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FOLLOW-UP SURVEY

Participant Contact Information	
Last Name:	
First Name:	
Telephone:	
Email:	
Address:	
Preferred Method of Contact:	<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Other:
Best time(s) to contact:	

Randomized to: ☐ Intervention ☐ Control

DETACH THIS PAGE FROM FORM AFTER PROCESSING.

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Interview Date (dd/mm/yy): _____ Interviewer name: _____

H. PYLORI MEDICATION

INSTRUCTIONS FOR INTERVIEWER:

If this is the 2-month interview: start at Q1.

If this is the 6-month interview and the participant did not complete the 2-month interview: start at Q1

If this is the 6-month interview, the participant has completed the 2-month interview **and**:

--The participant has started a second course of H. pylori medication: start at Q1

--We have not received the participant's confirmatory test results: start at Q8

--We have received the participant's confirmatory test results: start at Q9

Now I am going to ask you some questions about your H. pylori medication. Please remember that your answers are confidential.

1. Did you ever forget to take the H. pylori medication?

- ☐ a. Yes ☐ b. No ☐ Refused

2. Did you always take the medication at the specified time?

- ☐ a. Yes ☐ b. No ☐ Refused

3. Did you ever stop taking the medication if you felt ill?

- ☐ a. Yes ☐ b. No ☐ Refused

4. Did you forget to take the medication during the weekend?

- ☐ a. Yes ☐ b. No ☐ Refused

5. During the course of treatment, how many times did you not take a dose?

- ☐ a. 0 times ☐ f. Don't know/unsure
☐ b. 1-2 times ☐ g. Refused
☐ c. 3-5 times
☐ d. 6-10 times
☐ e. More than 10 times

6. During the course of treatment, how many **full days** did you **not** take the medication?

_____ days

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If missed medication dose or failed to take at specified time: Situations come up that make it difficult for people to take their medications as prescribed. Can you tell me why you did not take the medicine as prescribed?

7. What kind of side effects did you experience during the course of the medication? (*Check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> a. Bitter or unpleasant taste in mouth | <input type="checkbox"/> e. Abdominal pain, cramps, or gas |
| <input type="checkbox"/> b. Diarrhea | <input type="checkbox"/> f. Headache |
| <input type="checkbox"/> c. Constipation | <input type="checkbox"/> e. No side effects |
| <input type="checkbox"/> d. Nausea or vomiting | <input type="checkbox"/> f. Other, specify: _____ |

8. What is the result of your confirmatory re-test?

- ☐ a. Negative
- ☐ b. Positive
- ☐ c. Scheduled retest but have not done the test/received results yet
- ☐ d. Did not schedule retest
- ☐ e. Don't know/unsure
- ☐ f. Refused

H. PYLORI KNOWLEDGE

9. Now I will ask you some questions about H. pylori to see what you know. Can you tell me if you think the following are associated with **H. pylori transmission**?

	Associated	Not associated	Unsure
a. Blood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Untreated/contaminated water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Rats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Mosquitoes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Contaminated food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Vomit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Poor sanitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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h. Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Now I will ask you some questions about stomach cancer to see what you know. Can you tell me if you think the following are associated with the **risk of getting stomach cancer**?

	Associated	Not associated	Unsure
a. Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Spicy food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Family history	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. H. pylori infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Salty food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Being physically inactive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Pickled food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Food high in sugar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SELF-EFFICACY, HEALTH LITERACY AND MEDICATION ADHERENCE

I am now going to ask you some questions about how confident you feel when you are making decisions and choices about your health and medical treatment options – for example, if you have been diagnosed with an illness. I would like you to rate, on a scale of 0 to 4, with 0 being not at all confident, and 4 being very confident, how confident you feel in your ability to perform the things described **if language was not a barrier**.

11. I feel confident that I can get the facts about the medical treatment choices available to me (for example, treatment, medicine, information, etc). *(Circle a number from 0 to 4)*

Not at all confident	0	1	2	3	4	Very confident
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12. I feel confident that I can get the facts about the benefits of each medical choice.

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<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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13. I feel confident that I can get the facts about the risks and side effects of each medical choice.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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14. I feel confident that I understand the information enough to be able to make a choice.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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15. I feel confident that I can ask questions without feeling dumb.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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16. I feel confident that I can get express my concerns about each choice.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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17. I feel confident that I can ask for advice.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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18. I feel confident that I can figure out the medical treatment options that best suits me.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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19. I feel confident that I can handle unwanted pressure from others in making my choice.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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20. I feel confident that I can let the clinic team know what's best for me.

