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Original article

Public awareness of sepsis in Spain: a nationwide cross-sectional survey and factors associated with knowledge gaps

Conocimiento de la población sobre la sepsis en España: estudio transversal de ámbito nacional y factores asociados a las lagunas de conocimiento

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Abstract

Introduction: Sepsis causes an estimated 11 million deaths worldwide each year and approximately 27,000 in Spain. Most episodes begin in the community, where recognition depends on the patient. Public awareness is low internationally but has never been assessed nationally in Spain. We aimed to determine the prevalence of sepsis awareness among Spanish adults, identify sociodemographic factors independently associated with it, and characterize the depth of sepsis-related knowledge.

Material and methods: Nationwide cross-sectional survey conducted in July 2025 by computer-assisted web interviewing. Of 2,896 panel members invited, 2,423 adults completed the questionnaire (participation rate 83.7%), recruited under quotas for sex, age group and autonomous community. The primary outcome was self-reported awareness of sepsis. Multivariable logistic regression was used to identify independently associated factors.

Results: Awareness was reported by 47.8% of respondents (95% CI 45.8-49.7). Media exposure was the leading source of knowledge (57.0%). Female sex (adjusted OR 1.57, 95% CI 1.33-1.85), older age (1.013 per year, 1.008-1.019) and higher educational level (1.16 per level, 1.09-1.23) were independently associated with awareness (all p<0.001). Awareness ranged from 38.9% to 60.0% across autonomous communities. Knowledge depth was limited: 9.9% correctly estimated annual incidence, 11.5% annual mortality and 26.0% knew that recovery may take months or years. The mean symptom recognition score was 2.78 (SD 2.53) of 11.

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Conclusions: Fewer than half of Spanish adults recognize sepsis, and knowledge is shallow even among those who do. Male sex, younger age and lower educational attainment identify the groups that public education should prioritize.

Keywords: Sepsis. Health knowledge, attitudes, practice. Health literacy. Cross-sectional studies. Surveys and questionnaires. Spain.

Resumen

Introducción: La sepsis causa unos 11 millones de muertes anuales en todo el mundo y unas 27.000 en España. La mayoría de los episodios se inicia en la comunidad, donde el reconocimiento depende del paciente, pero el conocimiento público nunca se había evaluado en España a escala nacional. El objetivo fue determinar su prevalencia, los factores sociodemográficos asociados de forma independiente y su profundidad.

Material y métodos: Encuesta transversal nacional en julio de 2025 mediante entrevista web asistida por ordenador. De 2.896 panelistas invitados, 2.423 adultos completaron el cuestionario (participación del 83,7%), con cuotas de sexo, edad y comunidad autónoma. La variable principal fue el conocimiento autodeclarado. Se empleó regresión logística multivariante.

Resultados: Declaró conocer la sepsis el 47,8% (IC 95% 45,8-49,7). Los medios de comunicación fueron la principal fuente (57,0%). El sexo femenino (OR ajustada 1,57; IC 95% 1,33-1,85), la mayor edad (1,013/año) y el mayor nivel educativo (1,16/nivel) se asociaron de forma independiente (p<0,001). El conocimiento osciló entre el 38,9% y el 60,0% según la comunidad autónoma. Su profundidad fue limitada: el 9,9% estimó correctamente la incidencia anual, el 11,5% la mortalidad y el 26,0% sabía que la recuperación puede durar meses o años. La puntuación media de síntomas fue 2,78 (DE 2,53) sobre 11.

Conclusiones: Menos de la mitad de los adultos españoles reconoce la sepsis y el conocimiento es superficial incluso entre quienes dicen conocerla. El sexo masculino, la menor edad y el menor nivel educativo identifican los grupos prioritarios para la educación sanitaria.

Palabras clave: Sepsis. Conocimientos, actitudes y práctica en salud. Alfabetización en salud. Estudios transversales. Encuestas y cuestionarios. España.

Introduction

Sepsis, defined as life-threatening organ dysfunction caused by a dysregulated host response to infection, accounts for an estimated 11 million deaths each year, close to one in five deaths worldwide [1,2]. Modeled estimates place the burden in Spain at approximately 138,000 incident cases and 27,000 sepsis-related deaths annually [2]. Between 70% and 90% of episodes originate in the community [3,4]. Survival falls with delay in antimicrobial therapy and source control, and outcomes become progressively less modifiable once multiorgan failure is established [5]. The first link in that time-dependent chain is not the clinician but the patient, or the relative who decides whether the illness warrants urgent attention. Code Sepsis protocols and the Sepsis-3 framework have improved recognition inside the hospital [1,6], yet they can only act once the patient has arrived.

