**Title: Common alternative therapies used by persons with Chronic Non-Communicable Diseases (Hypertension and Type 2 Diabetes) in Western Jamaica**

## Interview for Diabetes

**ID: ____________** **Date: __________**

1. Are you currently using any alternative treatments/home remedies for your diabetes?

   Yes No

   If yes, which alternative treatment method do you currently use? **Mark all that apply**

   | | |
   |---|---|
   | Herbal medicine | Exercise |
   | Nutritional supplements | Spiritual healing |
   | Diet modifications | Relaxation techniques |
   | Manual techniques | Other, please specify________________ |

2. If you are not currently using an alternative treatment, have you used alternative treatments previously?

   Yes No

   If yes, why did you discontinue use of alternative treatments?

**Demographic Information:**

3. Parish: Hanover St. James Westmoreland Trelawny
4. District: ________________________
5. Sex: Male Female
6. Date of Birth: ___/___/_____ Age: ______
7. What is the highest level of education you have completed?

   | | |
   |---|---|
   | Some Primary | Completed Secondary Technical/Vocational |
   | Completed Primary | College/University |
   | Some Secondary | No education |

8. Religious Affiliation:

   | | |
   |---|---|
   | Catholic | Jehovah Witness |
   | Protestant | Rastafarian |
   | Muslim | Adventist |

   Other, please specify: __________________
9. What is your marital status?

   Single Widowed/ Divorced

   Married/ Common Law
10. What is your living arrangement?

    House/Apartment/Condo you own

    House/Apartment/Condo you rent

    Stay with family/friend

    Other, please specify: __________________

**11.** What is your occupation?

None

Professional (e.g. teacher, policeman, doctor, ………..)

Skilled (e.g. plumber, mechanic, electrician, hairdresser, lab technicians ………..)

Clerical (e.g. secretary,

Unskilled (e.g. sanitation/janitorial, ward assistants, porters……..)

Other, please specify_____________________

**12.** What is your individual monthly income?

No income (being supported by the family)

Less than J$24,800 (min. wage J$6,200 weekly)

J$24,801-J$60,000

J$60,001-J$120,000

J$120,001—J$200,000

11a. Other Income: J$_______________

**13.** How many people live in the same house with you?

Number of adults (≥18 years) including you: ________

Number of children (under 18 years): ________

Number of children in school: ________

## Type 2 Diabetes Mellitus Questions

**14.** When were you diagnosed with diabetes?

Within the past year

2-5 years ago

6-10 years ago

>10 years ago

**15.** Are you currently on medication from the clinic or a doctor for your diabetes?

Yes No

**16.** Where do you receive medications for your diabetes?

Health center

Pharmacy

Hospital

**17.** Do you have difficulty in picking up your diabetes medicine?

Yes No

If Yes, what difficulty do you experience?

**18.** Do you get your diabetes medication free of cost or do you have to pay? If you pay, how much?

**19.** Do you always refill your diabetes medication on-time (i.e. before you run out)?

Yes No

**20.** If no, why don't you always fill your diabetes medicine on time?

**21.** Do you always take your diabetes medicine(s) as prescribed?

Yes No

If no, why not?

**22.** Do you think that your diabetes medicine is controlling your diabetes?

Yes No

If no, why do you think so?

**23.** Do you experience any side effects from your diabetes medicine(s)?

Yes No

If yes, what side effects do you experience?

## Alternative Treatment Use and Knowledge

**24.** Name the herbal medicines that you take for diabetes and how often you take them.

1. ______________________________________

| 1-3 days a week | 4-6 days a week | 7 days a week | Every other week |
|---|---|---|---|
| Once a month | Every 2 months | Every 3 months or less | |

2. ______________________________________

| 1-3 days a week | 4-6 days a week | 7 days a week | Every other week |
|---|---|---|---|
| Once a month | Every 2 months | Every 3 months or less | |

3. ______________________________________

| 1-3 days a week | 4-6 days a week | 7 days a week | Every other week |
|---|---|---|---|
| Once a month | Every 2 months | Every 3 months or less | |

4. ______________________________________

| 1-3 days a week | 4-6 days a week | 7 days a week | Every other week |
|---|---|---|---|
| Once a month | Every 2 months | Every 3 months or less | |

5. ______________________________________

| 1-3 days a week | 4-6 days a week | 7 days a week | Every other week |
|---|---|---|---|
| Once a month | Every 2 months | Every 3 months or less | |

**25.** Do you think these herbal medicines control your diabetes?

If yes, why do you think so?

**26.** When you use herbal medicine, do you still take your prescription medication as prescribed?

Yes No

If no, what do you do?

**27.** Have you received information about alternative treatments?

Yes No

If Yes, what have you heard about alternative treatments for diabetes?

Where or from whom did you receive the information?

**28.** Have you discussed alternative treatments for diabetes with your healthcare provider?

Yes No

If no, why not?

**29.** Why do you choose to use alternative medication to treat your diabetes?

**30.** When do you take alternative medications?

Do you take them when you cannot afford your prescribed medications?

**31.** Do you experience any negative side effects when taking alternative medication?

If so, what do you experience?

**32.** Are there any possible harmful effects of using both herbal and prescription medicines at the same time? If so, what are possible harmful effects?

## Knowledge Regarding Alternative Treatments

Do you believe:

**33.** Alternative treatments should **always** be used instead of prescription medication?

Yes No

**34.** Alternative treatments are **more** effective at treating diabetes than prescription medication?

Yes No

**35.** If you are experiencing unpleasant side effects of prescription medication, is it okay to stop taking the medicine without consulting your healthcare provider?

