

**Institut National d'Etudes Démographiques, Paris
Social Research Institute, Chiang Mai University, Chiang Mai**

PARENT/GUARDIAN QUESTIONNAIRE

April 2010

ID Number:

HN Number of the child:

Child

Sex of child you are responsible of:

₁ Male

₂ Female

Interview date: |__|__| day |__|__| month |_2_|_5_|_5_|_ _| yr

Time interview begun: |__|__| Hour |__|__| Minutes

Please introduce the study and ask for consent

Interviewer's Name :

Code: |__|__|

Site:

Code : |__|__|

SECTION R: RESPONDENT

We would like first to know about you, as the caregiver of the child			
R.0	Sex	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	
R.00	Age of respondent	__ __ years	
R.1	What is your relationship with the child?	__ __
R.2	What is your marital status?	<input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Married <input type="checkbox"/> 3 Divorced/separated <input type="checkbox"/> 4 Widowed	
G.1	What is your nationality?	<input type="checkbox"/> 1 Thai citizen <input type="checkbox"/> 2 Non Thai, specify.....	__ __
G.2	What is your ethnicity?	<input type="checkbox"/> 1 Thai <input type="checkbox"/> 2 Others, specify.....	__ __
R.3	Have you ever attended school? Comments:	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	⇒Q R.5
R.4	What was your education level when you finished school	Highest Grade level: __ __ <input type="checkbox"/> 1 Primary <input type="checkbox"/> 2 Secondary <input type="checkbox"/> 3 Teacher college <input type="checkbox"/> 4 Vocational college <input type="checkbox"/> 5 University <input type="checkbox"/> 6 Other (specify).....	
R.5	What is your current occupation?	__ __
R.6	How would you rate your health status situation <i>REFER TO THE "SMILE" SCALE</i> Comments:	<input type="checkbox"/> 1 Very poor <input type="checkbox"/> 2 poor <input type="checkbox"/> 3 Fair <input type="checkbox"/> 4 good <input type="checkbox"/> 5 Very good	__ __
R.7	Do you have any chronic disease (including HIV infection) or permanent disability?	<input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes, specify:	

SECTION A: THE CHILD'S LIFE

NO.	QUESTIONS & FILTERS	CODING CATEGORIES	GO TO
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CHILD:

	Now we are going to ask you some questions about the child you are responsible for		
A.1.	Age (column 2) How old is the child ? <i>CIRCLE THE AGE OF THE CHILD</i>	_ _ years old today	Column 2 Age
A.2	Years (Column 1) What is his/her date of birth (year that he/she was born)	_ _ _ _ _ _ _ _2_ _5_ _ _ DAY MONTH YEAR	Column 1 Years
	1. COMPLETE THE YEAR OF BIRTH AND ALL THE YEARS UNTIL THE PRESENT YEAR. 2. DRAW A LINE FOR THE PRESENT YEAR		

G.3	What is the child's nationality?	<input type="checkbox"/> 1 Thai citizen <input type="checkbox"/> 2 Non Thai specify.....	_ _
G.4	What is the child's ethnicity?	_ _

Situation of the child's biological parents

MOTHER

B.3	<p>Only if the child's mother is not the respondent, ask the following question</p> <p>Is the child's mother alive?</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₁₀ Live in the household → B.6 <input type="checkbox"/> ₁₁ Do not live in the household → B.6 <p style="text-align: center;">Note that you will have to complete Section BB next page</p> <input type="checkbox"/> ₃ No <input type="checkbox"/> ₉₈ Don't know
B.4	<p>WRITE MDTH IN THE COLUMN PARENTS STATUS (COLUMN 3) AT THE AGE OF THE CHILD WHEN THE MOTHER DIED</p> <p style="text-align: center;">MDTH __ __ years or __ __ age</p>	Column 3
B.5	<p>If the mother has died, was the death related to HIV/AIDS?</p>	<input type="checkbox"/> ₁ Yes, comments: <input type="checkbox"/> ₂ No, Comments: <div style="text-align: right;"><input type="checkbox"/> ₉₈ Don't know</div>