Public awareness of sepsis is consistently lower than that of other time-critical emergencies such as stroke or acute myocardial infarction [7]. Population surveys have reported awareness in 5% of respondents in Singapore, 21% in Sweden, 33% in Belgium, 41% to 45% in Great Britain, 48% in Saudi Arabia and 62% in Canada [8-13]. Recognizing the word, however, is a poor proxy for knowing what to do. In Germany fewer than 60% of adults aged 60 years or older who had heard of sepsis could define it correctly [14], and in Canada, the mean knowledge score across definition, symptoms, risk factors and prevention was 32% [13]. German patients at high risk of sepsis recognized, on average, only 27% of sepsis vignettes as emergencies [15]. Awareness that does not translate into recognition of a time-dependent emergency is unlikely to shorten time to presentation.

No nationwide study had examined public knowledge of sepsis in Spain. We conducted a cross-sectional survey of 2,423 Spanish adults to determine the prevalence of sepsis awareness, to identify the sociodemographic factors independently associated with it, and to characterize the depth of knowledge across symptom recognition, etiology, perceived urgency, epidemiological burden and expected recovery.

Material and methods

Study design

Nationwide cross-sectional survey of the adult population resident in Spain, conducted in July 2025 and reported in accordance with the CHERRIES checklist for internet surveys [16]. The study was promoted by *Fundación Código Sepsis* and Sepsisinfo.es, and

was designed and fielded by an independent market research organization.

Sampling and data collection

Data were collected by computer-assisted web interviewing. The sample was supplied by an ISO 20252-certified panel provider from its own opt-in online panel. Recruitment into the panel is open and continuous and takes place mainly through online channels, including social media campaigns and a mobile application; any adult resident in Spain may enroll. Enrollment follows a double opt-in procedure: the candidate registers, supplies an e-mail address and confirms it through a link sent to that address. Sociodemographic data are recorded at enrollment and updated periodically. Members receive redeemable credits for participation. Quality controls applied by the provider include digital fingerprint deduplication, captcha, cross-verification of age and sex against panel records at each survey, attention-check items and a minimum completion time threshold.

Eligible participants were adults aged 18 years or older resident in Spain. For the present study the provider drew members from the panel register to fill the pre-specified quotas and sent the invitation by e-mail through the panel platform. The investigators had no access to the panel register and obtained no e-mail address or other identifier: only the anonymized response file was transferred to the research team. Of 2,896 invitations issued, 2,423 questionnaires were completed, giving a participation rate of 83.7% among those invited. This figure is a participation rate within a pre-recruited panel and not a population response rate.

Quotas were set for sex, age group (18-34, 35-49, 50-64 and 65 years or older) and autonomous community. Allocation across autonomous communities was deliberately non-proportional: larger samples were assigned to the more populated communities, and a minimum number of interviews was guaranteed in the less populated ones, in order to preserve an analyzable base for territorial comparison. No design weights or elevation factors were applied by the fieldwork organization. Under the assumption of simple random sampling and maximum heterogeneity ($p=q=0.50$), the sampling error for the total sample is ±1.39% at a 95.5% confidence level.

Survey instrument

The questionnaire was purpose-built for this study, drawing on the domains covered by previously published sepsis awareness surveys [13,14]. It comprised 13 items in three blocks: sociodemographic profile; awareness of sepsis and its source; and knowledge, covering conceptual definition, symptom recognition, perceived causes, sepsis as a medical emergency, estimated annual incidence and mortality in Spain, and expected duration of recovery. All items were compulsory except for a final optional free text comment. The instrument was administered in Spanish and was not subjected to formal psychometric validation. On completion, participants were shown a debriefing screen with the correct answers. The full questionnaire is provided as **Supplementary material**.

Outcomes and variable definitions

The primary outcome was self-reported awareness of sepsis (yes or no). Secondary outcomes were: selection of the conceptually correct definition, namely an extreme response of the immune system to an infection, consistent with Sepsis-3 [1]; a symptom recognition score, calculated as the sum of 11 binary symptom items (range 0 to 11); recognition of sepsis as a medical emergency (agree or strongly agree on a five-point Likert scale); identification of any infection as a potential cause; knowledge that recovery may take months or years; and correct estimation of the annual incidence and mortality of sepsis in Spain.

