

**HURRICANE MARIA NATIONAL CONSTRUCTION SAFETY TEAM
INVESTIGATION: VERBAL AUTOPSY AND SOCIO-ENVIRONMENTAL SURVEY
FULL IMPLEMENTATION**

OMB Control # 0693-0078

Expiration Date 7/31/2022

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with an information collection subject to the requirements of the Paperwork Reduction Act of 1995 unless the information collection has a currently valid OMB Control Number. The approved OMB Control Number for this information collection is 0693-0078. Without this approval, we could not conduct this information collection. Public reporting for this information collection is estimated to be approximately 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information collection. All responses to this information collection are voluntary. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the National Institute of Standards and Technology at: 100 Bureau Drive, Gaithersburg, MD 20899, Attn: Dr. Maria Dillard, Associate Team Lead for the NIST Hurricane Maria Program, NIST Engineering Laboratory; or contact at maria.dillard@nist.gov.

Part 1: Introduction

Instruction: "Hello, I am part of an investigation of impacts from Hurricane María by the NIST/UPR/GWU. I am interested in hearing about the deceased's experience leading up to Hurricane María's landfall on Puerto Rico on September 20, 2017, particularly the 14 days after. I realize that the hurricane was a few years ago, and so I will ask questions related to the event to aid your memory.

The survey is expected to take 60 minutes. You will not receive compensation for participating in this survey, and your participation is completely voluntary. However, your feedback will help us to better understand the causes of death from Hurricane María and will lead to recommendations to improve codes, standards, and practices for Puerto Rico. In our reported findings, your responses will be kept anonymous and will not be associated with your name or other personally identifiable information."

Part 2: Questionnaire

Q#	Question	Response
I. Informant Characterization		
This section asks about the informant and relationship to the deceased.		

1.1	What was the full name of the deceased? (INTERVIEWER: VERIFY THE NAME IS CONSISTENT WITH THE DECEASED PERSON THE INTERVIEW SHOULD REFER TO ACCORDING TO PRE-ENTERED INFORMATION)	<input type="checkbox"/> _First name(s) <input type="checkbox"/> _Last name(s) <input type="checkbox"/> _Mother's last name(s) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
1.2	What was your relationship to the deceased?	<input type="checkbox"/> _Father <input type="checkbox"/> _Mother <input type="checkbox"/> _Sister <input type="checkbox"/> _Brother <input type="checkbox"/> _Son <input type="checkbox"/> _Daughter <input type="checkbox"/> _Aunt <input type="checkbox"/> _Uncle <input type="checkbox"/> _Grandmother <input type="checkbox"/> _Grandfather <input type="checkbox"/> _Non-relative (specify:___)

1.3	At the time of Hurricane María, did you live with the deceased?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
1.4	How many years did you know the deceased?	<input type="checkbox"/> Integer <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
II. Deceased Characterization		
This section asks about characteristics of the deceased (him/her).		
INTERVIEWER: FROM THIS POINT, REFER TO THE DECEASED AS HE/SHE AND HIM/HER.		
2.1	How old was he/she when he/she died?	<input type="checkbox"/> Integer <input type="checkbox"/> Years <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.2	Approximately how long did he/she lived in the last permanent residence?	<input type="checkbox"/> Integer <input type="checkbox"/> Years <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.3	What was his/her ethnicity?	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other (specify: _____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.4	What was the main language spoken in his/her household?	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> French <input type="checkbox"/> Other (specify: _____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.5	What was his/her marital status?	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Live together <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other (specify: _____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

2.6	Was he/she able to read and/or write?	<input type="checkbox"/> _Read only <input type="checkbox"/> _Write only <input type="checkbox"/> _Both <input type="checkbox"/> _None <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
2.7	What was his/her highest level of schooling?	<input type="checkbox"/> _Did not attend school <input type="checkbox"/> _Elementary school <input type="checkbox"/> _Middle school <input type="checkbox"/> _High school <input type="checkbox"/> _Some college <input type="checkbox"/> _Associate degree <input type="checkbox"/> _Bachelor degree <input type="checkbox"/> _Postgraduate <input type="checkbox"/> _Other <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
2.8	During the 3 months prior to Hurricane María, what was his/her main occupation, that is, what kind of work did he/she mainly do?	<input type="checkbox"/> _Management, Business and financial operations <input type="checkbox"/> _Professional and related occupation <input type="checkbox"/> _Service occupations <input type="checkbox"/> _Sales and related occupations <input type="checkbox"/> _Office and Administrative support occupations <input type="checkbox"/> _Farming, fishing and forestry occupations <input type="checkbox"/> _Construction and extraction occupations <input type="checkbox"/> _Installation, maintenance and repair occupations <input type="checkbox"/> _Production occupations <input type="checkbox"/> _Transportation and material moving occupations <input type="checkbox"/> _Student <input type="checkbox"/> _Unemployed <input type="checkbox"/> _Retired <input type="checkbox"/> _Other (specify: _____) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know

2.9	What was the total annual household gross income during the time of Hurricane María? The total annual household gross income means income before taxes of the Head of Household plus all other incomes in the household.	<input type="checkbox"/> <\$5,000 <input type="checkbox"/> \$5,000 - \$9,999 <input type="checkbox"/> \$10,000 - \$14,999 <input type="checkbox"/> \$15,000 - \$19,999 <input type="checkbox"/> \$20,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$34,999 <input type="checkbox"/> \$35,000 - \$44,999 <input type="checkbox"/> \$45,000 - \$54,999 <input type="checkbox"/> \$55,000 - \$64,000 <input type="checkbox"/> \$65,000 or more <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.10	Did he/she have health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.11	Was he/she a member of any community organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO SECTION III.		
2.12	What community organization was he/she a member?	<input type="checkbox"/> Volunteer at local organization <input type="checkbox"/> Member at local church group <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.13	Did he/she ever work together with his/her community on preparation, mitigation, or other elements of potential disasters, to improve the community's resilience?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
2.14	Did he/she have family, friends and/or another network in the community, that could support him/her in case of an emergency (for example: help providing transportation; help to access medical care or medicines; help to provide food, water, other provisions; help providing shelter, etc)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

III. Household and Neighborhood Characteristics		
This section asks about the permanent residence of the deceased, and surrounding neighborhood characteristics.		
3.1	Was his/her permanent residence owned or rented?	<input type="checkbox"/> It was owned by him/her or others <input type="checkbox"/> It was rented by him/her or others <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.2	What was the predominant material of the floor?	<input type="checkbox"/> Soil or dirt <input type="checkbox"/> Concrete <input type="checkbox"/> Tile <input type="checkbox"/> Wood <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.3	What was the predominant material of the roof?	<input type="checkbox"/> Slate <input type="checkbox"/> Tile <input type="checkbox"/> Shingle <input type="checkbox"/> Concrete <input type="checkbox"/> Metal (Zinc Corrugated Panels) <input type="checkbox"/> Steel <input type="checkbox"/> Wood <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.4	What was the predominant material of the walls?	<input type="checkbox"/> Reinforced Concrete <input type="checkbox"/> Concrete blocks <input type="checkbox"/> Masonry <input type="checkbox"/> Wood panel <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.5	On a scale of 1 to 5, 1 represents "unlikely" and 5 represents a "certain", what was the likelihood of the following hazards affecting the area of the residence? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Winds (_1 _2 _3 _4 _5) <input type="checkbox"/> Floods (_1 _2 _3 _4 _5) <input type="checkbox"/> Rains (_1 _2 _3 _4 _5) <input type="checkbox"/> Landslides (_1 _2 _3 _4 _5) <input type="checkbox"/> Coastal flooding (_1 _2 _3 _4 _5) <input type="checkbox"/> Coastal erosion (_1 _2 _3 _4 _5)
3.6	How many rooms did the residence have for sleeping?	<input type="checkbox"/> 1 room <input type="checkbox"/> 2 rooms <input type="checkbox"/> 3 rooms <input type="checkbox"/> 4 rooms <input type="checkbox"/> >5 rooms

		<u>_Refused to answer</u> <u>_Don't know</u>
--	--	---

3.7	What was the primary source of drinking water?	<input type="checkbox"/> Tap water <input type="checkbox"/> Bottled water <input type="checkbox"/> Spring/River <input type="checkbox"/> Water well <input type="checkbox"/> Cistern <input type="checkbox"/> Rain water <input type="checkbox"/> Cistern trucks <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.8	What was the primary type of fuel/energy used for cooking?	<input type="checkbox"/> Wood <input type="checkbox"/> Coal <input type="checkbox"/> Gas <input type="checkbox"/> Electricity <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.9	Did the residence have an active electricity service connection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO QUESTION 3.11		
3.10	Which was the source?	<input type="checkbox"/> Public electric/power grid <input type="checkbox"/> Power generators <input type="checkbox"/> Solar panels <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.11	Before the landfall of Hurricane María, from the list of items, which of the following was in use and/or functioning? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Landline phone <input type="checkbox"/> Cellphone <input type="checkbox"/> Wi-Fi <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Car <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.12	From this list of services, which of the following was of walking distance from the residence? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Supermarket <input type="checkbox"/> Pharmacy <input type="checkbox"/> Gas station <input type="checkbox"/> Health Center or 'CDT' <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