FATHER

B.6	<p>Only if the child's father is not the respondent, ask the following question</p> <p>Is the child's father alive?</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₁₀ Live in the household → B.9 <input type="checkbox"/> ₁₁ Do not live in the household → B.9 <p style="text-align: center;">Note that you will have to complete Section BB next page</p> <input type="checkbox"/> ₃ No <input type="checkbox"/> ₉₈ Don't know
B.7	<p>WRITE FDTH IN THE COLUMN PARENTS STATUS (COLUMN 3) AT THE AGE OF THE CHILD WHEN THE FATHER DIED</p> <p style="text-align: center;">FDTH __ __ years or __ __ age</p>	Column 3
B.8a	<p>If the father has died, was the death related to HIV/AIDS?</p>	<input type="checkbox"/> ₁ Yes, comments: <input type="checkbox"/> ₂ No, Comments: <div style="text-align: right;"><input type="checkbox"/> ₉₈ Don't know</div>
B.8b	<p>IF THE PARENTS GOT SEPARATED, WRITE FM-SEP THE YEAR THEY SEPARATED</p> <p style="text-align: center;">FM-SEP __ __ years or __ __ age</p>	Column 3

SIBLINGS (only from same father and mother)

B.9	<p>How many siblings has the child including those who have died? <i>If other siblings (not same father and mother) are mentioned, specify:</i></p>	<p> __ __ including the child</p>
B.10	<p>How many are still alive?</p>	<p> __ __ <input type="checkbox"/> ₉₈ Don't know</p>
B.11	<p>How many siblings are infected with HIV?</p>	<p> __ __ <input type="checkbox"/> ₉₈ Don't know</p>
B.12	<p>How many siblings died of HIV/AIDS?</p>	<p> __ __ <input type="checkbox"/> ₉₈ Don't know</p>

CARE-GIVERS OF THE CHILD



B.13	<p>Life Events Table: caregivers (Column 4) <i>LIST THE CHILD'S CAREGIVERS SINCE BIRTH (RELATIONSHIP WITH THE CHILD IN FULL)</i></p>	Column 4 Caregiver
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HOUSEHOLD OF THE CHILD

I will ask you now about the persons living with the child			
	Household Form	Co-residents	Household Form
H.1	1. FILL IN THE PART H OF THE HOUSEHOLD FORM: 2. LIST THE CO-RESIDENTS ONE BY ONE, ASK THEIR AGE, THEIR RELATIONSHIP WITH THE CHILD , AS WELL AS THEIR OCCUPATION		

Section BB

This section only applies if the mother is alive and is not living in the household or if the father is alive and is not living in the household

	Father's status 	Mother's status 
BB.1	Is the father HIV infected? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₉₈ Don't know	Is the mother HIV infected? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₉₈ Don't know
BB.2	Where does he lives?.....	Where does she lives?.....
BB.3	What is his occupation?.....	What is her occupation?.....
BB.4	Does he send money for the child care <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	Does she send money for the child care <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
BB.5	What is the father's family situation <input type="checkbox"/> ₁ Still Married <input type="checkbox"/> ₂ Separated <input type="checkbox"/> ₃ Remarried, <input type="checkbox"/> ₄ Remarried with other children <input type="checkbox"/> ₅ Other..... <input type="checkbox"/> ₉₈ Don't know	What is the mother's family situation <input type="checkbox"/> ₁ Still Married <input type="checkbox"/> ₂ Separated <input type="checkbox"/> ₃ Remarried, <input type="checkbox"/> ₄ Remarried with other children <input type="checkbox"/> ₅ Other..... <input type="checkbox"/> ₉₈ Don't know
BB.6	How often the child has seen his/her father in the past year ? <input type="checkbox"/> ₁ More than once a week <input type="checkbox"/> ₂ A few times a month <input type="checkbox"/> ₃ A few times a year <input type="checkbox"/> ₄ Once a year or less..... <input type="checkbox"/> ₅ Never <input type="checkbox"/> ₆ Other (specify): (Only one answer possible)	How often has the child has seen his/her mother in the past year ? <input type="checkbox"/> ₁ More than once a week <input type="checkbox"/> ₂ A few times a month <input type="checkbox"/> ₃ A few times a year <input type="checkbox"/> ₄ Once a year or less..... <input type="checkbox"/> ₅ Never <input type="checkbox"/> ₆ Other (specify): (Only one answer possible)

PLACES OF RESIDENCE OF THE CHILD

I want to talk with you about the places where the child has lived for <u>more than one year</u> throughout his/her life		
A.3	Places of Residence (Column 5) Where (town/village) have they been living since birth and when? <i>FILL IN ALL THE PLACES OF RESIDENCE (town/village) EVER LIVED FOR AT LEAST ONE YEAR SINCE BIRTH UNTIL THE PRESENT YEAR</i>	Column 5 <i>Residence</i>