Responses of more than 50,000 annual cases and more than 15,000 annual deaths were classified as correct, benchmarked against the national figures in public circulation at the time of fieldwork. Neither item offered a “do not know” option. Educational attainment was coded on an eight-level ordinal scale (0, no formal education; 7, doctoral degree).

Healthcare professional status was recorded only as one of the response options to the item on source of knowledge, which was presented exclusively to respondents who reported awareness. Healthcare professionals among unaware respondents could therefore not be identified, and this variable was not used as a covariated in any model.

Statistical analysis

Categorical variables are presented as counts and percentages, and continuous variables as means with standard deviation. Confidence intervals for proportions were calculated by the Wilson method. Bivariate associations were tested with the Pearson chi-squared test, and monotonic trends across ordered categories with a test for linear trend. Multivariable binary logistic regression was used to identify factors independently associated with awareness, entering sex, age (continuous) and educational level (ordinal) simultaneously. Crude and adjusted odds ratios are reported with 95% confidence intervals. Model fit was assessed by the McFadden pseudo-R^2 statistic and the Akaike information criterion. Symptom recognition scores were compared with the independent-samples t-test. A sensitivity analysis applied iterative post-stratification

weighting to sex, age group and autonomous community using national population distributions. A second sensitivity analysis re-classified correct estimation of mortality against modeled rather than coded national figures. All tests were two-sided with a significance threshold of 0.05. Analyses were performed in Python 3.12 (SciPy 1.11, statsmodels 0.14).

Ethics

The study was an anonymous opinion survey of adults, without intervention, without collection of personal identifiers and without health data relating to the participants. It therefore falls outside the scope of Spanish Law 14/2007 on Biomedical Research and Royal Decree 1090/2015, and did not require review by a research ethics committee. Participation was voluntary: panel members received an invitation to take part and accessed the questionnaire by affirmative action, and were able to abandon it at any point. Data were processed in accordance with Regulation (EU) 2016/679 and Organic Law 3/2018. The study conformed to the principles of the Declaration of Helsinki.

Results

Sample

A total of 2,423 adults completed the survey. Mean age was 50.1 years (SD 15.4), with a range of 18 to 88 years, and 49.9% were women. All 17 autonomous communities and both autonomous cities were represented. University-level qualifications were held by 48.8% of respondents (**Table 1**).

Awareness of sepsis

Awareness of sepsis was reported by 1,157 of 2,423 respondents (47.8%, 95% CI 45.8-49.7). Awareness was higher among women than men (53.3% versus 42.2%; p<0.001), increased across age groups (41.5%

Table 1. Sample characteristics and awareness of sepsis by sociodemographic subgroup (n=2,423)

Variable	n	Aware, % (95% CI)	p
Total	2,423	47.8 (45.8-49.7)	
Sex			<0.001
Male	1,213	42.2	
Female	1,210	53.3	
Age group, years			<0.001 (trend)
18-34	424	41.5	
35-49	763	46.4	
50-64	722	49.4	
65 or older	514	52.5	
Educational level			<0.001 (trend)
No formal education	27	33.3	
Primary, incomplete	57	33.3	
Lower secondary	222	37.4	
Upper secondary or VET	930	46.3	
University diploma	376	50.8	
University degree	446	54.0	
Master's degree	303	48.2	
Doctorate	58	60.3	
Not stated	4		

CI: confidence interval; VET: vocational education and training.

Values are percentages of respondents reporting awareness of sepsis. The total row shows the overall prevalence with its 95% Wilson confidence interval.

Pearson chi-squared test, except where a test for linear trend across ordered categories is indicated.

at 18–34 years to 52.5% at 65 years or older; test for trend p<0.001) and rose with educational attainment (33.3% among those with no formal education to 60.3% among doctoral graduates; test for trend p<0.001) (**Table 1**, **Figure 1A and 1B**). In the weighted sensitivity analysis, awareness was 47.0%, and no estimate differed from its unweighted value by more than 1 percentage point.

Among the 1,157 respondents who reported awareness, the leading source of knowledge was media exposure through television, radio or the internet (57.0%), followed by other reasons (29.5%), being a healthcare professional (14.6%) and having been a sepsis patient (0.9%) (**Figure 2B**).

