



**SECTION A. HEALTH FACILITY UTILIZATION**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
A01	During the last 6 months, did you or any member of your household visit any of the following facilities:  Code      Name of Facility 1      Barangay Health Station? 2      Rural Health Unit/Urban Health Center? 3      Municipal Hospital? 4      District Hospital? 5      Provincial Hospital? 6      Regional Hospital/Public Medical Center? 7      Private Clinic? 8      Private Hospital? 9      Other?	YES      NO  BARANGAY HEALTH STATION..... 1      2 RURAL HEALTH UNIT/URBAN HEALTH CENTER ..... 1      2 MUNICIPAL HOSPITAL ..... 1      2 DISTRICT HOSPITAL ..... 1      2 PROVINCIAL HOSPITAL ..... 1      2 REGIONAL HOSP/PUBLIC MED CENTER ..... 1      2 PRIVATE CLINIC ..... 1      2 PRIVATE HOSPITAL ..... 1      2 OTHER ..... 1      2		
A02	CHECK A01: AT LEAST ONE "YES" CIRCLED <input type="checkbox"/>	NOT A SINGLE "YES" CIRCLED <input type="checkbox"/>	→ B01	
A03	What type of service did you or any member of your household utilized?  a. Treatment when ill or injured b. Routine check-ups c. Laboratory services d. Immunization e. Family planning f. Health and nutrition education g. Prenatal, delivery and postnatal h. Other	FACILITY ..... <input type="checkbox"/>  (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME  YES      NO 1      2 1      2 1      2 1      2 1      2 1      2 1      2 1      2	FACILITY ..... <input type="checkbox"/>  (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME  YES      NO 1      2 1      2 1      2 1      2 1      2 1      2 1      2 1      2	FACILITY ..... <input type="checkbox"/>  (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME  YES      NO 1      2 1      2 1      2 1      2 1      2 1      2 1      2 1      2
	(CONTINUATION)  a. Treatment when ill or injured b. Routine check-ups c. Laboratory services d. Immunization e. Family planning f. Health and nutrition education g. Prenatal, delivery and postnatal h. Other	FACILITY ..... <input type="checkbox"/>  (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME  YES      NO 1      2 1      2 1      2 1      2 1      2 1      2 1      2	FACILITY ..... <input type="checkbox"/>  (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME  YES      NO 1      2 1      2 1      2 1      2 1      2 1      2 1      2	FACILITY ..... <input type="checkbox"/>  (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME  YES      NO 1      2 1      2 1      2 1      2 1      2 1      2 1      2

**SECTION B. NONCOMMUNICABLE DISEASES**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
B01	<p>What do you do to keep yourself healthy?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.</p>	<p>AVOID EATING TOO MUCH FAT .....A</p> <p>AVOID EXCESSIVE INTAKE OF SALT AND SALTY FOOD .....B</p> <p>AVOID/MODERATE DRINKING OF ALCOHOLIC BEVERAGES .....C</p> <p>AVOID SMOKING .....D</p> <p>BE PHYSICALLY ACTIVE .....E</p> <p>CHECK-UP BY DOCTOR .....F</p> <p>CONSUME MILK AND MILK PRODUCTS .....G</p> <p>EAT ADEQUATE/BALANCE DIET.....H</p> <p>EAT FISH, LEAN MEAT, POULTRY AND DRIED BEANS .....I</p> <p>EAT PLENTY OF FRUITS, VEGETABLES AND ROOTCROPS.....J</p> <p>HAVE ENOUGH SLEEP .....K</p> <p>MAINTAIN GOOD HYGIENE .....L</p> <p>MAINTAIN HAPPY PERSONALITY .....M</p> <p>MONITOR BLOOD PRESSURE .....N</p> <p>TAKE VITAMINS/FOOD SUPPLEMENT .....O</p> <p>OTHER.....X</p> <p>NONE .....Y</p>	
