be incorporated into diverse resource kits, intended for strengthening national vital statistics systems. Additional language versions will be made available through similar channels.

Experience from the field and publications on the most widely used and validated VA instruments and procedures (WHO VA standards, InterVA and Population Health Metrics Research Consortium -PHMRC VA instrument)<sup>1-3</sup> were systematically reviewed and also assessed against experience in using analytical software for cause of death assignment (InterVA and SmartVA). The utility of each VA question was discussed with VA users. Experiences from field testing and cognitive reviews of the 2012 instrument, and the results of a simplification of the PHMRC Tariff method also contributed to the development of 2016 WHO VA instrument. These reviews and assessments have resulted in a simplified instrument with a reduced number of questions and causes of death, compared to 2007. However, the number of questions has slightly increased compared to the 2012 instrument, because some questions were added, and some complex questions were split into two thus making sure they ask about only one indicator at a time. Furthermore, the 2016 WHO VA instrument also facilitates the use of publicly available analytical software for assigning the cause of death, including InterVA and SmartVA.

The systematic application of the 2016 WHO VA instrument will facilitate the application of VA in routine surveillance of vital events and introduce more consistency and cross-comparability of VA-derived mortality data. The correspondence table (Appendix 1) allows for easy conversion to and from ICD-10.

The application of the 2016 Instrument in routine use and research with its standardized international set of questions will facilitate the compilation of larger databases that finally would provide the evidence for stepwise improvement of VA questionnaires internationally, and become a basis for continuous development of analytical methods.



## 2 Introduction to verbal autopsy

Reliable data on the levels and causes of mortality are cornerstones for building a solid evidence base for health policy, planning, monitoring and evaluation.

The main objective of VA is to describe the causes of death at the community level or population level where civil registration and death certification systems are weak and where most people die at home without having had contact with the health system.

In settings where the majority of deaths occur at home and where civil registration systems do not function, there is little chance that deaths occurring away from health facilities will be recorded and the cause of death certified. As a partial solution to this problem, VA has become a primary source of information about causes of death in populations lacking vital registration and medical certification. VA has become an essential public health tool for obtaining a reasonable direct estimation of the cause structure of mortality at population level, although it may not be an accurate method for attributing causes of death at the individual level.

Verbal autopsy is a method used to ascertain the cause of a death based on an interview with next of kin or other caregivers. The interview is done using a standardized questionnaire that elicits information on signs, symptoms, medical history and circumstances preceding death. The cause of death, or the sequence of causes that led to death, are assigned based on the data collected using the VA questionnaire and any other available information. Rules and guidelines, algorithms or computer programs, may assist in interpreting the information collected using the VA questionnaire to determine the cause of death<sup>11</sup>.

A standard VA instrument comprises a VA questionnaire, a list of causes of death or mortality classification system, and sets of diagnostic criteria (either expert or data derived algorithms) for assigning causes of death. The VA process consists of several steps, and many factors can influence the cause specific mortality fractions estimated through this process.<sup>4</sup>

### 2.1 Historical background

In Europe, before the 19<sup>th</sup> century when modern systems of death registration were implemented, designated death searchers visited the households of deceased people to assess the nature of deaths. The need for lay reporting of causes of death remained in low and middle income countries where there was a lack of medical capacity to produce death certificates for the population. As an alternative, in the 1950s and 60s in Asia and Africa, systematic interviews by physicians were used to determine causes of death. Workers at the Narangwal project in India labelled this new technique “verbal autopsy”<sup>5,6</sup>. [ENREF 4](#)

The interest of WHO in VA (formerly “lay reporting”) of health data was first demonstrated in a publication by Dr. Yves Biraud in 1956. During the 1970s, WHO encouraged the use of lay reporting of health information by people with no medical training, leading to development in 1975 of lay reporting forms (WHO 1978). Since the late 1970s and early 80s when the Reproductive Age Mortality Studies (RAMOS), Matlab (Bangladesh) and Niakhar (Senegal) questionnaires first emerged, several other

questionnaires have been developed for use in research settings and in national or large-scale regional surveys.<sup>5</sup>

The past two decades have seen a proliferation of interest, research and development in all aspects of the VA process, including VA data-collection systems, VA questionnaires' content and format, cause of death assignment process, coding and tabulation of causes of death, and validation of VA instruments.

In 2007, needs and demands for standardization led to the development and publication of the WHO\_2007 VA standard tools, which many researchers have adopted.<sup>7</sup> The standards tools included:<sup>8</sup>

- Verbal autopsy questionnaires for three age groups (under four weeks; four weeks to 14 years; and 15 years and above);
- Cause of death certification and coding resources consistent with the International Classification of Diseases and Related Health Problems, tenth revision (ICD-10); and
- A cause-of-death list for VA mapped according to the ICD-10.

The WHO\_2007 VA questionnaire has been modified in several projects to accommodate the local needs. In 2011, evidence from use of the WHO instrument and related VA instruments was reviewed to formulate the 2012\_WHO\_VA tools. Besides elimination of unreported causes and focus on useful questions, it was designed to facilitate VA use in routine vital registration systems to improve national cause-specific mortality data.

Over the past years, efforts have been made to develop and implement software programs for automated interpretation of VA data to generate computer-based diagnosis of causes of death. Currently, the two most commonly used programs are the InterVA method developed by the Umea University (Sweden) and the Tariff method (SmartVA) developed by the Institute of Health Metrics and Evaluation (USA). However, these two programs are based on slightly different versions of VA questionnaires. So far, it is not clear which of these two methods perform better and whether they complement each other, despite several comparative studies<sup>9-12</sup>. In order to facilitate the application of the two commonly used and publicly available automated methods for interpreting VA and to allow comparison the causes of death data determined by these methods comparative analysis of these commonly used automated methods of VA interpretation, the WHO VA instrument was updated in 2016 to include all input variables required for the optimum performance of these two software programs. Experience from the field in using the 2012\_WHO VA tools and the interim 2014\_WHO VA tools, and cognitive testing<sup>13</sup> provided further inputs in the refinement of the 2016\_WHO VA instrument.

This version of the WHO instrument is recommended for field implementation in conjunction with vital registration to enable use of automated VA interpretation programs as well as by physician coders of verbal autopsies.

## 2.2 Uses and users of VA data

VA is used in three main ways. First, it has been primarily used as a research tool in the context of longitudinal population studies, intervention research or epidemiological studies. Second, it has become a source of cause of death statistics to meet the demand for population-level cause-specific mortality data to be used in policy, planning, priority

setting and benchmarking. Third, VA data are gaining acceptance as a source of cause of death statistics to be used for monitoring progress and evaluating what works and what does not. Because vital registration coverage has not significantly improved in developing countries, VA methods have been mainly applied in the following data collection systems: clinical trials and large-scale epidemiological studies; demographic surveillance systems; national sample surveillance systems; and household surveys.<sup>6</sup>

Over the past decade, due to the growing demand for robust estimates of vital events and determinants of health, the primary objective of health and demographic surveillance system (HDSS) sites evolved to encompass: 1) the production of population-based health information to support evidence-based health policies and 2) the monitoring and evaluation of health interventions in settings where routine health information and vital registration systems are incomplete. Most HDSS sites collect VA data and provide population level cause specific mortality data. However, HDSS sites may not provide representative data for national estimates of cause-specific mortality. Application of VA in large cross sectional surveys or in sample vital registration systems have been used to obtain national and sub-national level mortality estimates.,

Potential users of data generated using VA include communities, health care planners and managers, researchers, global decision-makers and donors. While there is a degree of overlap, these users have different perspectives on the uses of mortality data, which have an impact on the desirable characteristics of VA instruments. Researchers, epidemiologists and global-level decision-makers want VA data to inform burden of disease estimation and program evaluation, implying that cause of death estimates must meet high accuracy standards and be comparable over time and across countries.<sup>7</sup> National and sub-national decision-makers and health system managers require cause of death data for planning, budgeting and resource allocation and for monitoring and reporting to donors, implying that VA data needs to be actionable and program relevant.