3.13	How many people lived in the residence?	<input type="checkbox"/> Integer <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.14	How many people in the residence were in the following age categories? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> <1 year old <input type="checkbox"/> 1-5 years old <input type="checkbox"/> 6-12 years old <input type="checkbox"/> 13-18 years old <input type="checkbox"/> 19-64 years old <input type="checkbox"/> 65+ years old <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.15	Did the deceased or a household member suffer from any of the following? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> A hearing difficulty <input type="checkbox"/> A vision difficulty <input type="checkbox"/> A cognitive difficulty <input type="checkbox"/> An ambulatory difficulty <input type="checkbox"/> A self-care difficulty <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
3.16	Were there pets and/or farm animals on the property?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER OR DON'T KNOW, SKIP TO NEXT SECTION IV		
3.17	During the landfall of Hurricane María, did having a pet(s) or farm animal(s) affect the decision of whether go to a shelter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IV. Circumstances and Location of the Deceased at Time of Hurricane María		
This section asks about his/her location and circumstances during the time of Hurricane María and during the first 14 days after Hurricane María landfall.		
4.1	Did he/she die days before, the day of, or days after landfall of Hurricane María?	<input type="checkbox"/> The days before landfall (19 th and prior) <input type="checkbox"/> The day of landfall (Sept. 20) <input type="checkbox"/> The days after landfall (21 st onward) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF AFTER SKIP TO QUESTION 4.4, IF DURING SKIP TO QUESTION 4.5		

4.2	What was the exact day and time (before the landfall of the hurricane) in which the person died?	<input type="text"/> / <input type="text"/> / <input type="text"/> Month/day/year <input type="text"/> : <input type="text"/> Hours Minutes <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
SKIP TO SECTION V		
4.3	What was the exact day and time (after the landfall of the hurricane) in which the person died?	<input type="text"/> / <input type="text"/> / <input type="text"/> Month/day/year <input type="text"/> : <input type="text"/> Hours Minutes <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
4.4	In the day of the landfall and the 14 days after Hurricane María's landfall, where was he/she living? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Permanent residence <input type="checkbox"/> Family <input type="checkbox"/> Friend's <input type="checkbox"/> Neighbor <input type="checkbox"/> Shelter <input type="checkbox"/> Health center or 'CDT' <input type="checkbox"/> Hospital <input type="checkbox"/> Vehicle <input type="checkbox"/> Other (specify: <input type="text"/>) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
4.5	Had he/she evacuated his/her permanent residence at the time of Hurricane María?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO QUESTION 4.9.		
4.6	When did he/she and his/her family evacuate the residence?	<input type="checkbox"/> The day of landfall (Sept. 20) <input type="checkbox"/> The days before landfall (19 th and prior) <input type="checkbox"/> The days after landfall (21 st onward) <input type="checkbox"/> During Hurricane María <input type="checkbox"/> After Hurricane María <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
4.7	When evacuating the residence, where did he/she find shelter?	<input type="checkbox"/> At a relative's house <input type="checkbox"/> At a friend's house

		<input type="checkbox"/> Government shelter <input type="checkbox"/> NGO shelter <input type="checkbox"/> Faith-based organization shelter <input type="checkbox"/> Evacuated to mainland <input type="checkbox"/> Hospital <input type="checkbox"/> Hotel <input type="checkbox"/> Other (specify: ___) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
4.8	Since first evacuating, did he/she move subsequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
4.9	In the day of the landfall and the 14 days after Hurricane María's landfall, how many places did the deceased live in?	<input type="checkbox"/> Integer <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
4.10	Can you mention where the deceased person lived and/or found shelter?	Place 1: specify (_____) Place 2: specify (_____) Place 3: specify (_____) Place 4: specify (_____)
4.11	Can you mention how long the deceased person lived and/or found shelter in each one of these places?	Place 1: _ integer Place 2: _ integer Place 3: _ integer Place 4: _ integer
4.12	Can you confirm, at the time when he/she died, where was he/she living?	<input type="checkbox"/> Place 1 <input type="checkbox"/> Place 2 <input type="checkbox"/> Place 3 <input type="checkbox"/> Place 4 <input type="checkbox"/> Other (specify:_____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
V. Environmental and Socio-Environmental Factors and Stressors		
This section asks about the environmental and socio-environmental factors and stressors that may have affected him/her.		
This part of the sections asks about what happened <u>during Hurricane María</u> , <u>this includes the 1-4 days previous to the landfall.</u>		
5.1	In the previous section, you said that during Hurricane María he/she was living in (CONFIRM WITH QUESTION 4.4 RESPONSE).	<input type="checkbox"/> His/her permanent residence <input type="checkbox"/> Family <input type="checkbox"/> Friend's <input type="checkbox"/> Neighbor <input type="checkbox"/> Shelter <input type="checkbox"/> Health center or 'CDT'

		<input type="checkbox"/> _Hospital <input type="checkbox"/> _Vehicle <input type="checkbox"/> _Other (specify:____) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.2	During 1-4 days prior Hurricane María landfall, how many people were living with him/her?	<input type="checkbox"/> _Integer <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.3	During 1-4 days prior Hurricane María landfall, what was the primary source of drinking water?	<input type="checkbox"/> _Tap water <input type="checkbox"/> _Bottled water <input type="checkbox"/> _Spring/River <input type="checkbox"/> _Water well <input type="checkbox"/> _Cistern <input type="checkbox"/> _Rain water <input type="checkbox"/> _Cistern trucks <input type="checkbox"/> _Other (specify:____) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.4	During 1-4 days prior Hurricane María landfall, what was the primary type of energy used for cooking?	<input type="checkbox"/> _Firewood <input type="checkbox"/> _Coal <input type="checkbox"/> _Gas <input type="checkbox"/> _Electricity <input type="checkbox"/> _Other <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.5	During 1-4 days prior Hurricane María landfall, was there an active electricity supply?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO QUESTION 5.7		
5.6	During 1-4 days prior Hurricane María landfall, what was the source?	<input type="checkbox"/> _Public electric/power grid <input type="checkbox"/> _Power generators <input type="checkbox"/> _Solar panels <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know

5.7	During 1-4 days prior Hurricane María landfall, which of the following items were in use and/or functioning? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Landline phone <input type="checkbox"/> Cellphone <input type="checkbox"/> Wi-Fi <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Car <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
5.8	During 1-4 days prior Hurricane María landfall, which of the following services were open, functioning and within walking distance? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Supermarket <input type="checkbox"/> Pharmacy <input type="checkbox"/> Gas station <input type="checkbox"/> Diagnostic and Treatment Center (CDT) <input type="checkbox"/> Health center <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
5.9	During 1-4 days prior Hurricane María landfall, how many of the people living with him/her were in the following age categories? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> <1 year old <input type="checkbox"/> 1-5 years old <input type="checkbox"/> 6-12 years old <input type="checkbox"/> 13-18 years old <input type="checkbox"/> 19-64 years old <input type="checkbox"/> 65+ years old
5.10	During 1-4 days prior Hurricane María landfall, did the deceased or any of the people living with him/her, suffer from any of the following? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> A hearing difficulty <input type="checkbox"/> A vision difficulty <input type="checkbox"/> A cognitive difficulty <input type="checkbox"/> An ambulatory difficulty <input type="checkbox"/> A self-care difficulty <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
<p>Now, I will ask you about the day of the landfall and the 14 days after Hurricane María made landfall. If he/she lived in more than one place, think about the first place where</p>		

he/she lived in that period.

QUESTIONS 5.11 TO 5.33 WILL BE COMPLETED FOR EACH OF THE PLACES WHERE THE PERSON LIVED, REFERRING IN THE PROGRAMMING TO PLACE 1, PLACE 2, ETC.

SKIP TO SECTION VI IF THE PERSON DIED BEFORE THE LANDFALL.

5.11	Was the residence affected by Hurricane María?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, SKIP TO QUESTION 5.14		
5.12	How was the residence affected by Hurricane María? (INTERVIEWER: READ OPTIONS AND CHECK ALL THAT APPLY)	<input type="checkbox"/> Rain entered house <input type="checkbox"/> Flood waters entered house <input type="checkbox"/> Loss of power <input type="checkbox"/> Loss of water <input type="checkbox"/> Loss of telecommunications <input type="checkbox"/> Damage to windows, doors, walls <input type="checkbox"/> Minimal to moderate damage to roof; less than 50% impacted <input type="checkbox"/> Considerable damage to roof; more than 50% destroyed <input type="checkbox"/> Collapse of house, or completely destroyed
5.13	Based on your observations, was the residence damaged by one of the following? (INTERVIEWER: READ OPTIONS AND CHECK ALL THAT APPLY)	<input type="checkbox"/> Coastal floods <input type="checkbox"/> Floods <input type="checkbox"/> Wind <input type="checkbox"/> Rainfall <input type="checkbox"/> Flying objects <input type="checkbox"/> Landslide <input type="checkbox"/> Other
5.14	Was there running potable water where he/she was living?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF YES, SKIP TO QUESTION 5.16		
5.15	How many days was he/she living without running water?	OPEN <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

