

AUTHORITY: Commonwealth Act No. 591 authorizes this survey and the Philippines National Statistics Office to collect information on fertility, family planning and health. CONFIDENTIALITY: Sec. 4 of CA No. 591 provides that all information furnished on this form is held <i>STRICTLY CONFIDENTIAL</i> .	PHILIPPINES NATIONAL STATISTICS OFFICE 2003 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY HEALTH MODULE	NDHS Form 4 NSCB Approval No. NSO-0305-04 Expires March 31, 2004
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Set _____ of _____ sets

IDENTIFICATION				
PROVINCE _____ CITY/MUNICIPALITY _____ BARANGAY _____ URBAN/RURAL(URBAN=1, RURAL=2) REPLICATE PSU EA STRATUM HOUSEHOLD CONTROL NUMBER NDHS HOUSEHOLD SEQUENTIAL NUMBER NAME AND LINE NUMBER OF RESPONDENT NAME OF HOUSEHOLD HEAD ADDRESS				

INTERVIEW RECORD				
	1	2	3	FINAL VISIT
DATE _____ INTERVIEWER'S NAME _____ RESULT* _____				DAY _____ MONTH _____ YEAR <div style="display: inline-block; border: 1px solid black; padding: 2px;">2 0 0 3</div> INT.CODE _____ RESULT* _____
NEXT VISIT: DATE TIME				TOTAL NO. OF VISITS <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; vertical-align: middle;"></div>
* 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 _____ <div style="text-align: right;">(SPECIFY)</div>				TIME OF INTERVIEW TIME STARTED HOUR <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; vertical-align: middle;"></div> MINUTE <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; vertical-align: middle;"></div> TIME ENDED HOUR <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; vertical-align: middle;"></div> MINUTE <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; vertical-align: middle;"></div>

LANGUAGE OF QUESTIONNAIRE**	<div style="border: 1px solid black; padding: 2px;">7</div>	LANGUAGE OF INTERVIEW**	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	TRANSLATOR USED	YES 1 NO 2
LOCAL LANGUAGE OF RESPONDENT**	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>				
**LANGUAGE CODES 1 TAGALOG 3 ILOCANO 5 HILIGAYNON 7 ENGLISH 2 CEBUANO 4 BICOL 6 WARAY 8 OTHER _____ <div style="text-align: right;">(SPECIFY)</div>					

SUPERVISOR <div style="display: inline-block; border: 1px solid black; width: 40px; height: 20px;"></div>	FIELD EDITOR <div style="display: inline-block; border: 1px solid black; width: 40px; height: 20px;"></div>	OFFICE EDITOR <div style="display: inline-block; border: 1px solid black; width: 40px; height: 20px;"></div>	ENCODER <div style="display: inline-block; border: 1px solid black; width: 40px; height: 20px;"></div>
_____ Name and Signature Date	_____ Name and Signature Date		