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<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
-----------------------------	----------	----------	----------	----------	----------	-----------------------

21. I feel confident that I can delay my decision if I feel I need more time.

<i>Not at all confident</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Very confident</i>
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22. How often do you have someone help you read hospital materials, if the materials are in Chinese (or in your preferred language)?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> a. Always | <input type="checkbox"/> d. Occasionally |
| <input type="checkbox"/> b. Often | <input type="checkbox"/> e. Never |
| <input type="checkbox"/> c. Sometimes | |

23. How often do you have problems learning about your medical condition because of difficulty understanding written information in Chinese (or in your preferred language)?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> a. Always | <input type="checkbox"/> d. Occasionally |
| <input type="checkbox"/> b. Often | <input type="checkbox"/> e. Never |
| <input type="checkbox"/> c. Sometimes | |

24. How often do you have a problem understanding what is told to you in Chinese (or in your preferred language) about your medical condition?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> a. Always | <input type="checkbox"/> d. Occasionally |
| <input type="checkbox"/> b. Often | <input type="checkbox"/> e. Never |
| <input type="checkbox"/> c. Sometimes | |

25. How confident are you filling out medical forms by yourself, if the forms are in Chinese (or in your preferred language)?

- | | |
|--|---|
| <input type="checkbox"/> a. Not at all | <input type="checkbox"/> d. Quite a bit |
| <input type="checkbox"/> b. A little bit | <input type="checkbox"/> e. Extremely |
| <input type="checkbox"/> c. Somewhat | |

Now I am going to read you some statements about your medication-taking behavior. You should think about **all your medications in general** when answering these questions. Your answers are confidential. Please let me know – for the following scenarios – whether you do this always, often, sometimes, rarely, or never.

26. I forget to take my medication.

- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> a. Always | <input type="checkbox"/> d. Rarely |
| <input type="checkbox"/> b. Often | <input type="checkbox"/> e. Never |
| <input type="checkbox"/> c. Sometimes | |

27. I change the dosage of my medication.

- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> a. Always | <input type="checkbox"/> d. Rarely |
| <input type="checkbox"/> b. Often | <input type="checkbox"/> e. Never |
| <input type="checkbox"/> c. Sometimes | |

28. I stop taking my medication for a while.

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- ☐ a. Always
☐ b. Often
☐ c. Sometimes

- ☐ d. Rarely
☐ e. Never

29. I decide to skip one of my medication dosages.

- ☐ a. Always
☐ b. Often
☐ c. Sometimes

- ☐ d. Rarely
☐ e. Never

30. I use my medication less than is prescribed.

- ☐ a. Always
☐ b. Often
☐ c. Sometimes

- ☐ d. Rarely
☐ e. Never

DIET AND DRINKING

31. For the next two questions, I am going to ask you about healthy eating.

How important is it to you to eat a healthy diet?

- ☐ a. Not at all important
☐ b. Somewhat important
☐ c. Very important

- ☐ d. Don't know/unsure
☐ e. Refused

32. In general, how healthy is your diet overall?

- ☐ a. Excellent
☐ b. Very good
☐ c. Good
☐ d. Fair

- ☐ e. Poor
☐ d. Don't know/unsure
☐ e. Refused

33. Please tell me whether you agree or disagree with the following statements.

	Agree	Disagree	Unsure
a. It is difficult for me to choose a healthy snack.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I cannot afford to buy healthier foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I do not have the time to prepare healthier foods.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. There is no store for me to buy healthy foods.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. It is uncomfortable for me to refuse unhealthy foods when they are offered to me at get-togethers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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f. I do not like how healthier foods taste.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I do not cook healthier foods because my family does not like them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

34. Please tell me whether you agree or disagree with the following statements. **Are you confident that you can...**

	Agree	Disagree	Unsure
a. Know what foods constitute a healthy diet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Stay on a healthy diet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cook a healthy diet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Decrease the amount of highly salted foods you eat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Decrease the amount of processed foods you eat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Stay on a healthy diet when eating outside your home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. How often do you eat food outside? (at a restaurant or food bought from vendors)

- | | |
|--|---|
| <input type="checkbox"/> a. All of the time | <input type="checkbox"/> e. Don't know/unsure |
| <input type="checkbox"/> b. Most of the time | <input type="checkbox"/> f. Refused |
| <input type="checkbox"/> c. Some of the time | |
| <input type="checkbox"/> d. None of the time | |

36. How often do you add salt to your food before you eat it?

- | | |
|--|---|
| <input type="checkbox"/> a. All of the time | <input type="checkbox"/> e. Don't know/unsure |
| <input type="checkbox"/> b. Most of the time | <input type="checkbox"/> f. Refused |
| <input type="checkbox"/> c. Some of the time | |
| <input type="checkbox"/> d. None of the time | |

37. Please rate how you usually like your food to taste: not salty, slightly salty, salty, or very salty.

- | | |
|--|---|
| <input type="checkbox"/> a. Not salty | <input type="checkbox"/> e. Don't know/unsure |
| <input type="checkbox"/> b. Slightly salty | <input type="checkbox"/> f. Refused |
| <input type="checkbox"/> c. Salty | |
| <input type="checkbox"/> d. Very salty | |

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38. How much salt do you think you consume?