5.16	What sources of water were used for cooking? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Bottled water <input type="checkbox"/> Spring/River <input type="checkbox"/> Water well <input type="checkbox"/> Cistern <input type="checkbox"/> Rain water <input type="checkbox"/> Cistern trucks <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
5.17	What sources of water were used for drinking? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Bottled water <input type="checkbox"/> Spring/River <input type="checkbox"/> Water well <input type="checkbox"/> Cistern <input type="checkbox"/> Tap water <input type="checkbox"/> Rain water <input type="checkbox"/> Cistern trucks <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF RESPONSE IS BOTTLED WATER, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO QUESTION 5.19		
5.18	What kind of disinfection method(s) (if any) was used to make potable water? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Boiled the water <input type="checkbox"/> Chlorinated the water <input type="checkbox"/> Used water filters <input type="checkbox"/> Did not treat the water <input type="checkbox"/> Did not need to treat the water <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
5.19	What sources of water were used for bathing? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Tap water <input type="checkbox"/> Bottled water <input type="checkbox"/> Spring/River <input type="checkbox"/> Water well <input type="checkbox"/> Cistern <input type="checkbox"/> Rain water <input type="checkbox"/> Cistern trucks <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
	What was the primary type of fuel used for	<input type="checkbox"/> Firewood

5.20	cooking?	<input type="checkbox"/> _Coal <input type="checkbox"/> _Gas <input type="checkbox"/> _Electricity <input type="checkbox"/> _Other <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.21	Was there active electricity supply from their public electrical utility?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF YES, SKIP TO QUESTION 5.30		
5.22	How many days was he/she without an active electricity supply?	OPEN <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF 0 DAYS, SKIP TO QUESTION 5.29		
5.23	If 1 or more days without active electricity supply: Was there active electricity supply for some HOURS a day?	<input type="checkbox"/> _Yes, (Integer) <input type="checkbox"/> _None <input type="checkbox"/> _Variable/unpredictable <input type="checkbox"/> _Other (specify:____)
5.24	Was there a fully functioning electric portable generator to cover the electricity demand?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER OR DON'T KNOW, SKIP TO QUESTION 5.29		
5.25	What fuel did the generator use?	<input type="checkbox"/> _Gas (liquified petroleum gas) <input type="checkbox"/> _Gasoline <input type="checkbox"/> _Diesel <input type="checkbox"/> _Other (specify:____) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.26	How many hours a day, on average, did the portable electric generator run?	<input type="checkbox"/> _<3 hours <input type="checkbox"/> _3-6 hours <input type="checkbox"/> _6-9 hours <input type="checkbox"/> _9-12 hours <input type="checkbox"/> _12-15 hours <input type="checkbox"/> _>15 hours <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know

5.27	Where was the portable electric generator located?	<input type="checkbox"/> Interior of the residence <input type="checkbox"/> Exterior of the residence <input type="checkbox"/> Carport/garage <input type="checkbox"/> Balcony <input type="checkbox"/> Back yard <input type="checkbox"/> Front yard <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
5.28	Was the portable electric generator located near a door or window?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
5.29	Was there a working carbon monoxide detector at the residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
5.30	To the best of your knowledge, which of the following additional hazardous conditions and elements was he/she exposed to? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Presence and abundance of mosquitoes <input type="checkbox"/> Extreme heat during the day <input type="checkbox"/> Extreme heat during the night <input type="checkbox"/> Molds <input type="checkbox"/> Air pollution (emissions associated with portable electric generators) <input type="checkbox"/> Noise pollution (noise associated with portable electric generators) <input type="checkbox"/> Debris <input type="checkbox"/> Rodents (mice, rats, others) <input type="checkbox"/> Garbage <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

5.31	Were there any of the following sources of toxic chemical and/or harmful pollutants nearby, if any? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> _Oil/fuel plants <input type="checkbox"/> _Gas stations <input type="checkbox"/> _Insecticides/pesticides <input type="checkbox"/> _Paint shops <input type="checkbox"/> _Hardware stores <input type="checkbox"/> _Landfill <input type="checkbox"/> _Factories <input type="checkbox"/> _Toxic waste sites <input type="checkbox"/> _Mechanical workshops <input type="checkbox"/> _Other potential hazardous substances sites <input type="checkbox"/> _No toxic chemicals identified <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.32	How often did he/she sleep in temperatures that he/she considered uncomfortably hot? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> _Never <input type="checkbox"/> _Rarely <input type="checkbox"/> _Sometimes <input type="checkbox"/> _Often <input type="checkbox"/> _Always <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
5.33	Did he/she use any of the following to stay cool inside the residence? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> _AC <input type="checkbox"/> _Ceiling or other fans <input type="checkbox"/> _Open windows and doors <input type="checkbox"/> _Other (specify:____) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
<p>INTERVIEWER: IF THE DECEASED ONLY LIVED IN ONE PLACE OVER THE LANDFALL AND 14 DAY PERIOD, GO TO THE NEXT SECTION. IF THE DECEASED LIVED IN >1 PLACE, RESTART FROM QUESTION 5.11, REFERRING TO THE SECOND PLACE. THE QUESTIONNAIRE PROGRAMMED IN THE TABLE WILL DIRECT YOU THERE. THE PROGRAM WILL MAKE AS MANY LOOPS NECESSARY TO MATCH THE NUMBER OF PLACES MENTIONED IN QUESTION 4.8.</p>		

VI. Preparedness Management Phases		
This section asks about the measures taken in preparation, that is, an emergency plan, for Hurricane María.		
6.1	To the best of your knowledge, had he/she lived through any other natural hazards before hurricanes María and Irma? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Earthquakes <input type="checkbox"/> Floods <input type="checkbox"/> Hurricanes <input type="checkbox"/> Tsunamis <input type="checkbox"/> Extreme heat episodes <input type="checkbox"/> Landslides <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
6.2	Did he/she have an emergency plan to face the hurricane impact?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO QUESTION 6.4		
6.3	What actions were there taken as an emergency plan? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> Stock of food and water <input type="checkbox"/> Stock of medicines and other medical supplies <input type="checkbox"/> Had batteries and flashlights <input type="checkbox"/> Securing the envelope of the building: windows, or openings <input type="checkbox"/> Securing the roof with clip/straps <input type="checkbox"/> Identifying the shelter they had to attend <input type="checkbox"/> Other (specify: ___) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
6.4	Did the household prepare for the hurricane with protective actions to the structure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO QUESTION 6.6		

6.5	What protective actions to the structure did he/she prepare for the hurricane? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Protecting windows or openings with shutters <input type="checkbox"/> Protecting windows or opening with plywood <input type="checkbox"/> Pruning the trees <input type="checkbox"/> Disconnected the electrical appliances <input type="checkbox"/> Didn't leave any garbage, debris or trash outside <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
6.6	For how many days did he/she have enough food?	OPEN <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
6.7	For how many days did he/she have enough water? (Assuming 1 person = 1 gallon/day)	OPEN <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

VII. Verbal Autopsy: Injuries

This section asks about the occurrence of Injuries and other harm he/she suffered at the time of Hurricane María

7.1	Did he/she suffer from any injury before, or at the time of Hurricane María?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
-----	--	--

IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO NEXT SECTION: VIII

7.2	How was he/she injured? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Drowning <input type="checkbox"/> Asphyxia <input type="checkbox"/> Struck by a lightning <input type="checkbox"/> Hit by flying debris <input type="checkbox"/> Hit by collapsing tree <input type="checkbox"/> Hit by external structure <input type="checkbox"/> Hit by internal structure <input type="checkbox"/> Road traffic crash/injury <input type="checkbox"/> Fall <input type="checkbox"/> Poisoning <input type="checkbox"/> Bite or sting by venomous animal <input type="checkbox"/> Burn/fire <input type="checkbox"/> Cutting/bleeding <input type="checkbox"/> Self inflicted harm <input type="checkbox"/> Intentionally inflicted by other <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
-----	--	--

7.3	If the response is yes for drowning, asphyxia, flying debris, hit by collapsing tree, hit by external structure or hit by internal structure were there any of the hazardous conditions present? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Coastal floods <input type="checkbox"/> Floods <input type="checkbox"/> Wind <input type="checkbox"/> Rainfall <input type="checkbox"/> Landslide <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
7.4	If the response is yes for road traffic crash/injury, were there any of the following hazardous conditions present? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Hazardous conditions previous to landfall like flying debris <input type="checkbox"/> Hazardous conditions previous to landfall like wind and rain <input type="checkbox"/> Hazardous conditions occurring during Hurricane María like flying debris <input type="checkbox"/> Hazardous conditions occurring during Hurricane María like wind and rain <input type="checkbox"/> Hazardous conditions after the hurricane, like fallen objects and trees, <input type="checkbox"/> Hazardous conditions after the hurricane, like flooding <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
7.5	If the response is yes for poisoning, what was the poisoning from?	<input type="checkbox"/> Carbon monoxide <input type="checkbox"/> Gas from the kitchen <input type="checkbox"/> Gas from another household appliance <input type="checkbox"/> Household cleaning products (bleach, disinfectants) <input type="checkbox"/> Inhalation of fumes/smoke <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
7.6	If the response is yes for carbon monoxide, what was the exposure from?	<input type="checkbox"/> Generator <input type="checkbox"/> Automobile/RV <input type="checkbox"/> Boat <input type="checkbox"/> Kerosene/Gas space heater <input type="checkbox"/> Gas powered tools <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer

		<input type="checkbox"/> _Don't know
7.7	Was the injury self-inflicted?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
7.8	Was the injury intentionally inflicted (e.g. an assault) by someone else?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
VIII. Verbal Autopsy: Symptoms and/or Signs		
FOR THE INTERVIEWER:	What age group does the deceased's last known age fall into? (INTERVIEWER: VERIFY THAT THE RESPONSE TO THIS QUESTION MATCHES WITH THE MODULE OF THE VA WHERE YOU ARE DIRECTED)	<input type="checkbox"/> _Adolescent/Adult <input type="checkbox"/> _Child <input type="checkbox"/> _Neonate
8.1. ADOLESCENT/ADULT SECTION TO BE ANSWERED IF THE DECEASED IS 12 YEARS OR OLDER. VERIFY WITH QUESTION 2.1 AND PREVIOUS INFORMATION ABOUT THE DECEASED.		
8.1.1 Pre-Existing Medical Condition		
To the best of your knowledge, was he/she ever told by a health professional that he or she ever suffered from one of the following?		
8.1.1.1 1	Asthma	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1.1 2	Cancer	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1.1 3	COPD (Chronic Obstructive Pulmonary Disease)	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1.1 4	Dementia/Alzheimer	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1.1 5	Depression/mood changes	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know

8.1.1. 6	Epilepsy	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1. 7	Heart Disease	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1. 8	High Blood Pressure/Hypertension	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1. 9	Tuberculosis	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1. 10	Diabetes	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1. 11	Stroke	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.1. 12	AIDS	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.2 Symptoms Checklist		
Now I will ask you about some symptoms he/she may have experience around the time of death.		
8.1.2. 1	Did he/she have a fever?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.4		
8.1.2. 2	If you could not measure the fever: How severe would you say the fever was?	<input type="checkbox"/> _Mild <input type="checkbox"/> _Moderate <input type="checkbox"/> _Severe <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.1.2.	What was the pattern of the fever?	<input type="checkbox"/> _Continuous

3		<input type="checkbox"/> On and off <input type="checkbox"/> Only at night <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 4	Did he/she have a rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.6		
8.1.2. 5	Where was the rash located?	<input type="checkbox"/> Face <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities <input type="checkbox"/> Everywhere <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 6	Did he/she have sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.8		
8.1.2. 7	Did the sores have clear fluid or pus?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 8	Did he/she have an ulcer (pit) on the foot?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.11		
8.1.2. 9	Did the ulcer ooze pus?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.11		

8.1.2. 10	For how many days did the ulcer ooze pus?	<input type="text"/> __ <input type="text"/> days Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 11	Did he/she have yellow discoloration of the eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.13		
8.1.2. 12	For how long did he/she have the yellow discoloration?	<input type="text"/> __ <input type="text"/> days Enter 99 if unknown <input type="text"/> __ <input type="text"/> months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 13	Did he/she have puffiness on his/her face?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.15		
8.1.2. 14	For how long did he/she have puffiness on his/her face?	<input type="text"/> __ <input type="text"/> days Enter 99 if unknown <input type="text"/> __ <input type="text"/> months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 15	Did he/she have general puffiness all over his/her body?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 16	Did he/she have a lump in the neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2.	Did he/she have a lump in the armpit?	<input type="checkbox"/> Yes

17		<input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 18	Did he/she have a lump in the groin?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 19	Did he/she have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.22		
8.1.2. 20	Did the cough produce sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 21	Did he/she cough blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 22	Did he/she have difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 23	Did he/she experience pain in the chest in the month preceding death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.25		
8.1.2. 24	How long did the pain last?	<input type="checkbox"/> Less than 30 minutes <input type="checkbox"/> 30 minutes to 24 hours <input type="checkbox"/> More than 24 hours <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.1.2. 25	Did he/she have more frequent loose or liquid stools than usual?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 26	Was there blood in the stool?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.28		
8.1.2. 27	Was there blood in the stool up until death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 28	Did he/she stop urinating?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 29	Did he/she vomit in the week preceding the death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.33		
8.1.2. 30	Was there blood in the vomit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 31	Was the vomit black?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 33	Did he/she have difficulty swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.35		

8.1.2 33	For how long before death did he/she have difficulty swallowing?	<input type="text"/> <input type="text"/> days Enter 99 if unknown <input type="text"/> <input type="text"/> months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 34	Was the difficulty with swallowing with solids, liquids, or both?	<input type="checkbox"/> Solids <input type="checkbox"/> Liquids <input type="checkbox"/> Both <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 35	Did he/she have pain upon swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 36	Did he/she have belly pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.39		
8.1.2. 37	For how long before death, did he/she have belly pain?	<input type="text"/> <input type="text"/> hours Enter 99 if unknown <input type="text"/> <input type="text"/> days Enter 99 if unknown <input type="text"/> <input type="text"/> months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 38	Was the pain in the upper or lower belly?	<input type="checkbox"/> Upper belly <input type="checkbox"/> Lower belly <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 39	Did he/she have a more than usual protruding belly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.42		
8.1.2. 40	For how long before death, did he/she have a protruding belly?	<input type="text"/> __ __ days Enter 99 if unknown <input type="text"/> __ __ months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 41	How rapidly did he/she develop the protruding belly?	<input type="checkbox"/> Rapidly <input type="checkbox"/> Slowly <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 42	Did he/she have any mass in the belly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.44		
8.1.2. 43	For how long before death did he/she have a mass in the belly?	<input type="text"/> __ __ days Enter 99 if unknown <input type="text"/> __ __ months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 44	Did he/she have a stiff neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.46		
8.1.2. 45	For how long before death, did he/she have stiff neck	<input type="text"/> __ __ days Enter 99 if unknown <input type="text"/> __ __ months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2.	Did he/she experience a period of loss of	<input type="checkbox"/> Yes

46	consciousness?	<input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.49		
8.1.2. 47	Did the period of loss of consciousness start suddenly or slowly?	<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 48	Did it continue until death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 49	Did he/she have convulsions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.2.52		
8.1.2. 50	For how long before death did the convulsions last?	<input type="checkbox"/> ___ ___ days Enter 99 if unknown <input type="checkbox"/> ___ ___ months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.1.2. 51	Did the person become unconscious immediately after the convulsions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.2. 52	Was he/she in any way paralyzed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW: 1. IF THE DECEASED WAS FEMALE, THEN GO TO SECTION 8.1.3: QUESTIONS FOR WOMEN; 2. IF THE DECEASED WAS MALE, THEN GO TO SECTION 8.1.4: TOBACCO USE.		
8.1.2. 53	Which were the limbs or body parts paralyzed?	<input type="checkbox"/> Right side (arm and leg) <input type="checkbox"/> Left side (arm and leg)

	(INTERVIEWER: READ THROUGH THE LIST IN SEQUENCE AND MARK ALL THAT APPLY)	<input type="checkbox"/> Lower part of the body <input type="checkbox"/> Upper part of the body <input type="checkbox"/> One leg only <input type="checkbox"/> One arm only <input type="checkbox"/> Whole body <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF THE DECEASED WAS FEMALE, THEN CONTINUE TO SECTION 8.1.3: QUESTIONS FOR WOMEN. IF THE DECEASED WAS MALE, THEN GO TO SECTION 8.1.4: TOBACCO USE		
8.1.3 Questions for Women		
8.1.3. 54	Did she have any swelling or lump in the breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 55	Did she have any ulcers (pits) in the breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF THE DECEDENT IS UNDER 18 YEARS OLD GO TO QUESTION 8.1.3.56 IF THE DECEDENT IS 18-39 YEARS OLD GO TO QUESTION 8.1.3.58 IF THE DECEDENT IS OVER 40 YEARS OLD GO TO QUESTION 8.1.3.57		
8.1.3. 56	Did she ever have a period or menstruate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF YES, DON'T KNOW OR REFUSED TO ANSWER GO TO QUESTION 8.1.3.59 IF NO SKIP TO SECTION 8.1.4: TOBACCO USE		
8.1.3. 57	Had her periods stopped naturally because of menopause?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, SKIP TO QUESTION 8.1.3.59		

