

A cross-sectional study to examine distinct patterns of attitude towards complementary and alternative medicines (CAM) in people hypothetically facing rheumatoid arthritis.

¹*Srishti Vats, ²Saksham Pandey, ²Raushan Kumar

¹Research Professional, Department of Translational and Clinical Research, School of Chemical and Life Sciences, Jamia Hamdard, New Delhi, India.

²Research Scientist, Department of Medicine, Maulana Azad Medical College, New Delhi, India.

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Abstract

Background:

Rheumatoid Arthritis (RA) is a chronic autoimmune inflammatory disorder affecting 0.3-1.0% of the global population, managed through conventional, complementary, and alternative treatment strategies. Awareness and acceptance of Complementary and Alternative Medicine (CAM) among the general population remain poorly understood, particularly in relation to educational background and personal exposure to RA. This study aimed to assess CAM awareness and identify factors influencing hypothetical treatment selection for RA.

Methods:

A cross-sectional, mixed-methods study was conducted among 200 randomly selected participants using an online, bilingual (English/Hindi) structured questionnaire. Participants were presented with a hypothetical RA scenario and asked to select preferred treatment options among conventional, complementary, and alternative therapies. The influence of educational qualification and prior acquaintance with an RA patient on treatment selection was analyzed using Fisher's exact test.

Results:

Of 200 participants, 110 (55.0%) were male, and 90 (45.0%) were female; 136 (68.0%) were aged 18–30 years. Overall, 55.3% were unaware of the term CAM. Diet, physiotherapy, meditation, and yoga were among the most preferred treatment options. Educational qualification significantly influenced meditation/yoga selection ($p = 0.0139$), while prior acquaintance with an RA patient significantly increased selection of diet/physiotherapy ($p = 0.0006$) and meditation/yoga ($p = 0.0026$).

Conclusion:

Personal exposure to RA, rather than education alone, was a stronger predictor of preference for complementary, lifestyle-based therapies, underscoring the need for greater public awareness of CAM in RA management.

Recommendation:

The study recommends improving public awareness of CAM and its evidence-based role in RA management, particularly regarding appropriate complementary and lifestyle-based therapies.

Keywords: Rheumatoid Arthritis; Complementary and Alternative Medicine; treatment selection; educational qualification; patient awareness; cross-sectional study.

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Corresponding author: Srishti Vats

Email: srishtivats27@gmail.com

Research Professional, Department of Translational and Clinical Research, School of Chemical and Life Sciences, Jamia Hamdard, New Delhi, India.

Introduction

Rheumatoid Arthritis (RA) is a chronic, autoimmune, progressive inflammatory disorder that manifests as a symmetric polyarthritis of small and large joints, leading to joint and periarticular structural damage along with the consequences of systemic inflammation. Because it is an autoimmune disease, the immune system mistakenly attacks the synovium- the tissue lining around a joint that produces fluid for smooth movement — causing it to thicken, which makes the joint area painful, tender, red, swollen, and difficult to move. RA affects 0.3–1.0% of the global population [1]. Women are five times more likely than men to develop RA, and prevalence is highest in those over 40 [2], rising to 5% among women over 70. In India, an estimated 10 million people have RA, a prevalence of 0.7%. Early RA typically affects the smaller joints of the fingers and legs, later spreading to the wrists, knees, ankles, elbows, hips, and shoulders, usually symmetrically on both sides of the body. About 40% of RA patients also experience extra-articular symptoms affecting the skin, eyes, lungs, heart, or kidneys.

Treatment strategies for RA fall into three broad categories: conventional medicine, complementary medicine, and alternative medicine. Conventional treatments include NSAIDs, which are effective for pain relief but have little impact on the progression of bone and cartilage destruction [3]; DMARDs, which reduce pain and inflammation, prevent joint damage, and preserve joint structure and function, and are also used for related conditions like ankylosing spondylitis, psoriatic arthritis, and systemic lupus erythematosus [4]; biologics, which are genetically engineered proteins that target the immune cells responsible for RA symptoms and can slow joint damage [5]; and surgery, used for irreversible joint damage, including knee and hip replacement, carpal tunnel release, synovectomy, and bone or joint fusion [6]. Complementary approaches include acupuncture, which does not alter disease progression but may benefit some patients as an adjunct therapy [7]; physiotherapy, which helps reduce inflammation and joint discomfort while restoring muscle strength, mobility, and flexibility [8]; dietary therapy, informed by evidence linking altered gut microbiota to RA pathogenesis and progression [9]; and yoga, recommended for maintaining strength, flexibility, and stress management [10]. Alternative systems such as Ayurveda attribute RA to disturbances in Agni and the accumulation of systemic ama affecting the joints [10], while Unani medicine (which terms RA "Waja-ul-Mafasil," or localized joint pain) attributes it to weak immunity and poor digestion, treating it with polyherbal preparations [11].

