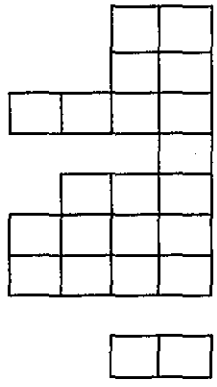
NDHS Form 3
NSCB Approval No. NSO-9721-03
Expires June 30, 1998

Republic of the Philippines
NATIONAL STATISTICS OFFICE
1998 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY
HEALTH MODULE

Confidentiality: This survey is authorized by Commonwealth Act No. 591. All information is strictly confidential.

IDENTIFICATION

PROVINCE _____
CITY/MUNICIPALITY _____
BARANGAY _____
URBAN/RURAL(URBAN=1, RURAL=2) .....
NDS SAMPLE NUMBER .....
HOUSEHOLD CONTROL NUMBER .....
NDHS HOUSEHOLD SEQUENTIAL NUMBER .....
ADDRESS _____
NAME AND LINE NUMBER OF RESPONDENT _____



INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY / MONTH / YEAR (1 9 9 8)
INTERVIEWER'S NAME				INT. CODE
RESULT*				RESULT*
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

RESULT CODES: *
01 COMPLETED, ORIGINAL HOUSEHOLD
02 COMPLETED, PRESENT OCCUPANT OF DWELLING
03 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT
04 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME
05 POSTPONED
06 REFUSED
07 DWELLING VACANT OR ADDRESS NOT A DWELLING
08 DWELLING DESTROYED
09 DWELLING NOT FOUND
10 OTHER _____ (SPECIFY)

TIME OF INTERVIEW
TIME STARTED
HOUR .....
MINUTES ...
TIME ENDED
HOUR .....
MINUTES ....

LANGUAGE OF QUESTIONNAIRE** [7]
LANGUAGE OF INTERVIEW** [ ]
LOCAL LANGUAGE OF RESPONDENT** [ ]
TRANSLATOR USED YES ..... 1 NO 2

**LANGUAGE CODES
1 TAGALOG 3 ILOCANO 5 HILIGAYNON 7 ENGLISH 8 OTHER _____ (SPECIFY)
2 CEBUANO 4 BICOL 6 WARAY

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____ [ ]	NAME _____ [ ]	[ ]	[ ]
DATE	DATE		

SECTION A. ENVIRONMENTAL HEALTH

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	How does your household usually dispose of garbage?	GARBAGE TRUCK/CART COLLECTION ..... 1 INDIVIDUAL OPEN DUMPING ..... 2 INDIVIDUAL BURNING ..... 3 COMPOSTING ..... 4 INDIVIDUAL BURYING ..... 5 FEEDING TO DOMESTIC ANIMALS ..... 6 DUMPING INTO LOW LAND AREA ..... 7 OTHERS, SPECIFY _____ 8	
2	How frequently is the garbage usually collected/disposed?	EVERYDAY ..... 1 ONCE IN TWO DAYS ..... 2 ONCE OR TWICE A WEEK ..... 3 OTHERS, SPECIFY _____ 4	
3	IS THERE A GARBAGE OR TRASH AROUND THE HOUSE OR YARD THAT ATTRACTS FLIES?	YES ..... 1 NO 2	
4	Does your household regularly buy cooked food from... Ambulant vendors? Carinderia? Restaurants? ENCIRCLE "1," IF YES AND "2," IF NO.	YES NO Ambulant vendors ..... 1 2 Carinderia ..... 1 2 Restaurants 1 2	