SCHOOLING AND WORK OF THE CHILD

A.4	School/Work (Column 6) <i>FILL IN THE YEARS THE CHILD STARTED AND FINISHED SCHOOL (INTERRUPT THE LINE WHEN THE CHILD WAS OUT OF SCHOOL FOR MORE THAN 6 MONTHS (EXPLAIN WHY IN A NOTE). COMPLETE Q.A.5 AND Q.A.6</i> IF THE CHILD IS NOT AT SCHOOL AND IS WORKING, FILL IN THE WORKS OF THE CHILD THE SAME WAY .	Column 6 <i>School/ Work</i>
A.5	What kind of school does/did the child attend(ed)? <div style="float: right; margin-left: 20px;"> <input type="checkbox"/> ₁ Public school <input type="checkbox"/> ₁ Private school <input type="checkbox"/> ₂ School at the temple <input type="checkbox"/> ₃ Other, specify: </div>	
A.6	Did the child ever repeated a school year? <div style="float: right; margin-left: 20px;"> <input type="checkbox"/> ₁ No <input type="checkbox"/> ₂ Yes, specify number of years: </div>	
If the child is currently working		
A.7.	What is his occupation?	
A.8	Can you tell the child approximate income? __ __ , __ __ __ Baht <input type="checkbox"/> ₁ Per month (last month) <input type="checkbox"/> ₂ Per day If per day, specify how many days of work in the last month: __ __	
A.9	Does she child share his income with the household? <div style="float: right; margin-left: 20px;"> <input type="checkbox"/> ₁ No <input type="checkbox"/> ₂ Yes </div>	

SECTION C: HEALTH OF THE CHILD

Now I would like to ask you a few questions about the child's HIV infection history.

C.1	Life Events Table: Disease (Column 7) Can you tell me when/at what age the child was diagnosed as HIV infected <i>FILL IN THE AGE OF THE CHILD IN COLUMN 7: DISEASE</i>	__ __ years or __ __ month <input type="checkbox"/> ₉₈ Don't know TEST	Column 7 <i>Disease</i>
C.2	What was the reason for the diagnosis to be made? <i>Spontaneous comments:</i> <i>Spontaneous comments on how the child was infected:</i> <input type="checkbox"/> <i>Mother-to-child transmission:</i> <input type="checkbox"/> <i>Other, specify:</i>	<input type="checkbox"/> ₁ At the hospital because of HIV symptoms (specify):..... <input type="checkbox"/> ₂ At the hospital for another reason (specify): <input type="checkbox"/> ₃ Because his/her parent was found HIV positive during pregnancy and the child was tested after birth <input type="checkbox"/> ₄ Because his/her parent was ill <input type="checkbox"/> ₅ Because his/her parent died of AIDS <input type="checkbox"/> ₆ Because of illness or death of a sibling <input type="checkbox"/> ₇ Other (specify): <input type="checkbox"/> ₉₈ Don't know	

HIV SYMPTOMS

C.3	Life Events Table: Disease (Column 7) Could you tell me at what age the child first experienced some signs/symptoms of HIV/AIDS? <i>FILL IN THE AGE OF THE CHILD IN COLUMN 7: DISEASE</i>	<input type="checkbox"/> ₁ Never → C.5 __ __ years or __ __ month <input type="checkbox"/> Don't know SYMPT	Column 7 <i>Disease</i>																											
C.5	Did the child suffer any of the following disease <i>Can be more than one answer</i> <i>Comments:.....</i>	<table border="0"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: right;">Tuberculosis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Pneumonia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Meningitis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Parotitis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Skin problem</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Growth retardation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Mental retardation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Other, specify:.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Yes	No	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Parotitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin problem	<input type="checkbox"/>	<input type="checkbox"/>	Growth retardation	<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:.....	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No																												
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>																												
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>																												
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>																												
Parotitis	<input type="checkbox"/>	<input type="checkbox"/>																												
Skin problem	<input type="checkbox"/>	<input type="checkbox"/>																												
Growth retardation	<input type="checkbox"/>	<input type="checkbox"/>																												
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>																												
Other, specify:.....	<input type="checkbox"/>	<input type="checkbox"/>																												
C.6	Does the child currently experience any symptoms or health problems?	<input type="checkbox"/> ₁ No <input type="checkbox"/> ₂ Yes (specify):																												