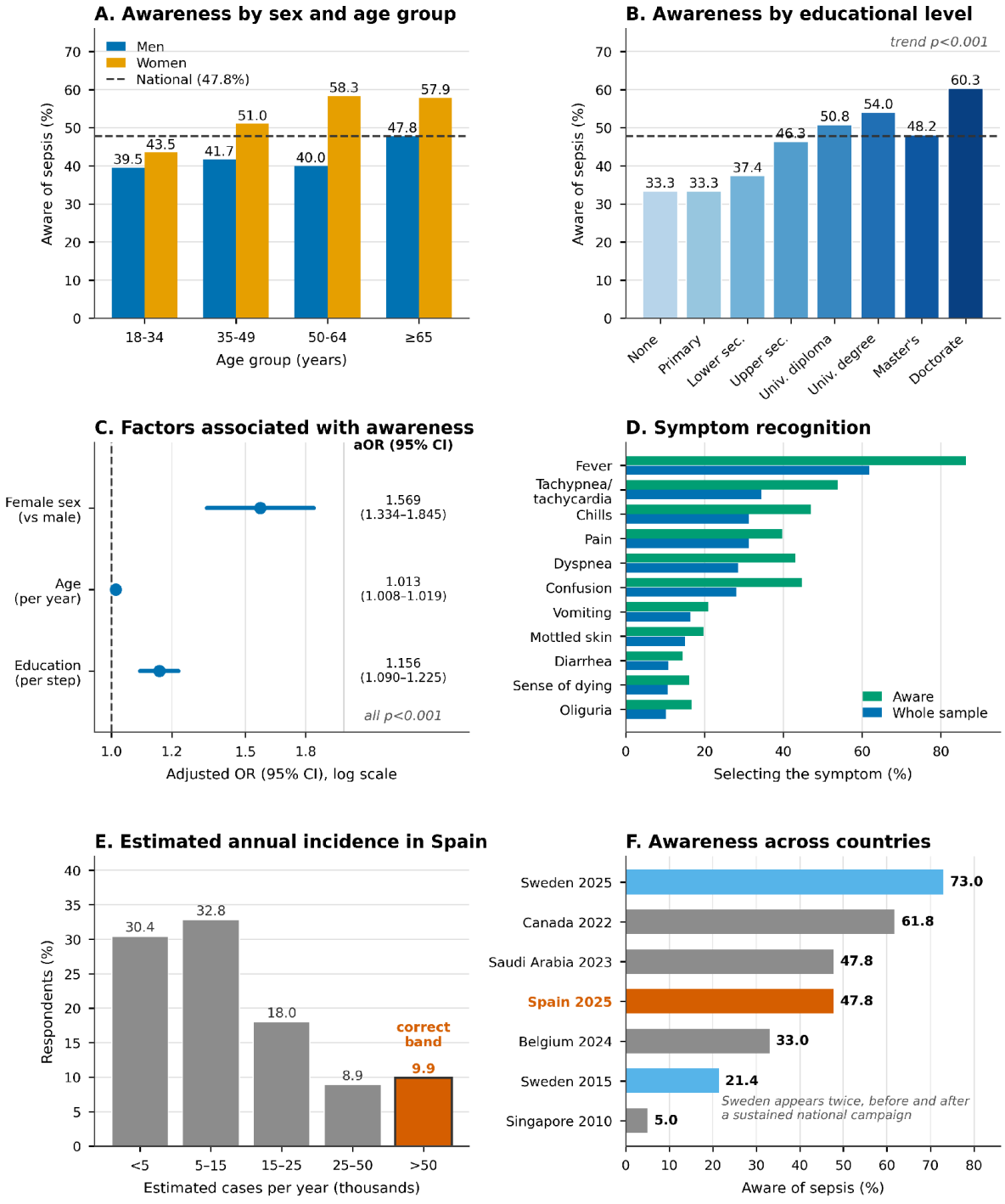


Figure 1. Public awareness of sepsis in Spain and depth of knowledge (n=2,423). (A) Awareness by sex and age group; the dashed line marks the national figure of 47.8%. (B) Awareness by educational level. (C) Adjusted odds ratios with 95% confidence intervals for the factors independently associated with awareness. (D) Symptom recognition in the whole sample and among aware respondents. (E) Distribution of estimates of the annual incidence of sepsis in Spain; the correct band is highlighted. (F) International comparison of public sepsis awareness; Sweden is shown at two time points, before and after a sustained national awareness campaign

Factors independently associated with awareness

Female sex, older age and higher educational level were each independently associated with awareness (**Table 2**, **Figure 1C**). Adjusted odds ratios were 1.57 (95% CI 1.33-1.85) for female sex, 1.013 (95% CI 1.008-1.019) per year of age and 1.16 (95% CI 1.09-1.23) per educational level, all with p<0.001. The model included 2,419 respondents with complete covariate data (McFadden pseudo-R^2 0.021; Akaike information criterion 3285.3).