SECTION B. HEALTH FACILITY UTILIZATION

1	During the last 6 months, did you visit a health facility? YES .....1 ↓ NO ..... 2 → **SKIP TO SECTION C**									
2	What type of health facility did you visit? READ EACH FACILITY TO THE RESPONDENT. ENCIRCLE "1" IF THE RESPONDENT UTILIZED THE FACILITY. OTHERWISE, ENCIRCLE "2".	Regional Hospital 1 2 → SKIP TO NEXT FACILITY			Provincial Hospital 1 2 → SKIP TO NEXT FACILITY			District Hospital 1 2 → SKIP TO NEXT FACILITY		
3	FOR COLS. 1,4,7 ASK: When you visited (FACILITY) what type of service did you utilize?	SERVICE AVAILED	SATIS-FIED/ *DIS-*SATIS-FIED SATIS-FIED ...1 DIS-SATIS-FIED ...2	REASONS*	SERVICE AVAILED	SATIS-FIED/ DIS-SATIS-FIED SATIS-FIED ...1 DIS-SATIS-FIED ...2	REASONS*	SERVICE AVAILED	SATIS-FIED/ *DIS-*SATIS - FIED SATIS-FIED ...1 DIS-SATIS-FIED ...2	REASONS*
4	FOR COLS. 2,5,8 ASK: Were you satisfied or dissatisfied with the service?									
5	FOR COLS. 3,6,9 ASK: Why were you satisfied or dissatisfied with the service?									
	TYPE OF SERVICE AVAILED *READ EACH SERVICE TO THE* RESPONDENT	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	A. Treatment when ill or injured	1 2 ↓			1 2 ↓			1 2 ↓		
	B. Routine Check-ups	1 2 ↓			1 2 ↓			1 2 ↓		
	C. Laboratory Services	1 2 ↓			1 2 ↓			1 2 ↓		
	D. Immunization	1 2 ↓			1 2 ↓			1 2 ↓		
	E. Family Planning	1 2 ↓			1 2 ↓			1 2 ↓		
	F. Health and Nutrition Education	1 2 ↓			1 2 ↓			1 2 ↓		
	G. Prenatal, Delivery and Postnatal	1 2 ↓			1 2 ↓			1 2 ↓		
	H. Others _____ (SPECIFY)	1 2			1 2			1 2		

*CODES FOR REASONS FOR SATISFACTION/DISSATISFACTION (DO NOT READ TO RESPONDENT)

AVAILABILITY OF MEDICINE ..... A
POTENCY/EFFECTIVITY OF MEDICINES GIVEN ..... B
ADEQUACY OF HEALTH EQUIPMENT AND OTHER FACILITIES C
AVAILABILITY AND ACCESSABILITY OF HEALTH PERSONNEL ..... D
HEALTH PERSONNEL APPROACHABILITY ..... E
TECHNICAL COMPETENCY OF HEALTH PERSONNEL ..... F
COURTEOUSNESS OF HEALTH CARE FACILITY STAFF ..... G
CHARGES FOR SERVICES OR MEDICINES ..... H
IMPORTANCE GIVEN TO PATIENTS' RIGHT IN HEALTH CARE I
AVAILABILITY/QUALITY OF LINENS/BEDDINGS ..... J
AVAILABILITY /QUALITY OF FOOD ..... K
AVAILABILITY OF SERVICE L
OTHERS, SPECIFY _____ X

SECTION B. HEALTH FACILITY UTILIZATION

		Municipal Hospital 1 2 → SKIP TO NEXT FACILITY			Rural Health Unit 1 2 → SKIP TO NEXT FACILITY			Barangay Health Station 1 2 → SKIP TO NEXT FACILITY		
3	FOR COLS. 10,13,16 ASK: When you visited (FACILITY) what type of service did you utilize?	SERVICE AVAILED	SATIS-FIED/ DIS-SATIS-FIED SATIS-FIED ...1 DIS-SATIS-FIED ...2	REASONS*	SERVICE AVAILED	SATIS-FIED/ DIS-SATIS-FIED SATIS-FIED ...1 DIS-SATIS-FIED ...2	REASONS*	SERVICE AVAILED	SATIS-FIED/ DIS-SATIS-FIED SATIS-FIED ...1 DIS-SATIS-FIED ...2	REASONS*
4	FOR COLS. 11,14,17 ASK: Were you satisfied or dissatisfied with the service?									
5	FOR COLS. 12,15,18 ASK: Why were you satisfied or dissatisfied with the service?									
	TYPE OF SERVICE AVAILED READ EACH SERVICE TO THE RESPONDENT	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
	A. Treatment when ill or injured	1 2 ↓			1 2 ↓			1 2 ↓		
	B. Routine Check-ups	1 2 ↓			1 2 ↓			1 2 ↓		
	C. Laboratory Services	1 2 ↓			1 2 ↓					
	D. Immunization	1 2 ↓			1 2 ↓			1 2 ↓		
	E. Family Planning	1 2 ↓			1 2 ↓			1 2 ↓		
	F. Health and Nutrition Education	1 2 ↓			1 2 ↓			1 2 ↓		
	G. Prenatal, Delivery and Postnatal	1 2 ↓			1 2 ↓			1 2 ↓		
	H. Others _____ (SPECIFY)	1 2			1 2			1 2		