B02	<p>Have you ever heard of a disease called cancer?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	<p>→ B07</p>
B03	<p>What signs and symptoms would make you suspect that a person may have cancer?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.</p>	<p>BLEEDING .....A</p> <p>CHANGE OF BOWEL MOVEMENT .....B</p> <p>HOARSENESS OF VOICE .....C</p> <p>IRREGULAR URINATION.....D</p> <p>LUMP OR MASS IN ANY PART OF THE BODY .....E</p> <p>PERSISTENT PAIN .....F</p> <p>SORE (WOUND) THAT DOES NOT HEAL .....G</p> <p>SUDDEN WEIGHT LOSS .....H</p> <p>WEAK .....I</p> <p>OTHER.....X</p> <p>NONE .....Y</p> <p>DON'T KNOW .....Z</p>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
B04	Have you ever been screened/examined for cancer?	YES ..... 1 NO ..... 2	→ B07
B05	What part of your body was screened?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	BLOOD ..... A BONE ..... B BREAST ..... C CERVIX ..... D ESOPHAGUS ..... E LARYNX ..... F LIVER ..... G LUNG ..... H MOUTH/ORAL CAVITY ..... I OVARY ..... J PROSTATE ..... K STOMACH ..... L UTERINE ..... M OTHER ..... X DON'T KNOW ..... Z	→ B07
B06	Where were you screened/examined?  PROBE: Anything Else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	PUBLIC/PRIVATE HOSPITAL ..... A HEALTH CENTER ..... B PRIVATE CLINIC ..... C COMPANY CLINIC ..... D SCHOOL CLINIC ..... E HOME/SELF/HOME VISIT ..... F SEMINAR ON REPRODUCTIVE HEALTH ..... G OTHER ..... X DON'T KNOW ..... Z	
B07	Have you been told on more than one occasion that your blood pressure is high?	YES ..... 1 NO ..... 2 BLOOD PRESSURE WAS NEVER TAKEN ..... 3	
B08	Have you ever heard of heart disease?	YES ..... 1 NO ..... 2	→ B10

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
B09	<p>Who are likely to have heart disease?</p> <p>PROBE: Anybody else?</p> <p>CIRCLE ALL MENTIONED.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>THOSE WHO SMOKE HEAVILY .....A</p> <p>THOSE WHO ARE FAT (OBESE) .....B</p> <p>THOSE WHO DRINK HEAVILY .....C</p> <p>THOSE WHO EAT HIGH FAT, HIGH SALT DIET .....D</p> <p>THOSE WHO ARE UNDER STRESS .....E</p> <p>THOSE WHO DO NOT EXERCISE .....F</p> <p>THOSE WHO HAVE ELEVATED BLOOD PRESSURE .....G</p> <p>THOSE WITH FAMILY HISTORY OF HEART DISEASE .....H</p> <p>THOSE WHO LACK SLEEP .....I</p> <p>OTHER .....X</p> <p>DON'T KNOW .....Z</p>	
B10	<p>Have you ever heard of diabetes?</p>	<p>YES .....1</p> <p>NO .....2</p>	<p>→ C01</p>
B11	<p>Who are likely to have diabetes?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>FAT/OBESE PEOPLE .....A</p> <p>HEAVY DRINKERS OF ALCOHOL .....B</p> <p>HEAVY SMOKERS .....C</p> <p>OLDER PEOPLE/MENOPAUSAL WOMEN .....D</p> <p>PEOPLE WHO EAT PLENTY OF SWEETS AND FATTY FOODS .....E</p> <p>THOSE HOW DO NOT EXERCISE REGULARLY .....F</p> <p>THOSE WHERE DIABETES RUNS IN THE FAMILY .....G</p> <p>OTHER .....X</p> <p>DON'T KNOW .....Z</p>	