There have been a few instances where VA has been administered on a large scale as an explicit part of the development of national statistics.<sup>8</sup> Users of VA have identified the need for simpler data collection instruments coupled with convenient IT-based solutions (e.g. mobile phones or hand-held devices). These large scale users of VA have a perspective different from that of researchers, giving priority to the VA instrument's simplicity, feasibility and adaptability to local contexts, cost-effectiveness and program relevance.<sup>7</sup> A simplified VA instrument coupled with automated methods to ascertain causes of death can be a stepping-stone to increase the coverage of operational and representative civil and vital registration systems.



### 3 The development of the 2016\_WHO verbal autopsy instrument

The simplified instrument (2016\_WHO VA instrument) comprises a short list of causes of death of public health importance that can be ascertained from a limited number of questions suitable for use in VA interviews and amenable to automated assignment of cause of death using analytical software. The design of the VA questionnaire allows for addition of a narrative section where so desired and addition of locally relevant questions and diagnoses. The 2016\_WHO VA instrument has been informed by field testing and cognitive reviews<sup>13</sup> of the 2012\_WHO instrument, and the results of a simplification of the PHMRC Tariff method.

The WHO standard VA instrument published in 2007 has been successfully applied in many research settings since then. In recent years, there has been growing interest in strengthening countries' CRVS systems, which has led to the demand for a more simplified and practical VA instrument that is associated with IT applications for data collection and analysis.

To produce a simplified 2012 VA instrument, WHO carried out a systematic review of the use of VA and led an expert group of researchers, data users and other stakeholders, in collaboration with HMN, the University of Queensland (UQ) and the INDEPTH Network. Based on the compiled experience and evidence from the most widely-used and validated VA procedures (WHO VA standards, InterVA and PHMRC VA instrument),<sup>1-3,14</sup> consensus was reached on a simplified VA instrument for routine use as part of civil registration and vital statistics systems in settings where many deaths are not medically certified.

#### 3.1 2016 List of causes of death for VA

VA cannot ascertain all causes of death and, as many validation studies have shown, VA does not perform equally well for all causes that it can ascertain. Taking these limitations into account, the 2007\_list of causes of death for VA was revised to develop the 2016 list that includes all causes of death that could be ascertained with reasonable accuracy from a well-administered VA interview (Appendix 1). In developing the 2016 WHO VA instrument, a review was undertaken to compile evidence for the revision and simplification of the 2007 WHO VA standard cause of death list. The review included VA research studies that used either physician certified VA (PCVA) or automated analytical software to assign the cause of death<sup>15</sup>. In addition to research studies, a review of the materials and inputs from VA experts provided evidence on the feasibility and relevance of causes of death that can be reliably ascertained by VA.

The revision and simplification of the 2007 standard WHO VA cause of death list was based on:

- The frequency of a given cause of death being reported in VA; the importance and relevance of a given cause of death to global mortality levels<sup>1</sup>;

---

<sup>1</sup> In the simplification of the list of diagnoses, attention has been given to the Global Burden of Disease (GBD) groupings. In view of the ongoing edits of the GBD, the correspondence table does not

- The cause of death can be addressed by public health interventions; and
- The feasibility of the cause of death being ascertained through VA.

The list of causes of death resulting from the above process is presented in Appendix 1.

Using a minimum set of causes of death facilitates the merging and comparison of data from VA on an international scale. The mapping of the list of causes of death using ICD-10 codes shown in Appendix 1 allow comparison of mortality data determined by VA with ICD-10 coded causes of death data ascertained using the international certificate of causes of death.

### **3.2 List of indicators and their definitions, relevant age and sex groups and sample questions**

The 2016\_WHO VA questionnaire cause of death related indicators for all age groups in one sheet, but only subsets are used for the different age groups. The list of indicators is subdivided into 4 sections and 118 subgroups. Within sections and subgroups of the instrument, skip patterns are driven by the age and sex of the deceased and whether it, was a maternal or perinatal death. The indicators were selected by reviewing the 2007\_WHO VA questionnaire; identifying unused and uninformative indicators from the field experience of VA experts; and with input from cause of death assignment results using analytical software (InterVA and Tariff), and cognitive assessment of the WHO 2012 Instrument. Field testing with the interim 2014 Version and a final expert review and consolidation of the results led to the formulation of the present list of indicators.

*The table shows the distribution of questions by age group and broad section of the questionnaire.*

*The levels refer to the skip questions. The 'entry level' questions will always have to be asked.*

*Questions for CRVS are a set recommended by the UN Statistical Division. They may not be necessary in all settings.*

*The questions asking for content of a medical certificate of cause of death may provide helpful information in certain settings and in case such a certificate has been issued.*

---

include GBD references. The mentioned ICD-10 codes may serve to distribute cases to the relevant GBD groups.

| Segment/depth  | Neonate    | Child      | Adult (incl. maternal) |
|--|------------|------------|------------------------|
| Presets  | 3          | 3          | 3                      |
| Information on the respondent and background about interview | 5          | 5          | 5                      |
| Personal (Information on the Deceased)                       | 19         | 23         | 24                     |
| Entry Level  | 12         | 12         | 12                     |
| Level 2  | 7          | 11         | 12                     |
| Civil registration numbers                                   | 7          | 7          | 7                      |
| Entry Level  | 1          | 1          | 1                      |
| Level 2  | 6          | 6          | 6                      |
| Verification of possible stillbirth                          | 13         | 0          | 0                      |
| Entry Level  | 4          | 0          | 0                      |
| Level 2  | 9          | 0          | 0                      |
| History of injuries/accidents                                | 22         | 22         | 24                     |
| Entry Level  | 1          | 1          | 1                      |
| Level 2  | 21         | 21         | 23                     |
| Health history   | 160        | 187        | 210                    |
| Entry Level  | 35         | 27         | 26                     |
| Level 2  | 125        | 160        | 184                    |
| Background and context                                       | 10         | 10         | 10                     |
| Entry Level  | 6          | 6          | 6                      |
| Level 2  | 4          | 4          | 4                      |
| Death certificate with cause of death                        | 12         | 12         | 12                     |
| Entry Level  | 1          | 1          | 1                      |
| Level 2  | 11         | 11         | 11                     |
| Open narrative   | 1          | 1          | 1                      |
| <b>Grand Total</b>   | <b>252</b> | <b>270</b> | <b>296</b>             |
| <b>Entry Level</b>   | <b>60</b>  | <b>48</b>  | <b>47</b>              |

The full set of indicators that were considered and the rationale for inclusion or exclusion of each indicator in the 2016 VA instrument is available for download at [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards). The list of indicators is further described in Section 4.2.

The instrument allows for the addition of indicators of topical interest such as risk factors where necessary. However, such augmentation of the 2016 instrument is not encouraged (see Section 4.4 “Guidelines on augmentation, and local adaptation”), because the 2016 instrument is comprehensive and if correct cause of death certification and coding procedures are used, it should be possible to generate comparable data over time across populations. Any addition of indicators should be done in consultation with WHO in order to ensure operability of the analytical software for assigning cause of death and comparability of results. See Section 4.4 for further guidance.