Regional variation

Awareness ranged from 38.9% in the Balearic Islands to 60.0% in Cantabria. Cantabria, Galicia (58.2%) and Asturias (53.7%) were above the national figure, whereas Castilla-La Mancha (39.6%) and Andalusia (42.2%) were below it (**Figure 2A**).

Depth of knowledge

The conceptually correct definition of sepsis was selected by 48.2% of respondents, while 29.3% described it as a blood infection and 18.6% did not know. Fever was the most frequently recognized symptom (61.8%), followed by rapid breathing with elevated heart rate (34.5%), chills (31.3%), pain (31.2%), difficulty breathing (28.6%) and confusion or disorientation (28.0%) (**Figure 1D**). Mottled skin was recognized by 15.0%. No symptom at all could be identified by 25.4% of respondents. The mean symptom recognition score was 2.78 (SD 2.53) of 11, and differed between aware and unaware respondents (4.02, SD 2.49, versus 1.65, SD 1.97; p<0.001) (**Table 3**).

Bloodstream infection was the most frequently cited cause (46.4%), followed by any other infection (34.7%); 10.3% accepted that all the proposed causes could lead to sepsis and 22.1% did not know. Sepsis was considered a medical emergency by 68.4% of respondents, while 22.7% expressed no opinion.

Estimates of the epidemiological burden were low. Correct estimation of annual incidence was reached by 9.9% of respondents, and 63.2% placed it below 15,000 cases (**Figure 1E**). For mortality, 11.5% answered correctly whereas 65.2% believed that fewer than 5,000 people die of sepsis in Spain each year. When mortality was re-classified against modeled rather than coded national figures, correct estimation fell to 4.2%. Recovery lasting months or years was identified by 26.0% of respondents, and 40.9% were unable to estimate its duration (**Table 3**).

Discussion

In this nationwide survey, fewer than half of Spanish adults reported knowing what sepsis is. The figure is close to those reported in Great Britain and Saudi Arabia, above Belgium and below Canada [10-13] (**Figure 1F**). Nominal awareness, however, overstates what people actually know. Only 9.9% correctly estimated the annual incidence of sepsis in Spain and 11.5% its annual mortality, and the mean symptom recognition score was 2.78 of 11. The same dissociation has been described in Germany and Canada, where mean knowledge scores remained below 45% among respondents who had heard of the term [13,14]. Awareness measured as term recognition is therefore an inadequate endpoint for public health surveillance because it does not capture the knowledge required to act.

Female sex, older age and higher educational attainment were independently associated with awareness. The sex difference is consistent with Canada, where men had roughly half the odds of having heard of sepsis, and with Germany [13,15]. A plausible explanation, which this study did not measure, and which should therefore be read as a hypothesis, is the greater use of health services by women [17]. The positive gradient with age may reflect greater cumulative contact with health services, again a hypothesis rather than a finding. The gradient with education is the most consistent signal across international surveys [13,14] and points to general health literacy as a structural determinant of sepsis knowledge. Regional variation of more than 20 percentage points suggests that

Table 2. Factors independently associated with awareness of sepsis. Binary logistic regression (n=2,419)

Factor	Crude OR (95% CI)	Adjusted OR (95% CI)	p
Female sex (vs male)	1.56 (1.33-1.84)	1.57 (1.33-1.85)	<0.001
Age, per year	1.011 (1.006-1.016)	1.013 (1.008-1.019)	<0.001
Educational level, per step	1.13 (1.07-1.20)	1.16 (1.09-1.23)	<0.001

OR: odds ratio; CI: confidence interval.

Reference category for sex is male. Educational level was coded on an eight-level ordinal scale (0, no formal education; 7, doctoral degree).

Model fit: McFadden pseudo-R^2 0.021; Akaike information criterion 3285.3.