**SECTION C. INFECTIOUS DISEASES**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
C01	Have you ever heard of leprosy?	YES ..... 1 NO ..... 2	→ C05
C02	How does leprosy spread from one person to another?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	CONTACT WITH LEPROSY PATIENT ..... A DROPLETS/AIRBORNE ..... B EATING CERTAIN TYPES OF FOOD ..... C EXPOSURE TO HOT THEN COLD "PASMA" ..... D HEREDITARY ..... E SKIN TO SKIN ..... F OTHER ..... X DON'T KNOW ..... Z	
C03	Can leprosy be cured?	YES ..... 1 NO ..... 2	→ C05
C04	In your opinion, can persons with leprosy be treated at home?	YES ..... 1 NO ..... 2	
C05	Have you ever heard of dengue fever?	YES ..... 1 NO ..... 2	→ C09
C06	How does dengue spread from one person to another?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	BLOOD BORNE/BLOOD TRANSFUSION ..... A CONTACT WITH DENGUE PATIENT ..... B DRINKING CONTAMINATED WATER ..... C DROPLETS/AIRBORNE ..... D MOSQUITO BITE ..... E POLLUTED AIR ..... F OTHER ..... X DON'T KNOW ..... Z	
C07	Can dengue fever be prevented?	YES ..... 1 NO ..... 2	→ C09
C08	How can it be prevented?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	ELIMINATE MOSQUITOES IN THE SURROUNDINGS ..... A REMOVE BREEDING PLACES (STAGNANT WATER) OF MOSQUITOES INSIDE AND OUTSIDE THE HOUSE ..... B SPRAYING/FOGGING/FUMIGATION ..... C STAY AWAY FROM PEOPLE WITH DENGUE ..... D TAKE MEDICINES SO AS NOT TO GET SICK ..... E USE OF MOSQUITO COILS ..... F USE MOSQUITO NETS ..... G USE OF MOSQUITO REPELLANTS ..... H WASH HANDS BEFORE EATING ..... I OTHER ..... X DON'T KNOW ..... Z	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
C09	Have you ever heard of malaria?	YES .....1 NO .....2	→ C14
C10	What do you think is the cause of malaria?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	CONTAMINATION IN THE WATER .....A INHERITED .....B MOSQUITO BITES .....C OVER FATIGUE.....D PARASITES IN THE BLOOD .....E POLLUTED AIR .....F OTHER.....X DON'T KNOW .....Z	
C11	How does malaria spread from one person to another?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	POLLUTED AIR .....A CONTACT WITH MALARIA PATIENT .....B DRINKING CONTAMINATED WATER .....C EATING SOUR FOODS.....D MOSQUITO BITES .....E OVER FATIGUE.....F OTHER.....X DON'T KNOW .....Z	
C12	Can malaria be prevented?	YES .....1 NO .....2	→ C14
C13	How can it be prevented?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	AVOIDANCE OF CERTAIN FOODS AT CERTAIN SEASONS .....A HOUSE SPRAYING .....B REMOVE BREEDING PLACES (STAGNANT WATER) OF MOSQUITOES INSIDE AND OUTSIDE THE HOUSE .....C STREAM CLEARING .....D USE OF MOSQUITO COILS .....E USE OF MOSQUITO NETS .....F USE OF MOSQUITO REPELLANTS .....G OTHER.....X DON'T KNOW .....Z	
C14	Now I would like to ask you about dogs. Apart from feeding or bathing the dog, what do you think is/are the responsibility/ies of a dog owner?  PROBE: Anything else? CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	IMMUNIZE DOG .....A IMMUNIZE DOG YEARLY .....B IN CASE OF DOG BITE, PROVIDE NECESSARY TREATMENT FOR THE VICTIM .....C RESTRAIN/CONFINE DOG WITHIN THE YARD/HOUSE .....D OTHER.....X NOTHING.....Y	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