## 4 Application and implementation of the 2016 WHO verbal autopsy instrument

This section describes the application and implementation of the 2016 WHO VA instrument. The 2016 WHO VA instrument and supporting documentation for implementation include the following components:

- 2016 Cause of Death List with ICD Codes (Appendix 1, described in Section 3.1, identical with the 2014 version)
- Table of Indicators: For each indicator, describes the variable ID and the data type, defines threshold values to categorize numeric values, defines skip patterns, and includes notes for translators and interviewers.
- 2016 WHO VA instrument
  - Excel- and XML-files and references to data collection platforms (posted on WHO website at: [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards))
  - 3 Sample (Paper) Questionnaires
- Tools and guidance for remote data collection and storage in a database (described in Section 4.8.2; will be posted on WHO website at: [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards))
- Instrument translation tables (described in Section 4.5, available for download at [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards))
- 2016 WHO VA instrument training manuals (are posted on WHO website at: [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards))
- Analytical tools for cause of death assignment are available at:
  - InterVA : <http://www.interva-4.net/>
  - Tariff : <http://www.healthdata.org/verbal-autopsy/tools>
  - openVA<sup>2</sup>: <https://openva.net>

Details for application and implementation described in this section include: a description of the structure and indicators included in the 2016 WHO VA instrument; guidelines for local adaptation and translation of the instrument; guidelines for data collection, management, and storage; and guidelines for cause of death assignment and use of VA data.

---

<sup>2</sup> openVA is a software that runs automated VA coding algorithms and is available as a package for the R statistical software. Available algorithms include: InSilicoVA, InterVA4, InterVA5 and Naïve Bayes Classifier, and Tariff. Tariff2 will be available in the near future.





## 4.1 Sections of the 2016 WHO VA instrument

The 2016 VA instrument contains both common sections and specific sections appropriate to both the age and sex of the deceased.

**NOTE: Age, sex, information about the season, the local prevalence of HIV and malaria, section 3, 4, and 5 are essential information for the analytical software that assigns causes of death. No questions must be removed from these sections. The numbering of the questions must remain unchanged. Questions added locally will not be used by the currently available analytical software.**

Other components of the personal information and the respondent can be adjusted to the local legal requirements.

The instrument consists of the following sections:

1. Preset HIV-Malaria mortality and season (the project office may make this question hidden to the interviewers in the electronic format);
2. Information on the respondent and background about interview;
3. Information about the deceased and vital registration;
  - a. Information on the deceased
  - b. Civil registration numbers.
4. History of injury/accidents;
5. Health history;
  - a. Duration of illness
  - b. Medical history associated with final illness
  - c. General signs and symptoms associated with final illness
  - d. Signs and symptoms associated with pregnancy and women
  - e. Neonatal and child history, signs and symptoms
  - f. Health service utilization
  - g. Background and context
  - h. Death certificate with cause of death.
6. Open narrative (text field).
  - a. Check list of additional items to record in the narrative open space.

**Section 1** collects information about the prevalence of malaria and HIV in the area where the deceased lived and whether death occurred in rainy or dry season. This information is essential for selecting the appropriate algorithm used by some software for assigning the cause of death. In most settings this information will be pre-completed by study staff or supervisors.

**Section 2** collects information about the respondent, consent if required in certain contexts and time the VA interview was started.

**Section 3** contains key identifying and socio-demographic information and data fields necessary for the management of completed forms.

**Section 4** provides essential information for assigning the cause of death due to accidental and intentional injuries.

**Section 5** contains several sub-sections that collect information required for assigning causes of death. Section 5a) has questions to determine the duration of the final illness; 5b) history known past or present diseases that would give clues to the causes of death; 5c) contains symptoms and signs that are relevant for all deaths; 5d) contains symptoms and signs specific to maternal deaths; 5e) contains symptoms and signs relevant for neonatal and child deaths; and 5f) contains questions about the utilisation of health services and contextual factors. Section 5g has fields for recording information from a medical certificate of cause of death if this is available.

**Section 6** is an open narrative text field that allows for comments and adding additional information. This section is particularly useful for quality control and for providing additional information for physician assessment of the cause of death if needed. While its use is optional, it is recommended that this question be asked, even if it is not recorded, in order to complete the checklist of some indicators (section 6a) that are required for assigning causes of death using Tariff 2.0.

## 4.2 Technical description of the Table of Indicators (ODK XLS)

The Table of Indicators of the 2016 WHO VA instrument<sup>3</sup> consists of one table containing all indicators for all age groups with relevant details describing each indicator. The questions are grouped by sections, as is described above. Relevant skip patterns by age and sex are defined for each indicator.

Questions, hints and skip instructions are listed in the sheet “survey”. Selectable values are listed in sheet “choices”.

Quick overview of the columns in the sheet “survey”

|                |   |
|----------------|---|
| type           | Describes the kind of question, e.g. yes/no, multiple choice, integer, or text  |
| name           | language independent identifier of the question   |
| label::English | question in a specified language: here English. You may add a column with the title “label:: <i>mylanguage</i> ” for the language of your choice. Having several language columns active allows to create multilingual forms. |
| hint::English  | hint for the question in the specified language. You may add a column with the title “hint:: <i>mylanguage</i> ” for the language of your choice. Having several language columns active allows to create multilingual forms. |
| relevant       | here you have the information for the skip patterns.  |
| required       | determines whether the question must be answered, if asked  |
| appearance     | describes appearance of questions in the form   |

<sup>3</sup> Available at WHO VA standards webpage:

<https://www.who.int/healthinfo/statistics/verbalautopsystandards/en/>

## Application and implementation of the 2016 WHO VA instrument

calculation specifies calculations using the values of preceding questions. It is used to determine the age group

default

constraint add constraints to the data fields;

constraint message used to display a message why the entry is not accepted

Details about the format are available online at <http://xlsform.org/> and more generally at <https://opendatakit.org>.

### 4.3 Sample questionnaires

The 2016 WHO VA instrument is designed for use with an electronic data collection platform. Excel- and XML-files with the required instructions are posted on the WHO website at: [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards). A set of sample/paper questionnaires that demonstrate the layout of the questions, as described in the Table of Indicators, are also provided for v1.5.1 of the instrument, as a guide to the user.

The sample questionnaires may also serve as a guide for data collection using paper-based questionnaires. However, to facilitate 1) the use of automated analytical software for the assignment of cause of death, and 2) the comparison of the responses across VA studies, all data (regardless of data collection method) should be entered into a database following the instructions provided in Section 4.8.2. It is especially important to retain the variable IDs as defined in the Table of Indicators.

#### 4.3.1 Sample VA questionnaire 1: death of a child aged under four weeks

Sample VA questionnaire 1 is designed to determine causes of early neonatal deaths, late neonatal deaths, perinatal deaths and stillbirths. In addition to a “signs and symptoms noted during the final illness” list, the questionnaire contains questions concerning the history of the pregnancy, delivery, the condition of the baby soon after birth, and the mother’s health and contextual factors.

#### 4.3.2 Sample VA questionnaire 2: death of a child aged four weeks to 11 years

Sample VA questionnaire 2 is designed to ascertain the major causes of post-neonatal child mortality (i.e. starting from the fourth week of life), as well as causes of death that may be seen through 11 years of age. Questionnaire 2 includes all the common sections and questions described above, as well as questions related to causes of death in children aged four weeks to 11 months. The skip pattern is indicated by references to the next question.

#### 4.3.3 Sample VA questionnaire 3: death of a person aged 12 years and above

Sample VA questionnaire 3 is designed to identify all major causes of death among adolescents and adults (i.e. starting at age 12), including deaths related to pregnancy and childbirth. Questionnaire 3 includes a section for all female deaths, in addition to the above mentioned common sections and questions.

### 4.4 Guidelines on augmentation and local adaptation

The indicators contained in the 2016 WHO VA instrument address the most relevant causes of death in most populations where the use of VA is a necessary means to obtain cause of death information. The 2016 WHO VA instrument by design allows for evolution of the instrument. Users may add questions but under no circumstances should questions be removed from the list because of the resulting impact on the comparability of the causes of death information and the further data based evolution of the instrument.