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	YES	NO	
	1 Barangay Health Station?	BARANGAY HEALTH STATION..... 1	2	
	2 Rural Health Unit/Urban Health Center?	RURAL HEALTH UNIT/URBAN HEALTH CENTER 1	2	
	3 Municipal Hospital?	MUNICIPAL HOSPITAL 1	2	
	4 District Hospital?	DISTRICT HOSPITAL 1	2	
	5 Provincial Hospital?	PROVINCIAL HOSPITAL 1	2	
	6 Regional Hospital/Public Medical Center?	REGIONAL HOSP/PUBLIC MED CENTER 1	2	
	7 Private Clinic?	PRIVATE CLINIC 1	2	
	8 Private Hospital?	PRIVATE HOSPITAL 1	2	
	9 Other?	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?	FACILITY (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME	FACILITY (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME	FACILITY (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME
	a. Treatment when ill or injured	YES NO 1 2	YES NO 1 2	YES NO 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. Other	1 2	1 2	1 2
	(CONTINUATION)	FACILITY (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME	FACILITY (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME	FACILITY (NAME OF FACILITY) REFER TO A01 FOR THE FACILITY CODE AND NAME
	a. Treatment when ill or injured	YES NO 1 2	YES NO 1 2	YES NO 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. Other	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.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>AVOID EATING TOO MUCH FATA</p> <p>AVOID EXCESSIVE INTAKE OF SALT AND SALTY FOODB</p> <p>AVOID/MODERATE DRINKING OF ALCOHOLIC BEVERAGESC</p> <p>AVOID SMOKINGD</p> <p>BE PHYSICALLY ACTIVEE</p> <p>CHECK-UP BY DOCTORF</p> <p>CONSUME MILK AND MILK PRODUCTSG</p> <p>EAT ADEQUATE/BALANCE DIET.....H</p> <p>EAT FISH, LEAN MEAT, POULTRY AND DRIED BEANSI</p> <p>EAT PLENTY OF FRUITS, VEGETABLES AND ROOTCROPS.....J</p> <p>HAVE ENOUGH SLEEPK</p> <p>MAINTAIN GOOD HYGIENEL</p> <p>MAINTAIN HAPPY PERSONALITYM</p> <p>MONITOR BLOOD PRESSUREN</p> <p>TAKE VITAMINS/FOOD SUPPLEMENTO</p> <p>OTHER.....X</p> <p>NONEY</p>	
B02	<p>Have you ever heard of a disease called cancer?</p>	<p>YES 1</p> <p>NO2 → 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.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>BLEEDINGA</p> <p>CHANGE OF BOWEL MOVEMENTB</p> <p>HOARSENESS OF VOICEC</p> <p>IRREGULAR URINATION.....D</p> <p>LUMP OR MASS IN ANY PART OF THE BODYE</p> <p>PERSISTENT PAINF</p> <p>SORE (WOUND) THAT DOES NOT HEALG</p> <p>SUDDEN WEIGHT LOSSH</p> <p>WEAK.....I</p> <p>OTHER.....X</p> <p>NONEY</p> <p>DON'T KNOWZ</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 HEAVILYA</p> <p>THOSE WHO ARE FAT (OBESE)B</p> <p>THOSE WHO DRINK HEAVILYC</p> <p>THOSE WHO EAT HIGH FAT, HIGH SALT DIETD</p> <p>THOSE WHO ARE UNDER STRESS.....E</p> <p>THOSE WHO DO NOT EXERCISEF</p> <p>THOSE WHO HAVE ELEVATED BLOOD PRESSUREG</p> <p>THOSE WITH FAMILY HISTORY OF HEART DISEASEH</p> <p>THOSE WHO LACK SLEEPI</p> <p>OTHER.....X</p> <p>DON'T KNOWZ</p>	
B10	<p>Have you ever heard of diabetes?</p>	<p>YES1</p> <p>NO2</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 PEOPLEA</p> <p>HEAVY DRINKERS OF ALCOHOLB</p> <p>HEAVY SMOKERSC</p> <p>OLDER PEOPLE/MENOPAUSAL WOMEND</p> <p>PEOPLE WHO EAT PLENTY OF SWEETS AND FATTY FOODSE</p> <p>THOSE HOW DO NOT EXERCISE REGULARLYF</p> <p>THOSE WHERE DIABETES RUNS IN THE FAMILYG</p> <p>OTHER.....X</p> <p>DON'T KNOWZ</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 "PASHA" 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?	YES1 NO2	→ 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 WATERA INHERITEDB MOSQUITO BITESC OVER FATIGUE.....D PARASITES IN THE BLOODE POLLUTED AIRF OTHER.....X DON'T KNOWZ	
C11	How does malaria spread from one person to another? PROBE: Anything else? CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	POLLUTED AIRA CONTACT WITH MALARIA PATIENTB DRINKING CONTAMINATED WATERC EATING SOUR FOODS.....D MOSQUITO BITESE OVER FATIGUE.....F OTHER.....X DON'T KNOWZ	
C12	Can malaria be prevented?	YES1 NO2	→ C14
C13	How can it be prevented? PROBE: Anything else? CIRCLE ALL MENTIONED. DO NOT READ OUT RESPONSES.	AVOIDANCE OF CERTAIN FOODS AT CERTAIN SEASONSA HOUSE SPRAYINGB REMOVE BREEDING PLACES (STAGNANT WATER) OF MOSQUITOES INSIDE AND OUTSIDE THE HOUSEC STREAM CLEARINGD USE OF MOSQUITO COILSE USE OF MOSQUITO NETSF USE OF MOSQUITO REPELLANTSG OTHER.....X DON'T KNOWZ	
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 DOGA IMMUNIZE DOG YEARLYB IN CASE OF DOG BITE, PROVIDE NECESSARY TREATMENT FOR THE VICTIM.....C RESTRAIN/CONFINE DOG WITHIN THE YARD/HOUSED 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
		↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
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
		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?	<div style="text-align: right;">YES NO</div> HILOT 1 2 PAGTATAWAS 1 2 ORACION 1 2 SPIRITUAL HEALING 1 2	