Yes No

**36.** Do you think it is okay to use both prescription medication and alternative treatments at the same time to treat diabetes?

Yes No

**37.** Do you think that you should always discuss any alternative treatments for your condition with your healthcare provider?

Yes No

Why or why not?

# Patient Clinical Data

1. Date diagnosed with Type 2 Diabetes (mm/dd/yyyy) : ___MM___DD_____YYYY

2. Glucose and AIC readings

   Date: ___MM___DD______YYYY      Reading: ______________________

   Date: ___MM___DD______YYYY      Reading: ______________________

   Date: ___MM___DD______YYYY      Reading: ______________________

3. Weight: ___________      Date weighed: ___MM___DD______YYYY
4. Height: ___________      Date measured: ___MM___DD______YYYY

## Interview for Hypertension

**38.** Are you currently using any alternative treatments/home remedies for your hypertension/high blood pressure?

Yes      No

If Yes, which alternative treatment method do you currently use?

Herbal medicine      Exercise

Nutritional supplements      Spiritual healing

Diet modifications      Relaxation techniques

Manual techniques      Other, please specify: _________________

**39.** If you are not currently using an alternative treatment, have you used alternative treatments previously?

Yes      No

If yes, why did you discontinue use of alternative treatments?

**40.** When were you diagnosed with high blood pressure?

Within the past year

2-5 years ago

5-10 years ago

>10 years ago

**41.** Are you currently on medication from the clinic or a doctor for your high blood pressure?

Yes      No

**42.** Where do you receive your medications for your High blood pressure?

Health center

Pharmacy

Hospital

**43.** Do you have difficulty in picking up your blood pressure medicine?

Yes      No

If Yes, what difficulty do you experience?

**44.** Do you get your blood pressure medication free of cost or do you have to pay? If you pay, how much?

**45.** Do you always refill your high blood pressure medication on-time?

Yes No

**46.** If no, why don't you always fill your blood pressure medicine on time?

**47.** Do you take your blood pressure medicine(s) as prescribed?

Yes No

If no, why not?

**48.** Do you think that your blood pressure medicine is controlling your high blood pressure?

Yes No

If no, why do you think so?

**49.** If you get a normal blood pressure reading, do you stop taking your prescription medicine?

Yes No

**50.** Does a normal (120/80) blood pressure reading mean that:

You are cured
Your blood pressure is normal at the time but you still have high blood pressure
Other, please specify

**51.** Do you experience any side effects from your high blood pressure medicine(s)?

Yes No

If yes, what side effects do you experience?

## Alternative Treatment Use and Knowledge

**52.** Name the herbal medicines that you take for high blood pressure and how often you take them.

1. ______________________________________

1-3 days a week | 4-6 days a week | 7 days a week | Every other week
Once a month | Every 2 months | Every 3 months or less

2. ______________________________________

1-3 days a week | 4-6 days a week | 7 days a week | Every other week
Once a month | Every 2 months | Every 3 months or less

3. ______________________________________

1-3 days a week | 4-6 days a week | 7 days a week | Every other week
Once a month | Every 2 months | Every 3 months or less

4. ________________________________________

|  |  |  |  |
|---|---|---|---|
| 1-3 days a week | 4-6 days a week | 7 days a week | Every other week |
| Once a month | Every 2 months | Every 3 months or less |  |

5. ________________________________________

|  |  |  |  |
|---|---|---|---|
| 1-3 days a week | 4-6 days a week | 7 days a week | Every other week |
| Once a month | Every 2 months | Every 3 months or less |  |

**53.** Do you think these herbal medicines control your high blood pressure?

If yes, why do you think so?

**54.** When you use herbal medicine, do you still take your medication from the doctor as prescribed?

Yes No

If no, what do you do?

**55.** Have you received information about alternative treatments?

Yes No

If Yes, what have you heard about alternative treatments for hypertension?

Where or from whom did you receive the information?

**56.** Have you discussed alternative treatments for hypertension with your healthcare provider?

Yes No

If no, why not?

**57.** Why do you choose to use alternative medication to treat your hypertension?

**58.** When do you take alternative medications?

Do you take them when you cannot afford your prescribed medications?

**59.** Do you experience any negative side effects when taking alternative medication?

If so, what do you experience?

**60.** Are there any possible harmful effects of using both herbal and prescription medicines at the same time? If so, what are possible harmful effects?

## Knowledge Regarding Alternative Treatments

Do you believe:

**61.** Alternative treatments should **always** be used instead of prescription medication?

Yes No

**62.** Alternative treatments are **more** effective at treating hypertension than prescription medication?

Yes No

**63.** If you are experiencing unpleasant side effects of prescription medication, is it okay to stop taking the medicine without consulting your healthcare provider?

Yes No

**64.** Do you think it is okay to use both prescription medication and alternative treatments at the same time to treat hypertension?

Yes No

**65.** Do you think you should always discuss any alternative treatments for your condition with your healthcare provider?

Yes No

Why or why not?

## Patient Clinical Data

**5.** Date diagnosed with HTN: ___MM___DD_____YYYY

**6.** Blood Pressure readings

Date: ___MM___DD______YYYY Reading: ______________________

Date: ___MM___DD______YYYY Reading: ______________________

Date: ___MM___DD______YYYY Reading: ______________________

**7.** Weight: ___________ Date weighed: ___MM___DD______YYYY

**8.** Height: ___________ Date measured: ___MM___DD______YYYY