- | | |
|---|---|
| <input type="checkbox"/> a. Far too much | <input type="checkbox"/> d. Very little |
| <input type="checkbox"/> b. Too much | <input type="checkbox"/> e. Don't know/unsure |
| <input type="checkbox"/> c. Just the right amount | <input type="checkbox"/> f. Refused |

39. How important to you is lowering the salt or sodium in your diet?

- | | |
|--|---|
| <input type="checkbox"/> a. Not at all important | <input type="checkbox"/> d. Don't know/unsure |
| <input type="checkbox"/> b. Somewhat important | <input type="checkbox"/> e. Refused |
| <input type="checkbox"/> c. Very important | |

40. Do you read nutrition labels on packaged foods?

- ☐ a. Yes
- ☐ b. No —————> Skip to Q42
- ☐ c. Don't know what a nutrition label is —————> Skip to Q42
- ☐ d. Refused

41. **If yes:** what are you checking the label for? (Do not read list; check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> a. Calories | <input type="checkbox"/> f. Don't know/unsure |
| <input type="checkbox"/> b. Sodium/salt | <input type="checkbox"/> g. Refused |
| <input type="checkbox"/> c. Fats and cholesterol | |
| <input type="checkbox"/> d. Sugar | |
| <input type="checkbox"/> e. Other, specify: _____ | |

42. Do you drink alcohol?

- ☐ a. Yes ☐ b. No —————> Skip to Q46 ☐ c. Refused

43. How often do you drink alcohol? (Read all, check only one)

- | | |
|--|---|
| <input type="checkbox"/> a. Rarely (special occasions) | <input type="checkbox"/> e. Everyday |
| <input type="checkbox"/> b. Occasionally (once a month) | <input type="checkbox"/> f. Don't know/unsure |
| <input type="checkbox"/> c. Once or twice a week | <input type="checkbox"/> g. Refused |
| <input type="checkbox"/> d. Regularly (several times a week) | |

44. When you drink alcohol, how many drinks do you have per day? (Read all, check only one)

One drink is defined as one can or small bottle of beer, one glass of wine, or one shot of liquor such as baijiu.

- | | |
|--|---|
| <input type="checkbox"/> a. 1-2 drinks | <input type="checkbox"/> d. Don't know/unsure |
| <input type="checkbox"/> b. 3-4 drinks | <input type="checkbox"/> e. Refused |
| <input type="checkbox"/> c. 5 or more drinks | |

45. In the past 30 days, on how many days did you have 4 or more alcoholic drinks in one occasion?

- _____ times ☐ a. Don't know/unsure ☐ b. Refused

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SMOKING

46. Do you currently smoke cigarettes?

- ☐ a. Everyday
☐ b. Some days

- ☐ c. Not at all → Skip to Q50
☐ d. Refused

47. If “Everyday” or “Some days”: How many cigarettes do you smoke per day?

_____ per day ☐ a. Don’t know/unsure ☐ b. Refused

48. During the past 12 months, have you stopped smoking for 24 hours or longer because you were trying to quit smoking?

- ☐ a. Yes ☐ b. No → Skip to Q50 ☐ c. Refused

49. What best describes your intentions about quitting cigarette smoking?

- | | |
|--|---|
| <input type="checkbox"/> a. I may quit in the future, but not in the next 6 months | <input type="checkbox"/> d. I am currently trying to quit |
| <input type="checkbox"/> b. I plan to quit in the next 6 months | <input type="checkbox"/> e. Don’t know/unsure |
| <input type="checkbox"/> c. I plan to quit in the next 30 days | <input type="checkbox"/> f. Refused |

PHYSICAL ACTIVITY

50. During the last 7 days, on how many days did you do **moderate physical activities**?

[Moderate physical activities make you breathe somewhat harder than normal, but not so much that you are out of breath. Activities can take place at home, work, or in the gym, but think only about those physical activities that you do for at least 10 minutes at a time, such as brisk walking, carrying shopping bags or laundry, gardening, or taichi.]