C15	<p>If you or any member of your household is bitten by a dog, what do you think should be done to the person?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>APPLY GARLIC ON SITE OF BITE ..... A</p> <p>CONSULT ANIMAL BITE CENTER ..... B</p> <p>CONSULT HEALTH CENTER/PHYSICIAN ..... C</p> <p>SOUGHT "TANDOK"/HERBULARIO..... D</p> <p>TAKE DRUGS SO AS NOT TO GET RABIES ..... E</p> <p>WASH BITE/WOUND WITH SOAP AND WATER ..... F</p> <p>OTHER ..... X</p> <p>NOTHING ..... Y</p>	
C16	<p>If you or any member of your household is bitten by a dog, what do you think should be done to the dog?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>CONFINE DOG WITHIN THE YARD/HOUSE..... A</p> <p>IF THE DOG DIES, SUBMIT THE HEAD FOR EXAMINATION.... B</p> <p>IMMEDIATELY KILL THE DOG..... C</p> <p>OBSERVE THE DOG ..... D</p> <p>OTHER ..... X</p> <p>NOTHING ..... Y</p>	
C17	<p>Are you aware of any local (city/municipal) rabies ordinance control?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ D01
C18	<p>What is this local ordinance?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>DOG LEASHING ..... A</p> <p>DOG REGISTRATION..... B</p> <p>STRAY DOG IMPOUNDING ..... C</p> <p>YEARLY DOG IMMUNIZATION ..... D</p> <p>OTHER ..... X</p> <p>DON'T KNOW ..... Z</p>	

**SECTION D. TRADITIONAL MEDICINES, HEALING PRACTICES AND  
ALTERNATIVE HEALTH CARE MODALITIES**

D01	There are some locally produced herbs that have medicinal values. I would like to find out if you know some of these.											
	Are you familiar with (NAME OF HERB) which is used as a medicine?	Lagundi*	Yerba Buena*	Sam-bong*	Tsaang gubat*	Niyog-niyogan*	Baya-bas*	Acapul-co*	Ulasimang bato (pansit pansitan)*	Bawang*	Ampalaya*	
	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 NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	
	1 2	1 2	1 2	1 2	1 2	1 2	1 2	1 2	1 2	1 2		
	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘		
	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8	Col. 9	Col. 10	D06		
D02	From what source have you heard/read (NAME OF HERB)?											
	A. GOVERNMENT HEALTH PERSONNEL	A	A	A	A	A	A	A	A	A	A	
	B. PRIVATE PRACTITIONER/NGO	B	B	B	B	B	B	B	B	B	B	
	C. RADIO	C	C	C	C	C	C	C	C	C	C	
	D. TV	D	D	D	D	D	D	D	D	D	D	
	E. NEWSPAPER/PAMPHLET/MAGAZINE/BOOKS	E	E	E	E	E	E	E	E	E	E	
	F. SCHOOLS	F	F	F	F	F	F	F	F	F	F	
	G. SEMINARS/TRAININGS	G	G	G	G	G	G	G	G	G	G	
	H. FRIENDS/RELATIVES	H	H	H	H	H	H	H	H	H	H	
	I. OTHER	J	J	J	J	J	J	J	J	J	J	
	D03	In what form have you heard about (NAME OF HERB)?										
		A. FRESH	A	A	A	A	A	A	A	A	A	A
B. TABLET		B	B	B	B	B	B	B	B	B	B	
C. CAPSULE		C	C	C	C	C	C	C	C	C	C	
D. SYRUP		D	D	D	D	D	D	D	D	D	D	
E. TEA		E	E	E	E	E	E	E	E	E	E	
F. OINTMENT		F	F	F	F	F	F	F	F	F	F	
G. SOAP		G	G	G	G	G	G	G	G	G	G	
H. OTHER		H	H	H	H	H	H	H	H	H	H	
D04		For what illness or disease do you think (NAME OF HERB) is used? CIRCLE CODES OF ALL ILLNESSES MENTIONED.										