8.1.3. 58	Did she have vaginal bleeding after cessation of menstruation? (post-menopausal)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 59	Did she have vaginal bleeding other than her period? (intermenstrual)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 60	Was there excessive vaginal bleeding in the week prior to death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 61	At the time of death was her period overdue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.3.63		
8.1.3. 62	For how many weeks was her period overdue?	_____ weeks Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 63	Did she have a sharp pain in the belly shortly before death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 64	Was she pregnant at the time of death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.1.3.71		
8.1.3. 65	For how many months was she pregnant?	_____ months Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.1.3. 66	Did she die during an abortion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF YES, GO TO QUESTION 8.1.3.73		
8.1.3. 67	Did bleeding occur while she was pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 68	Did she have excessive bleeding during labor or delivery? ("Labor" is the period of time by which contractions are less than 10 minutes apart.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 69	Did she die during labor or delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.3. 70	For how long, was she in labor?	<input type="text"/> <input type="text"/> hours Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF ANSWER TO QUESTION 8.1.3.69 IS YES, SKIP TO SECTION 8.1.4: TOBACCO USE		
8.1.3. 71	Did she die within 6 weeks of having an abortion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF YES, SKIP TO QUESTION 8.1.3.73		
8.1.3. 72	Did she die within 6 weeks of childbirth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, SKIP TO SECTION 8.1.4: TOBACCO USE		
8.1.3. 73	Did she have excessive bleeding after delivery or abortion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.1.4 Tobacco Use		
8.1.4. 77	Did he/she use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO SECTION 8.1.5: HEALTH RECORDS		
8.1.4. 78	What kind of tobacco did he/she use?	<input type="checkbox"/> Cigarettes <input type="checkbox"/> E-cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Hookah <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Local form of tobacco <input type="checkbox"/> Other (specify:___) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF "YES" TO CIGARETTES, CONTINUE TO QUESTION 8.1.4.79. IF "NO" TO CIGARETTES, GO TO SECTION 8.1.5: HEALTH RECORDS		
8.1.4. 79	How many cigarettes did he/she smoke daily?	<input type="checkbox"/> Number ___ ___ <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.1.5 Health Records		
8.1.5. 1	Do you have any health records that belonged to the deceased?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER OR DON'T KNOW, SKIP TO QUESTION 8.1.5.3		
8.1.5. 2	Can you read to me the health records?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.1.5.3	Are the dates known for the two most recent visits to a health care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER OR DON'T KNOW, SKIP TO NEXT SECTION IX.		
8.1.5.4	What is the date of most recent visit to a healthcare provider	__/__/____ dd mm yyyy
8.1.5.5	What is the date of second most recent visit a healthcare provider	__/__/____ dd mm yyyy
8.2. NEONATAL VA SECTION TO BE ANSWERED IF THE DECEASED IS UNDER 1 MONTH. CHECK WITH QUESTION 2.1 AND PREVIOUS INFORMATION ABOUT THE DECEASED.		
8.2.1 Background		
	IF MOTHER IS RESPONDENT, MARK 8.2.1.1 AS "YES". IF MOTHER IS NOT RESPONDENT, GO TO QUESTION 8.2.1.1	
8.2.1.1	Is the mother still alive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.2	What was the weight of the deceased at birth?	<input type="checkbox"/> Grams <input type="checkbox"/> Kilograms <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF WEIGHT OF THE DECEASED AT BIRTH WAS KNOWN, GO TO QUESTION 8.2.1.4. IF REFUSED TO ANSWER OR DON'T KNOW, GO TO QUESTION 8.2.1.3		
8.2.1.3	At the time of the delivery what was the size of the deceased: Read the question and slowly read the first 4 choices. (INTERVIEWER: RESPONDENT SHOULD HEAR ALL FOUR CHOICES AND THEN RESPOND.)	<input type="checkbox"/> Very small <input type="checkbox"/> Smaller than usual <input type="checkbox"/> About average <input type="checkbox"/> Larger than usual <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.4	Was the baby born alive or dead?	<input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.2.1.5	Did the baby ever cry?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.6	Did the baby ever move?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.7	Did the baby ever breathe?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.8	INTERVIEWER ONLY: REFER TO QUESTIONS 8.2.1.5, 8.2.1.6, AND 8.2.1.7. IF ALL THREE RESPONSES ARE "NO" THEN CHECK "YES". OTHERWISE, CHECK "NO".	<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YOU ANSWERED "YES" TO QUESTION 8.2.1.8 (STILLBIRTH), THEN GO TO QUESTION 8.2.1.9 IN YOU ANSWERED "NO" TO QUESTION 8.2.1.8 (LIVEBIRTH), GO TO QUESTION 8.2.1.13		
8.2.1.9	Were there any bruises or signs of injury on the baby's body at birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.1 0	Was the baby's body (skin and tissue) pulpy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.1 1	Was any part of the baby physically abnormal at time of delivery? (INTERVIEWER: READ EXAMPLES: "body part too large or too small", "additional growth on body")	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO SECTION 8.2.2: MATERNAL HISTORY.		
8.2.1.1	What were the abnormalities? (INTERVIEWER:	<input type="checkbox"/> Head size very small at time of birth

2	MARK ALL THAT APPLY)	<input type="checkbox"/> Head size very large at time of birth <input type="checkbox"/> Mass defect on the back of head <input type="checkbox"/> Other (specify:_____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
AFTER COMPLETING 8.2.1.12, CONTINUE TO SECTION 8.2.2: MATERNAL HISTORY.		
8.2.1.1 3	How old was the baby/child when the fatal illness started? (INTERVIEWER: LESS THAN 24 HOURS = 00 DAYS. ENTER AGE IN DAYS UP TO 27 DAYS. ENTER 28 DAYS AS 1 MONTH. FROM 1-11 MONTHS ENTER AGE IN MONTHS.)	<input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.1 4	How long did the illness last? (INTERVIEWER: LESS THAN 24 HOURS = 00 DAYS. ENTER AGE IN DAYS UP TO 27 DAYS. ENTER 28 DAYS AS 1 MONTH. FROM 1-11 MONTHS ENTER DURATION OF ILLNESS IN MONTHS. ENTER 12 MONTHS 1 YEAR. FROM 1-11 YEARS ENTER AGE IN YEARS.)	<input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.1.1 5	INTERVIEWER: MARK THE BABY'S AGE AT THE TIME OF DEATH	<input type="checkbox"/> Less than 28 days <input type="checkbox"/> 28 days to 11 years
8.2.2 Maternal History		
8.2.2.1	Was the late part of the pregnancy (defined as the last 3 months), labor, or delivery complicated by any of the following problems? (INTERVIEWER: READ EACH COMPLICATION AND MARK ALL THAT APPLY.) (READ "THE MOTHER" IF THE MOTHER IS NOT THE RESPONDENT.)	<input type="checkbox"/> You (the mother) had convulsions <input type="checkbox"/> You (the mother) had high blood <input type="checkbox"/> You (the mother) had severe anemia <input type="checkbox"/> You (the mother) had diabetes <input type="checkbox"/> Child delivered not head first <input type="checkbox"/> Cord delivered first <input type="checkbox"/> Cord around child's neck <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Fever during labor <input type="checkbox"/> Premature rupture of membranes (water breaks prematurely) <input type="checkbox"/> No complications <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.2.2.2	Was the baby moving in the last few days before the birth?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
---------	--	--

8.2.2.3	What was the color of the liquid when the water broke?	<input type="checkbox"/> Green or brown <input type="checkbox"/> Clear (normal) <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.2.4	How much time did the labor and delivery take? (INTERVIEWER: LESS THAN 1 HOUR == "00")	<input type="checkbox"/> Hours Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.2.5	Who delivered the baby?	<input type="checkbox"/> Doctor <input type="checkbox"/> Nurse/midwife <input type="checkbox"/> Relative <input type="checkbox"/> Self (the mother) <input type="checkbox"/> Traditional birth attendant <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.2.6	How was the baby delivered? (INTERVIEWER: READ THE CHOICES AND MARK ONE.)	<input type="checkbox"/> Vaginal, with forceps <input type="checkbox"/> Vaginal, without forceps <input type="checkbox"/> Vaginal, don't know if forceps or not <input type="checkbox"/> C-Section <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
STOP. REFER BACK TO QUESTION 8.2.1.8. IF YOU ANSWERED "YES," GO TO SECTION: <u>8.1.5 HEALTH RECORDS</u> . IF YOU ANSWERED "NO," AND CHILD IS LESS 28 DAYS OLD CONTINUE TO SECTION 8.2.3: NEONATAL DEATHS.		
8.2.3 Neonatal Death		
8.2.3.1	Was any part of the baby physically abnormal at time of delivery? (INTERVIEWER: FOR EXAMPLE: "BODY PART TOO SMALL", "ADDITIONAL GROWTH ON BODY")	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.2.3.3		

8.2.3.2	What were the abnormalities? (INTERVIEWER: MARK ALL THAT APPLY)	<input type="checkbox"/> Head size very large at time of birth <input type="checkbox"/> Mass defect on the back of head <input type="checkbox"/> Other (specify:_____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.3	Did the baby breathe immediately after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, GO TO QUESTION 8.2.3.5		
8.2.3.4	Did the baby have difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.5	Was anything done to try to help the baby breathe at birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.6	Did the baby cry immediately after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF YES, GO TO QUESTION 8.2.3.8		
8.2.3.7	How long after birth did the baby first cry? (INTERVIEWER: MARK ONE)	<input type="checkbox"/> Within 5 minutes <input type="checkbox"/> Within 6-30 minutes <input type="checkbox"/> More than 30 minutes <input type="checkbox"/> Never <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NEVER, GO TO QUESTION 8.2.3.9		
8.2.3.8	Did the baby stop being able to cry?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.2.3.9	Was the baby able to suckle in a normal way during the first day of life?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF YES, GO TO QUESTION 8.2.3.11		
8.2.3.1 0	Did the baby ever suckle in a normal way?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.2.3.1 1	During the illness that led to death, did the baby have difficult breathing?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.2.3.13		
8.2.3.1 2	For how many days did the difficult breathing last?	<input type="checkbox"/> _Days <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.2.3.1 3	During the illness that led to death, did the baby have fast breathing?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.2.3.15		
8.2.3.1 4	For how many days did the fast breathing last?	<input type="checkbox"/> _Days <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.2.3.1 5	During the illness that led to death, did the baby have indrawing of the chest?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.2.3.1 6	During the illness that led to death, did the baby become cold to touch?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.2.3.18		