*CODES FOR REASONS FOR SATISFACTION/DISSATISFACTION (DO NOT READ TO RESPONDENT)

AVAILABILITY OF MEDICINE ..... A
POTENCY/EFFECTIVITY OF MEDICINES GIVEN ..... B
ADEQUACY OF HEALTH EQUIPMENT AND OTHER FACILITIES C
AVAILABILITY AND ACCESSABILITY OF HEALTH PERSONNEL ..... D
HEALTH PERSONNEL APPROACHABILITY ..... E
TECHNICAL COMPETENCY OF HEALTH PERSONNEL ..... F
COURTEOUSNESS OF HEALTH CARE FACILITY STAFF ..... G
CHARGES FOR SERVICES OR MEDICINES ..... H
IMPORTANCE GIVEN TO PATIENTS' RIGHT IN HEALTH CARE I
AVAILABILITY/QUALITY OF LINENS/BEDDINGS ..... J
AVAILABILITY /QUALITY OF FOOD ..... K
AVAILABILITY OF SERVICE L
OTHERS, SPECIFY _____ X

SECTION B. HEALTH FACILITY UTILIZATION

		Private Hospital 1 2 → SKIP TO NEXT FACILITY			Private Clinic 1 2 → SKIP TO NEXT FACILITY			Others, Specify 1 2 → GO TO SECTION C		
3	FOR COL. 19,22,25, ASK: When you visited (FACILITY) what type of service did you utilize?	SERVICE AVAILED	SATIS-FIED/DIS-SATIS-FIED	REASONS*	SERVICE AVAILED	SATIS-FIED/DIS-SATIS-FIED	REASONS*	SERVICE AVAILED	SATIS-FIED/DIS SATIS-FIED	REASONS*
4	FOR COL. 20,23,26, ASK: Were you satisfied or dissatisfied with the service?		SATIS-FIED ...1			SATIS-FIED ...1			SATIS-FIED ...1	
5	FOR COL. 21,24,27, ASK: Why were you satisfied or dissatisfied with the service?		DIS-SATIS-FIED ...2			DIS-SATIS-FIED ...2			DIS-SATIS-FIED ...2	
	TYPE OF SERVICE AVAILED READ EACH SERVICE TO THE RESPONDENT	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)
	Treatment when ill or injured	1 2			1 2			1 2		
	B. Routine Check-ups	1 2			1 2			1 2		
	C. Laboratory Services	1 2			1 2			1 2		
	D. Immunization	1 2			1 2			1 2		
	E. Family Planning	1 2			1 2			1 2		
	F. Health and Nutrition Education	1 2			1 2			1 2		
	G. Prenatal, Delivery and Postnatal	1 2			1 2			1 2		
	H. Others _____ (SPECIFY)	1 2			1 2			1 2		

*CODES FOR REASONS FOR SATISFACTION/DISSATISFACTION (DO NOT READ TO RESPONDENT)

AVAILABILITY OF MEDICINE ..... A
POTENCY/EFFECTIVITY OF MEDICINES GIVEN ..... B
ADEQUACY OF HEALTH EQUIPMENT AND OTHER FACILITIES C
AVAILABILITY AND ACCESSABILITY OF HEALTH PERSONNEL ..... D
HEALTH PERSONNEL APPROACHABILITY ..... E
TECHNICAL COMPETENCY OF HEALTH PERSONNEL ..... F
COURTEOUSNESS OF HEALTH CARE FACILITY STAFF ..... G
CHARGES FOR SERVICES OR MEDICINES ..... H
IMPORTANCE GIVEN TO PATIENTS' RIGHT IN HEALTH CARE I
AVAILABILITY/QUALITY OF LINENS/BEDDINGS ..... J
AVAILABILITY /QUALITY OF FOOD ..... K
AVAILABILITY OF SERVICE L
OTHERS, SPECIFY _____ X

SECTION C. NONCOMMUNICABLE DISEASES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	How do you keep yourself healthy? PROBE: Anything else?	EXERCISE ..... A AVOID EATING TOO MUCH FAT ..... B LOW SALT DIET ..... C NO SMOKING ..... D MODERATE DRINKING ..... E MONITOR BLOOD PRESSURE REGULARLY ..... F PROPER NUTRITION ..... G OTHERS, SPECIFY _____ X NONE ..... Y	
2	How many members of your household smoke cigarette?	SPECIFY NUMBER ..... ☐ (ENTER "0" IF NONE)	
3	In your opinion, how does smoking affect the health of all the people in the household? PROBE. Anything else?	CAN CAUSE TB ..... A CAN CAUSE LUNG CANCER ..... B CAN CAUSE LUNG DISEASE ..... C CAN CAUSE HEART DISEASE ..... D CAN CAUSE ASTHMA ..... E CAN CAUSE ULCER ..... F OTHERS, SPECIFY _____ X NO EFFECT ..... Y	
4	What signs and symptoms would make you suspect that a person may have cancer? PROBE: Anything else?	LUMP OR MASS IN ANY PART OF THE BODY ..... A SORE(WOUND) THAT DOES NOT HEAL ..... B SUDDEN WEIGHT LOSS ..... C BLEEDING ..... D IRREGULAR BOWEL MOVEMENT ..... E IRREGULAR URINATION ..... F HOARSENESS OF VOICE ..... G PERSISTENT PAIN ..... H OTHERS, SPECIFY _____ X NONE ..... Y DON'T KNOW ..... Z	

SECTION D. COMMUNICABLE DISEASE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
1	What do you think is the cause of TB?	MICROBES/GERMS/BACTERIA	A	
		INHERITED	B	
		LIFESTYLE	C	
		SMOKING	D	
	PROBE: Anything else?	ALCOHOL DRINKING	E	
		FATIGUE	F	
		OTHERS, SPECIFY _____	X	
		DON'T KNOW CAUSE TB	Y	
		DOES NOT KNOW TB	Z	→ 5
2	How long do you think TB should be treated?	ONE MONTH	1	
		TWO MONTHS	2	
		THREE MONTHS	3	
		FOUR MONTHS	4	
		SIX MONTHS	5	
		EIGHT MONTHS	6	
		ONE YEAR OR MORE	7	
		DON'T KNOW	8	
3	Is there a member of your household who is currently taking anti-TB medicines?	YES	1	
		NO	2	→ 5
		DON'T KNOW	8	→ 5
4	If Yes, where does that person get the anti-TB medicines?	HEALTH CENTER	A	
		BUY MEDICINES FROM DRUGSTORE	B	
		N.G.O	C	
	PROBE: Anything else?	PRIVATE CLINIC/HOSPITAL	D	
		GOVERNMENT HOSPITAL	E	
		OTHERS, SPECIFY _____	X	
		DON'T KNOW	Z	
5	How do you think is leprosy spread?	SKIN TO SKIN	A	
		DROPLETS/AIRBORNE	B	
		HEREDITARY	C	
	PROBE: Anything else?	EXPOSURE TO HOT THEN COLD "PASMA"	D	
		EATING CERTAIN TYPES OF FOOD	E	
		OTHERS, SPECIFY _____	X	
		DON'T KNOW MODE OF TRANSMISSION	Y	
		DON'T KNOW LEPROSY	Z	→ 8
6	Do you think leprosy is curable?	YES	1	
		NO	2	→ 8
7	In your opinion can leprosy patients be treated at home?	YES	1	
		NO	2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
8	Have you heard of "dengue" fever?	YES	1	
		NO	2 →	10
9	What can you do to protect yourself from getting dengue fever?	STAY AWAY FROM PEOPLE WITH DENGUE	A	
		REMOVE BREEDING PLACES (STAGNANT WATER) OF MOSQUITOES WITHIN SURROUNDINGS	B	
	PROBE: Anything else?	TAKE MEDICINES SO AS NOT TO GET SICK	C	
		USE MOSQUITO NETS	D	
		WASH HANDS BEFORE EATING	E	
		ELIMINATE ALL FLIES IN YOUR SURROUNDINGS	F	
		OTHERS, SPECIFY _____	X	
		NONE	Y	
		DON'T KNOW	Z	
10	Apart from feeding or cleaning the dog, what do you think is the responsibility of a dog owner?	IMMUNIZE DOG	A	
		RESTRAIN/CONFINE DOG WITHIN THE YARD/HOUSE	B	
	PROBE: Anything else?	IN CASE OF DOG BITE, PROVIDE NECESSARY TREATMENT FOR THE VICTIM	C	
		OTHERS, SPECIFY _____	X	
		NONE	Y	
11	During the last 3 months, was any member of your family bitten by a dog?	YES	1	
		NO	2 →	SECT. E
12	What was done to treat the bite?	WASHED BITE WOUND WITH SOAP AND WATER	A	
		APPLIED GARLIC ON SITE OF BITE	B	
	PROBE: Anything else?	CONSULTED HEALTH CENTER/ PHYSICIAN	C	
		SOUGHT AN HERBULARIO	D	
		IMMEDIATELY KILLED THE DOG	E	
		OBSERVED THE DOG	F	
		OTHERS, SPECIFY _____	X	
		NOTHING	Y	

SECTION E. TRADITIONAL MEDICINES

There are some locally produced herbs that have medicinal values. I would like to find out if you know some of these.

		Ampalaya*	Ulasimang bato (pansit pansitan)*	Lagundi*	Niyog-niyogan*	Sambong*	Tsaang gubat*	Yerba Buena*	Bayabas*	Bawang*	Acapulco*
1	Are you familiar with (NAME OF HERB) which is used as a medicine? READ EACH HERBAL MEDICINE TO THE RESPONDENT. ENCIRCLE "1" IF THE RESPONDENT IS FAMILIAR, OTHERWISE ENCIRCLE "2".	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
		YES..1 NO..2 GO TO (2)	YES..1 NO..2 GO TO (3)	YES..1 NO..2 GO TO (4)	YES..1 NO..2 GO TO (5)	YES..1 NO..2 GO TO (6)	YES..1 NO..2 GO TO (7)	YES..1 NO..2 GO TO (8)	YES..1 NO..2 GO TO (9)	YES..1 NO..2 GO TO (10)	YES..1 NO..2 GO TO SECT. F.
2	For what illness or disease do you think (NAME OF HERB) is used? CIRCLE CODES OF ALL ILLNESSES MENTIONED.										
	A. HEADACHE	A	A	A	A	A	A	A	A	A	A
	B. FEVER	B	B	B	B	B	B	B	B	B	B
	C. ABDOMINAL PAIN/DIARRHEA	C	C	C	C	C	C	C	C	C	C
	D. COUGH/ASTHMA	D	D	D	D	D	D	D	D	D	D
	E. ASCARIS	E	E	E	E	E	E	E	E	E	E
	F. DIABETES	F	F	F	F	F	F	F	F	F	F
	G. GOUTY ARTHRITIS/ RAYUMA	G	G	G	G	G	G	G	G	G	G
	H. HYPER CHO-LESTEROLEMIA	H	H	H	H	H	H	H	H	H	H
	I. SKIN INFECTION/ CLEANING WOUNDS	I	I	I	I	I	I	I	I	I	I
	J. DIURETIC/FOR URINARY STONES	J	J	J	J	J	J	J	J	J	J
	K. OTHERS, SPECIFY	K___	K___	K___	K___	K___	K___	K___	K___	K___	K___
3	Have you used (NAME OF HERB) during the past 3 months?	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2	YES..1 NO...2
4	Do you know if (NAME OF HERB) is endorsed by the DOH?	YES..1 NO...2 GO TO (2)	YES..1 NO...2 GO TO (3)	YES..1 NO...2 GO TO (4)	YES..1 NO...2 GO TO (5)	YES..1 NO...2 GO TO (6)	YES..1 NO...2 GO TO (7)	YES..1 NO...2 GO TO (8)	YES..1 NO...2 GO TO (9)	YES..1 NO...2 GO TO (10)	YES..1 NO...2 GO TO SECT. F.