D06A	CHECK D06: AT LEAST ONE <input type="checkbox"/> "YES" CIRCLED <input type="checkbox"/>	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?	<div style="text-align: right;">YES NO</div> 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 <input type="checkbox"/>	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.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>GOVERNMENT HEALTH PERSONNELA</p> <p>PRIVATE PRACTITIONER/NGOB</p> <p>RADIOC</p> <p>TELEVISIOND</p> <p>NEWSPAPER/PAMPHLET/MAGAZINE/BOOKSE</p> <p>SCHOOLSF</p> <p>SEMINARS/TRAININGSG</p> <p>FRIENDS/RELATIVESH</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 → E01</p>	
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.</p> <p>DO NOT READ OUT RESPONSES.</p>	<p>ACUPUNCTUREA</p> <p>ACUPRESSURE/THERAPEUTIC.....B</p> <p>MASSAGE.....C</p> <p>IRIDOLOGYD</p> <p>PRANIC HEALINGE</p> <p>AROMATHERAPY.....F</p> <p>CHIROPRACTICG</p> <p>HOMEOPATHYH</p> <p>OTHER.....X</p> <p>NONEY</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.	PHILHEALTHA HMO/PRIVATE INSURANCE ..B LGU/COMMUNITY/COOPC OTHER.....X DON'T KNOWZ (SKIP TO E10) ←	PHILHEALTH.....A HMO/PRIVATE INSURANCE...B LGU/COMMUNITY/COOP.....C OTHER.....X DON'T KNOW.....Z (SKIP TO E10) ←	PHILHEALTHA HMO/PRIVATE INSURANCE ..B LGU/COMMUNITY/COOPC OTHER.....X DON'T KNOWZ (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)?	INDIGENT1 PRIVATE EMPLOYED2 GOV'T EMPLOYED3 INDIV. PAYING/VOLUNTARY ..4 NON-PAYING.....5 OFW6 DON'T KNOW8	INDIGENT1 PRIVATE EMPLOYED2 GOV'T EMPLOYED3 INDIV. PAYING/VOLUNTARY ..4 NON-PAYING5 OFW6 DON'T KNOW8	INDIGENT1 PRIVATE EMPLOYED2 GOV'T EMPLOYED3 INDIV. PAYING/VOLUNTARY ..4 NON-PAYING.....5 OFW6 DON'T KNOW8
E05	Have you (Has any member of your household) or any of your (his/her) dependents utilized Philhealth benefits within the last 12 months?	YES1 NO2 (SKIP TO E10) ← DON'T KNOW8 (SKIP TO E11) ←	YES.....1 NO2 (SKIP TO E10) ← DON'T KNOW.....8 (SKIP TO E11) ←	YES1 NO2 (SKIP TO E10) ← DON'T KNOW8 (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-PATIENT1 2 OUT-PATIENT1 2	YES NO IN-PATIENT1 2 OUT-PATIENT1 2	YES NO IN-PATIENT1 2 OUT-PATIENT1 2
E07	Who availed of the service?	YES NO MEMBER1 2 DEPENDENT1 2	YES NO MEMBER1 2 DEPENDENT1 2	YES NO MEMBER.....1 2 DEPENDENT1 2
E08	Were (Was) you (he/she) was satisfied or dissatisfied with the service?	SATISFIED.....1 (SKIP TO E11) ← DISSATISFIED.....2 DON'T KNOW8 (SKIP TO E11) ←	SATISFIED1 (SKIP TO E11) ← DISSATISFIED2 DON'T KNOW8 (SKIP TO E11) ←	SATISFIED.....1 (SKIP TO E11) ← DISSATISFIED.....2 DON'T KNOW8 (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 LONGD OTHER.....X DON'T KNOWZ E11 ←	TOO MANY REQUIREMENTS A LIMITED HOSPITALIZATION BENEFITSB LIMITED OUT-PATIENT BENEFITSC CLAIMS PROCESSING TOO LONGD OTHER.....X DON'T KNOWZ E11 ←	TOO MANY REQUIREMENTS A LIMITED HOSPITALIZATION BENEFITS.....B LIMITED OUT-PATIENT BENEFITS.....C CLAIMS PROCESSING TOO LONGD OTHER.....X DON'T KNOWZ 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 NEARBYB LACK OF INFORMATION ON PHILHEALTHC 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 NEARBYB LACK OF INFORMATION ON PHILHEALTH.....C NO MONEY FOR EXCESS BILLINGD ONLY IN-PATIENT BENEFITS PROVIDEDE TOO MANY REQUIREMENTS ...F OTHER.....X	DID NOT GET SICK.....A NO ACCREDITED HEALTH FACILITY NEARBYB LACK OF INFORMATION ON PHILHEALTHC 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			

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?	<div style="text-align: right; margin-bottom: 10px;">YES NO DK</div> <div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> AMBULANT VENDORS 1 2 8 </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> CARINDERIA 1 2 8 </div> <div style="display: flex; justify-content: space-between;"> RESTAURANT 1 2 8 </div> </div>	
F01A	CHECK F01: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> AT LEAST ONE "YES" CIRCLED <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto; position: relative;"> <div style="position: absolute; bottom: 5px; left: 50%; transform: translateX(-50%);">↓</div> </div> </div> <div style="text-align: center;"> NOT A SINGLE "YES" CIRCLED <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto; position: relative;"> <div style="position: absolute; bottom: 5px; left: 50%; transform: translateX(-50%);">→ F03</div> </div> </div> </div>		
F02	How often did the members of your household buy cooked food from ambulant vendors, carinderia, or restaurants in the last 3 months?	DAILY1 AT LEAST ONCE A WEEK2 AT LEAST ONCE A MONTH3	
F03	Does your household practice segregation of garbage?	YES1 NO2	
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 <div style="text-align: center; margin-top: 10px;">(SPECIFY)</div>	