ARV TREATMENT

C.7	Life Events Table: Disease (Column 7) Could you tell me when/at what age the child first received ARV treatment? FILL IN THE AGE OF THE CHILD IN COLUMN 7: DISEASE	__ __ years old <input type="checkbox"/> Don't know <i>If the child did not initiate ARV treatment, Skip to C.14</i>	Column 7 DISEASE
C.8	Do you think that it easy or difficult for the child to remember to take the treatment? <i>REFER TO THE "SMILE" SCALE</i>	<input type="checkbox"/> 5 Very Easy <input type="checkbox"/> 4 Easy <input type="checkbox"/> 3 OK <input type="checkbox"/> 2 Difficult <input type="checkbox"/> 1 Very difficult	
C.9	Do you have to remind the child to take the treatment	<input type="checkbox"/> 1 Never <input type="checkbox"/> 2 Sometimes <input type="checkbox"/> 3 Often <input type="checkbox"/> 4 Always because I am the person in charge of the treatment	→ C11
C.10	When reminded to take the treatment, is the child compliant?	<input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 98 Don't know	
C.11	How do you evaluate the child's adherence to treatment <i>REFER TO THE "SMILE" SCALE</i>	<input type="checkbox"/> 5 Very Good <input type="checkbox"/> 4 Good <input type="checkbox"/> 3 Fair <input type="checkbox"/> 2 Poor <input type="checkbox"/> 1 Very poor	
C.12	Can you tell in which circumstances the child may forget to take the treatment? (the most frequent situation) Only one answer Comments:	<input type="checkbox"/> 0 Never forget <input type="checkbox"/> 1 Sick <input type="checkbox"/> 2 Too Busy <input type="checkbox"/> 3 Not At Home <input type="checkbox"/> 4 Festival/Holidays/Camps <input type="checkbox"/> 5 With friends <input type="checkbox"/> 6 Other (specify)	
C.14	Was the child hospitalized at least one night for a health problem? <i>If yes and the reason is spontaneously mentioned, specify:</i>	<input type="checkbox"/> 1 Never Skip to C.16 <input type="checkbox"/> 2 Yes	
C.15	If yes, how many times?	Before ARV initiation: __ __ After ARV initiation: __ __ In the past 12 months __ __ <input type="checkbox"/> 98 Don't know	
C.16	Life Events Table: Health Status (column 8) How would you rate the child health status throughout his life <i>USE THE "SMILE" SCALE</i> <i>FILL IN THE HEALTH STATUS THROUGHOUT LIFE, IN PARTICULAR BEFORE AND AFTER ARV</i>	5: VERY GOOD 4: GOOD 3: FAIR 2: POOR 1: VERY POOR	Life-event column 8

HIV DISCLOSURE

C.17	Does the child know that he/she is infected with HIV? <i>Spontaneous comments:</i>	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not sure	
C.18	Was the child formally told about his HIV status? <i>Spontaneous comments:</i>	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No, but knew by himself as he/she grew up → D1 <input type="checkbox"/> 3 No → D1	
C.19	Life Events Table: Disease (Column 7) Can you tell me when/at what age or the period the child knew about his/her HIV status	<input type="checkbox"/> 1 Never → D1 At __ __ years old Or between __ __ and __ __ years <input type="checkbox"/> Don't know	Column 7 <i>Disease</i>
FILL IN THE AGE OF THE CHILD WHEN HE HAD SYMPTOMS IN COLUMN 7: DISEASE DISCLOS			
C.20	Who told the child about his/her HIV status	__ __
C.21	If the child was told about his/her HIV status Why was he/she told at that particular moment? <i>Comments:</i>	<input type="checkbox"/> 1 Adequate age <input type="checkbox"/> 2 Was asking about his/her disease/treatment <input type="checkbox"/> 3 Heard it from friends or at school <input type="checkbox"/> 4 Mom/Dad was ill/died <input type="checkbox"/> 5 Child was ill <input type="checkbox"/> 6 Other, specify: <input type="checkbox"/> 98 Don't know	
C.22	What was the child reaction at the time of disclosure? <i>Comments:</i>	<input type="checkbox"/> 1 Relieved to know <input type="checkbox"/> 2 Depressed <input type="checkbox"/> 3 Angry <input type="checkbox"/> 4 Non responsive <input type="checkbox"/> 5 Other, specify: <input type="checkbox"/> 98 Don't know	
C.23	If the child was receiving ARV at that time, did the disclosure had an impact on his/her adherence <i>Comments:</i>	<input type="checkbox"/> 1 No impact <input type="checkbox"/> 2 Improved <input type="checkbox"/> 3 Decreased <input type="checkbox"/> 98 Don't know	