8.2.3.1 7	At what age did the baby start feeling cold to touch?	<input type="checkbox"/> Days <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.1 8	During the illness that led to death, did the baby become lethargic, after a period of normal activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.1 9	During the illness that led to death, did the baby become unresponsive or unconscious?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.2 0	During the illness that led to death, did the baby have pus drainage from the umbilical cord stump?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.2 1	During the illness that led to death, did the baby have an area(s) of skin with redness and swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.2 2	During the illness that led to death, did the baby have yellow skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.2.3.2 3	Did the infant appear to be healthy and then just die suddenly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3. CHILD VA SECTION TO BE ANSWERED IF THE DECEASED IS BETWEEN 1 MONTH AND 12 YEARS OLD. CHECK WITH QUESTION 2.1 AND PREVIOUS INFORMATION ABOUT THE DECEASED.		
8.3.1.1	Did he/she suffer an injury or accident that led to death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO <u>SECTION 8.3.2: BACKGROUND</u>		

8.3.2. BACKGROUND		
8.3.2.1	Is the mother still alive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF YES, GO TO QUESTION 8.3.2.4		
8.3.2.2	Did the mother die during or after the delivery?	<input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF DURING DELIVERY, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.2.4		
8.3.2.3	How long after the delivery did the mother die? (INVIEWER: LESS THAN 24 HOURS == 00 DAYS. ENTER AGE IN DAYS UP TO 27 DAYS. ENTER 28 DAYS AS 1 MONTH. FROM 1-11 MONTHS ENTER AGE IN MONTHS.)	___ ___ days Enter 99 if unknown ___ ___ months Enter 99 if unknown <input type="checkbox"/> Refused to answer
8.3.2.4	Where was the deceased born?	<input type="checkbox"/> Hospital <input type="checkbox"/> Other health facility <input type="checkbox"/> On route to hospital or other health facility <input type="checkbox"/> Home <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.2.5	At the time of the delivery what was the size of the deceased: (INVIEWER: READ THE QUESTION AND SLOWLY READ THE FIRST 4 CHOICES. RESPONDENT SHOULD HEAR ALL FOUR CHOICES AND THEN RESPOND.)	<input type="checkbox"/> Very small <input type="checkbox"/> Smaller than usual <input type="checkbox"/> About average <input type="checkbox"/> Larger than usual <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.2.6	How old was the baby/child when the fatal illness started? (INVIEWER: LESS THAN 24 HOURS == 00	___ ___ days Enter 99 if unknown ___ ___ months

	DAYS. ENTER AGE IN DAYS UP TO 27 DAYS. ENTER 28 DAYS AS 1 MONTH. FROM 1-11 MONTHS ENTER AGE IN MONTHS.)	Enter 99 if unknown _ _ _ years Enter 99 if unknown _ Refused to answer
8.3.2.7	How long did the illness last? (INTERVIEWER: LESS THAN 24 HOURS = 00 DAYS. USE 1 MONTH = 28 DAYS TO DETERMINE THE NUMBER OF MONTHS.)	_ _ _ days Enter 99 if unknown _ _ _ months Enter 99 if unknown _ Refused to answer
8.3.2.8	How old was the deceased at the time of death? (INTERVIEWER: USE ONE MONTH = 28 DAYS TO DETERMINE THE NUMBER OF MONTHS.)	_ _ _ days Enter 99 if unknown _ _ _ months Enter 99 if unknown _ _ _ years Enter 99 if unknown _ Refused to answer
8.3.2.9	Has the deceased's (biological) mother ever been tested for HIV?	_ Yes _ No _ Refused to answer _ Don't know
8.3.2.1 0	Was the HIV test ever positive?	_ Yes _ No _ Refused to answer _ Don't know

8.3.2.1 0	Has the deceased's (biological) mother ever been told she had AIDS by a health worker?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3. Infant and Child Deaths		
8.3.3.1	During the illness that led to death, did he/she have a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.5		
8.3.3.2	How many days did the fever last?	<input type="checkbox"/> Less than 24 hours <input type="checkbox"/> ___ ___ days Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.3	Did the fever continue until death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.5		
8.3.3.4	How severe was the fever?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.5	During the illness that led to death, did he/she have more frequent loose or liquid stools than usual?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.8		
8.3.3.6	How many stools did he/she have on the day that loose or liquid stools were most frequent?	<input type="checkbox"/> ___ ___ stools Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.7	Did the frequent loose or liquid stools	<input type="checkbox"/> Yes

	continue until death?	<input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.3.3.8	During the illness that led to death, did the child have a cough?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.11		
8.3.3.9	For how many days did the cough last?	_ _ _ days Enter 99 if unknown <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.3.3.1 0	Was the cough very severe?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.3.3.1 1	During the illness that led to death, did he/she have difficult breathing?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.13		
8.3.3.1 2	For how many days did the difficult breathing last?	_ _ _ days Enter 99 if unknown <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
8.3.3.1 3	During the illness that led to death, did he/she have fast breathing?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.15		

8.3.3.1 4	For how many days did the fast breathing last?	<input type="text"/> __ __ days Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
If BOTH 8.3.3.11 AND 8.3.3.13 ARE "NO" GO TO QUESTION 8.3.3.17		
8.3.3.1 5	During the illness that led to death, did he/she have indrawing of the chest?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.1 6	During the illness that led to death, did his/her breathing sound like grunting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.1 7	Did he/she experience any generalized convulsions or fits during the illness that led to death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.1 8	Was he/she unconscious during the illness that led to death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
If NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.20		
8.3.3.1 9	How long before death did unconsciousness start?	<input type="checkbox"/> Less than 6 hours <input type="checkbox"/> 6-23 hours <input type="checkbox"/> 24 hours or more <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 0	Did he/she have a stiff neck during the illness that led to death? INTERVIEWER: (Demonstrate)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 1	Did he/she have a bulging fontanelle during the illness that led to death? INTERVIEWER: (Show photo)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.3.3.2 2	During the month before he/she died, did he/she have a skin rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 8.3.3.24		
8.3.3.2 3	How many days did the rash last?	_ _ _ days Enter 99 if unknown <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 4	During the illness that led to death, did he/she skin flake off in patches?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 5	Did his/her hair change in color to a reddish or yellowish color?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 6	Did he/she have a protruding belly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 7	During the illness that led to death, did he/she suffer from "lack of blood" or "pallor"?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 8	During the illness that led to death, did he/she have swelling in the armpits?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
8.3.3.2 9	During the illness that led to death, did he/she bleed from anywhere?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

8.3.3.3 0	During the illness that led to death, did he/she have areas of the skin that turned black?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
--------------	--	--

IX. Response of Health Care System

This section asks about the medical care and health care system response to his/her needs at the time of Hurricane María and the first 14 days after landfall.

IF THE PERSON DIED BEFORE THE LANDFALL OF THE HURRICANE, SKIP TO SECTION X

9.1 PERMANENT LIFE SUPPORT NEEDS

9.1.1	Did he/she have a permanent need of in-home treatment support, or care for critical medical conditions, or need of essential medicines?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
-------	---	--

IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 9.1.3

9.1.2	What was the permanent need of in-home or essential care? (INTERVIEWER: READ OPTIONS AND SELECT ALL THAT APPLY)	<input type="checkbox"/> _ Medical equipment for oxygen support <input type="checkbox"/> _ Medical equipment for enteric nutrition/ feeding <input type="checkbox"/> _ Medical equipment for permanent intravenous treatment <input type="checkbox"/> _ Medical equipment for dialysis <input type="checkbox"/> _ Essential medicines for diabetes (insulin) <input type="checkbox"/> _ Essential medicine for heart disease (example nitroglycerin) <input type="checkbox"/> _ Essential medicine for asthma or other respiratory chronic condition <input type="checkbox"/> _ Essential medicine for epilepsy status, esquizofrenia, depression, or another mental health chronic condition <input type="checkbox"/> _ Essential medicine for ulcer treatment or another severe gastrointestinal chronic illness <input type="checkbox"/> _ Essential medicine for liver problems <input type="checkbox"/> _ Essential medicine for renal problems <input type="checkbox"/> _ Other <input type="checkbox"/> _ Refused to answer <input type="checkbox"/> _ Don't know
-------	---	---

9.1.3	Was he/she affected by lack of needed medication?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Other (specify:____) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
9.1.4	Was he/she affected by lack of needed access to dialysis?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
9.2. FIRST RESPONSE EMERGENCY		
This section asks about the emergency services that he/she (or any other person living with him/her) tried to seek for medical help. This includes 911, another ground ambulance, a health department, the Red Cross, Police Department, Fire Department, or another emergency system.		
9.2.1	When he/she was injured or suffered the illness, did he/she seek medical care?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, REFUSED TO ANSWER, OR DON'T KNOW, GO TO QUESTION 9.3.3		
9.2.2	To the best of your knowledge, was he/she in a life-threatening emergency when care was sought?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
9.2.3	Did he/she or anyone living with him/her call 911? Or any equivalent emergency agency for immediate help?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, SKIP TO QUESTION 9.3.1		
9.2.4	Did the 911 or other ambulance arrive?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, SKIP TO QUESTION 9.3.2		
9.2.5	Was he/she taken to a health care facility?	<input type="checkbox"/> _Yes <input type="checkbox"/> _No <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
IF NO, SKIP TO QUESTION 9.3.2		

