**Additional file 3-A: Patient Questionnaire**

**S1 Basic Information**

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| --- | --- |
| **S1.0** | **General Information**Data collection date: | d | d **| |** m | m | m **| |** y | y | y | y |Country Code\_ \_ Site ID \_ \_ Patient ID \_ \_ \_ \_ Interviewer ID\_ \_  |
| **S1.1** | **Gender of the patient**☐ 1 Male ☐ 2 Female ☐ 99 Cannot be determined |
| **S1.2** | **Year of birth of the patient**19\_\_\_ |
| **S1.3** | **In total, how many years have you spent at school and full-time study excluding pre-school?**\_\_\_ Year |
| **S1.4** | **What is your marital status?**☐1 Never married/never lived together ☐2 Married/living together ☐3 Divorced/Separated ☐4 Widowed  |
| **S1.5** | **Which of the followings best describes your main work status over the past 12 months?**☐1Government employee ☐2 Non-government employee ☐3 Self-employee ☐4 Non-paid ☐5Student ☐6 Homemaker ☐7 Retired ☐8 Unemployed ☐9 Unknown employed☐10 Other (please specify)\_\_\_\_\_ |
| **S1.6** | **How do you rate your health status compared to others of your age?**☐1 Very good ☐2 Good ☐3 Same☐4 Bad ☐5 Very bad ☐99 Don’t know/refused |
| **S1.7** | **Do you have a mobile phone?**☐1 Yes, basic phone (go to S1.9) ☐2 Yes, smart phone (go to S1.9) ☐3 No (go to S1.8) |
| **S1.8** | **Do your family have a mobile phone?**☐1 Yes, basic phone(go to S1.9) ☐2 Yes, smart phone (go to S1.9)☐3 No (go to S2.1) |
| **S1.9** | **On a daily basis, how many messages do you receive and send on the mobile phone that you can reach?**☐1 0 ☐2 1☐3 2 ☐4 3 ☐5 4 or more |

**S2 Disease History**

|  |
| --- |
| **1.Hypertension/High Blood pressure** |
| **S2.1** | **Have you ever had your blood pressure measured by a medical professional?**☐1 Yes (go to S2.1A) ☐2 No(go to S2.2)Date of the last blood pressure measurement YY/MM/DD |
| **S2.1A** | **Have you ever been told by a medical professional that you have raised blood pressure or hypertension?** ☐1 Yes ☐2 No (go to S2.2) |
| **S2.1B** | **First diagnosed by** ☐1 Medical professional in the primary healthcare facilities☐2 Medical professionals in the regional or higher level hospitals ☐ Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **S2.1C** | **How many years have you had hypertension?** □□ Years |
| **2. Diabetes/High Blood Glucose** |
| **S2.2** | **Have you ever had your blood sugar measured by a medical professional?**☐1 Yes (go to S2.2A) ☐2 No(go to S2.3)Date of the last blood sugar measurement YY/MM/DD |
| **S2.2A** | **Have you ever been told by a medical professional that you have raised blood sugar or diabetes?** ☐1 Yes ☐2 No (go to S2.3) |
| **S2.2B** | **First diagnosed by** ☐1 Medical professional in the primary healthcare facilities ☐2 Medical professionals in the regional or higher level hospitals ☐3  Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **S2.2C** | **How many years have you had diabetes?** □□ Years |
| **3. Heart diseases** |
| **S2.3** | **Have you ever had a heart attack or chest pain from heart disease (angina)?**☐1 Yes ☐2 No (go to S2.4) |
| **S2.3A** | **First diagnosed by** ☐1 Medical professional in the primary healthcare facilities☐2 Medical professionals in the regional or higher level hospitals ☐3 Traditional healer ☐4 Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **S2.3B** | **When was it first diagnosed** □□□□ year  |
| **S2.3C** | **When was the latest event** □□□□ year |
| **4. Stroke** |
| **S2.4** | **Have you ever had a stroke before?**☐1 Yes ☐2 No  |
| **S2.4A** | **First diagnosed by** ☐1 Medical professional in the primary healthcare facilities ☐2 Medical professionals in the regional or higher level hospitals ☐3 Traditional healer ☐4 Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **S2.4B** | **Type of stroke?** ☐1 Ischemic stroke ☐2 Hemorrhagic stroke ☐ 99 Don’t know |
| **S2.4C** | **When was it first diagnosed □□□□ year**  |
| **S2.4D** | **When was the last time that you had a stroke**  □□□□ year |

**If the participants answered NO to all of S2.1A, S2.2A, S2.3 and S2.4, then end questionnaire here as the participants do not satisfy our inclusion criteria.**