SECTION D: DISCRIMINATION

D.1	Do you think that people in your community know about the child's HIV status? Comments:	<input type="checkbox"/> 1 Yes most of the community <input type="checkbox"/> 2 Yes some of them <input type="checkbox"/> 3 No <input type="checkbox"/> 98 Don't know					
D.2	Do you think that the school staff knows about the child's HIV status?	<input type="checkbox"/> 1 Yes most of them <input type="checkbox"/> 2 Yes some of them <input type="checkbox"/> 3 No <input type="checkbox"/> 98 Don't know					
D.3	Do you think that the students at school know about the child's HIV status?	<input type="checkbox"/> 1 Yes most students <input type="checkbox"/> 2 Yes some students <input type="checkbox"/> 3 No <input type="checkbox"/> 98 Don't know					
D.4	Household Form In your household, who knows about the child's HIV status?						Household Form
FILL IN THE COLUMN D.3 OF THE HOUSEHOLD FORM							
D.5	Is there someone else who is HIV infected in the Household and is he/she receiving ARV?						
D.6	Do you know whether the child ever experienced stigma or discrimination related to his/her HIV status : From family members From friends At school At work (if the child is working) At the hospital From people in the village /neighborhood Others:	Yes once	Yes regularly	No	Don't Know	NA	
D.7		Is there a particular experience of stigmatization concerning the child that you can tell us about 					

SECTION E: HOUSEHOLD INCOME

E.1	Do you have a regular income from work?	<input type="checkbox"/> ₁ No..... <input type="checkbox"/> ₂ Yes	⇒QE.3
E.2	Please tell me your approximate income per month or per day from your work?	_ _ _ , _ _ _ Bahts <input type="checkbox"/> ₁ Per month (last month) <input type="checkbox"/> ₂ Per day If per day, specify how many days of work in the last month: _ _	
E.3	HOUSEHOLD INCOME You said that ____ persons were living in your house. Could you tell me the approximate income per month (or per year) of each household member?		Household Form
FILL IN THE COLUMN E.3 OF THE HOUSEHOLD FORM			

E.4	Do you receive support from the government on a regular basis?	You <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	Partner <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	Child <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	Co-resident <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
		Amount (Bahts)			
		_ _ _	_ _ _	_ _ _	_ _ _
E.5	Do you or your household receive support from someone else or from local organizations on a regular basis?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No			⇒Q E.7
E.6	If yes, how much per month?	_ _ _ _ _ Bahts			
E.7	Do you currently own the following items?	Don't have	Fully owned	Owned by relative	Mortgaged/ on loan
	House	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Land	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Car	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Motorcycle	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	TV	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Refrigerator	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Mobile phone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	

E.8	<p>What is your health coverage?</p> <p><i>Comments:</i></p> <p>.....</p>	<input type="checkbox"/> 0 None <input type="checkbox"/> 1 Universal coverage <input type="checkbox"/> 2 Social Security Scheme <input type="checkbox"/> 3 Workmen Compensation Fund <input type="checkbox"/> 4 Civil Servant Medical Benefit Scheme <input type="checkbox"/> 5 Other (specify):
	<p>What is the health coverage of your child?</p>	<input type="checkbox"/> 0 None <input type="checkbox"/> 1 Universal coverage <input type="checkbox"/> 2 Social Security Scheme <input type="checkbox"/> 3 Workmen Compensation Fund <input type="checkbox"/> 4 Civil Servant Medical Benefit Scheme <input type="checkbox"/> 5 Other (specify):
E.9	<p>Do you pay the child ARV treatment?</p>	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No