	A. ABDOMINAL PAIN/DIARRHEA	A	A	A	A	A	A	A	A	A	A	
	B. ANEMIC	B	B	B	B	B	B	B	B	B	B	
	C. ASCARIS	C	C	C	C	C	C	C	C	C	C	
	D. COLD	D	D	D	D	D	D	D	D	D	D	
	E. COUGH/ASTHMA	E	E	E	E	E	E	E	E	E	E	
	F. DIABETES	F	F	F	F	F	F	F	F	F	F	
	G. DIURETIC/URINARY STONE	G	G	G	G	G	G	G	G	G	G	
	H. FEVER	H	H	H	H	H	H	H	H	H	H	
	I. GOUTY-ARTHRITIS/RAYUMA	I	I	I	I	I	I	I	I	I	I	
	J. EDEMA (MANAS)	J	J	J	J	J	J	J	J	J	J	
	K. HIGH BLOOD PRESSURE	K	K	K	K	K	K	K	K	K	K	
	L. HYPER-CHOLESTEROLEMIA	L	L	L	L	L	L	L	L	L	L	
	M. SKIN INFECTION/CLEANING WOUNDS	M	M	M	M	M	M	M	M	M	M	
	N. MALASE	N	N	N	N	N	N	N	N	N	N	
	O. OTHER	O	O	O	O	O	O	O	O	O	O	
	D05	Have you or any member of your household used (NAME OF HERB) during the past 3 months?										
YES NO		YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	
	1 2	1 2	1 2	1 2	1 2	1 2	1 2	1 2	1 2	1 2		
	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘	↓ ↘		
	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8	Col. 9	Col. 10			

\*Refer to Interviewer's Manual for Other Names of These Herbs

**SECTION D. TRADITIONAL MEDICINES, HEALING PRACTICES AND  
ALTERNATIVE HEALTH CARE MODALITIES**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																											
D06	Have you ever heard of traditional healing practices such as: a) Hilot? b) Pagtatawas? c) Oracion? d) Spiritual healing?	<table border="0"> <tr> <td></td> <td align="right">YES</td> <td align="right">NO</td> </tr> <tr> <td>HILOT .....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>PAGTATAWAS.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>ORACION.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>SPIRITUAL HEALING .....</td> <td align="right">1</td> <td align="right">2</td> </tr> </table>		YES	NO	HILOT .....	1	2	PAGTATAWAS.....	1	2	ORACION.....	1	2	SPIRITUAL HEALING .....	1	2													
	YES	NO																												
HILOT .....	1	2																												
PAGTATAWAS.....	1	2																												
ORACION.....	1	2																												
SPIRITUAL HEALING .....	1	2																												
D06A	CHECK D06: AT LEAST ONE <input type="checkbox"/> "YES" CIRCLED <span style="margin-left: 100px;">↓</span>	NOT A SINGLE <input type="checkbox"/> "YES" CIRCLED	→ D10																											
D07	Where/how/from whom did you hear about the traditional healing practices?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	GOVERNMENT HEALTH PERSONNEL ..... A PRIVATE PRACTITIONER/NGO ..... B RADIO ..... C TELEVISION ..... D NEWSPAPER/PAMPHLET/MAGAZINE/BOOKS..... E SCHOOLS ..... F SEMINARS/TRAININGS ..... G FRIENDS/RELATIVES ..... H OTHER ..... X																												
D08	Have you or any household member ever tried using any traditional healing practice?	YES ..... 1 NO ..... 2	→ D10																											
D09	What traditional healing practices have you or any member of your household tried?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	HILOT ..... A PAGTATAWAS..... B ORACION..... C SPIRITUAL HEALING ..... D OTHER ..... X NOTHING ..... Y																												