_____ days/week ☐ a. Don’t know/unsure ☐ b. Refused

51. How much time did you usually spend doing these **moderate** types of physical activities on a normal day? *[If participant answers that the length of time varies, ask them to think about a normal day or the last day they did these types of physical activities]*

_____ minutes/day ☐ a. Don’t know/unsure ☐ b. Refused

52. During the last 7 days, on how many days did you do **large effort physical activities**?

[Large effort physical activities make your heart rate and breathing faster. Activities can take place at home, work, or in the gym, but think only about those physical activities that you do for at least 10 minutes at a time, such as running or jogging, swimming, or aerobics.]

_____ days/week ☐ a. Don’t know/unsure ☐ b. Refused

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53. How much time did you usually spend doing these **large effort** types of physical activities on a normal day? *[If participant answers that the length of time varies, ask them to think about a normal day or the last day they did these types of physical activities]*

_____ minutes/day

☐ a. Don't know/unsure

☐ b. Refused

54. I would like you to rate, on a scale of 0 to 4, with 0 being not at all confident, and 4 being very confident, how confident you feel in your ability to do moderate exercise for at least 30 minutes, 5 times per week in the future. *(Circle one number from 0 to 4)*

Not at all confident	0	1	2	3	4	Very confident
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55. How often do you suggest doing something active when you get together with family or friends, such as going for a walk, biking, or swimming?

☐ a. Almost never

☐ d. Almost always

☐ b. Sometimes

☐ e. Refused

☐ c. Often

56. How often do you set aside a special time to do physical activity?

☐ a. Almost never

☐ d. Almost always

☐ b. Sometimes

☐ e. Refused

☐ c. Often

57. How often do you ask a friend or relative to do some physical activity with you?

☐ a. Almost never

☐ d. Almost always

☐ b. Sometimes

☐ e. Refused

☐ c. Often

58. How often do you talk to others about the benefits of physical activity?

☐ a. Almost never

☐ d. Almost always

☐ b. Sometimes

☐ e. Refused

☐ c. Often

HEALTH STATUS

I am now going to ask you some questions about your general health.

59. In general, would you say your health is:

☐ a. Poor

☐ d. Very good

☐ b. Fair

☐ e. Excellent

☐ c. Good

☐ f. Refused

60. In general, would you say your quality of life is:

☐ a. Poor

☐ d. Very good

☐ b. Fair

☐ e. Excellent

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- ☐ c. Good ☐ f. Refused

61. In general, how would you rate your physical health?

- ☐ a. Poor ☐ d. Very good
☐ b. Fair ☐ e. Excellent
☐ c. Good ☐ f. Refused

62. In general, how would you rate your mental health, including your mood and your ability to think?

- ☐ a. Poor ☐ d. Very good
☐ b. Fair ☐ e. Excellent
☐ c. Good ☐ f. Refused

63. In general, how would you rate your satisfaction with your social activities and relationships?

- ☐ a. Poor ☐ d. Very good
☐ b. Fair ☐ e. Excellent
☐ c. Good ☐ f. Refused

64. In general, please rate how well you carry out your usual social activities and roles. (*Includes activities at home, at work, and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.*)

- ☐ a. Poor ☐ d. Very good
☐ b. Fair ☐ e. Excellent
☐ c. Good ☐ f. Refused

65. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- ☐ a. Not at all ☐ d. Mostly
☐ b. A little ☐ e. Completely
☐ c. Moderately ☐ f. Refused

66. In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

- ☐ a. Always ☐ d. Rarely
☐ b. Often ☐ e. Never
☐ c. Sometimes ☐ f. Refused

67. In the past 7 days, how would you rate your fatigue on average?

- ☐ a. Very severe ☐ d. Mild
☐ b. Severe ☐ e. None
☐ c. Moderate ☐ f. Refused

68. In the past 7 days, how would you rate your pain on average? Please give me a number from 0, which is no pain, to 10, which is worst imaginable pain. (*Circle a number from 0 to 10*)

0	1	2	3	4	5	6	7	8	9	10
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No pain

Worst imaginable pain

69. Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly everyday	Refused
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

70. How motivated do you feel right now to make changes in your life to improve your health?

- | | |
|--|---|
| <input type="checkbox"/> a. Not at all motivated | <input type="checkbox"/> e. Extremely motivated |
| <input type="checkbox"/> b. Slightly motivated | <input type="checkbox"/> f. Don't know/unsure |
| <input type="checkbox"/> c. Somewhat motivated | <input type="checkbox"/> g. Refused |
| <input type="checkbox"/> d. Moderately motivated | |

END OF SURVEY

Interviewer Instructions:

For 2 month follow-up survey, end here.

For 6 month follow-up survey:

- If the participant is in the intervention group, complete the CHW evaluation Form 3.
- If the participant is in the control group, end here.