9.2.6	Where was he/she taken?	<input type="checkbox"/> Urgent care services <input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization services/hospital <input type="checkbox"/> Primary health care center/health center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Community center <input type="checkbox"/> Red Cross <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.2.7	In what municipality is this place/facility located?	<input type="checkbox"/> Adjuntas <input type="checkbox"/> Aguada <input type="checkbox"/> Aguadilla <input type="checkbox"/> Aguas Buenas <input type="checkbox"/> Aibonito <input type="checkbox"/> Arecibo <input type="checkbox"/> Arroyo <input type="checkbox"/> Añasco <input type="checkbox"/> Barceloneta <input type="checkbox"/> Barranquitas <input type="checkbox"/> Bayamón <input type="checkbox"/> Cabo Rojo <input type="checkbox"/> Caguas <input type="checkbox"/> Camuy <input type="checkbox"/> Canóvanas <input type="checkbox"/> Carolina <input type="checkbox"/> Cataño <input type="checkbox"/> Cayey <input type="checkbox"/> Ceiba <input type="checkbox"/> Ciales <input type="checkbox"/> Cidra <input type="checkbox"/> Coamo <input type="checkbox"/> Comerío <input type="checkbox"/> Corozal <input type="checkbox"/> Culebra <input type="checkbox"/> Dorado <input type="checkbox"/> Fajardo <input type="checkbox"/> Florida <input type="checkbox"/> Guayama <input type="checkbox"/> Guayanilla <input type="checkbox"/> Guaynabo <input type="checkbox"/> Gurabo <input type="checkbox"/> Guánica

		<ul style="list-style-type: none">_Hatillo_Hormigueros_Humacao_Isabela_Jayuya_Juana Díaz_Juncos_Lajas_Lares_Las Marías_Las Piedras_Loiza_Luquillo_Manatí_Maricao_Maunabo_Mayagüez_Moca_Morovis_Naguabo_Naranjito_Orocovis_Patillas_Peñuelas_Ponce_Quebradillas_Rincón_Rio Grande_Sabana Grande_Salinas_San Germán_San Juan_San Lorenzo_San Sebastián_Santa Isabel_Toa Alta_Toa Baja_Trujillo Alto_Utuado_Vega Alta_Vega Baja_Vieques_Villalba_Yabucoa
--	--	--

		_Yauco
9.2.8	What was the name of the place/facility visited?	OPEN _Refused to answer _Don't know
9.2.9	How long did it take to get there?	_Integer _Minutes _Hours _Days _Refused to answer _Don't know
9.2.1 0	Did he/she receive care at the healthcare facility?	_Yes _No _Refused to answer _Don't know
9.2.1 1	Was he/she hospitalized in the ER/hospital?	_Yes _No _Other (specify:____) _Refused to answer _Don't know
IF NO, SKIP TO QUESTION 9.2.14		
9.2.1 2	During the time he/she was in the hospital/ healthcare facility, were there noticeable disruptions of critical services?	_No _Yes, interruption of the electricity _Yes, A/C (ventilation) not functioning _Yes, interruption of the water supply _Yes, not enough personnel available _Yes, not enough medical supplies _Yes, not enough medical gases available (oxygen) _Other (specify:____) _Refused to answer _Don't know
9.2.1 3	Did he/she die in the hospital (medical services)?	_Yes _No _Other (specify:____) _Refused to answer _Don't know
IF YES, SKIP TO SECTION X		

9.2.1 4	Was he/she discharged during the first 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.2.1 5	Was he/she transferred to another healthcare facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.2.1 6	Why did he/she need to be transferred? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Healthcare facility was damaged <input type="checkbox"/> Healthcare facility was closed <input type="checkbox"/> There wasn't enough personnel available <input type="checkbox"/> The hospital did not have the required personnel/equipment for treatment of the condition <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.2.1 7	Where was he/she referred to?	<input type="checkbox"/> Different hospital emergency room <input type="checkbox"/> Different hospital non-emergency sector <input type="checkbox"/> Emergency military hospital <input type="checkbox"/> Different health clinic <input type="checkbox"/> Medical shelter <input type="checkbox"/> Red Cross health post/shelter <input type="checkbox"/> Pharmacy for medication <input type="checkbox"/> Community health center <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

9.3. EMERGENCY MEDICINE NETWORK

This section asks about the emergency units/hospitals where he/she (or anyone living with him/her) tried to seek medical assistance.

9.3.1	Why was 911 not called? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Cell phone battery died <input type="checkbox"/> Couldn't charge cell phone <input type="checkbox"/> Didn't have signal <input type="checkbox"/> Didn't have landline telephone <input type="checkbox"/> Landline was interrupted <input type="checkbox"/> 911 not available <input type="checkbox"/> Refused to answer
-------	--	--

		<input type="checkbox"/> Don't know
9.3.2	Did he/she or anyone close to or living with him/her seek medical care elsewhere?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF YES, SKIP TO QUESTION 9.3.4		

9.3.3	What was the reason for not seeking care? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> He/she was too ill to leave the house <input type="checkbox"/> It wasn't considered necessary <input type="checkbox"/> The roads were damaged <input type="checkbox"/> There was no means of transport <input type="checkbox"/> Unable to afford care <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
SKIP TO SECTION X.		

9.3.4	In total, how many places, did he/she or anyone close to the deceased, look for medical care?	<input type="checkbox"/> Integer <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
-------	---	---

Now, I will ask you about the first place.

9.3.5	Where was medical care sought? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Hospital emergency room <input type="checkbox"/> Hospital non-emergency sector <input type="checkbox"/> Emergency military hospital <input type="checkbox"/> Different health clinic <input type="checkbox"/> Medical shelter <input type="checkbox"/> Red Cross health post/shelter <input type="checkbox"/> Pharmacy for medication <input type="checkbox"/> Community health center <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.3.6	Which means of transportation was used to get there? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Own car <input type="checkbox"/> Relative, friend or neighbor's car <input type="checkbox"/> Taxi or Uber <input type="checkbox"/> Public service transportation <input type="checkbox"/> Walking <input type="checkbox"/> Biking <input type="checkbox"/> Other <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

9.3.7	How long did it take to get there?	<input type="checkbox"/> Integer <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.3.8	Did it take longer than usual to get there?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, REFUSED TO ANSWER OR DON'T KNOW SKIP TO QUESTION 9.3.10		
9.3.9	How much time longer than usual, did it take to get there?	<input type="checkbox"/> Integer <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.3.10	In what municipality is this place/facility located?	<input type="checkbox"/> Adjuntas <input type="checkbox"/> Aguada <input type="checkbox"/> Aguadilla <input type="checkbox"/> Aguas Buenas <input type="checkbox"/> Aibonito <input type="checkbox"/> Arecibo <input type="checkbox"/> Arroyo <input type="checkbox"/> Añasco <input type="checkbox"/> Barceloneta <input type="checkbox"/> Barranquitas <input type="checkbox"/> Bayamón <input type="checkbox"/> Cabo Rojo <input type="checkbox"/> Caguas <input type="checkbox"/> Camuy <input type="checkbox"/> Canóvanas <input type="checkbox"/> Carolina <input type="checkbox"/> Cataño <input type="checkbox"/> Cayey <input type="checkbox"/> Ceiba <input type="checkbox"/> Ciales <input type="checkbox"/> Cidra <input type="checkbox"/> Coamo <input type="checkbox"/> Comerío <input type="checkbox"/> Corozal <input type="checkbox"/> Culebra <input type="checkbox"/> Dorado <input type="checkbox"/> Fajardo

		<ul style="list-style-type: none">_Florida_Guayama_Guayanilla_Guaynabo_Gurabo_Guánica_Hatillo_Hormigueros_Humacao_Isabela_Jayuya_Juana Díaz_Juncos_Lajas_Lares_Las Marías_Las Piedras_Loiza_Luquillo_Manatí_Maricao_Maunabo_Mayagüez_Moca_Morovis_Naguabo_Naranjito_Orocovis_Patillas_Peñuelas_Ponce_Quebradillas_Rincón_Rio Grande_Sabana Grande_Salinas_San Germán_San Juan_San Lorenzo_San Sebastián_Santa Isabel_Toa Alta_Toa Baja_Trujillo Alto
--	--	---

		<input type="checkbox"/> Utuado <input type="checkbox"/> Vega Alta <input type="checkbox"/> Vega Baja <input type="checkbox"/> Vieques <input type="checkbox"/> Villalba <input type="checkbox"/> Yabucoa <input type="checkbox"/> Yauco
--	--	--

9.3.11	What was the name of the place/facility visited?	OPEN <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.3.12	Did he/she receive care in the healthcare facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know