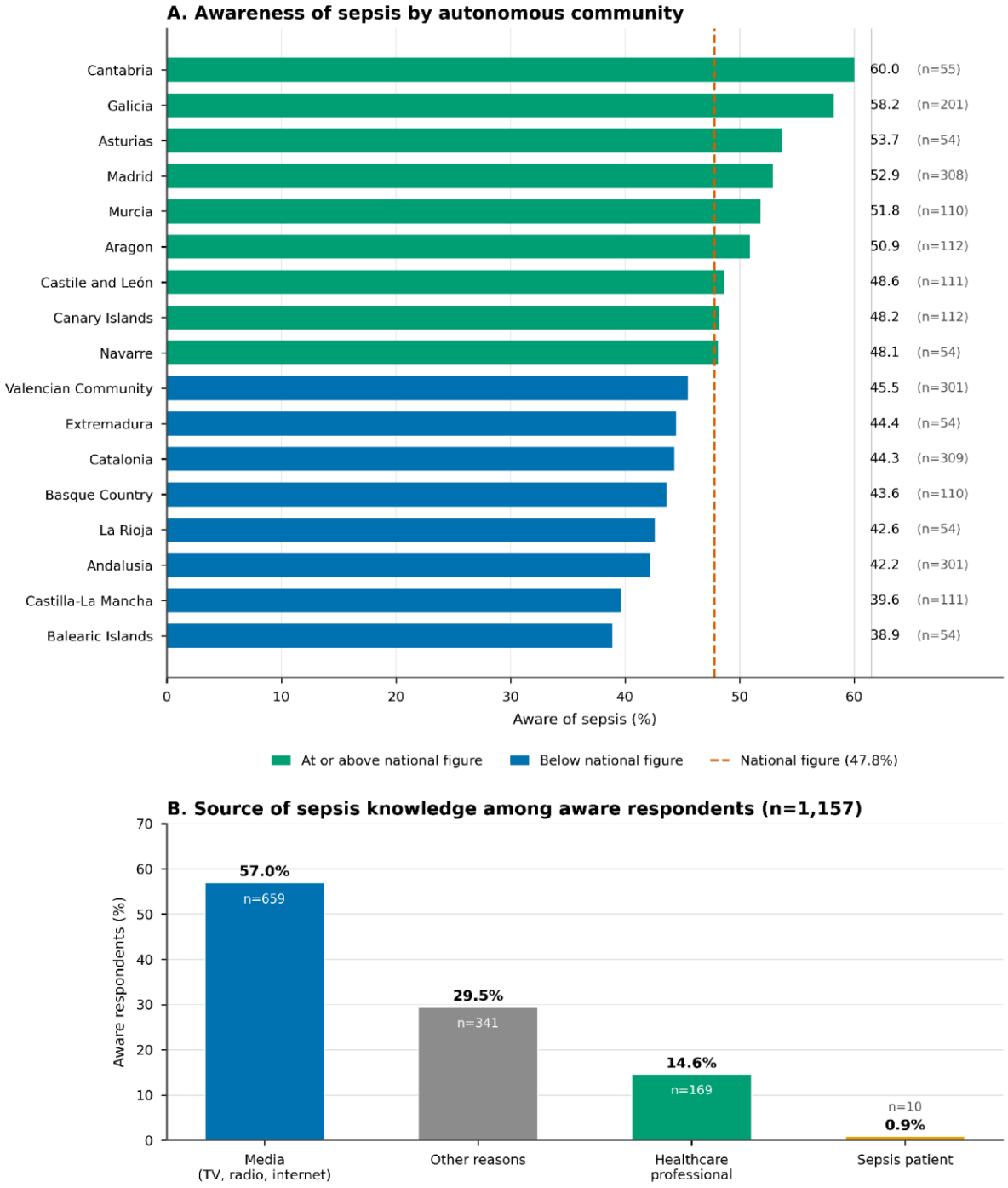


Figure 2. (A) Awareness of sepsis by autonomous community, ordered by percentage; the dashed line marks the national figure of 47.8%; Ceuta (n=7) and Melilla (n=5) are not shown owing to small numbers. (B) Sources of sepsis knowledge among respondents who reported awareness (n=1,157); more than one response was allowed

exposure to sepsis-related information is unevenly distributed across the country, although our design cannot identify its causes.