1. **Lifestyle Information**

|  |  |
| --- | --- |
| **A1** | **During the past month, on about how many days did you drink any alcoholic beverage?** ☐1 0 (go to A4) ☐ \_ \_ days  |
| **A2** | **During the past month, on the days when you drank, about how many alcoholic drinks did you have, on average?**☐1 0 (go to A4) ☐2 1 ☐3 2 ☐4 3 ☐5 4 ☐6 ≥5 |
| **A3** | **During the past month, considering all types of alcoholic beverages, how many times did you have ≥ 5drinks (males) or ≥ 4 drinks (females) on one occasion?**☐1 0 ☐2 1 ☐3 2 ☐4 3 ☐5 4 ☐6 ≥5 |
| **A4** | **Have you ever smoked cigarettes in your entire life?**  ☐ 1 Yes, more than 100 ☐ 2 Yes, less than 100 ☐ 3 No (Go to A7)  |
| **A5** | **Do you currently smoke cigarettes every day, some days, or not at all?**☐ 1 Everyday ☐ 2 Somedays ☐ 3 Not at all (Go to A7)  |
| **A6** | **On average, when you smoke during the past month, about how many cigarettes did you smoke a day?** \_\_\_\_cigarettes/day |
| **A7** | **In the past 3 months, on average, how many servings of fruit (fresh, frozen, or stewed) did you eat per day? Do not include fruit juice, canned fruit or dried fruit. Please select one answer only.**  ☐ 0 I don’t eat fruit ☐ 3 2 servings per day ☐ 1 Less than 1 serving per day ☐ 4 3 servings per day ☐ 2 1 servings per day ☐ 5 4 or more servings per day |
| **A8** | **In the past 3 months, on average, how many servings of vegetable (fresh and frozen) do you eat per day? Do not include vegetable juice. Please select one answer only.** ☐ 0 I don’t eat vegetable ☐ 3 2 servings per day ☐ 1 Less than 1 serving per day ☐ 4 3 servings per day ☐ 2 1 servings per day ☐ 5 4 or more servings per day |
| **A9** | **During the last 7 days, on how many days did you do vigorous physical activates like heavy weight lifting, fast cycling, running, swimming, or basketball or soccer? Think only about those physical activities that you did for at least 10 minutes at a time.** \_\_\_Days per week ☐ 99 Don’t know/Refused |
| **A10** | **How much time did you usually spend doing vigorous physical activities on one of those days?** \_\_\_Minutes per day ☐ 99 Don’t know/Refused |
| **A11** | **During the last 7 days, how many days did you do moderate physical activities like speed walking, light weight lifting, dancing, or normal cycling? Think only about those physical activities that you did for at least 10 minutes at a time.** \_\_\_Days per week ☐ 99 Don’t know/Refused |
| **A12** | **How much time did you usually spend doing moderate physical activities on one of those days?** \_\_\_Minutes per day ☐ 99 Don’t know/Refused |
| **A13** | **During the last 7 days, on how many days did you walk for at least 10 minutes at a time?** \_\_\_Days per week ☐ 99 Don’t know/Refused |
| **A14** | **How much time did you usually spend walking on one of those days?** \_\_\_Minutes per day ☐ 99 Don’t know/Refused |
| **A15** | **During the last 7 days, how much time did you usually spend sitting on a week day?**\_\_\_Hours \_\_\_Mins per weekday ☐ 99 Don’t know/Refused |
| **A16** | **Did you see a medical professional for medical reasons within the last 3 months** **☐1 Yes ☐2 No *(if No go to B1)*** |
| **A17** | **During the past 3 months, has a medical professional told you to?**1. Quit using tobacco or don’t start ☐1 Yes ☐2 No
2. Reduce the use of alcohol/don’t start ☐1 Yes ☐2 No
3. Reduce salt in your diet ☐1 Yes ☐2 No
4. Reduce use of refined sugar in your diet ☐1 Yes ☐2 No
5. Eat at least five servings of fruit and/or vegetables each day ☐1 Yes ☐2 No
6. Reduce fat in your diet ☐1 Yes ☐2 No
7. Start or do more physical activity ☐1 Yes ☐2 No
8. Maintain a healthy body weight or lose weight ☐1 Yes ☐2 No
 |