**NOTE: Age, sex, information about the season, the local prevalence of HIV and malaria, section 3, 4, and 5 are essential information for the analytical software that assigns causes of death. No questions must be removed from these sections. The**

**numbering of the questions must remain unchanged. Questions added locally will not be used by the analytical software.**

It is acknowledged that there may be a desire to expand the instrument to address locally relevant conditions. However, adding signs and symptoms to the 2016 WHO VA instrument needs to be carried out with much caution because alteration can compromise the comparability of VA data between populations. In particular, the addition of new questions about particular diseases of interest may bias results if a disproportionate amount of information about only one condition is available in the cause of death assignment process. Modifications may be necessary if there are emerging or locally important causes of death for which there are no questions on the 2016 VA questionnaires. In these circumstances, advice may be sought from WHO for making such modifications. If modifications are necessary, they should be carefully documented and distinguished from the 2016 questionnaire sections and variables. In general, only changes to the wording of existing variables for the purposes of enhancing local comprehension or ensuring cultural acceptability of questions are to be undertaken. The definitions in the 2016 WHO VA instrument may provide some guidance about the meaning that needs to be preserved in such changes. Any need for modification should be shared with WHO together with the rationale for modification. The reporting of modifications made to WHO will inform future revisions of this instrument.

Examples of modifications that are unlikely to affect the comparability of results include:

- Adding questions or sections about household characteristics or environmental or behavioural risk factors;
- Adding or changing questions about usage of a particular health context.

Examples of modifications that may affect the comparability of results include:

- Changing or adding to response categories in the checklist of “signs and symptoms noted during the final illness”;
- Adding new questions about diseases of particular interest (e.g. malaria, HIV/AIDS, diarrhoeal disease).

Adding and removing questions will impact the comparability of the data **but also may compromise the usability of analytical software** for assigning cause of death. It may either not be possible to use the existing analytical software for assigning the newly added causes of death at all, or the outputs from the software become unreliable.

## **4.5 Translation**

The specific terminology used for indicators and interviewer and translator notes (in the Table of Indicators) aims to convey the highest level of clarity about the intent of a question. Indicators, instructions and data collection tool need to be translated or adapted for local use (even if administered in English, as lay language differs across English speaking regions). The notes in the Table of Indicators are intended to guide translators in the translation process; both the questions in the instrument and the hints in the Table of Indicators should be translated, as the notes will also provide guidance to interviewers.

Translators may need to adapt the wording of the questions to the local terminology used in the locations where interviews will be conducted. For quality assurance, a second translator should carry out a back-translation to English.

For any translations, please use the XLS form for the 2016 WHO VA instrument that you can download at [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards). Fill in your translations in the sheets “survey” and “choices” adding columns and do it the same way it was done for the existing translations. The given identifiers and the resulting multilingual file will allow users to 1. re-use a translation as necessary for other projects, and 2. load translations into the WHO software for immediate use, if so desired.

## **4.6 Vital registration**

For use of the 2016 WHO VA instrument in routine vital registration, two options are possible:

- 1) A death has been reported and notified, and an interviewer is sent to query the cause of death. In this case, the personal data are known and the interview will be conducted only to identify the cause of death. The “information on the deceased” section will be prefilled before the interview based on information from the death notification form, and a death registration number (or a similar identifier) will allow the user to link the VA outcome with the related entry in the death registration registry.
- 2) A death is reported and the certification and interview are conducted at the same time. In this case, the personal data are not known, or are known only in part, and need to be recorded at the time of the interview, using the “information on the deceased” section. A registration number will be required to ensure the vital registration linkage between the death registry and the VA data.

## **4.7 Age categories of death**

Some projects may be interested only in particular age categories of death, such as perinatal, maternal, child or adult deaths. In this case, the relevant subset of questions can be extracted from the list of indicators of the 2016 WHO VA instrument. The three age-group specific paper questionnaires for three age groups (under four weeks; 4weeks-11 years, 12 years and above) may serve as examples here. Where data are captured electronically, the embedded skip patterns will ensure that only the relevant subset of questions is applied.

Where interviews are conducted for all age categories of deaths, ideally the interview data should be captured electronically using the embedded skip patterns. Otherwise (eventually using paper if there is no other way), the interviewers should always be sure to have questionnaires available for all three age group during house visits for VA interviews.

## **4.8 Infrastructure**

In routine surveillance contexts, information needs to be timely and linked to a response that involves effective dissemination mechanisms, appropriate use of data, and periodic evaluation of the surveillance system. The latter can trigger formulation of

recommendations for a revision of the components of the 2016 WHO VA instrument to WHO and local workflows of the VA system in use. Thus, use of VA in routine surveillance involves monitoring, accountability, planning and programming.

To develop an adequate instrument for application in large-scale surveillance, the VA instrument needs to have a system that synergizes with other national mechanisms that are already in place. A permanent team that conducts Verbal autopsies on a representative sample of deaths is likely the most feasible way.

The infrastructure will depend largely on the given setting. Data should ideally be stored in a centralized location but at a level that facilitates necessary queries. Usually this is likely to be at the district level. All verified district data would then be forwarded to a central database at the national level.

Arrangements regarding collection, storage and handling of the vital registration and cause of death data should be made between the offices that are involved. Depending on the national infrastructure these offices are most frequently the Statistical Office, Ministry of Health, Ministry of Justice and Ministry of Interior.

Different arrangements may be necessary where VA is conducted in another context, as for research or disease specific programmes.

### 4.8.1 Interviewers

Interviewers should be trained on using the instrument and on conducting interviews with persons who may still be in mourning and may become upset during the interview. Interviewers should be given enough time to prepare and carry out VA interviews. It is proposed that at least one VA interview per month should be conducted by each VA interviewer to retain their proficiency in conducting VA interviews. Interviewers involved in the application of the VA should have the following minimum qualifications:

- Have completed at least secondary school and have good working knowledge in the relevant local language(s);
- Be acceptable to the local community; where possible, selected by the local community;
- Have good training in conducting VA interviews;
- Know very well the content and uses of the VA instrument.

The following steps are recommended to train VA interviewers. First the trainee interviewer should review all elements and the flow of questions with the help of an expert VA trainer. After discussing any questions that need clarification with the VA trainer, the interviewer can role play a VA interview using the VA trainer as proxy VA respondent. For this role play the VA trainer should have different case scenarios. Such scenarios would include the different age groups of the deceased (maternal, perinatal, child, adult) and thus varying relationship of the respondent to the deceased and also probable local behaviour on the interview per se, and on sensitive questions. In the next step, the interviewer would conduct real VA interviews in the presence of the expert trainer. The number of VA interviews to be conducted in the presence of the VA trainer required to certify proficiency of individual trainee VA interviewer will vary depending on the skills and abilities. Nevertheless typically it would take at least five VA interviews to become confident in doing VA interviews.



The interviewer guide that explains the meaning and importance of each indicator and how to ask each question included in the 2016 WHO VA instrument is posted on the WHO website at [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards).

#### 4.8.2 Data collection software, database, technology and staff

The 2016 WHO VA instrument is designed to be compatible with electronic data collection platforms and automated analytical software to assign cause of death.

The 2016 Instrument form is provided in a format that is fully compatible with the Open Data Kit (ODK - <http://opendatakit.org>). This allows one to quickly start collecting data using Internet cloud-based services as well as local servers. Data is output in a table format and at any time ready for analysis. A link to the demo version for testing and download is available at [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards). The electronic data collection form includes embedded skip patterns that automatically navigate the various combinations of age-, sex-, maternal- and perinatal-specific indicators within a single, comprehensive instrument.

Any software can be programmed for data collection using this instrument, as long as all answers to all questions, assigned cause of death and method of assigning cause of death are recorded in a database. Further, any tool for assigning the cause of death can be used, as long as the data collected are what is required for the specific analytical tool.