*REFER TO INTERVIEWER'S MANUAL FOR OTHER NAMES OF THESE HERBS.

SECTION F. HEALTH CARE FINANCING

1. Are you or any member of your household a member of MEDICARE, Employer-based Health Maintenance Organization (HMO), Private Health Insurance, Community/Cooperative Health Financing Scheme or any Health Insurance Plan?

YES .....1 NO .....2, END INTERVIEW

FROM NDHS Form 1 Col. (2) and Col. (1)	RESPONDENT NAME: _____ LINE NO.: _____	HOUSEHOLD MEMBER NAME: _____ LINE NO.: _____	HOUSEHOLD MEMBER: NAME: _____ LINE NO.: _____
2. What kind of Health Insurance Plan? PROBE: Anything else?	MEDICARE .....A HMO .....B PRIVATE .....C COMMUNITY/COOP. .....D OTHERS, SPECIFY —— E	MEDICARE .....A HMO .....B PRIVATE .....C COMMUNITY/COOP. .....D OTHERS, SPECIFY —— E DON'T KNOW .....Z (SKIP TO 7)	MEDICARE .....A HMO .....B PRIVATE .....C COMMUNITY/COOP. .....D OTHERS, SPECIFY —— E DON'T KNOW .....Z (SKIP TO 7)
3. CHECK Q.2	"A" is encircled ☐ "A" is not encircled ☐ (SKIP TO 7)	"A" is encircled ☐ "A" is not encircled ☐ (SKIP TO 7)	"A" is encircled ☐ "A" is not encircled ☐ (SKIP TO 7)
4. Have you (Has any member of your household) or any of your (his/her) dependents utilized MEDICARE benefits within the last 12 months?	YES .....1 NO .....2 (SKIP TO 7)	YES .....1 NO .....2 (SKIP TO 7)	YES .....1 NO .....2 (SKIP TO 7)
5. Were you (Do you think he/she was) satisfied or dissatisfied with the service?	SATISFIED .....1 (SKIP TO 7) DISSATISFIED 2	SATISFIED .....1 (SKIP TO 7) DISSATISFIED .....2 DON'T KNOW .....8 (SKIP TO 7)	SATISFIED .....1 (SKIP TO 7) DISSATISFIED .....2 DON'T KNOW .....8 (SKIP TO 7)
6. Why were you (do you think he/she was) not satisfied with the service? PROBE: Anything else?	PROCESSING OF CLAIMS TOO LONG .....A TOO MANY REQUIREMENTS .....B LIMITED HOSPITALIZATION/ FINANCIAL BENEFITS .C BENEFITS CAN'T BE AVAILED OF UNLESS HOSPITALIZED .....D PREMIUM NOT REFUNDABLE .....E LACK OF INFORMATION ABOUT MEDICARE .....F OTHERS _____ X (SPECIFY)	PROCESSING OF CLAIMS TOO LONG .....A TOO MANY REQUIREMENTS .....B LIMITED HOSPITALIZATION/ FINANCIAL BENEFITS .C BENEFITS CAN'T BE AVAILED OF UNLESS HOSPITALIZED .....D PREMIUM NOT REFUNDABLE .....E LACK OF INFORMATION ABOUT MEDICARE .....F OTHERS _____ X (SPECIFY) DON'T KNOW .....Z	PROCESSING OF CLAIMS TOO LONG .....A TOO MANY REQUIREMENTS .....B LIMITED HOSPITALIZATION/ FINANCIAL BENEFITS .C BENEFITS CAN'T BE AVAILED OF UNLESS HOSPITALIZED .....D PREMIUM NOT REFUNDABLE .....E LACK OF INFORMATION ABOUT MEDICARE .....F OTHERS _____ X (SPECIFY) DON'T KNOW .....Z
7.	GO TO NEXT HH MEMBER OR IF NO MORE MEMBER END INTERVIEW	GO TO NEXT HH MEMBER OR IF NO MORE MEMBER END INTERVIEW	GO TO NEXT HH MEMBER OR IF NO MORE MEMBER END INTERVIEW

10