1. **Access to Primary Healthcare facility**

|  |  |
| --- | --- |
| **B1** | **How long does it take you to go to the nearest primary health facility that you know of?** \_\_\_Hours \_\_\_Minutes |
| **B2** | **How would you rate this travel time?** ☐1 Very long ☐2 Long ☐3 Reasonable ☐4 Short ☐5 Very short ☐99 Don’t know |
| **B3** | **How do you usually go to your chosen primary healthcare facility ?**☐1 Bus ☐2 Car (for example, own car or taxi) ☐3 Motorbike ☐4Bicycle ☐5 Walked ☐6Other (please specify)………………………………………………. ☐7 I have never been to a primary healthcare facility. *(if never skip to C1)* |
| **B4** | **How much will be the total cost of transportation for this visit? Include the cost (to and from) for the patient and any necessary accompanying individuals.**\_\_\_\_\_\_\_\_ local currency ☐99 Don’t know/Refused |
| **B5** | **How would you rate the cost of transportation?**☐1 Very expensive ☐2 Somewhat expensive ☐3 Neither inexpensive nor expensive☐4 Somewhat inexpensive ☐5 Very inexpensive or free |
| **B6** | **How long did you wait between arriving at the facility and receiving medical attention?** \_\_\_Hours \_\_\_Minutes |
| **B7** | **How would you rate this waiting time?**☐1 Very long ☐2 Long ☐3 Reasonable ☐4 Short ☐5 Very short☐99 Don’t know/Refused |

1. **Treatment and control of Cardiovascular diseases**

|  |  |
| --- | --- |
| **C1** | **In the past 12 months, on average, how many times have you sought healthcare for any cardiovascular disease (as mentioned in section S2 above ) at this primary healthcare facility?**☐1 Never (**go to C2A**) \_\_\_\_\_Times (**go to C2B**) ☐99 Don’t know/Refused |
| **C2A** | **Why did you NOT come to this facility for cardiovascular diseases treatment? (*tick all applicable*)** ☐1 Unfriendly staff ☐2 Long waiting time ☐3Medicine unavailable ☐4Staff are unqualified ☐5 Services are expensive ☐6 Dirty facility ☐7 Would have paid ☐8 No privacy ☐9 Was referred ☐10 Beds not available ☐11 Distance too far ☐12 Other (specify)\_\_\_\_\_(**go to C10**) |
| **C2B** | **You came to this facility to seek treatment for (select all that apply)**☐1 diabetes (high blood glucose) ☐2 hypertension (high blood pressure) ☐3 heart diseases ☐4 stroke ☐5 others ☐99 Don’t know/Refused (**if answer include 1,2,3,4 go to C3,otherwise go to C11**) |
| **C3** | **What procedure did you go through when you come to this facility during the most recent CVD related visit? (Select all that apply)** ☐1 Testing blood pressure ☐2 Testing blood glucose ☐3 ECG ☐4 Consultation ☐5 Obtain medication ☐6 Others(specify)\_\_\_\_\_ |
| **C4** | **What was the total amount you paid for medically-related fees during the most recent CVD related visit? This includes formal and informal payments** for tests, procedures, medical consultation, user fee, registration, and any other medical services. It also includes the cost of any medical supplies you purchased or provided for your visit and medication costs (***Record 0 if all services were free)***\_\_\_\_\_\_\_\_\_(local currency) |
| **C5** | **How much of the total costs is covered by your insurance**? \_\_\_%  ☐99 Don’t know/Refused |
| **C6** | **How would you rate the total amount you paid for medically-related fees during the most recent CVD related visit?**☐1 Very expensive ☐2Somewhat expensive ☐3Neither inexpensive nor expensive☐4Somewhat inexpensive ☐5Very inexpensive or free |
| **C7** | **Were you prescribed any new medication at this visit?**☐1 Yes ☐2 No (go to C11) |
| **C8** | **Did the staff tell you what the medication was for?**☐1 Yes ☐2 No |
| **C9** | **Were all the medications you needed available at this facility?**☐1 Yes *(if YES, skip to C11)* ☐2 No |
| **C10** | **Why were you unable to obtain the medicines from this facility during the most recent CVD related visit?**☐1 Too expensive ☐2 Medicine(s) not in stock ☐3 Referred elsewhere by the medical professional ☐4 Other (Specify:\_\_\_\_) ☐99 Don’t know/Refused |
| **C11** | **Do you know where to go for treatment if you suffer from the following symptoms****(chest pain, heart attack, lightness or pain in the chest, neck, back, or arms, as well as fatigue, lightheadedness, abnormal heartbeat, and anxiety as a result of stroke or heart attack)?**☐1 Don’t know/Refused ☐2 Yes **(list names of the facilities below)****1.\_\_\_\_\_\_ 2. \_\_\_\_\_ 3.\_\_\_\_\_\_\_** |