IF NO, SKIP TO QUESTION 9.3.18

9.3.13	During the time he/she was in the health care facility, were there noticeable disruptions of medical services of the hospital? (INTERVIEWER, SELECT ALL THAT APPLY)	<input type="checkbox"/> No <input type="checkbox"/> Healthcare facility was closed <input type="checkbox"/> Yes, interruption of the electricity <input type="checkbox"/> Yes, A/C (ventilation) not functioning Yes, damage to building components (including roof, walls, windows, doors, or foundation) <input type="checkbox"/> Yes, damage to interior finishes and contents (equipment, furniture, appliances, computers, supplies, documents, etc.) <input type="checkbox"/> Yes, physical hazards that penetrated buildings (such as floodwater, wind-borne debris, or falling debris) <input type="checkbox"/> Yes, Damage to electrical and mechanical systems (HVAC, electrical and lighting, elevators, communications, plumbing, medical gas storage and distribution) <input type="checkbox"/> Shortage of oxygen <input type="checkbox"/> Yes, interruption of the water supply <input type="checkbox"/> Yes, not enough personnel
--------	---	--

		available <input type="checkbox"/> Yes, no enough medical supplies <input type="checkbox"/> Yes, no medical gases available (oxygen) <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.3.14	Was he/she hospitalized in the health care facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, SKIP TO QUESTION 9.3.17		
9.3.15	How long was he/she hospitalized?	<input type="checkbox"/> Integer <input type="checkbox"/> Days <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
9.3.16	Was he/she discharged during the first 14 days? (INTERVIEWER: READ OPTIONS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Died before <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF NO, SKIP TO NEXT SECTION X		
9.3.17	When discharged, where was he/she sent?	<input type="checkbox"/> Permanent residence <input type="checkbox"/> Place where he/she had been living prior to the hospitalization <input type="checkbox"/> Hospice <input type="checkbox"/> Referred to another health care facility <input type="checkbox"/> Other (specify:____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF THE RESPONSE IS REFERRED TO ANOTHER HEALTH CARE FACILITY, CONTINUE TO QUESTION 9.3.18 FOR ANY OTHER RESPONSE SKIP TO SECTION X		
9.3.18	Why was he/she referred to another place? (INTERVIEWER: SELECT ALL THAT APPLY)	<input type="checkbox"/> Healthcare facility was closed <input type="checkbox"/> Healthcare facility was damaged <input type="checkbox"/> Not enough personnel available <input type="checkbox"/> Unavailable equipment for treatment <input type="checkbox"/> Other

		<input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
<p>IF THE DECEASED ONLY SOUGHT CARE IN ONE PLACE, GO TO SECTION X. IF THE DECEASED SOUGHT CARE IN MORE THAN ONE PLACE, GO BACK TO QUESTIO 9.3.5. THE QUESTIONNAIRE PROGRAMMED IN THE TABLET WILL DO AS MANY LOOPS NECESSARY TO CAPTURE THE INFORMATION FOR ALL THE PLACES WHERE THE DECEASED SOUGHT CARE, AS INDICATED IN QUESTION 9.3.4.</p>		

X. Section: Place of Death		
This section asks about the death of (name of deceased).		
10.1	Where did he/she die?	<input type="checkbox"/> In the trajectory, vehicle/other means of transportation <input type="checkbox"/> At his/her permanent residence <input type="checkbox"/> At a friend/family's residence <input type="checkbox"/> At a community shelter <input type="checkbox"/> At a governmental shelter <input type="checkbox"/> At a Red Cross facility <input type="checkbox"/> At a hospital <input type="checkbox"/> Other (specify: _____) <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
IF RESPONSE IS NOT HOSPITAL OR HEALTH CARE FACILITY, GO TO SECTION XI		
10.2	Were there disruptions of critical services or other failures in the hospital?	<input type="checkbox"/> Unable to continue dialysis <input type="checkbox"/> Disruption of breathing support treatment or other life support that requires electricity (CPAP, BiPAP, or nebulizer) Damage to building components (including roof, walls, windows, doors, or foundation) <input type="checkbox"/> Damage to interior finishes and contents (equipment, furniture, appliances, computers, supplies, documents, etc.) <input type="checkbox"/> Physical hazards that penetrated buildings (such as floodwater, wind-borne debris, or falling debris) <input type="checkbox"/> Damage to electrical and mechanical systems (HVAC, electrical and lighting, elevators,

		communications, plumbing, medical gas storage and distribution) <input type="checkbox"/> _Shortage of oxygen <input type="checkbox"/> _Disruption in the operating theater <input type="checkbox"/> _Unable to get medicine because of supply chain problems <input type="checkbox"/> _Direct injury by structural collapse in the building <input type="checkbox"/> _Other (specify:____) <input type="checkbox"/> _Refused to answer <input type="checkbox"/> _Don't know
--	--	--

XI. Open Ended Question and Interviewer Comments/Observations

INTERVIEWER (SAY TO THE RESPONDENT): "THANK YOU FOR THE PATIENT RESPONSES TO THIS EXHAUSTIVE SET OF QUESTIONS. COULD YOU PLEASE SUMMARIZE, OR TELL US IN YOUR OWN WORDS HOW THE DEATH HAPPENED AND ANY ADDITIONAL INFORMATION ABOUT THE ILLNESS AND/OR DEATH?"

FOR THE INTERVIEWER: LISTEN TO WHAT THE RESPONDENT TELLS YOU IN HIS/HER OWN WORDS.

PROMPT TO MAKE SURE:

1. IF THE DEATH WAS RELATED TO AN INJURY VS. A NATURAL CAUSE
2. THE TIME OF DEATH (BEFORE, DURING, OR AFTER THE DISASTER, AND HOW LONG AFTER)

VERIFY THAT THE RIGHT SECTIONS OF THE VA WERE USED IF THE DEATH WAS RELATED TO AN INJURY VS. A NATURAL CAUSE.

DO NOT PROMPT FOR ANYTHING ELSE EXCEPT FOR ASKING WHETHER THERE WAS ANYTHING ELSE AFTER THE RESPONDENT FINISHES. IF THE RESPONDENT MENTIONS KEY WORDS REFERRING TO THE PRESENCE OF ANY OF THESE CONDITIONS, MARK "MENTIONED" ON THE CHECKLISTS.

Adult Checklist

Key Words	Mentioned
-----------	-----------

Chronic kidney disease	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Dengue fever	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Fever	<input type="checkbox"/>
Heart attack (AMI)	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Influenza	<input type="checkbox"/>
Leptospirosis	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>
Liver failure	<input type="checkbox"/>
Malaria	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>
Renal (kidney) failure	<input type="checkbox"/>
Sepsis	<input type="checkbox"/>
Stress/Anxiety	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Suicide	<input type="checkbox"/>
Death Scene Investigation	
Power outage	<input type="checkbox"/>
Road Closure	<input type="checkbox"/>
Heat illness	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>
Homeless	<input type="checkbox"/>
Heat-related warnings	<input type="checkbox"/>
Storm clean up	<input type="checkbox"/>
Response/Recovery efforts	<input type="checkbox"/>
State of emergency	<input type="checkbox"/>
Storm preparation	<input type="checkbox"/>
Position of safety	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>

Child Checklist

Key Words	Mentioned
Abdomen	<input type="checkbox"/>
Cancer	<input type="checkbox"/>

Dehydration	<input type="checkbox"/>
Dengue fever	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Fever	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>
Influenza	<input type="checkbox"/>
Jaundice (yellow skin or eyes)	<input type="checkbox"/>
Leptospirosis	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>
Rash	<input type="checkbox"/>
Renal failure	<input type="checkbox"/>
Sepsis	<input type="checkbox"/>
Stress/Anxiety	<input type="checkbox"/>
Death Scene Investigation	
Power outage	<input type="checkbox"/>
Heat illness	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>
Homeless	<input type="checkbox"/>
Heat-related warnings	<input type="checkbox"/>
Storm clean up	<input type="checkbox"/>
Response/Recovery efforts	<input type="checkbox"/>
State of emergency	<input type="checkbox"/>
Storm preparation	<input type="checkbox"/>
Position of safety	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>

Neonatal Checklist

Key Words	Mentioned
Asphyxia (lack of oxygen)	<input type="checkbox"/>
Incubator	<input type="checkbox"/>
Lung problems	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>
Preterm delivery	<input type="checkbox"/>
Respiratory distress	<input type="checkbox"/>
Death Scene Investigation	
Power outage	<input type="checkbox"/>
Heat illness	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>
Homeless	<input type="checkbox"/>
Heat-related warnings	<input type="checkbox"/>
Storm clean up	<input type="checkbox"/>
Response/Recovery efforts	<input type="checkbox"/>
State of emergency	<input type="checkbox"/>
Storm preparation	<input type="checkbox"/>
Position of safety	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>

	Confirm that no words of interest were used during the open response.	1. No word was mentioned	<input type="checkbox"/>
		9. Don't know	<input type="checkbox"/>

END OF INTERVIEW

INTERVIEWER (THANK RESPONDENT FOR PARTICIPATION): "This is the end of the interview. We are deeply sorry for the death of (name). We appreciate all your help and may come back to you with any clarification on this information only if it is strictly necessary.

Are we able to contact you in the future if there are further questions? Yes No

Finally, do you have any questions or comments?"

FOR THE INTERVIEWER: CLARIFY ANY QUESTION AND INCLUDE BELOW ANY COMMENTS YOU HAVE ABOUT THE INTERVIEW. PLEASE INCLUDE ANYTHING THAT SOUNDED UNUSUAL TO YOU AND THAT MAY BE OUT OF THE NORM OR HELPFUL TO UNDERSTAND THE INFORMATION PROVIDED IN THE INTERVIEW.