The ODK format has been adopted by several data collection software systems. Software with wide implementation are OpenSRP and DHIS2. Both can handle ODK standard instruments and have the ability to conduct batch processing and output of results. For DHIS, this requires setting up a separate server that feeds the data into the DHIS server.

Regardless of the data collection method (electronic or paper), answers to all questions and the cause of death assigned to each case should be recorded in a database. The database should retain the cause of death together with a variable that identifies the method of assigning the cause of death. The name of the interviewer and date, time and duration of the interview should also be retained in the database. If data are reported electronically this information can be generated automatically. If physician review is used to assign the cause or causes of death, then all assigned causes and the identity of the physician who assigned each should be recorded.

In order to facilitate the use of data collection and analytical software and to simplify the interviews, most questions follow a simple yes/no pattern. However some questions address a time interval or a frequency. All continuous variables should be recorded as continuous variables in the database and will be categorized in a second step using a recommended threshold value. Categorization depends on the analytical software that is used to identify the cause of death. The converter tool will include the necessary algorithms.

The compilation of the information above into a database will provide a tool for reviewing cases as well as enable sharing of results with WHO to facilitate further improvements to this instrument.

In addition to the questions, a narrative can be helpful if physician assessment is a possibility, for quality assurance, and for later review. The full *verbatim* narrative should be stored in the database as well.

In order to use the existing analytical software, the data collected with the WHO VA Instrument need to be converted into the formats that can be processed by the analytical software that determines the cause of death. WHO makes available conversion algorithms in collaboration with the University of Washington and the Swiss TPH. These include a simple conversion (programmed in R) and an all-in-one R package (openVA - <https://cran.r-project.org/web/packages/openVA/index.html>) that does the conversion and runs the analytical software and outputs the cause of death. Links to the packages are also available from the WHO website [www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards).

VA, using ODK or other electronic data collection methods, requires at a minimum a central server, and mobile devices for data collection. The data will be stored on the central server as soon as a mobile or wired internet connection to the server is available. Sufficient maintenance staff with IT administration skills is necessary in order to set up and maintain the technical infrastructure. Data and software staff will ensure that data collection is complete and workflows work. Statistical and epidemiological staff will use the outputs from the system for tabulation and analysis.

### 4.8.3 Methods for determining causes of death

In the past decade, methodological developments in automated methods for assigning cause of death for VA have emerged with significant potential for future application in routine national and research data collection platforms. These methods create new opportunities for reliable, timely, and useful cause-specific mortality measurement. These developments have created a shift away from limited individual-level and clinical paradigms towards population-based epidemiological thinking and public health.<sup>16</sup>

The 2016 WHO VA instrument contains information on diseases, signs and symptoms, the age and sex of the deceased as well as his or her medical history (if available). Additional information may be recorded in the open text field at the end of the interview. To facilitate application in routine surveillance systems, the 2016 WHO VA instrument was specifically developed to ascertain cause of death through automated methods. As a more cost-effective and feasible alternative to physician-coded VA, the WHO recommends the use of automated methods for cause of death identification. The use of automated VA cause of death assignment methods also ensures that causes of death are determined in a standard fashion, removing the variability inherent with physician coding of VA.

Analytical software tools compatible with the 2016 WHO VA instrument for cause of death assignment without the use of physicians are listed on the WHO VA website ([www.who.int/healthinfo/statistics/verbalautopsystandards](http://www.who.int/healthinfo/statistics/verbalautopsystandards)). At present (2014) InterVA4 (University Umea), SmartVA (PHMRC/IHME) and InsilicoVA (University of Washington) are fully compliant with the 2016 WHO VA instrument and can be linked for batch processing to the data collection software.

The intended possible use of these software will allow to assess both against the same database of indicators and contribute to further development of this Verbal Autopsy instrument as well as of the software.

In case physicians assess the cause of death, ideally two physicians will review the outcome of an interview and formulate a cause of death independently. If there were a

discrepancy, a third physician would arbitrate the result. The opinion of each physician involved should be separately recorded in the database, as well as the consensus finding.

#### 4.8.4 Legal requirements, privacy, confidentiality, informed consent

Ideally, informed consent should be sought from the respondent. Where the legislation or local regulations require that VA be conducted, informed consent may not always be necessary.

Personal data, in particular name, geographical information and contact information about the respondent, should be kept separate from the epidemiological data and ideally be encrypted to protect privacy and ensure confidentiality. Additional measures to anonymize the individual record may be subject to the legislation in force. A common case-ID in the person identifiable VA dataset and the diagnostic VA dataset will allow data linkage between personal and diagnostic data upon formal request in line with national and international regulations.

### 4.9 Appropriate respondents and recall period

The respondent who provides information about the deceased and allows the interviewer to complete the VA questionnaire should be the primary caregiver (usually a family member) who was with the deceased in the period leading to death or a witness to a sudden death or accident. This individual is likely to provide the most reliable and accurate account of the signs and symptoms of importance. It is not uncommon for a VA respondent to require assistance from other household or family members in answering the VA questions. However, the verbal autopsy interviews should be conducted in privacy. The VA interviews should be conducted as soon as practically possible after the report of the event is received, but after any culturally prescribed mourning period has passed. Recalls of more than one year should be interpreted with caution. In general, shorter recall periods are preferable.

### 4.10 Use of verbal autopsy-generated data

The purpose of VA is to describe the causes of death at the community level or population level in instances where no better alternative sources of mortality data exist. Therefore, VA serves as a limited but essential substitute for medical certification. The quality of information of the assigned cause of death varies depending on the skills of the interviewer and the ability of the respondents to recognise, recall and report key indicators.

The 2016 WHO VA cause of death list (Appendix 1) is a core mortality classification system, specifying the most important causes of death in low-income and middle-income countries where it is deemed feasible to certify cause of death using VA. Coding causes of death using the ICD coding system facilitates the comparison of data and the retention of as much detail as needed in local settings.

The context and method of information gathering to assign cause of death from VA is different from the medical certification of cause of deaths by a physician. The certainty of the cause of death is much lower in VA, and VA cannot reliably ascertain some causes of death. Thus, causes of death data obtained from these two systems should not be merged, as it would conceal differences that may result from these methods and lead to misinterpretation of the results.

ICD-10 provides tabulation lists for mortality and morbidity in volume 1. Other professional groups have made different lists for grouping diseases and presenting mortality statistics. Regardless of the list used, deaths should be classified by sex and into the following age groups: aged < 1 year, aged 1–4 years, and then in 5-year groups from age 5 years to 84 years, followed by a group for those aged 85 years or older. Volume 2, section 5.6.1 of ICD-10, contains a full set of instructions for tabulation.