D10	Have you ever heard of alternative health care modalities such as: a) Acupuncture? b) Acupressure/Therapeutic? c) Massage? d) Iridology? e) Pranic Healing? f) Aromatherapy? g) Chiropractic? h) Homeopathy?	<table border="0"> <tr> <td></td> <td align="right">YES</td> <td align="right">NO</td> </tr> <tr> <td>ACUPUNCTURE.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>ACUPRESSURE/THERAPEUTIC.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>MASSAGE.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>IRIDOLOGY.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>PRANIC HEALING.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>AROMATHERAPY.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>CHIROPRACTIC.....</td> <td align="right">1</td> <td align="right">2</td> </tr> <tr> <td>HOMEOPATHY.....</td> <td align="right">1</td> <td align="right">2</td> </tr> </table>		YES	NO	ACUPUNCTURE.....	1	2	ACUPRESSURE/THERAPEUTIC.....	1	2	MASSAGE.....	1	2	IRIDOLOGY.....	1	2	PRANIC HEALING.....	1	2	AROMATHERAPY.....	1	2	CHIROPRACTIC.....	1	2	HOMEOPATHY.....	1	2	
	YES	NO																												
ACUPUNCTURE.....	1	2																												
ACUPRESSURE/THERAPEUTIC.....	1	2																												
MASSAGE.....	1	2																												
IRIDOLOGY.....	1	2																												
PRANIC HEALING.....	1	2																												
AROMATHERAPY.....	1	2																												
CHIROPRACTIC.....	1	2																												
HOMEOPATHY.....	1	2																												
D11	CHECK D10: AT LEAST ONE <input type="checkbox"/> "YES" CIRCLED <span style="margin-left: 100px;">↓</span> D12	NOT A SINGLE <input type="checkbox"/> "YES" CIRCLED	→ E01																											

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
D12	<p>Where/how/from whom did you hear about alternative health care modalities?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.</p>	<p>GOVERNMENT HEALTH PERSONNEL .....A</p> <p>PRIVATE PRACTITIONER/NGO .....B</p> <p>RADIO .....C</p> <p>TELEVISION .....D</p> <p>NEWSPAPER/PAMPHLET/MAGAZINE/BOOKS .....E</p> <p>SCHOOLS .....F</p> <p>SEMINARS/TRAININGS .....G</p> <p>FRIENDS/RELATIVES .....H</p> <p>OTHER .....X</p>	
D13	<p>Have you or any household member ever tried using alternative health care modalities?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ E01
D14	<p>What alternative health care modalities have you or any member of the household tried?</p> <p>PROBE: Anything else?</p> <p>CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.</p>	<p>ACUPUNCTURE .....A</p> <p>ACUPRESSURE/THERAPEUTIC .....B</p> <p>MASSAGE .....C</p> <p>IRIDOLOGY .....D</p> <p>PRANIC HEALING .....E</p> <p>AROMATHERAPY .....F</p> <p>CHIROPRACTIC .....G</p> <p>HOMEOPATHY .....H</p> <p>OTHER .....X</p> <p>NONE .....Y</p>	

**SECTION E. HEALTH CARE FINANCING**

E01	Are you or any member of your household a member of PHILHEALTH, Employer-based Health Maintenance Organization (HMO), Private Health Insurance, Community/Cooperative Health Financing Scheme or any Health Insurance Plan? YES.....1      NO.....2      → SECTION F			
	COPY LINE NUMBER AND NAME OF MEMBER FROM NDHS Form 1 Col. (2) and Col. (1)	HOUSEHOLD MEMBER NAME: _____ LINE NO ..... <input type="text"/> <input type="text"/>	HOUSEHOLD MEMBER NAME: _____ LINE NO ..... <input type="text"/> <input type="text"/>	HOUSEHOLD MEMBER NAME: _____ LINE NO ..... <input type="text"/> <input type="text"/>
E02	What kind of Health Insurance Plan? PROBE: Anything else? CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	PHILHEALTH ..... A HMO/PRIVATE INSURANCE .. B LGU/COMMUNITY/COOP ..... C OTHER..... X DON'T KNOW ..... Z (SKIP TO E10) ←	PHILHEALTH.....A HMO/PRIVATE INSURANCE..B LGU/COMMUNITY/COOP.....C OTHER .....X DON'T KNOW.....Z (SKIP TO E10) ←	PHILHEALTH ..... A HMO/PRIVATE INSURANCE .. B LGU/COMMUNITY/COOP ..... C OTHER..... X DON'T KNOW ..... Z (SKIP TO E10) ←
E03	CHECK Q.2	"A" is encircled <input type="checkbox"/> "A" is not encircled <input type="checkbox"/> (SKIP TO E11) ←	"A" is encircled <input type="checkbox"/> "A" is not encircled <input type="checkbox"/> (SKIP TO E11) ←	"A" is encircled <input type="checkbox"/> "A" is not encircled <input type="checkbox"/> (SKIP TO E11) ←
E04	What type of Philhealth member are (is) you (NAME)?	INDIGENT ..... 1 PRIVATE EMPLOYED ..... 2 GOV'T EMPLOYED ..... 3 INDIV. PAYING/VOLUNTARY . 4 NON-PAYING..... 5 OFW..... 6 DON'T KNOW ..... 8	INDIGENT.....1 PRIVATE EMPLOYED .....2 GOV'T EMPLOYED.....3 INDIV. PAYING/VOLUNTARY...4 NON-PAYING .....5 OFW .....6 DON'T KNOW.....8	INDIGENT .....1 PRIVATE EMPLOYED .....2 GOV'T EMPLOYED .....3 INDIV. PAYING/VOLUNTARY ...4 NON-PAYING.....5 OFW .....6 DON'T KNOW .....8
E05	Have you (Has any member of your household) or any of your (his/her) dependents utilized Philhealth benefits within the last 12 months?	YES ..... 1 NO ..... 2 (SKIP TO E10) ← DON'T KNOW ..... 8 (SKIP TO E11) ←	YES.....1 NO .....2 (SKIP TO E10) ← DON'T KNOW.....8 (SKIP TO E11) ←	YES ..... 1 NO ..... 2 (SKIP TO E10) ← DON'T KNOW ..... 8 (SKIP TO E11) ←
E06	What kind of service did you (the member of the household) or any of your (his/her) dependents availed? a) In patient b) Out-patient	YES      NO IN-PATIENT ..... 1      2 OUT-PATIENT ..... 1      2	YES      NO IN-PATIENT ..... 1      2 OUT-PATIENT ..... 1      2	YES      NO IN-PATIENT ..... 1      2 OUT-PATIENT ..... 1      2
E07	Who availed of the service?	YES      NO MEMBER ..... 1      2 DEPENDENT ..... 1      2	YES      NO MEMBER ..... 1      2 DEPENDENT ..... 1      2	YES      NO MEMBER..... 1      2 DEPENDENT ..... 1      2
E08	Were (Was) you (he/she) was satisfied or dissatisfied with the service?	SATISFIED..... 1 (SKIP TO E11) ← DISSATISFIED..... 2 DON'T KNOW ..... 8 (SKIP TO E11) ←	SATISFIED .....1 (SKIP TO E11) ← DISSATISFIED .....2 DON'T KNOW .....8 (SKIP TO E11) ←	SATISFIED..... 1 (SKIP TO E11) ← DISSATISFIED..... 2 DON'T KNOW ..... 8 (SKIP TO E11) ←
E09	Why were (was) you (he/she) not satisfied with the service? PROBE: Anything else? CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	TOO MANY REQUIREMENTS . A LIMITED HOSPITALIZATION BENEFITS ..... B LIMITED OUT-PATIENT BENEFITS ..... C CLAIMS PROCESSING TOO LONG ..... D OTHER..... X DON'T KNOW ..... Z E11 ←	TOO MANY REQUIREMENTS A LIMITED HOSPITALIZATION BENEFITS ..... B LIMITED OUT-PATIENT BENEFITS ..... C CLAIMS PROCESSING TOO LONG ..... D OTHER..... X DON'T KNOW ..... Z E11 ←	TOO MANY REQUIREMENTS A LIMITED HOSPITALIZATION BENEFITS ..... B LIMITED OUT-PATIENT BENEFITS ..... C CLAIMS PROCESSING TOO LONG ..... D OTHER..... X DON'T KNOW ..... Z E11 ←
E10	Why did you or your dependents not utilize Philhealth benefits within the last 12 months?	DID NOT GET SICK ..... A NO ACCREDITED HEALTH FACILITY NEARBY ..... B LACK OF INFORMATION ON PHILHEALTH ..... C NO MONEY FOR EXCESS BILLING..... D ONLY IN-PATIENT BENEFITS PROVIDED..... E TOO MANY REQUIREMENTS ... F OTHER..... X	DID NOT GET SICK.....A NO ACCREDITED HEALTH FACILITY NEARBY .....B LACK OF INFORMATION ON PHILHEALTH.....C NO MONEY FOR EXCESS BILLING .....D ONLY IN-PATIENT BENEFITS PROVIDED .....E TOO MANY REQUIREMENTS...F OTHER.....X	DID NOT GET SICK ..... A NO ACCREDITED HEALTH FACILITY NEARBY ..... B LACK OF INFORMATION ON PHILHEALTH ..... C NO MONEY FOR EXCESS BILLING..... D ONLY IN-PATIENT BENEFITS PROVIDED..... E TOO MANY REQUIREMENTS... F OTHER..... X
E11		GO TO NEXT HH MEMBER, ELSE GO TO F01	GO TO NEXT HH MEMBER, ELSE GO TO F01	GO TO NEXT HH MEMBER, ELSE GO TO F01

**SECTION F. ENVIRONMENTAL HEALTH**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
F01	In the last 3 months, did most members of your household buy cooked food from... a) Ambulant vendors?  b) Carinderia?  c) Restaurants?	<table border="0"> <tr> <td></td> <td align="center">YES</td> <td align="center">NO</td> <td align="center">DK</td> </tr> <tr> <td>AMBULANT VENDORS</td> <td align="center">1</td> <td align="center">2</td> <td align="center">8</td> </tr> <tr> <td>CARINDERIA</td> <td align="center">1</td> <td align="center">2</td> <td align="center">8</td> </tr> <tr> <td>RESTAURANT</td> <td align="center">1</td> <td align="center">2</td> <td align="center">8</td> </tr> </table>		YES	NO	DK	AMBULANT VENDORS	1	2	8	CARINDERIA	1	2	8	RESTAURANT	1	2	8	
	YES	NO	DK																
AMBULANT VENDORS	1	2	8																
CARINDERIA	1	2	8																
RESTAURANT	1	2	8																
F01A	CHECK F01:  AT LEAST ONE "YES" CIRCLED <input type="checkbox"/>	NOT A SINGLE "YES" CIRCLED <input type="checkbox"/>	→ F03																
F02	How often did the members of your household buy cooked food from ambulant vendors, carinderia, or restaurants in the last 3 months?	DAILY .....1 AT LEAST ONCE A WEEK .....2 AT LEAST ONCE A MONTH .....3																	
F03	Does your household practice segregation of garbage?	YES .....1 NO .....2																	
F04	How does your household dispose of garbage?  PROBE: Anything else?  CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	GARBAGE TRUCK/CART COLLECTION ..... A INDIVIDUAL OPEN DUMPING ..... B INDIVIDUAL BURNING ..... C COMPOSTING..... D INDIVIDUAL BURYING ..... E FEEDING TO DOMESTIC ANIMALS..... F DUMPING INTO LOW LAND AREA ..... G OTHER _____ X  (SPECIFY)																	