Given the range of available treatments- conventional, complementary, and alternative- and the fact that treatment preference varies with population-level factors, this study aims to assess general awareness of "Complementary and Alternative Medicines" (CAM) and to compare attitudes between respondents who personally know someone with RA and those who do not. Understanding how many respondents would prefer CAM as a treatment strategy is relevant for policymakers. The study therefore examines the patterns of treatment selection within the population and how factors such as education level and personal familiarity with RA influence that selection.

Methods

Study Design

A cross-sectional observational study was conducted, in which exposure and outcome variables were assessed concurrently.

Study Setting and Study Period

The study was conducted at Jamia Hamdard, New Delhi, India, with participants from the general population recruited through social media platforms. Data collection was carried out from January 2024 to January 2025.

Study Population and Sampling

The study population comprised 200 individuals from the general population, recruited via social media platforms using convenience sampling, irrespective of gender, educational qualification, or employment status.

Inclusion criteria: Individuals of any gender, aged 18-60 years, in good health, and able to provide voluntary informed consent.

Exclusion criteria: Individuals in poor health and those below 18 years and above 60 years of age.

Ethical Consideration

The study was approved by the Institutional Ethics Committee of Jamia Hamdard, New Delhi (Ref. No. 03/23 [1403/2023]). Written informed consent was obtained from all participants prior to enrollment, and the confidentiality of all participant information was maintained throughout the study.

Study Tool/Instrument

Data were collected using a structured questionnaire adapted from previously validated literature [1], made available in both English and Hindi. The questionnaire was organized into five sections: (1) participant information sheet, (2)

certificate of consent, (3) personal/demographic information, (4) knowledge of RA and CAM, and (5) treatment selection, the last of which presented a hypothetical RA scenario followed by items on illness perception, treatability beliefs, anticipated stigma, treatment preference, and perceived treatment efficacy, rated on four-point Likert-type scales.

Study Variables

Independent (predictor) variables analyzed in relation to treatment selection were educational qualification (postgraduate, graduate, other) and prior acquaintance with an RA patient (yes/no). Gender and employment status were collected as demographic descriptors but were not analyzed as predictors of treatment selection. The dependent (criterion) variables were awareness of the term CAM, belief in the treatability of RA with medication, perceived benefit of individual treatments, and selection of each treatment category (NSAIDs, DMARDs, biologics, surgery, diet/physiotherapy, meditation/yoga, ayurvedic medicine, and Unani medicine).

Data Collection Procedure

A mixed-methods approach was adopted, comprising quantitative and qualitative data collection. Prior to full-scale data collection, a pilot study was conducted to evaluate questionnaire clarity, formatting, and completion time, following which minor modifications were made. The finalized questionnaire was subsequently disseminated online, and responses were collected on a voluntary basis.

Bias

To minimize information and response bias, a standardized questionnaire adapted from validated literature was used. The questionnaire was available in English and Hindi and

was pilot-tested for clarity and comprehension. Anonymous data collection was used to reduce social desirability bias. Selection bias could not be completely eliminated due to the use of convenience sampling; however, recruitment was open to eligible individuals irrespective of gender, educational qualification, or employment status.

Statistical Analysis

Data were manually extracted and entered into Microsoft Excel for analysis. Participant responses were summarized as frequencies and percentages for demographic characteristics, awareness of CAM, and perceived treatability/benefit of individual RA treatments. To examine the influence of educational qualification and prior acquaintance with an RA patient on treatment selection, participants were cross-tabulated by selection of each treatment category, and associations were tested using Fisher's exact test. A p-value of <0.05 was considered statistically significant.

Results

Of the 200 participants, the majority were male (55%) and aged 18–30 years (68%), reflecting a young, digitally accessible sample consistent with the online recruitment method. Graduates formed the largest educational subgroup (44%), followed by postgraduates (35%) and those with primary/secondary/higher-secondary education (21%). Nearly equal proportions were employed (45%) and students (44%), with unemployed individuals and housewives each comprising 5%. Despite this reasonably educated sample, more than half (55.3%) were unaware of the term "Complementary and Alternative Medicine," and only 42% reported personally knowing someone with RA (Table 1).

Table 1 Demographic Profile of Participants (N = 200)

Variable	Category	n (%)
Gender	Male	110 (55.0)
	Female	90 (45.0)
Age group (years)	18–30	136 (68.0)
	30–40	21 (10.5)
	40–50	24 (12.0)
	50–60	18 (9.0)
	>60	1 (0.5)
Education	Postgraduate	70 (35.0)
	Graduate	88 (44.0)
	Others (primary/secondary/higher secondary)	42 (21.0)
Employment status	Employed	90 (45.0)
	Student	88 (44.0)

	Unemployed	10 (5.0)
	Housewife	10 (5.0)
Awareness of CAM	Yes	89 (44.7)
	No	110 (55.3)
Knows someone with RA	Yes	84 (42.0)
	No	116 (58.0)

Note. CAM = complementary and alternative medicine; RA = rheumatoid arthritis.

Less than half of the sample (44.7%) had prior awareness of the term "Complementary and Alternative Medicine," despite the majority being educated to graduate level or higher, indicating a knowledge gap between formal education and specific awareness of CAM as a category. When asked whether RA is treatable with medication, a majority (59%) agreed, while about a third (33%) disagreed, reflecting a generally optimistic view of RA management.

In terms of perceived benefit, complementary therapies (diet, physiotherapy, meditation, yoga) and select conventional therapies (DMARDs, biologics) were rated most favorably, ayurvedic treatment was viewed more positively than Unani, and surgery was rated least beneficial overall- together addressing the objectives of assessing CAM awareness and perceived treatment benefit (Table 2).

Table 2 Awareness of CAM and Perceived Treatability/Benefit of RA Treatments (N = 200)

Variable	Category	n (%)
Awareness of the term CAM	Aware	89 (44.7)
	Not aware	110 (55.3)
Belief that RA is treatable with medication	Fully disagree	~10 (5)
	Disagree	66 (33)
	Agree	118 (59)
Most beneficial treatments (participant-rated)	Fully agree	6 (3)
	Diet, physiotherapy, meditation, yoga	Highest agreement
	DMARDs, biologics	High agreement
	Ayurvedic	Moderate agreement (higher than Unani)
	Unani	Lower agreement
	Surgery	Lowest agreement (most "disagree" responses)

Note. CAM = complementary and alternative medicine; DMARDs = disease-modifying antirheumatic drugs; RA = rheumatoid arthritis.

Educational qualification showed no statistically significant association with selection of ayurvedic, Unani, NSAIDs, DMARDs, biologics, diet/physiotherapy, or surgery (all $p > 0.05$); a significant difference emerged only for meditation and yoga, favored more by graduates (64.77%) than post graduates (51.42%) or those with lower education (38.09%;

$p = 0.0139$). In contrast, prior acquaintance with an RA patient was significantly associated with greater selection of diet/physiotherapy (77.38% vs. 53.44%; $p = 0.0006$) and meditation/yoga (66.66% vs. 44.82%; $p = 0.0026$), while no significant differences were observed for the remaining treatment categories (Table 3).

Table 3 Effect of Educational Qualification and Prior Acquaintance with an RA Patient on Treatment Selection

Treatment	Postgraduates (n=70), n (%)	Graduates (n=88), n (%)	Others (n=42), n (%)	p-value (Education)	Knew RA patient (n=84), n (%)	Did not know RA patient (n=116), n (%)	p-value (Acquaintance)
Ayurvedic	26 (37.14)	40 (45.45)	17 (40.47)	0.5712	38 (45.23)	45 (38.79)	0.3856
Unani	13 (18.57)	9 (10.22)	5 (11.90)	0.3129	9 (10.70)	17 (14.65)	0.5241
NSAIDs	27 (38.57)	30 (34.09)	14 (33.33)	0.8260	32 (38.09)	40 (34.48)	0.6522
DMARDs	31 (44.28)	29 (32.95)	18 (42.85)	0.3066	34 (40.47)	45 (38.79)	0.8837
Biologics	20 (28.57)	18 (20.45)	8 (19.04)	0.4198	18 (21.42)	28 (24.13)	0.7345
Diet, physiotherapy	47 (67.14)	58 (65.90)	21 (50.00)	0.1517	65 (77.38)	62 (53.44)	0.0006
Meditation, yoga	36 (51.42)	57 (64.77)	16 (38.09)	0.0139	56 (66.66)	52 (44.82)	0.0026
Surgery	11 (15.71)	20 (22.72)	11 (26.19)	0.3472	15 (17.85)	26 (22.41)	0.4809

Note. RA = rheumatoid arthritis; NSAIDs = nonsteroidal anti-inflammatory drugs; DMARDs = disease-modifying antirheumatic drugs. **Bold indicates statistically significant associations at $p < .05$.**

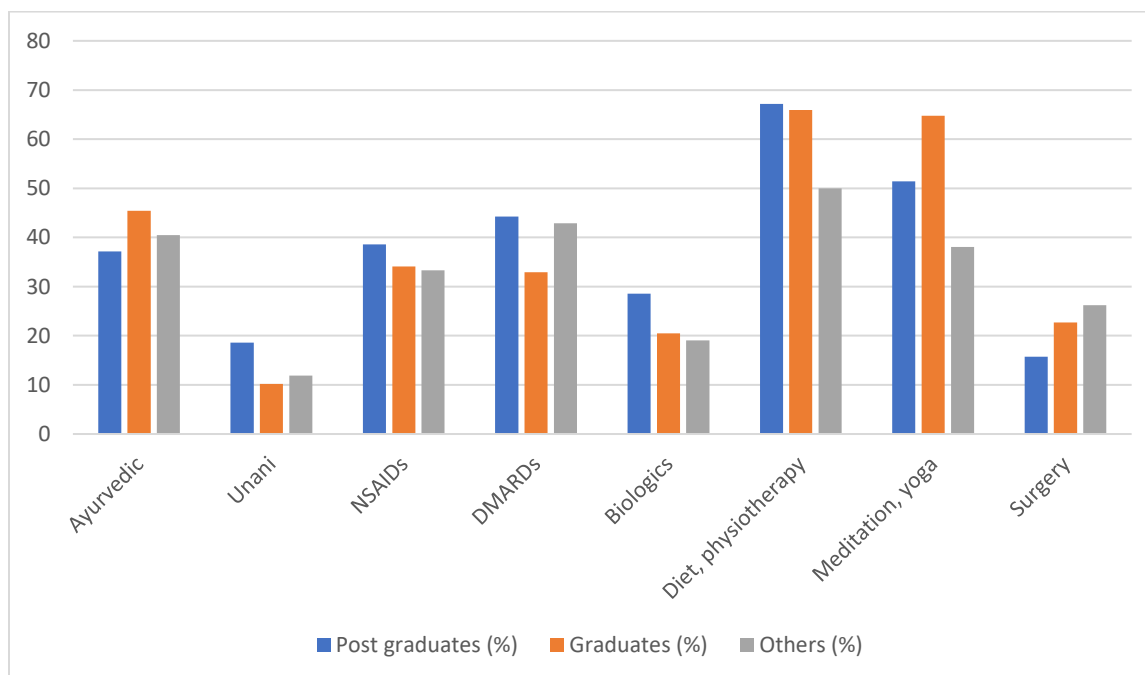


Figure 1: Treatment Selection by Educational Qualification (%)

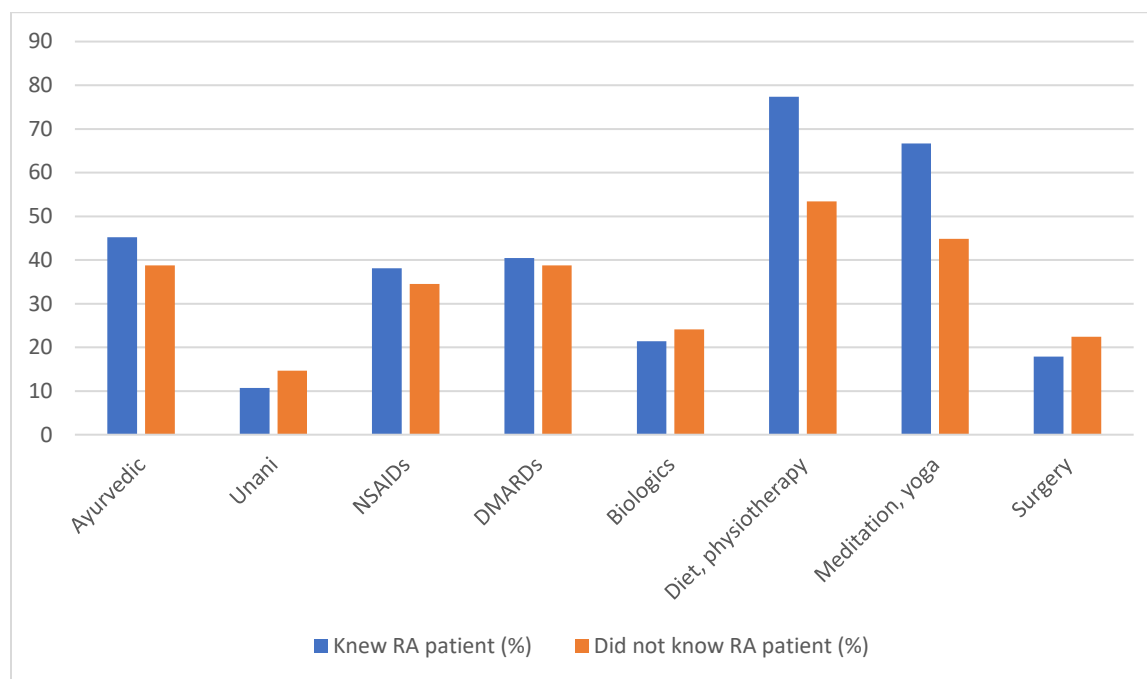


Figure 2: Treatment Selection by Acquaintance with an RA Patient (%)

When asked about the treatability of RA with medication, the majority of participants (59% agree, 3% fully agree) held a positive view, while 38% (33% disagree, 5% fully disagree) were skeptical. In terms of perceived treatment benefit, complementary therapies (diet, physiotherapy, meditation, yoga) and select conventional therapies (DMARDs, biologics) were rated most favorably by participants. Among alternative treatments, ayurvedic medicine was perceived as more beneficial than Unani, while surgery was rated least favorably overall, receiving the highest proportion of "disagree" responses among all treatment options assessed.

Discussion

The present study aimed to assess the proportion of the general population aware of Complementary and Alternative Medicine (CAM), and to compare treatment preferences between those who knew someone with RA and those who did not, alongside examining the influence of educational qualification on treatment selection, using data from 200 participants. These findings can be contextualized against prior literature on CAM use among RA patients. Bhalerao et al. (2013), in a study conducted in India, found

that 42.7% of RA patients used CAM, with only 54.1% satisfaction among users and Ayurveda as the most commonly used modality (57.1%) [14]. Almuhareb et al. (2019), in Riyadh, Saudi Arabia, reported a considerably higher CAM prevalence of 67%, predominantly among female patients (92.1%), with CAM use more common among illiterate patients (24.3%) and those with intermediate incomes, while non-users were more often postgraduate-educated [13]. Similarly, Lee et al. (2008) found that 82% of RA patients in Korea had used CAM, often on the recommendation of family members, with 35% reporting symptomatic improvement [14]. Peltzer et al. (2016) further demonstrated across 32 countries that gender, education, and socioeconomic status influence CAM use broadly [15]. In comparison, the present study found a lower baseline awareness of CAM, with only 45% of participants familiar with the term. However, diet, physiotherapy, meditation, and yoga were the most preferred options, followed by Ayurvedic and Unani medicine, suggesting that participants may favor familiar, non-pharmacological approaches even when they are not explicitly recognized under the broader term "CAM."

With respect to educational qualification, treatment preferences were broadly similar across education groups, with no statistically significant differences for most treatment categories, suggesting that educational attainment may have had limited influence on participants' overall treatment choices. The exception was meditation and yoga, which were selected significantly more often by graduates (64.77%) and postgraduates (51.42%) than by school pass-outs (38.09%). This pattern may reflect greater awareness among more educated participants of the side effects associated with conventional therapies such as NSAIDs and biologics [3,5], as well as the more gradual, delayed onset of benefit typical of mind-body interventions [10]. Yoga and meditation, despite requiring sustained practice to show effect, are associated with minimal adverse effects and documented benefits for pain and sleep in RA [10], which may make them a more appealing long-term option for participants with greater health literacy. Participants with lower educational attainment, by contrast, may have been less aware of such trade-offs and more inclined toward treatments offering more immediate relief.

Regarding prior acquaintance with an RA patient, 42% of participants reported knowing someone with the condition, while 58% did not, indicating that direct exposure to RA was relatively common but not experienced by the majority of participants. No significant differences were observed in the selection of ayurvedic medicine, Unani medicine, NSAIDs, DMARDs, biologics, or surgery based on prior acquaintance, suggesting that familiarity with an RA patient may have had limited influence on preferences for these treatment categories. Overall, diet and physiotherapy were rated the most effective treatment strategy, followed by DMARDs, biologics, and meditation/yoga, while Unani medicine, NSAIDs, and surgery were considered least effective. The absence of significant differences for most conventional and alternative therapies may reflect the shared limitation that no available treatment can fully cure RA, with existing options offering only symptomatic relief [1], resulting in comparable selection across these categories. In contrast, the significant preference for complementary therapies among educated participants and those with direct exposure to an RA patient's experience likely reflects greater awareness of the side-effect burden of conventional treatment [3,5] and the favorable safety profile of lifestyle-based interventions [8,9,10]. A notable limitation of this study is its multiple-choice questionnaire format, which may have increased the likelihood of "hit and trial" responses, potentially introducing bias into the results.

Limitations

The use of convenience sampling and online recruitment may have introduced selection bias and limited the representativeness of the sample. The multiple-choice questionnaire may also have encouraged response bias or "hit-and-trial" responses, limiting the accuracy of reported treatment preferences.

Generalizability

The generalizability of these findings is limited by the use of convenience sampling through social media and the relatively small sample of 200 participants. Although participants were recruited irrespective of gender, education, and employment status, the findings may not fully represent the broader Indian population. Larger, multicentric studies using probability-based sampling are needed to confirm these findings across diverse populations.

Recommendation

Future studies should use larger, more diverse samples and probability-based or multicentric recruitment to improve generalizability. Validated questionnaires with more comprehensive response options should be used to better assess treatment preferences and perceptions of CAM in RA.

Conclusion

This cross-sectional study assessed awareness of Complementary and Alternative Medicine (CAM) and treatment preferences among 200 participants in the context of Rheumatoid Arthritis (RA), examining the influence of educational qualification and prior acquaintance with an RA patient on treatment selection. The findings revealed that despite a reasonably educated study population, more than half of the participants (55.3%) were unaware of the term CAM, though complementary therapies such as diet, physiotherapy, meditation, and yoga were still widely favored as beneficial treatment options, alongside conventional therapies like DMARDs and biologics. While educational qualification showed limited influence on treatment selection overall, it significantly affected the choice of meditation and yoga, which were preferred more by graduates and postgraduates than by those with lower educational attainment. Similarly, prior acquaintance with an RA patient significantly increased the likelihood of selecting diet, physiotherapy, meditation, and yoga, without meaningfully affecting attitudes toward conventional or purely alternative treatments such as NSAIDs, DMARDs, biologics, ayurveda, or Unani medicine. These findings suggest that direct or indirect exposure to RA, rather than

education alone, plays a more prominent role in shaping preference for lifestyle-based complementary therapies, highlighting the need for greater public awareness of CAM and more informed, patient-centered treatment counseling in RA management.

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List of Abbreviations

- CAM – Complementary and Alternative Medicine
- RA – Rheumatoid Arthritis
- NSAIDs – Nonsteroidal Anti-inflammatory Drugs
- DMARDs – Disease-modifying Antirheumatic Drugs

Source of Funding

No external funding was received for this study.

Conflict of Interest

The authors declare that they have no conflict of interest.

Author Contributions

Srishti Vats: Conceptualised the study, led the research design, contributed to data collection and analysis, and was involved in writing, drafting, revising, and finalising the manuscript.

Saksham Pandey: Contributed to data collection and manuscript preparation, including writing, reviewing, and finalising the draft manuscript.

Raushan Kumar: Contributed to the literature review, data analysis, interpretation of findings, and drafting, reviewing, and finalising the manuscript.

Data Availability

The data generated and analyzed during the present study are available from the corresponding author upon reasonable request, subject to appropriate ethical and confidentiality considerations.

Author Contributions

All authors contributed to the conception and design of the study, data collection, analysis and interpretation of data, and preparation and critical revision of the manuscript. All authors approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

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