SECTION F: LIFE STYLE		
This is the last section of the interview. We will just ask you a few questions about your lifestyle and how you perceive your child		
F.1	Are you a member of any groups that support people living with HIV or caregivers of children living with HIV?	<input type="checkbox"/> ₁ Yes, specify..... <input type="checkbox"/> ₂ No
F.2	Do you follow a religion?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No ⇒Q F.4
F.3	If yes, what is your religion?	<input type="checkbox"/> ₁ Buddhist <input type="checkbox"/> ₂ Christian <input type="checkbox"/> ₃ Muslim <input type="checkbox"/> ₄ Other (specify:)
F.4	How would you qualify your current financial situation <i>REFER TO THE "SMILE" SCALE</i> Comments:.....	<input type="checkbox"/> ₁ Very difficult <input type="checkbox"/> ₂ Difficult <input type="checkbox"/> ₃ Ok <input type="checkbox"/> ₄ good <input type="checkbox"/> ₅ Very good
F.5	How would you qualify your current happiness <i>REFER TO THE "SMILE" SCALE</i> Comments:.....	<input type="checkbox"/> ₁ Very unhappy <input type="checkbox"/> ₂ unhappy <input type="checkbox"/> ₃ Average <input type="checkbox"/> ₄ Happy <input type="checkbox"/> ₅ Very happy
A.7	How would you grade the child's intellectual capacity? <i>REFER TO THE "SMILE" SCALE</i> Comments:	<input type="checkbox"/> ₁ Very Low <input type="checkbox"/> ₂ Low <input type="checkbox"/> ₃ Average <input type="checkbox"/> ₄ Good <input type="checkbox"/> ₅ Very good
F.6	Do you think that the child is <i>REFER TO THE "SMILE" SCALE</i> Comments:.....	<input type="checkbox"/> ₁ Very unhappy <input type="checkbox"/> ₂ Unhappy <input type="checkbox"/> ₃ Average <input type="checkbox"/> ₄ Happy <input type="checkbox"/> ₅ Very happy

F.7	Do you think that the child is <i>REFER TO THE "SMILE" SCALE</i> Comments:.....	<input type="checkbox"/> 1 Very disobedient <input type="checkbox"/> 2 Somehow disobedient <input type="checkbox"/> 3 Average <input type="checkbox"/> 4 Nice <input type="checkbox"/> 5 Very nice	
F.9	Can you evaluate your communication with the child <i>REFER TO THE "SMILE" SCALE</i> Comments:.....	<input type="checkbox"/> 1 Very difficult <input type="checkbox"/> 2 Difficult <input type="checkbox"/> 3 OK <input type="checkbox"/> 4 Easy <input type="checkbox"/> 5 Very easy	
F.8	Does the child help at home <i>More than one answer possible</i> Comments:.....	<input type="checkbox"/> 0 No	<input type="checkbox"/> 0 Yes, <i>specify</i> <input type="checkbox"/> 1 cleaning the house? <input type="checkbox"/> 2 shopping <input type="checkbox"/> 3 cooking <input type="checkbox"/> 4 looking after younger relatives <input type="checkbox"/> 5 cleaning the dishes <input type="checkbox"/> 6 doing the laundry/ironing <input type="checkbox"/> 7 helping with parents activities (shop, farm, etc.) <input type="checkbox"/> 8 Other (specify):
F.10	Do you have conflicts with the child? Comments:.....	<input type="checkbox"/> 1 All the times <input type="checkbox"/> 2 sometimes <input type="checkbox"/> 3 rarely <input type="checkbox"/> 4 Never	
F.11	In case of conflict, what is the main reason for the conflicts?:		
F.13	Do you have any comments about the questionnaire:		

Thank you very much for your cooperation. Even if you felt some questions were a bit personal, you should be aware that your answers are important in order to better understand the situation of HIV infected adolescents in Thailand and to define programs to improve the situation at the national level.

SECTION I. INTERVIEWER'S COMMENTS

	Time interview ended: __ __ Hour __ __ Minutes		
I.1	The interview was performed	<input type="checkbox"/> ₁ Without any interruption <input type="checkbox"/> ₂ The person showed signs that he/she wanted to stop the interview <input type="checkbox"/> ₃ Was interrupted several times	
I.2	Describe the person interviewed : <i>(Can be more than one answer)</i>	<input type="checkbox"/> ₁ Was relaxed <input type="checkbox"/> ₂ Was OK <input type="checkbox"/> ₃ Was very emotional <input type="checkbox"/> ₄ Was watching at the time <input type="checkbox"/> ₅ Had difficulty understanding <input type="checkbox"/> ₆ Had difficulty expressing her/himself <input type="checkbox"/> ₇ Had difficulty remembering or dating events <input type="checkbox"/> ₈ Was physically tired	
I.3	The answers seemed	<input type="checkbox"/> ₁ Very reliable <input type="checkbox"/> ₂ Reliable <input type="checkbox"/> ₃ Not reliable <input type="checkbox"/> ₄ Not at all reliable <input type="checkbox"/> ₉₈ Don't know	