Media exposure was cited by 57% of aware respondents, whereas fewer than 1% reported having had sepsis themselves. Awareness in Spain therefore rests largely on opportunistic contact with mass media rather than on structured education or clinical encounter, which makes it fragile and dependent on continued media presence. Two specific gaps deserve attention. Only 26.0% knew that recovery may take months or years and 40.9% could not estimate it at all; post-sepsis syndrome, with its persistent physical, cognitive and psychological sequelae, affects survivors irrespective of whether they required intensive care, yet remains poorly recognized [18]. Second, fewer than half (45.0%) recognized that any infection can lead to sepsis, and 14.1% attributed it exclusively to bloodstream

Table 3. Depth of sepsis knowledge by awareness status (n=2,423)

Outcome	All (n=2,423)	Aware (n=1,157)	Unaware (n=1,266)	p
Conceptual knowledge				
Correct definition	48.2	63.6	34.0	<0.001
Sepsis is a medical emergency	68.4	90.7	48.0	<0.001
Any infection can cause sepsis	45.0	66.5	25.4	<0.001
Symptom recognition				
Fever	61.8	86.3	39.5	<0.001
Tachypnea and tachycardia	34.5	53.8	16.7	<0.001
Chills	31.3	46.9	17.0	<0.001
Dyspnea	28.6	43.0	15.4	<0.001
Confusion or disorientation	28.0	44.8	12.6	<0.001
Mottled skin	15.0	19.7	10.7	<0.001
Symptom score, mean (SD)	2.78 (2.53)	4.02 (2.49)	1.65 (1.97)	<0.001
Epidemiological knowledge				
Correct incidence (>50,000/year)	9.9	11.8	8.1	0.002
Correct mortality (>15,000/year)	11.5	16.0	7.4	<0.001
Correct mortality, modeled (>25,000/year)	4.2	5.2	3.3	0.029
Recovery takes months or years	26.0	35.2	17.7	<0.001

SD: standard deviation.

Values are percentages of respondents selecting each option, except the symptom score, which is the mean number of symptoms correctly identified out of 11.

Pearson chi-squared test for categorical outcomes; independent-samples t test for the symptom score.

Correct mortality was benchmarked primarily against coded national figures (>15,000 deaths per year) and, in a sensitivity analysis, against modeled estimates (>25,000 deaths per year).

infection. This is the message with the most direct bearing on time to presentation, and it is not reaching the public. Our correctness thresholds were benchmarked against the figures in public circulation, since the public cannot be expected to know an estimate that does not circulate. That choice is conservative: modeled estimates place the Spanish burden at 137,938 cases and 26,832 deaths [2], roughly double the coded national figures, a discrepancy attributable to systematic under-coding of sepsis in administrative data, where the source of infection takes precedence over sepsis itself [4]. Against those figures only 4.2% of respondents would have estimated mortality correctly. The direction of the argument does not change and its force increases.

This study has strengths and limitations. The sample is large, covers all autonomous communities and assesses several dimensions of knowledge rather than term recognition alone. Against this, the sample was recruited by quota from a volunteer opt-in panel, so self-selection cannot be excluded and participants may differ from the general population in ways the quota variables do not capture; allocation across autonomous communities was non-proportional and the estimates presented are unweighted, although weighting moved no estimate by more than 1 percentage point; healthcare professionals could be identified only among respondents who reported awareness; self-reported awareness is subject to social desirability bias; the instrument was not formally validated; the items on incidence and mortality forced an estimate, so respondents with no opinion cannot be distinguished from those who guessed; and the cross-sectional design precludes causal inference. These findings nonetheless identify where public education should be directed, namely men, younger adults, people with lower educational attainment and the communities with the lowest

awareness. A national sepsis plan is currently under development in Spain, and education of the population is one of its pillars; these data provide the baseline against which its targets can be set and its effect subsequently judged. The Swedish experience, where awareness rose from 21% in 2015 to 73% in 2025 under sustained campaigning, shows that population-level gains are attainable [19]. Messages should go beyond naming the condition and convey that any infection can progress to sepsis, that sepsis is a time-dependent emergency and that recovery is prolonged. Prevention of infection through vaccination, hygiene and prompt treatment of common infections belongs in the same message, since most sepsis arises from community-acquired infections that are potentially preventable or detectable at an early and treatable stage [3,4].

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Author contributions

Conceptualization, M.B., M.H., R.F. and M.S.L.; methodology, M.H.; formal analysis, A.G.; validation, M.B.; writing – original draft preparation, A.G.; writing – review and editing, M.B., M.H., R.F. and M.S.L.; visualization, A.G.; supervision, M.B.; project administration, M.H. All authors have read and agreed to the published version of the manuscript.

Conflicts of interest

The authors declare that there is no commercial or financial conflict of interest for this research.

AI statement

During the preparation of this work, the authors used a large language model (LLM) (Claude, Anthropic) as a support tool for drafting and editing the text, improving its clarity and readability, enhancing the visual presentation of the figures, and ensuring compliance with the journal's publication guidelines. The tool was not involved in the conception of the study, data collection or interpretation of the results. All authors reviewed and edited the content produced with this assistance, verified the data, analyses and references, and take full responsibility for the content of the publication.