## 5 Bibliography

- 1 Verbal autopsy standards: ascertaining and attributing cause of death. (World Health Organization, 2007).
- 2 InterVA. *InterVA*, <<http://www.interva.net/>> (2011).
- 3 Murray, C. J. *et al.* Population Health Metrics Research Consortium gold standard verbal autopsy validation study: design, implementation, and development of analysis datasets. *Popul Health Metr* **9**, 27, doi:1478-7954-9-27 [pii] 10.1186/1478-7954-9-27 (2011).
- 4 Soleman, N., Chandramohan, D. & Shibuya, K. Verbal autopsy: current practices and challenges. *Bull World Health Organ* **84**, 239-245, doi:S0042-96862006000300020 [pii] /S0042-96862006000300020 (2006).
- 5 Biraud Y. Méthodes pour l'enregistrement par des non médecins des causes élémentaires de décès dans les zones sous-développées. Geneva: World Health Organization; 1956. WHO document HS/60
- 6 Murray, C. J., Lopez, A. D., Feehan, D. M., Peter, S. T. & Yang, G. Validation of the symptom pattern method for analyzing verbal autopsy data. *PLoS Med* **4**, e327, doi:07-PLME-RA-0521 [pii] 10.1371/journal.pmed.0040327 (2007).
- 7 Abouzahr, C. Verbal autopsy: who needs it? *Popul Health Metr* **9**, 19, doi:1478-7954-9-19 [pii] 10.1186/1478-7954-9-19 (2011).
- 8 Setel, P. W. Verbal autopsy and global mortality statistics: if not now, then when? *Popul Health Metr* **9**, 20, doi:1478-7954-9-20 [pii] 10.1186/1478-7954-9-20 (2011).
- 9 Leitao, J. *et al.* Comparison of physician-certified verbal autopsy with computer-coded verbal autopsy for cause of death assignment in hospitalized patients in low- and middle-income countries: systematic review. *BMC medicine* **12**, 22, doi:10.1186/1741-7015-12-22 (2014).
- 10 Desai, N. *et al.* Performance of four computer-coded verbal autopsy methods for cause of death assignment compared with physician coding on 24,000 deaths in low- and middle-income countries. *BMC medicine* **12**, 20, doi:10.1186/1741-7015-12-20 (2014).
- 11 Lozano, R. *et al.* Performance of InterVA for assigning causes of death to verbal autopsies: multisite validation study using clinical diagnostic gold standards. *Popul Health Metr* **9**, 50, doi:10.1186/1478-7954-9-50 (2011).
- 12 Oti, S. O. & Kyobutungi, C. Verbal autopsy interpretation: a comparative analysis of the InterVA model versus physician review in determining causes of death in the Nairobi DSS. *Popul Health Metr* **8**, 21, doi:10.1186/1478-7954-8-21 (2010).
- 13 Scanlon, P., Nichols, E. (2014). National Center for Health Statistics. Hyattsville, MD Results of the Cognitive Interviewing Study of the 2012 WHO Verbal Autopsy Instrument in Nyanza Province, Kenya.
- 14 Bauni, E. *et al.* Validating physician-certified verbal autopsy and probabilistic modeling (InterVA) approaches to verbal autopsy interpretation using hospital causes of adult deaths. *Popul Health Metr* **9**, 49, doi:10.1186/1478-7954-9-49 (2011).

15. Leitaio, J. *et al.* Revising the WHO verbal autopsy instrument to facilitate routine cause-of-death monitoring. *Global health action* **6**, 21518, doi:10.3402/gha.v6i0.21518 (2013).
16. Fottrell, E. Advances in verbal autopsy: pragmatic optimism or optimistic theory? *Popul Health Metr* **9**, 24, doi:1478-7954-9-24 [pii] 10.1186/1478-7954-9-24 (2011).
17. World Health Organization (WHO). International guidelines for certification and classification (coding) of COVID-19 as a cause of death. 2020, World Health Organization: Geneva. Available from: <https://www.who.int/publications/i/item/revealing-the-toll-of-covid-19> (Accessed 31 July 2020)
18. World Health Organization (WHO), Global surveillance for COVID-19 caused by human infection with COVID-19 virus - Interim guidance – 20 March 2020 WHO, Geneva. Available from: <https://www.who.int/docs/default-source/coronaviruse/global-surveillance-for-covid-v-19-final200321-rev.pdf> (accessed 31 July 2020)
19. Centers for Disease Control and Prevention (CDC). Coronavirus Disease 2019 in Children — United States, 12 February–2 April 2020. *MMWR Morb Mortal Wkly Rep.* ePub: 6 April 2020. Available from: <https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e4.htm> (Accessed 26 April 2020)
20. Hussain-Alkhateeb L, D'Ambruoso L, Tollman S, Kahn K, Van Der Merwe M, Twine R, Schiöler L, Petzold M, Byass P. Enhancing the value of mortality data for health systems: adding Circumstances Of Mortality CATegories (COMCATs) to deaths investigated by verbal autopsy. *Global Health Action.* 12:1. 25 October 2019. DOI: [10.1080/16549716.2019.1680068](https://doi.org/10.1080/16549716.2019.1680068)
21. Li LQ, Huang T, Wang YQ, Wang ZP, Liang Y, Huang TB, et al. COVID-19 patients' clinical characteristics, discharge rate, and fatality rate of meta-analysis. *J Med Virol.* 12 March 2020.
22. Menni C, Valdes AM, Freidin MB, Sudre CH, Nguyen LH, Drew DA, et al. Real-time tracking of self-reported symptoms to predict potential COVID-19. *Nature Medicine.* 2020. DOI: 10.1038/s41591-020-0916-2
23. Sant Fruchtmann C, Kabadi G, Mwanza J, Mushi A, Matemba L, Msigwa G, et al. Telephone verbal autopsy (TeleVA) for cause of death estimation in CRVS systems where there is no doctor: A proof of concept study. Final Report v1.0. Aug 2019.
24. World Health Organization (WHO). Clinical management of COVID-19 disease. Geneva: World Health Organization; 27 May 2020. Available from <https://www.who.int/publications/i/item/clinical-management-of-covid-19> (accessed 31 July 2020)
25. WHO, Vital Strategies, (2020). Revealing the toll of COVID-19: A technical package for rapid mortality surveillance and epidemic response. NY: Vital Strategies; Geneva: WHO. <https://www.who.int/publications-detail-redirect/revealing-the-toll-of-covid-19>





## **Appendix 1: 2016 cause of death list for verbal autopsy with corresponding ICD-10 codes (identical with 2014)**

### **2016 cause of death list for verbal autopsy with corresponding ICD-10 codes.**

Column 1 contains the code for the verbal autopsy entity. Column 2 lists the related titles. Column 3 lists the ICD-10 codes that would be used if the condition labelled by column 2 were coded to ICD-10. The third column lists the ICD-10 codes that relate to the text label of the cause of death category in Column 2.

The use of this list is two-fold. For computer-coding VA (CCVA) algorithms that assign broad text labels for causes of death, this list could serve as a coding list, such that the CCVA program could directly code the death to one of these labels, and this table provides the related ICD codes. Alternatively, this list could serve as a tabulation list for other VA cause of death assignment methods such as physician coding or expert algorithms, which have the potential to directly assign specific text labels for causes of death with their individual ICD 3 or 4 character codes. In such situations, the detailed coded data from these methods could then be aggregated for tabulation according to the code groups in Column 3, to enable comparison with computer derived diagnosis. In other situations, the specifically coded data (3 or 4 character ICD codes) from physician coded VA or expert algorithms could be aggregated and analyzed using other tabulation lists such as the WHO Mortality Lists or the Global Health Estimates/Global Burden of Disease categories. In all situations, coded data from VA should be specifically labelled according to the data source and the type of coding approach used, and separately tabulated for each data source/coding method.

| Verbal autopsy code                             | Verbal autopsy title                             | ICD-10 codes (from ICD - 2016)  |
|---|--|---|
| <b>VAs-01 Infectious and parasitic diseases</b> |  |   |
| VAs-01.01                                       | Sepsis   | A40-A41   |
| VAs-01.02                                       | Acute respiratory infection, including pneumonia | J00-J22; J85  |
| VAs-01.03                                       | HIV/AIDS related death                           | B20-B24   |
| VAs-01.04                                       | Diarrheal diseases                               | A00-A09   |
| VAs-01.05                                       | Malaria  | B50-B54   |
| VAs-01.06                                       | Measles  | B05   |
| VAs-01.07                                       | Meningitis and encephalitis                      | A39; G00-G05  |
| VAs-01.08                                       | Tetanus <sup>4</sup>                             | A33-A35   |
| VAs-01.09                                       | Pulmonary tuberculosis                           | A15-A16   |
| VAs-01.10                                       | Pertussis  | A37   |
| VAs-01.11                                       | Haemorrhagic fever <sup>5</sup>                  | A92-A96, A98-A99  |
| VAs-01.12                                       | Dengue fever                                     | A97   |
| VAs-01.13                                       | Coronavirus disease (COVID-19)                   | U07.1; U07.2  |
| VAs-01.99                                       | Unspecified infectious disease                   | A17-A19;<br>A20-A32;<br>A36;<br>A38;<br>A42-A49;<br>B00-B04;<br>B06-B19;<br>B25-B49;<br>B55-B99 |

<sup>4</sup> Excludes: Neonatal tetanus VAs-10.05

<sup>5</sup> Excludes: Dengue VAs-01.12  
A1-2

## Non-communicable diseases

### Note:

This group covers all non-communicable conditions. Any infection of the systems that are listed in this section should be assigned to the suitable infectious disease category. Any maternal and perinatal condition should be assigned to the maternal and perinatal causes below.

|                         |  |  |
|-------------------------|--|--|
| VAs-98                  | Other and unspecified non-communicable disease | D65-D89;<br>E00-E07;<br>E15-E35;<br>E50-E90;<br>F00-F99;<br>G06-G09;<br>G10-G37;<br>G50-G99;<br>H00-H95;<br>J30-J39;<br>J47-J84;<br>J86-J99;<br>K00-K31;<br>K35-K38;<br>K40-K69;<br>K77-K93;<br>L00-L99;<br>M00-M99;<br>N00-N16;<br>N20-N99; |
| <b>VAs-02 Neoplasms</b> |  |  |
| VAs-02.01               | Oral neoplasms                                 | C00-C06  |
| VAs-02.02               | Digestive neoplasms                            | C15-C26  |
| VAs-02.03               | Respiratory neoplasms                          | C30-C39  |
| VAs-02.04               | Breast neoplasms                               | C50  |
| VAs-02.05               | Female reproductive neoplasms                  | C51-C58  |
| VAs-02.06               | Male reproductive neoplasms                    | C60-C63  |
| VAs-02.99               | Other and unspecified neoplasms                | C07-C14;<br>C40-C49;<br>C64-D48;<br>C91-C95  |



| <b>VAs-03 Nutritional and endocrine disorders</b> |  |   |
|---|--|---|
| VAs-03.01   | Severe anaemia                               | D50-D64   |
| VAs-03.02   | Severe malnutrition                          | E40-E46   |
| VAs-03.03   | Diabetes mellitus                            | E10-E14   |
| <b>VAs-04 Diseases of the circulatory system</b>  |  |   |
| VAs-04.01   | Acute cardiac disease <sup>6</sup>           | I11.0; I20-I26;<br>I46.1; I46.9; I50.1                                      |
| VAs-04.02   | Stroke                                       | I60-I69   |
| VAs-04.03   | Sickle cell with crisis                      | D57   |
| VAs-04.99   | Other and unspecified cardiac disease        | I00-I10;<br>I11.9-I15;<br>I27-I46.0;<br>I47-I50.0;<br>I50.9-I52;<br>I70-I99 |
| <b>VAs-05 Respiratory disorders</b>               |  |   |
| VAs-05.01   | Chronic obstructive pulmonary disease (COPD) | J40-J44   |
| VAs-05.02   | Asthma                                       | J45-J46   |
| <b>VAs-06 Gastrointestinal disorders</b>          |  |   |
| VAs-06.01   | Acute abdomen                                | R10   |
| VAs-06.02   | Liver cirrhosis <sup>7</sup>                 | K70.2; K70.3;<br>K71.7; K74   |
| <b>VAs-07 Renal disorders</b>                     |  |   |
| VAs-07.01   | Renal failure                                | N17-N19   |
| <b>VAs-08 Mental and nervous system disorders</b> |  |   |
| VAs-08.01   | Epilepsy                                     | G40-G41   |

<sup>6</sup> Includes: Ischaemic heart disease; Pulmonary embolism; Sudden cardiac death; Cardiac arrest, unspecified; Left ventricular failure; and Hypertensive heart disease with heart failure

<sup>7</sup> Includes Alcoholic fibrosis/ cirrhosis; Toxic liver cirrhosis; Fibrosis and cirrhosis of liver, excluding alcoholic and toxic, but including ‘unspecified liver cirrhosis’

| <b>VAs-09 Pregnancy-, childbirth and puerperium-related disorders</b> |  |   |
|---|--|---|
| VAs-09.01   | Ectopic pregnancy                              | O00   |
| VAs-09.02   | Abortion-related death                         | O03-O08   |
| VAs-09.03   | Pregnancy-induced hypertension                 | O10-O16   |
| VAs-09.04   | Obstetric haemorrhage                          | O46; O67;<br>O72  |
| VAs-09.05   | Obstructed labour                              | O63-O66   |
| VAs-09.06   | Pregnancy-related sepsis                       | O75.3; O85  |
| VAs-09.07   | Anaemia of pregnancy                           | O99.0   |
| VAs-09.08   | Ruptured uterus                                | O71.0-O71.1   |
| VAs-09.99   | Other and unspecified maternal cause           | O01-O02;<br>O20-O45;<br>O47-O62;<br>O68-O70;<br>O71.3-<br>O71.9;<br>O73-O84;<br>O86-O99 |
| <b>VAs-10 Neonatal causes of death</b>                                |  |   |
| VAs-10.01   | Prematurity or low birth weight                | P05; P07  |
| VAs-10.02   | Birth asphyxia <sup>8</sup>                    | P20-P22   |
| VAs-10.03   | Neonatal pneumonia                             | P23-P24   |
| VAs-10.04   | Neonatal sepsis                                | P36   |
| VAs-10.05   | Neonatal tetanus                               | A33   |
| VAs-10.06   | Congenital malformation                        | Q00-Q99   |
| VAs-10.99   | Other and unspecified perinatal cause of death | P00-P04;<br>P08-P15;<br>P25-P35;<br>P37-P94;<br>P96                                     |

<sup>8</sup> Includes: Hypoxia and respiratory distress

| <b>VAs-11 Stillbirths</b>  |  |                |
|--|--|----------------|
| VAs-11.01  | Fresh stillbirth                                       | P95            |
| VAs-11.02  | Macerated stillbirth                                   | P95            |
| <b>VAs-12 External causes of death</b><br><b>Note:</b><br><b>The list of questions contains sub questions that allow for more specificity for accidents.</b> |  |                |
| VAs-12.01  | Road traffic accident                                  | 9              |
| VAs-12.02  | Other transport accident                               |                |
| VAs-12.03  | Accidental fall  | W00-W19        |
| VAs-12.04  | Accidental drowning and submersion                     | W65-W74        |
| VAs-12.05  | Accidental exposure to smoke, fire and flames          | X00-X19        |
| VAs-12.06  | Contact with venomous animals and plants               | X20-X29        |
| VAs-12.07  | Accidental poisoning and exposure to noxious substance | X40-X49        |
| VAs-12.08  | Intentional self-harm                                  | X60-X84; Y87.0 |
| VAs-12.09  | Assault  | X85-Y09; Y87.1 |
| VAs-12.10  | Exposure to force of nature                            | X30-X39        |

<sup>9</sup> Distinction on the codes between VAs-12.01 and VAs 12.02 is on the basis whether the death was a road traffic accident. V01.1;V02.1;V03.1;V04.1;V05.1;V06.1; V09.2;V09.3; V10.4-V10.9; V11.4-V11.9; V12.4-V12.9; V13.4-V13.9; V14.4-V14.9; V15.4-V15.9; V16.4-V16.9; V17.4-V17.9; V18.4-V18.9; V19.4-V19.9; V20.4-V20.9; V21.4-V21.9; V22.4-V22.9; V23.4-V23.9; V24.4-V24.9; V25.4-V25.9; V26.4-V26.9; V27.4-V27.9; V28.4-V28.9; V29.4-V29.9; V30.5-V30.9; V31.5-V31.9; V32.5-V32.9; V33.5-V33.9; V34.5-V34.9; V35.5-V35.9; V36.5-V36.9; V37.5-V37.9; V38.5-V38.9; V39.4-V39.9; V40.5-V40.9; V41.5-V41.9; V42.5-V42.9; V43.5-V43.9; V44.5-V44.9; V45.5-V45.9; V46.5-V46.9; V47.5-V47.9; V48.5-V48.9; V49.4-V49.9; V50.5-V50.9; V51.5-V51.9; V52.5-V52.9; V53.5-V53.9; V54.5-V54.9; V55.5-V55.9; V56.5-V56.9; V57.5-V57.9; V58.5-V58.9; V59.4-V59.9; V60.5-V60.9; V61.5-V61.9; V62.5-V62.9; V63.5-V63.9; V64.5-V64.9; V65.5-V65.9; V66.5-V66.9; V67.5-V67.9; V68.5-V68.9; V69.4-V69.9; V70.5-V70.9; V71.5-V71.9; V72.5-V72.9; V73.5-V73.9; V74.5-V74.9; V75.5-V75.9; V76.5-V76.9; V77.5-V77.9; V78.5-V78.9; V79.4-V79.9; V80.0-V80.9;V81.1-V81.9; V82.1-V82.9; V83.0-V83.3; V84.0-V84.3; V85.0-V85.3; V86.0-V86.3; V87.0-V87.9; V89.2-V89.3; Y85.0; V90-V99; Y85.9

|           |   |   |
|-----------|---|---|
| VAs-12.99 | Other and unspecified external cause of death | (S00-T99);<br>W20-W64;<br>W75-W99;<br>X10-X19;<br>X50-X59;<br>Y10-Y84;<br>Y86; Y87.2;<br>Y88-Y89; |
|           |   |   |
| VAs-99    | Cause of death unknown                        | R95-R99   |



## Appendix 2: Considerations for the use of verbal autopsy in the identification of COVID-19 deaths

A set of questions to identify COVID-19 deaths has been included in version 1.5.3 of the electronic (ODK) 2016 WHO VA instrument. This brief technical note offers explanations for the use of VA to identify COVID-19 deaths.

### Background

There is an anticipation of community deaths associated with COVID-19 (coronavirus disease 2019). VA can complement information about causes of death, and also provide useful information on mortality profiles concerning COVID-19 where medical certification of cause of death is not available. This includes monitoring of excess deaths and potentially identifying individual COVID-19 cases.

The questions have been added to the WHO VA questionnaire upon request by countries and to standardize and align the set of questions proposed by different initiatives with the WHO definition of death due to COVID-19<sup>17</sup> and the underlying case definition for surveillance of COVID-19<sup>18</sup> and including the rapid mortality surveillance.

Evidence continues to evolve. Several studies have documented symptom patterns of COVID-19 patients<sup>19-23</sup>, and a core pattern of common symptoms has emerged. The WHO guidance “Clinical Management of COVID-19”<sup>24</sup> summarizes the current knowledge.

The most common symptoms of COVID-19 infection are fever, cough, shortness of breath or dyspnoea, myalgia or muscle aching, fatigue, headache and change of smell/taste.

Note:

- Fever, cough, dyspnoea, and headache are already captured by the 2016 WHO VA questionnaire before v1.5.3.
- Questions added include
  - Questions that complete the clinical presentation: loss or change of smell/taste, myalgia or fatigue.
  - Questions that may help identify a COVID-19 death or may provide information on comorbidities and other factors that are associated with increased risk of death or severe COVID-19 infection.
  - Questions relevant in the context of COVID-19 case definition<sup>17,18</sup>
- Using versions older than v1.5.3 of the 2016 WHO VA instrument (i.e. without the additional questions listed in Table 2), will NOT allow distinction between COVID-19 and other causes that share similar core symptoms (e.g., acute respiratory infection, including pneumonia).

## Questions to identify suspected COVID-19 deaths

New items added to v1.5.3 include core COVID-19 symptoms that were not included in the previous version of the WHO VA questionnaire:

- Testing status
- Close contact with a potential case
- Travel history in areas with widespread SARS-CoV-2 transmission

In such way, the criteria used in the WHO COVID-19 case definition<sup>17,18</sup> are adequately reflected.

These specific questions are aligned with the ones in rapid mortality surveillance (RMS)<sup>25</sup>.

Table 2 presents the new questions (n=7; 6 root questions and one follow-up question) that have been identified as of particular relevance for the identification of suspected COVID-19 deaths.

**Table 2: List of the additional interim questions for the identification of possible COVID-19 deaths**

1. (Id10482) Was there any diagnosis by a health professional of COVID-19?

- Yes
- No
- Don't know
- Refused to answer

2. (Id10483) Did s(h)e have a recent test by a health professional for COVID-19?

- Yes
- No
- Don't know
- Refused to answer

2.1. (Id10484) What was the result? (Hint for interviewer: Prompt for the result of the most recent test in case the deceased had more than one test performed)

- Positive
- Negative
- Unclear
- Don't know
- Refused to answer

3. (Id10485) Did s(h)e suffer from extreme fatigue? (Hint to interviewer: Probe whether the deceased felt so tired that (s)he found it hard to get out the bed and do the routine things like taking a shower or changing clothes)

- Yes
- No
- Don't know
- Refused to answer

Restriction: Only for adults.

4. (Id10486) Did (s)he experience a new loss, change or decreased sense of smell or taste?

- Yes
- No
- Don't know

- Refused to answer

Restriction: Only for adults

5. (Id10487) In the two weeks before death, did (s)he live with, visit, or care for someone who had any COVID-19 symptoms or a positive COVID-19 test? (*Hint to the interviewer: COVID-19 symptoms include fever, difficulty breathing, cough, extreme fatigue, and changes in sense of smell or taste. In the case of neonates or young children, please omit "care for".*)

- Yes
- No
- Don't know
- Refused to answer

6. (Id10488) In the two weeks before death, did (s)he travel to an area where COVID-19 is known to be present? (*Hint to the interviewer: Based on self-report of the respondent. If there is doubt, note the location in the narrative and check with the respective supervisor.*)

- Yes
- No
- Don't know
- Refused to answer

Physician Certified Verbal Autopsy (PCVA), is the recommended method for assigning the cause of death for COVID-19 deaths identified through VA. Guidance for the identification of probably COVID-19 deaths from VA data using PCVA will be soon made available on the WHO VA standards webpage.

As evidence is compiled, the symptom-cause information used by the existing automated algorithms for assigning the cause of death using the 2016 WHO VA questionnaire (e.g., InterVA, InSilicoVA, and SmartVA) will also be updated to include COVID-19, if and as it is determined appropriate to do so, by the respective algorithm developers. The performance of the newly added COVID-19 questions will be evaluated, and a final set of questions will be included in the next major revision of the WHO VA questionnaire.

## Considerations for VA implementation in the context of the COVID-19 pandemic

The information described in this appendix has been compiled with consideration to three key caveats:

1. VA, as described by standard WHO guidance, is well accepted as a method for understanding population-level cause of death patterns. However, it should not be used to assign a cause of death for individuals for legal purposes.
2. The appropriate methods for compiling cause of death information depend on the information goals; proper selection and application of VA methods requires an understanding of the purpose and limitations of the various methods. The full VA questionnaire is required for teams needing cause-specific mortality fractions across multiple causes. Alternatively, for teams wishing to determine if a death was possibly due to COVID-19 quickly, a rapid screener questionnaire may be sufficient<sup>25</sup>.

3. In the face of an epidemic, there is great value in death counts even in the absence of cause of death information. Monitoring for excess death by comparing all-cause mortality to a historical baseline can serve as an early warning signal to detect an outbreak and inform decision-making as an epidemic progresses<sup>25</sup>. If resources are limited, efforts to track all-cause mortality should not be sacrificed to obtain the probable cause of death information from VA.