**D Medication History**

|  |  |
| --- | --- |
| **D1** | **In the last one month, have you been on any medication for CVD conditions diagnosed?** ☐1 Yes **Condition (if yes) :\_\_\_\_\_\_\_\_**  ☐2 No*(if no skip to E1)* |
| **D2** | **To your knowledge, how many of those medication is for the treatment of CVD?****\_\_\_\_\_\_\_\_\_\_\_ (if 0 go to E)** |
| **D3** | **Who prescribes the CVD medications for you?**☐1 by myself ☐2 Nurse/Medical Officer at primary care facilities ☐3 Health staff from hospitals ☐4Others please specify\_\_\_\_ |
| **D4** | **Where do you usually get your CVD medications? *(Select all that apply)***☐1 This facility ☐2 Pharmacy at the facility where this clinic is located ☐3 Another facility(specify name) ☐4 Pharmacy elsewhere ☐99 Don’t know/Refused |
| **D5** | **What was the total formal cost of medicines for the past month? (Record 0 if free)**\_\_\_\_\_\_\_\_\_ (local currency) |
| **D6** | **How would you rate the cost of medicines in the past months?**☐1 Very expensive ☐2Somewhat expensive ☐3Neither inexpensive nor expensive☐4Somewhat inexpensive ☐5Very inexpensive or free |
| **D7** | **Do you have difficulties taking your medications as prescribed?**☐1 Yes ☐2 No  |
| **D8** | **Do you have unanswered questions about your medications?**☐1 Yes ☐2 No  |
| **D9** | **Do you ever forget to take medication?**☐1 Yes ☐2 No  |
| **D10** | **What kind of difficulty did you have in obtaining your/their CVD medications?**☐1 Pharmacy or clinic closed ☐2 Medication unavailable or out of stock ☐3 Too expensive ☐4 Other (Specify\_\_\_\_\_\_\_) |

If participant selected option 1 (Never) in **C1**, then end survey here. Otherwise, continue to Section E.

**E Patient Satisfaction**

|  |  |
| --- | --- |
| **E1** | **Please indicate to what extent you agree or disagree with the statements below**1. **During this visit, medical professionals treated me with courtesy and respect**

☐1 Strongly Disagree ☐2 Disagree ☐3 Agree ☐4 Strongly Agree1. **During this visit, medical professionals listened carefully to me**

☐1 Strongly Disagree ☐2 Disagree ☐3 Agree ☐4 Strongly Agree1. **During this visit, medical professionals explained things in a way I could understand**

☐1 Strongly Disagree ☐2 Disagree ☐3 Agree ☐4 Strongly Agree1. **The facility was clean**

☐1 Strongly Disagree ☐2 Disagree ☐3 Agree ☐4 Strongly Agree1. **The bathroom/latrines were clean (leave blank if not applicable)**

☐1 Strongly Disagree ☐2 Disagree ☐3 Agree ☐4 Strongly Agree1. **I had enough time to discuss my medical problem with the medical professionals**

☐1 Strongly Disagree ☐2 Disagree ☐3 Agree ☐4 Strongly Agree |
| **E2** | **On a scale of 0-10 (0 being the worst facility, 10 being the best facility), how would you rate this health facility?**☐1 1 ☐2 2 ☐3 3 ☐4 4 ☐5 5 ☐6 6 ☐7 7 ☐88 ☐9 9 ☐10 10  |
| **E3** | **Would you recommend this facility to your friends and family?**☐1 Definitely no ☐2 Probably no ☐3 Probably yes☐4 Definitely yes**Transport reimbursement** ☐1 Yes ☐2 No |

**Additional file 3-B: Patients’ interview guide**

**FAITH Study Patients’ Interview Guide**

**Aim:** To explore cardiovascular (CVDs) patients’ routine management needs in primary healthcare setting (PHC), as well as the factors associated with the access and utilization patterns of PHC in meeting such needs.

Our discussion may last up to 45 minutes based on the four questions we will ask. You may talk as much as you prefer. Our discussion will be recorded if consent is provided. Confidentiality will be maintained unless the informant wishes his/her name to be mentioned in published reports resulting from the study. Participation is completely voluntary and the interviewee has a right to withdraw participation during or after the interview. Where needed a translator will be present to assist the researcher.

**Step 1**: Read out relevant sections in Consent Form to interview participants

**Step 2**: Consenting participants to sign the Consent Form

**Step 3**: Casually chat with the participant to establish rapport

**Step 4**: Ask the questions below:

*Question 1: How are you managing your conditions nowadays? What is your preferred routine management method for cardiovascular diseases?*

*Question 2: Do you think you are getting all the care you need to manage your CVD on a daily basis? If not, what is preventing from receiving treatment?*

*Question 3: If you visit health centers to receive care, what are some of the goods things you enjoy about those facilities? Any things that you dislike about them? What will make you want to get your routine CVD care from this kind of facilities?*

*Question 4: Do you know where you can seek emergency CVD care should you have a heart attack or stroke? If you have had a heart attack or stroke before, how did you manage it and where did you seek help?*

*Question 5: Is there anything that you think I should know about your (diabetes/hypertension etc)*

**Step 5**: Thank the interviewee for their time.