Supplementary material

The supplementary material is available on the website of the Revista Española de Quimioterapia.

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REVISTA ESPAÑOLA DE Quimioterapia

SOCIEDAD ESPAÑOLA DE QUIMIOTERAPIA

SUPPLEMENTARY MATERIAL: SURVEY INSTRUMENT

Survey instrument

Public awareness of sepsis in Spain: a nationwide cross-sectional survey and factors associated with knowledge gaps

Self-administered online questionnaire (computer-assisted web interviewing) fielded in Spain in July 2025. The questionnaire was administered in Spanish; the items are presented here in English translation.

Asterisks (*) indicate mandatory items. Circles (○) indicate single-choice items and squares (☐) multiple-choice items.

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1. **Sex: ***
   - ○ Male
   - ○ Female
   - ○ Prefer not to answer
2. **Age: ***

   [ ]
3. **Autonomous community of residence: ***

   [ ]
4. **Do you know what sepsis is? ***
   - ○ Yes
   - ○ No
5. **I know what sepsis is because... ***

   Shown only to respondents who answered Yes to item 4.
   - ☐ I am a sepsis patient
   - ☐ I am a healthcare professional
   - ☐ I have heard about it on TV/radio/etc.
   - ☐ Other (please specify): _____
6. **What do you think sepsis is? If you are not familiar with this disease, indicate what you think sepsis might be. ***
   - ○ A rare type of cancer
   - ○ A blood infection
   - ○ An extreme response of the immune system to an infection
   - ○ A degenerative muscle disease
   - ○ Other (please specify): _____
   - ○ I don't know
7. **In your opinion, which symptoms may be signs of sepsis? Select all that apply. ***
   - ☐ Fever
   - ☐ Chills
   - ☐ Pain
   - ☐ Mottled skin
   - ☐ Rapid breathing and elevated heart rate
   - ☐ Difficulty breathing
   - ☐ Vomiting
   - ☐ Diarrhea
   - ☐ Passing little urine during the day
   - ☐ Confusion or disorientation
   - ☐ Feeling like you are going to die
   - ☐ Other (please specify): _____
   - ☐ I don't know
8. **What do you think can cause sepsis? Select all that apply. ***
   - ☐ A hospital stay or surgery
   - ☐ A bloodstream infection
   - ☐ Pneumonia
   - ☐ Meningitis

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- ☐ Any other infection (abdominal, appendicitis, skin/soft tissue, urinary, etc.)
- ☐ Fungi
- ☐ A virus
- ☐ Some types of parasites
- ☐ None of the above
- ☐ All of the above
- ☐ Other (please specify): _____
- ☐ I don't know

9. Do you think sepsis is a medical emergency? *

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree
- ○ I don't know

10. How many people do you think develop sepsis in Spain each year? *

- ○ Fewer than 5,000
- ○ Between 5,000 and 15,000
- ○ Between 15,000 and 25,000
- ○ Between 25,000 and 50,000
- ○ More than 50,000

11. How many people do you think die of sepsis in Spain each year? *

- ○ Fewer than 5,000
- ○ Between 5,000 and 15,000
- ○ Between 15,000 and 25,000
- ○ More than 25,000

12. How long can recovery from sepsis take? *

- ○ A few days, like the flu
- ○ It depends, until you are discharged from hospital
- ○ Months, even years
- ○ You cannot recover from sepsis; it is lifelong
- ○ I don't know

13. *Closing screen shown on completion*

Thank you very much for completing this survey. Your answers help us raise awareness of sepsis, a serious disease that can be better prevented and treated with appropriate information.

Below we tell you a little more about this disease:

Sepsis is a potentially life-threatening condition that occurs when the body responds incorrectly to an infection, attacking the organs and tissues of our own body.

The infection can be caused by bacteria, viruses, fungi or parasites.

In Spain, between 50,000 and 75,000 people develop sepsis every year, of whom 17,000 die as a result of its consequences.

Sepsis is a serious medical emergency. Delay in diagnosis and treatment can have a direct impact on survival, so it is crucial to act quickly and seek immediate medical attention.

Sepsis affects the whole body, so recovery also involves your whole body and can take months or years.

You can find more information at: http://sepsisinfo.es

Contact: hola@sepsisinfo.es

If you wish, you can add a comment in the following field: