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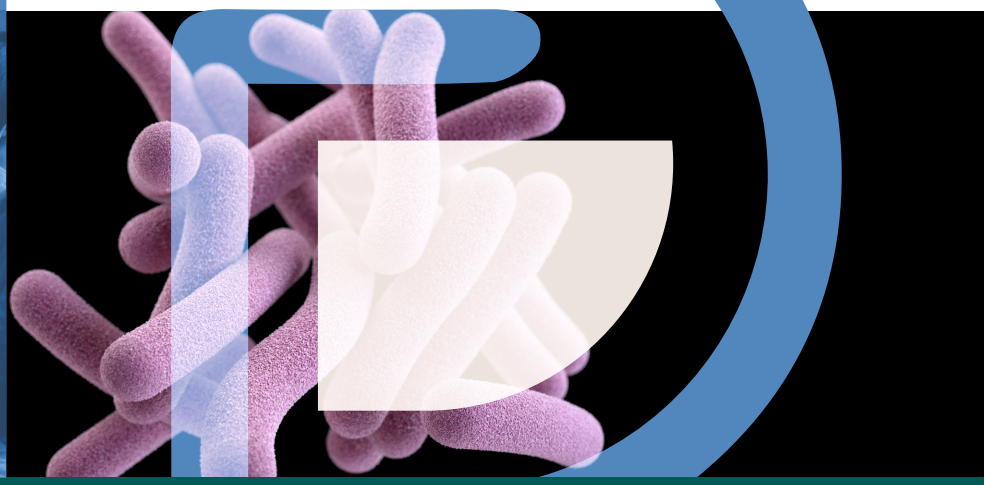
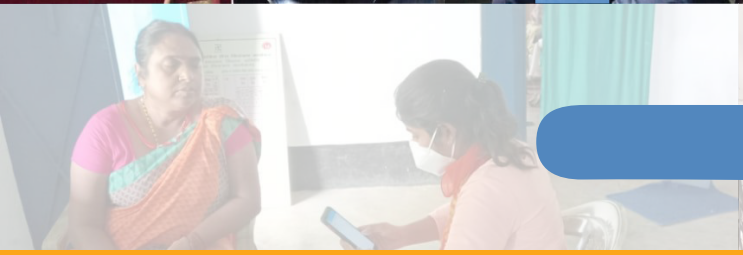


Estimating impact of involving a for-profit organisation on the quantity, quality and cost of TB care in India under the PPSA model

JUNE 2023



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Executive Summary

India has the highest TB burden in the world, constituting 28% of the global incidence and 36% of global deaths.[1] The public sector delivers standardized TB care through the National TB Elimination Programme (NTEP), but the private sector is the first point of contact for healthcare for 50–80% of patients.[2,3] Recognizing the importance of private sector engagement to advance TB Elimination targets, the Patient-Provider Support Agency (PPSA) model was integrated into the National Strategic Plan to more effectively manage the care of TB patients in the private sector.

In the PPSA model, a third-party agency is onboarded to engage the private sector and provide end-to-end services, including sample collection, access to free government Fixed dose combinations drugs (FDCs: medicines containing two or more active components in fixed proportion in a single dosage form)) at the private health facility, and patient counselling. The Central TB Division (CTD) approved PPSAs in 385 districts, with third-party agencies onboarded in 188 districts. Although partnership guidance released by CTD also allows for social enterprises and for-profit entities to qualify, PPSA agencies have largely been limited to not-for profit, nongovernmental organisations.

The Joint Effort for Elimination of Tuberculosis (JEET) is a large-scale private health sector engagement initiative for TB in India. The JEET initiative is aimed at addressing inefficiencies across the patient care cascade for TB patients. The programme is run by three agencies in India, namely, the William J. Clinton Foundation (WJCF, formerly CHAI), Centre for Health Research and Innovation (CHRI), and Foundation for Innovative New Diagnostics (FIND). William J. Clinton Foundation (WJCF) under JEET implemented two pilot programmes with TATA-1mg from July 2020 – June 2022 under the PPSA framework. TATA–1mg is a for-profit healthcare platform specialising in service delivery, primarily e-pharmacy. Other services include diagnostics, e-consultation and health content. The objective of the pilots was to assess if a model involving a specialised for-profit organisation for some of the PPSA activities can perform better in service delivery than traditional not-for-profit agency models engaged under PPSA. The two pilot programmes are described below.

Drug Delivery Pilot

The Drug Delivery pilot was implemented in the districts of Surat and Ahmedabad in the state of Gujarat. Within this pilot, the standard PPSA services (JEET 1.0) continued under a third-party (PPSA agency) while

[1] National Strategic Plan for Tuberculosis Elimination 2017-2025 ; Central TB Division, Ministry of Health and Family Welfare, https://tbcindia.gov.in/WriteReadData/NSP%20Draft%2020.02.2017%201. pdfhttps://tbcindia.gov.in/WriteReadData/NSP Draft 20.02.2017 1.pdf

[2] Juvekar SK, Morankar SN, Dalai DB, Rangan SG, Khanvilkar SS, Vadair AS, et al. Social and operational determinants of patient behaviour in lung tuberculosis. Ind J Tub. 1995;42:87.

[3] JEET Annual Report 2018-2020; FIND 2022, https://www.projectjeet.in/wp-content/uploads/2022/01/ JEET-report-2018-2020.pdf

TATA-1mg provided an additional service for doorstep delivery of FDCs to patients. Patients could upload their prescription and have FDCs delivered at home for monthly refills as prescribed for the treatment duration period. TATA 1-mg also made reminder calls to patients for refills based on estimated due dates. The PPSA agency continued to engage private providers and patients to facilitate routine services throughout the pilot period.

Service and Drug Delivery Pilot

The Service and Drug Delivery pilot was implemented in the district of Faridabad in the state of Haryana wherein the PPSA agency only did the private provider engagement under this pilot, while TATA-1mg managed the other services under the PPSA framework. TATA-1 mg facilitated doorstep delivery of FDCs; doorstep sample collection & report delivery; and patient counselling. The doorstep delivery of FDCs was similar to the Drug Delivery Pilot. The additional services of sample collection, reports, and counseling were add-on services to the Drug Delivery Pilot.

In this study, we estimated the impact of the above two pilots on the quality, scale, and cost of private-sector TB care under the PPSA model. We estimated the impact of the two pilots through: (1) programmatic data analysis to estimate the impact of the pilot on outcome measures of scale and quality of TB care; (2) qualitative study to understand the underlying reasons; and (3) programmatic cost analysis to estimate the per-case cost of delivering TB care in these pilots.

The key results of the evaluation are presented below.

Drug Delivery Pilot

We estimated the impact of the Drug Delivery pilot using a pre-post study design, whereby the pre period consisted of the standard PPSA services (JEET 1.0), and the post period is the period of the Drug Delivery pilot. We augmented the pre-post analysis with a difference-in-difference (DID) analysis to quantify the impact attributable to the pilot.

We find the FDC uptake (proportion of patients who took government FDCs) was significantly higher by 13 percentage points (55.87% Vs. 42.46%) in the post period. The DID analysis estimated that 8% of this increase could be attributed to the pilot. Other reasons for the increase could be the concurrent growing activities of the PPSA agency and sensitising providers on FDCs that likely led to a greater acceptance of FDCs with greater exposure time in the programme for providers.

Several pharmacological studies have utilized medication refill cycle data as a proxy to adherence. The proportion of patients documented to complete six 28-day FDC medication cycles was significantly higher by 32 percentage points (52% vs. 20%) in the post period, and "days without medication" in the initial two months was significantly lower (4.90 Vs. 6.83) for the patients who opted into the doorstep Drug Delivery model. However, it is important to note that this metric has a limitation. The data on which it was estimated only contained medication information for patients availing free FDCs, meaning if the patient switches to private drugs, that refill data is not available. The large difference in 28-day medication cycle completion can at least partially be attributed to the more complete documentation requirements of the Drug Delivery Pilot. Nonetheless, a greater transparency of medication cycles seen in the Drug Delivery pilot can be advantageous for improving quality of TB care.

The qualitative analysis indicated that patients benefited from the regular reminder calls to aid refill cycles. Patients who opted for the model also preferred doorstep delivery due to the minimal cost barriers. Additionally, the private providers were willing to share e-prescriptions for patients who opted into the pilot, saving patients the time to travel to the facility every month to procure medication. The discreet packaging of drugs to ensure patient privacy and the policy of non-divulgence of medication details by delivery agents to neighbours also

made patients less hesitant to accept doorstep delivery. These findings suggest that the Drug Delivery pilot may have directly contributed to improved completion rate of 28-day FDC medication cycles due to the increased convenience and mitigation of privacy concerns.

Under this pilot, there was no intervention by TATA-1 mg to improve CBNAAT testing through sample collection and report delivery or to improve patient counseling and care coordination. These services continued to be provided by the PPSA agency. We therefore did not expect any changes in corresponding metrics that can be attributed to the pilot. However, the DID estimate shows that 4 percent of the overall increase [10.1%, (35.23% Vs. 25.1)] can be attributed to the pilot.

We also observe the proportion of patients receiving counseling is higher by 3 percentage points (97.53% Vs. 94.50%) and the proportion of patients with a successful treatment outcome is higher by 2 percentage points (88.35% Vs 86.09%) in the post period. However, the difference-in-difference analysis shows no significant results, making these attributable to the improved PPSA services over time but not necessarily to the pilot.

Qualitative interviews indicated that critical and "extra-mile" care was delivered by the PPSA treatment coordinators with respect to disease and treatment education, medication adherence, mitigation of patient anxiety on stigma and privacy, facilitation of FDC access, and broader care coordination. Patient-level outcomes were likely improved due to increased exposure of patients to PPSA services that were explicitly targeting patient outcomes as well as more experience gained by PPSA to better deliver these services over time.

We also estimated the cost of implementation of the pilot and compared it with the cost of services provided under JEET 1.0. We estimated the per-case cost of Drug Delivery pilot at the current level of uptake using retrospective activity-based costing method to be Rs.4513 which was Rs.1291 higher than the cost under JEET 1.0 (Rs.3222). We found that nearly 65% of this cost could be ascribed to field personnels. This higher cost for the drug delivery pilot is expected in the case of the Drug Delivery pilot given that it offered an additional service to the existing PPSA services.

Service and Drug Delivery

We estimated the impact of the Service and Drug Delivery pilot by comparing the outcomes in the treatment geography (Faridabad) with control geography (Gurugram), a geography in the same state. This was done as Faridabad did not have a PPSA prior to the pilot. The control geography of Gurugram had the standard services (JEET 1.0) provided by a PPSA agency. There is a limitation to this analysis. Gurugram had an operational PPSA since January 2019, whereas there was no PPSA in Faridabad before the pilot. It is plausible that a longer exposure time to PPSA services improves programmatic metrics over time. To account for this, we undertook two separate analyses. In the first analysis, we compared the outcomes for the two geographies during the same calendar months (July 2020 – June 2022). In the second analysis, we compared the outcomes for the two geographies during the first three quarters of operations (January 2019 to September 2019 for Gurugram and July 2020 to March 2021 for Faridabad).

We found that FDC uptake (proportion of patients who took FDC) was lower in Faridabad than in Gurugram (21.90 vs. 32.74%) when comparing for the same calendar months. However, this result flips while assessing for the first three quarters of operation (Faridabad:16.4%; Gurugram:11.4%). We found that a higher proportion of patients completed six 28-day medication cycles in Faridabad than in Gurugram (27.97% Vs. 20.27%) when comparing for the same calendar months. However, this metric has a limitation. The data on which it was estimated only contained medication information for patients availing free FDCs, meaning if the patient switches to private drugs, that refill data is not available.

Qualitative interviews indicated that patients did not receive reminder calls in Faridabad, a critical beneficial feature identified by patients in the previously described Drug Delivery pilot. Additionally, patients were hesitant to avail doorstep delivery of services fearing isolation and stigma from people around them. This alludes to details about the service such as the delivery process and packaging details not being provided to patients. These findings suggest sub-optimal implementation of doorstep delivery model by TATA 1-mg. One possible explanation is that the addition of multiple services in this pilot diluted the operational efficiency of a single service component within the TATA 1-mg deployment model.

Facilitation of CBNAAT tests was conducted in both the treatment geography of Faridabad and the control geography of Gurugram; however, the modality of services differed. TATA 1-mg facilitated doorstep services for sample collection in Faridabad—whereas in Gurugram, sample collection was done by the PPSA agency at the clinic or facility. We observed no significant difference in the proportion of patients receiving CBNAAT tests between Faridabad and Gurugram when comparing for the same calendar months (15.73% Vs. 15.83%). However, when comparing for the first three quarters of operation, we found a significantly higher proportion of patients accessing CBNAAT tests in Faridabad than in Gurugram (15.2% Vs. 7.5%). Despite this observed increase, the overall proportion of 15.2% remained low for service standards.

Qualitative interviews indicated that private treating providers in Faridabad did not prescribe CBNAAT to all patients, citing issues of affordability and accessibility. A majority of patients in our study in both Faridabad and Gurugram also preferred going to hospitals to deposit their samples and collect reports (as opposed to opting in for doorstep services) for several reasons. First, they believed hospitals or labs would have better facilities and qualified medical professionals for sample collection. Second, they expressed concerns about the possibility of family members contracting infection during home sample collection. Third, patients were also worried about facing social stigma within the community. These findings suggest that perceptions of quality of care provided by any third-party entity (whether for-profit or non-profit) strongly guided decisions to opt into PPSA services.

Under this pilot, counselling of patients was conducted by the staff of TATA-1mg in Faridabad. We found that a lower proportion of patients received at least one counselling in Faridabad as compared to Gurugram. This is consistent for analysis by calendar months (26.98% vs. 75.59%) as well as by operational months (28.3% vs. 54.3%). Results from patient interviews reflected an inconsistency in the patient's knowledge about the disease, indicative of poor quality of counseling in Faridabad. This diminished scale and quality of counseling could be attributed to the limited on-ground resources deployed for patient counselling by TATA 1-mg, instead placing a greater emphasis placed on tele-counselling.

Under this pilot, a significantly higher proportion of patients had a successful treatment outcome in the treatment geography of Faridabad as compared to Gurugram (91.60% vs. 80.02%) in the calendar month comparison. This difference is even larger when comparing for the same operational months (Faridabad: 92%, Gurugram: 70.2%). We do not find evidence to support the finding or to attribute it to the pilot.

We also estimated the cost of implementation of the pilot using retrospective activity-based costing method. The per-case cost of Service and Drug Delivery pilot at the current level of uptake was Rs.3872. 28% of this cost can be ascribed to TATA-1mg's administration (includes personnels and maintenance), and nearly 32% can be attributed to TATA-1mg services.

Overall, we find that Drug Delivery model wherein PPSA agency provided standard services as under JEET 1.0 and TATA-1mg provided add on services of reminder calls and doorstep medication delivery, shows promise. We find an increase in the uptake of FDC, a lower number of days without medication, and a higher proportion of patients completed their six 28-days medication cycles. We see that this decrease in days without medication doesn't translate to better treatment outcomes in the post period. It is important to note that the success of the TATA-1mg pilot can largely be attributed to the efforts the PPSA staff that played a major role in establishing relationships with both patients and providers.

Under the Service and Drug Delivery pilot, services were outsourced to TATA-1mg, while the PPSA agency was involved only in provider engagement. We compare the performance of the pilot in Faridabad with PPSA in Gurugram, a control geography. Upon comparing the two geographies on the basis of the operational quarters of the pilots, we find that TATA-1mg fares better than the standard PPSA on uptake of CBNAAT, FDC. However, when compared for the same calendar months, standard PPSA performs better on all measures. We also see a gap in provider engagement, which could result in a lack of awareness about the services offered.

Overall, we find that the Service and Drug Delivery pilot performs worse than the JEET 1.0. However, it is not clear if this is due to inherent differences in the two geographies, differences between the two models and their incentive structure, or exposure time. Our study is unable to comment on the reason.

Considering India's high TB burden, further exploration and refinement of such collaborative approach is required to leverage the expertise of both for-profit and non-profit entities for patient management.

Section 1

Context Setting & Introduction

1.1 Private sector tuberculosis care in India

Tuberculosis (TB), a communicable disease, holds one of the highest global disease burdens. In 2021, TB claimed the lives of 1.6 million people. It ranks 13th among leading causes of death worldwide and is the second most deadly infectious disease (WHO, 2020)1. According to the Global TB Report 2021, India's estimated incidence of all TB forms in 2020 was 188 per 100,000 population, exceeding the global average of 127 per 100,000. India accounts for 28% of global TB cases and 36% of deaths.2 The National Strategic Plan (NSP) 2017–2025 aims to strategically reduce India's TB burden by 2025, five years ahead of the Sustainable Development Goals (SDG).3 Despite the Revised National Tuberculosis Control Programme (RNTCP) delivering standard TB care in the public sector, 50–80% of patients first seek healthcare in the private sector.4 Previous studies in India have found that two-thirds of TB patients initially consult private practitioners for chest symptoms, with over half being diagnosed by private doctors. 5,6,7 Recognizing the pivotal role of private healthcare providers in serving most of the population, India's national TB program emphasizes the need to involve these providers in all TB control and prevention efforts. The NSP underscores that the current level of private sector involvement in TB care is inadequate, especially given the scale of incidence and its persistent spread among vulnerable populations. Therefore, it is imperative to effectively engage the private sector to ensure universal access to high-quality TB diagnosis and treatment.

The NSP highlights that the current scale of private sector engagement for TB care is insufficient, especially in comparison to the scale of incidence and relentless spread among vulnerable population.

1.2 What is the PPSA model under JEET?

The PPSA model involves a third-party agency providing comprehensive services in the private sector, including sample collection, access to government provided FDC drugs, and patient counseling. The Central TB Division (CTD) approved PPSAs in 385 districts, with 188 districts having third-party agencies on board. While CTD guidance allows social enterprises and for-profit entities to qualify, PPSA agencies have mainly been non-profit NGOs.

The Joint Effort for Elimination of Tuberculosis (JEET) initiative, funded by the Global Fund, is a large-scale engagement effort in India's private health sector for TB. It aims to address inefficiencies in patient care for TB. The program is operated by three agencies in India: the Willian J Clinton Foundation (WJCF), Centre for Health Research and Innovation (CHRI), and Foundation for Innovative New Diagnostics (FIND). Under JEET, private sector providers receive support for various services, including patient notification on the Nikshay platform, sample collection and transportation for diagnostic tests, report delivery, free Fixed Dose Combination (FDC) drugs, and patient management assistance. Field Officers, Hub Agents, SCT agents, and Treatment Coordinators are hired to oversee operations in addition to administrative and supervisory staff.

All services are provided to patients with the consent of private providers, making engaging them a critical aspect of successful program operations. Field Officers are responsible for ensuring provider engagement and encouraging the use of these programs or government-sponsored services. Hub

Agents handle patient notification, Treatment Coordinators conduct counseling, both in-person and over the phone, and SCT agents handle sample collection and report delivery.

1.3 Pilot programmes with TATA-1mg under JEET

In recent years, for-profit organizations offering convenient doorstep drug delivery and diagnostic services have emerged nationwide. These entities utilize advanced technology platforms to provide services like drug delivery, sample collection and transportation, patient counseling, and online consultations. From 2020 to 2022, WJCF partnered with TATA-1mg, a for-profit digital healthcare platform, to implement two pilot programs in Ahmedabad and Surat, Gujarat, and Faridabad, Haryana. These programs leveraged TATA-1mg's existing network in a pay-for-service model, aiming to enhance service quality in a cost-effective manner, ultimately leading to improved treatment adherence and outcomes. These services complemented the existing PPSA model offerings in these regions. The standard services provided under the PPSA model, along with the additional services from the two TATA-1mg pilots, are outlined below:

Between 2020–2022, CHAI employed the services of TATA-1mg, a for-profit private digital consumer healthcare platform, to provide certain services to patients under two pilot programmes running in three districts, namely Ahmedabad and Surat in Gujarat and Faridabad in Haryana.

		Standard of care		
		Standard PPSA	Standard PPSA + Drug Delivery (TA-TA-1MG)	Standard PPSA + Service and Drug Delivery (TATA-1MG)
	Geography	Ahmedabad, Surat, Gurgaon*	Ahmedabad & Surat	Faridabad
Time Period	Start	Jan-2019	Jul-2020	Jul-2020
	End	June-2022	June-2022	June-2022

Note: 1) Dates given refer to program operations; new patients were enrolled into the program only until Feb 2022; Primary comparative district chosen for assessing the effectiveness of Faridabad will be Gurgaon (being the closest match in terms of socio-economic demographics)

1.3.1 Drug Delivery Pilot (Surat and Ahmedabad; July 2020–June 2022)

The PPSA model under JEET was launched in Ahmedabad and Surat in 2018, with the data collection and full project operations commencing in January 2019. In July 2020, in addition to the standard services, JEET engaged TATA-1mg to provide home delivery of government-sponsored FDCs and make reminder calls to patients for refills. This pilot continued until June 2022. This support was provided to the patients after getting consent from the providers and patients.

1.3.2 Service and Drug Delivery Pilot (Faridabad; July 2020 – June 2022)

The PPSA model under JEET was launched in Faridabad in 2020. Under this pilot, PPSA engaged TATA-1mg for home sample collection, report delivery and drug delivery, reminder calls for refills, and patient counselling. PPSA did not hire Hub Agents, SCT Agents or Treatment Coordinators for Faridabad, instead their services were provided by TATA-1mg staff. Note, unlike Surat and Ahmedabad, there was no PPSA in Faridabad prior to the rolling out of the pilot.

The PPSA model under JEET was launched in Ahmedabad and Surat in 2018, with the data collection and full project operations commencing in January 2019. In July 2020, JEET engaged TATA-1mg to provide home delivery of government-sponsored FDCs and make reminder calls to patients for refills.

Table 1 below presents the services provided and roles assigned under the TATA-1mg pilots and other JEET PPSAs (JEET 1.0).

Table 1: Services and roles assigned under the TATA-1mg programme vs other PPSA models

Activities	Standard PPSA Models (JEET 1.0)	Service and Drug Delivery pilot (Faridabad)	Drug Delivery pilot (Surat and Ahmedabad)
Provider engagement (includes provider training)	Field Officers	Field Officers	Field Officers
Patient notification on the National TB portal (Nikshay platform)	Hub Agent	TATA-1mg staff	Hub Agent
Sharing patient information with TA-TA-1mg	NA	Compounder/ Assistant to the doctor (incentivised)	Hub Agent
Sample collection	SCT Agent	TATA 1-mg delivery agent	SCT Agent
Initial drug delivery	Hub Agent	TATA-1mg Delivery Agent	Hub Agent/ TA-TA-1mg Delivery Agent
Follow-up prescriptions	NA	TATA-1mg Agent	Hub Agent or patients
Subsequent drug delivery	Hub Agent	TATA-1mg Delivery Agent	TATA-1mg Delivery Agent or Hub Agent at the clinic
Treatment adherence support	Treatment Coordinator	TATA-1mg Tele-Counsellor	Treatment Coordinator

* Hub Agents, SCT Agents, Field Officers, and Treatment Coordinators are hired JEET staff

Section 2

Research Objectives & Study Design

2.1 Key objectives

Under this project, we evaluated the impact of engaging a for-profit organisation (TATA-1mg) on the quality, quantity, and cost of TB care under the PPSA model in India. The evaluation aimed to explore the costs and benefits of engaging for-profit agencies in PPSA models. The services evaluated include a) notification of TB patients; b) uptake of CBNAAT (Xpert testing); c) uptake of free FDCs; and d) telephonic/doorstep counselling.

2.2 Study design

A mixed-methods evaluation research method is used for the project. The study design consisted of three methodologies.

- Secondary programmatic data analysis – For this we used the programmatic data obtained from WJCF to estimate the impact of pilots on the quantity and quality of services, and on patient outcomes, relative to JEET 1.0 programme (Section 3).
- Primary qualitative research – We conducted in-depth qualitative interviews with patients, service providers, and TATA-1mg or PPSA staff to capture their experiences and understand their behaviours with respect to accessing of services under these pilots (Section 4).
- Programmatic cost analysis – We used an activity-based costing (ABC) approach to estimate the per-case cost for the TATA-1mg pilots compared to standard JEET PPSAs (Section 5).

Section 3

Secondary Programmatic Data Analysis

3.1 Introduction

We used the programmatic data to evaluate the impact of TATA-1mg pilots on the quantity and quality of TB care services and patient outcomes. The subsequent sections of this report share the detailed methodology used for the evaluation, followed by the findings of the study.

The JEET PPSA commenced in January 2019 and the TATA-1mg pilot was implemented in July 2020. January 2019 to June 2020 is defined as the pre-pilot period while July 2020 to June 2022 is referred to as the post-period.

3.2 Methodology

For the quantitative analysis, programmatic data on notification, along with FDC drugs , testing services, treatment adherence support, and outcome status were shared by WJCF. The programmatic data was collated by the WJCF team from January 2019 to June 2022.

3.2.1 Design

To evaluate the Drug Delivery pilot, a pre-post study design is used. The PPSA commenced in January 2019 and the TATA-1mg pilot was implemented in July 2020. January 2019 to June 2020 is defined as the pre-pilot period while July 2020 to June 2022 is referred to as the post-period (hereafter called the intervention period). Further, the analysis is augmented with a test-control design. Providers and patients who were engaged with TATA-1mg during the intervention period are defined as the 'test' and providers and patients who did not engage with TATA-1mg as the 'control.'

Classification of providers into four sub-groups

Category	Description
Category 1	Providers whose data was available for both the pre- and intervention period and who engaged with TATA-1mg in the intervention period.
Category 2	Providers whose data was available for both the pre- and intervention-period but who did not engage with TATA-1mg in the intervention period.
Category 3	Providers whose data was available only for the intervention period and who engaged with TATA-1mg.
Category 4	Providers whose data was available only for the intervention period and did not engage with TATA-1mg.

Since there was no PPSA in Faridabad prior to the pilot, the Service and Drug Delivery pilot is evaluated using a test control design. Faridabad district (where TATA-1mg was implemented) is defined as the 'test', and Gurugram district (a nearby district in the same state) where JEET 1.0 was operational, is defined as the 'control.'

3.2.1.1 Exclusion criteria

The following patients were excluded from the study and its analysis:

- Paediatric patients, i.e., patients below 16 years of age
- Patients whose diagnosis or current facility was not in the study geographies
- Patients who got diagnosed with TB either before January 2019 or after October 2021

3.2.2 Variables of interest

To estimate the impact of TATA-1mg on the uptake and quality of services, variables of interest were defined as outlined in Table 2.

Table 2: Variables of interest for secondary quantitative data analysis

Category	Variable	Definition	Measure
Uptake	Notifications	Confirmed TB patients who were notified on the Nikshay platform	Number of monthly notifications per 100,000 population
	Government FDC	Patients who were prescribed government FDCs	Proportion of notified patients who received government FDC
Quality	CBNAAT tests	Patients who were prescribed the CBNAAT test for diagnosis	Proportion of notified patients who received CBNAAT test
	Counselling	Confirmed TB patients receiving counselling about the disease, medications, adverse drug reactions (ADRs), diet, etc.	Proportion of notified patients ever received counselling
Outcome	Days without medication	Days between the last day of medication from a prescription to the subsequent refill	Average days without medication over six months of medication
Status	Treatment outcome	Patient's outcome after treatment with successful outcomes including 'cured' or 'treatment completed', while unsuccessful outcomes including 'not evaluated' 'treatment failure' 'died' and 'lost to follow-up'	Proportion of notified patients whose treatment outcome was successful

3.2.3 Methods

Non-parametric bivariate descriptive analysis was used for evaluation. The results were augmented with logistics regression, linear regression, and difference-in-difference (DID) analysis. The DID analysis estimated the effect of TATA-1mg intervention by comparing the changes in outcome over time between providers (and their patients) who were engaged with TATA-1mg and those who were not engaged with TATA-1mg. Table 3 presents the analysis conducted for different variables of interest.

Table 3: Variable and analysis mapping

Variable of interest	Visualisation		Bivariate analysis		OLS/ LPM/Logistic regression		Difference-in-difference	
	DD	SDD	DD	SDD	DD	SDD	DD	SDD
Notification	✓	✓	✓	✓	✓	✓		NA
CBNAAT	✓	✓	✓	✓	✓	✓	✓	NA
Government FDC	✓	✓	✓	✓	✓	✓	✓	NA
Days without medication	✓	✓	✓	✓	✓	✓	✓	NA
Counselling	✓	✓	✓	✓	✓	✓	✓	NA
Outcomes	✓	✓	✓	✓	✓	✓	✓	NA

3.2.3.1 Regression models

We estimate the impact using the linear logistic regression and linear probability model. For the drug delivery pilot, difference-in- difference technique is also used. We used the logistic regression and linear probability model to estimate the impact of the independent variable (post-intervention period in our case) on the variables of interest (CBNAAT, FDC, etc) while controlling for other covariates (age, sex, etc). Further, for the Drug Delivery model, we also segregate the impact of TATA-1mg intervention using a difference-in-difference regression model. The regression equations are given below for each.

Drug Delivery Pilot

Assuming the errors are independent and identically distributed:

Logistic regression model: $logit\ [P(Y=1)]_i = \beta_0 + \beta\ Post_1 + \beta_2\ [covariates]_i + \beta_i$

Linear probability model: $Y_i = \beta_0 + \beta\ Post_i + \beta_2\ [covariates]_i + \beta_i$

DID: $Y_{i=}\boldsymbol{\beta}_0 + \beta\ Post_1 + \beta_2\ Test_1 + \beta_3 Post_1 \times Test_1 + \beta_4\ [covariates]_i + \beta_i$

Where

'i' = individual patient

Yi = Received CBNAAT* test | (Yes = 1, No = 0) | Received FDC | (Yes = 1, No = 0) | Ever received counselling | (Yes = 1, No = 0) | Successful treatment outcome | (Yes = 1, No = 0)

Test = 0 (if the patient is diagnosed at a provider who does not engage with TATA-1mg)

Test = 1 (if the patient is diagnosed at a provider who engages with TATA-1mg)

Post = 0 (if the patient is diagnosed in the pre-period)

Post = 1 (if the patient is diagnosed in the post intervention period)

Covariates: Age, sex, extrapulmonary TB (Yes = 1, No = 0)

*Due to a sharp decline in the CBNAAT test from July 2021 (due to pan country shortage of GX testing), that period has been dropped from the analysis of CBNAAT.

Service and Drug Delivery pilot

Assuming the errors are independent and identically distributed:

Logistic regression model: $logit\ [P(Y=1)]_i = \beta_0 + \beta\ Test_1 + \beta_2\ [covariates]_i + \varepsilon_i$

Linear probability model: $Y_i = \beta_0 + \beta\ Test_1 + \beta_2\ [covariates]_i + \varepsilon_i$

Where

'i' = individual patient:

Yi = Received CBNAAT* test | (Yes = 1, No = 0) | Received FDC | (Yes = 1, No = 0) | Ever received counselling | (Yes = 1, No = 0) | Yi = Successful treatment outcome | (Yes = 1, No = 0)

Covariates: Age, sex, extra-pulmonary (Yes = 1, No = 0)

Test = 0 (if the patient is diagnosed in Gurugram)

Test = 1 (if the patient is diagnosed in Faridabad)

*Due to a sharp decline in the CBNAAT test from July 2021 (due to pan country shortage of GX testing), that period has been dropped from the analysis of CBNAAT.

According to the programme implementers, there is a settlement period for any PPSA. This settlement period is for establishing trust and rapport and to set up all functions. Since there was no PPSA prior to the Service and Drug Delivery Pilot in Faridabad, this could possibly lead to making the estimates incomparable. To account for this, we plotted the first three-quarters of the programme for the Faridabad and Gurugram districts.

3.3 Results

3.3.1 Drug Delivery Pilot [Surat and Ahmedabad]

A) Notifications

The two figures below show the number of monthly notifications per 100,000 population for Surat and Ahmedabad districts where the Drug Delivery pilot was implemented. Figure 1 is for all providers, and Figure 2 provides the number of monthly notifications per 100,000 population disaggregated by the provider engagement status. The dotted line in the figures denotes the intervention line showing that the pilot was implemented in July 2020.

We find that after recording a sharp decline in notifications in the months preceding the intervention, there has been an increase in notifications during the pilot period. However, on running the test, the difference between average notification in the pre (9.28) and intervention period (9.15) was not significant (p value= 0.85). A similar result was noted for the engaged providers (those providers who availed TATA-1mg services).

Figure 1: Number of monthly notifications per 100,000 population

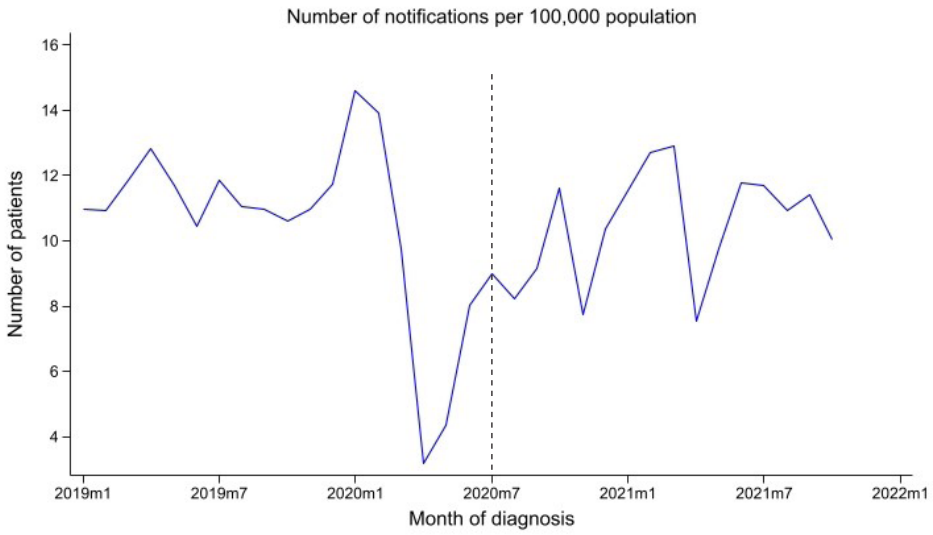
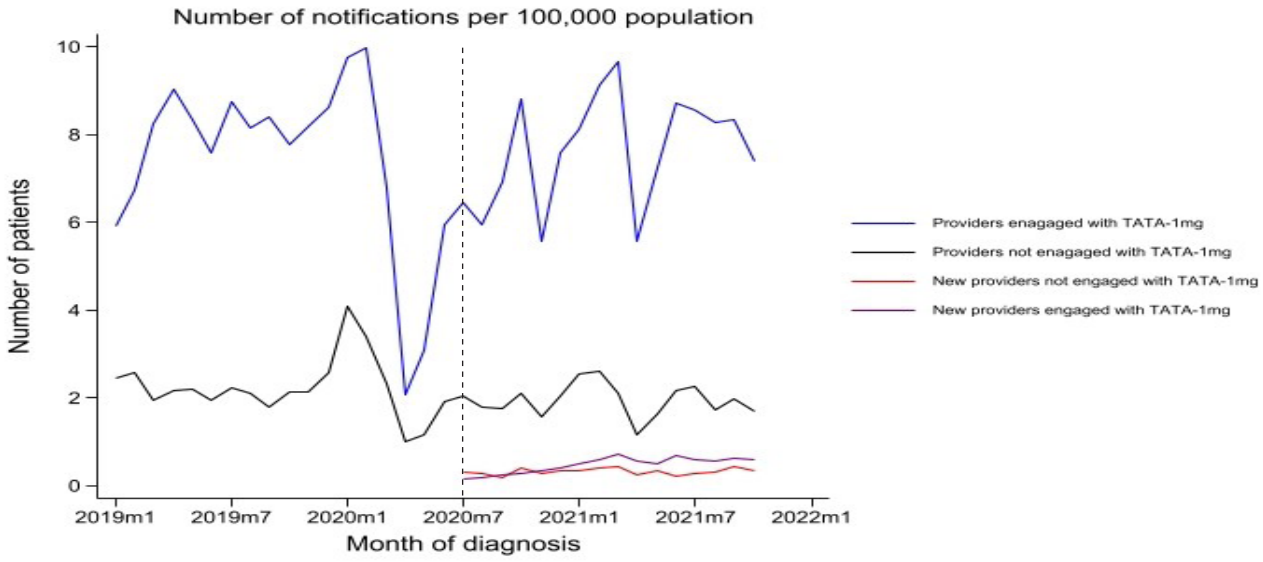


Figure 2: Number of monthly notifications per 100,000 population disaggregated by provider engagement status



Appendix Table 1 gives the average monthly notifications per 100,000 population in the pre- and intervention periods. While the average monthly notifications are higher in the pre-intervention period (9.28 Vs. 9.15), the difference is not significant.

B) CBNAAT tests

In October 2021, India experienced a shortage of CBNAAT testing cartridges.12 Thus, for the analysis, patients diagnosed after October 2021 are not considered for CBNAAT. Figure 3 shows the proportion of patients receiving CBNAAT tests in the pre and intervention periods. The dotted line in the graph is the intervention line showing that the pilot has been implemented in July 2020. It shows

the increase in this proportion, since the pilot got implemented.

Figure 3: Proportion of patients receiving CBNAAT tests in the pre- and intervention period

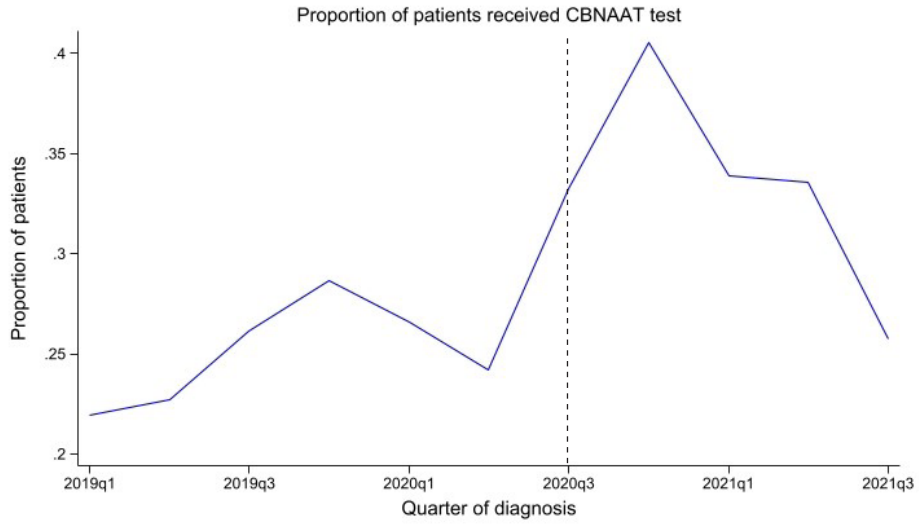
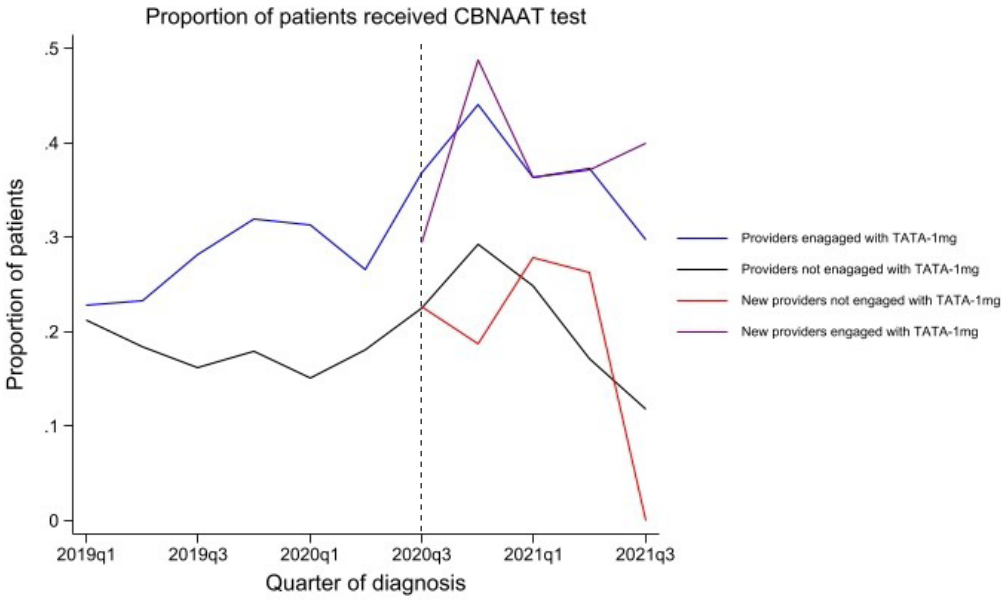


Figure 4 shows the proportion of patients who received CBNAAT tests disaggregated by the provider's engagement status in the intervention period. We observed that the providers who engaged with TATA-1mg in the intervention period were prescribing CBNAAT tests to a higher proportion of their patients as compared to the providers who did not engage with TATA-1mg. The new providers who engaged with TATA-1mg in the intervention period (purple line in the graph), prescribed CBNAAT to a higher proportion of their providers than those who were not engaging.

Figure 4: Proportion of patients receiving CBNAAT tests disaggregated by provider's engagement with TATA-1mg



Results from bivariate analysis and the three regression models show a significant increase in the proportion of patients getting CBNAAT tests in the intervention period. The DID result shows that approximately 4% of the overall increase (11%) can be attributed to the pilot (Appendix Table 2 through 5).

C) Government FDC

In the Drug Delivery pilot, doorstep delivery of medication was offered to the patients. Figure 5 shows the proportion of patients who received government FDC in the pre- and intervention periods. The dotted line is the intervention line denoting the month in which the pilot was implemented.

Figure 5: Proportion of patients receiving government FDCs in pre and intervention periods

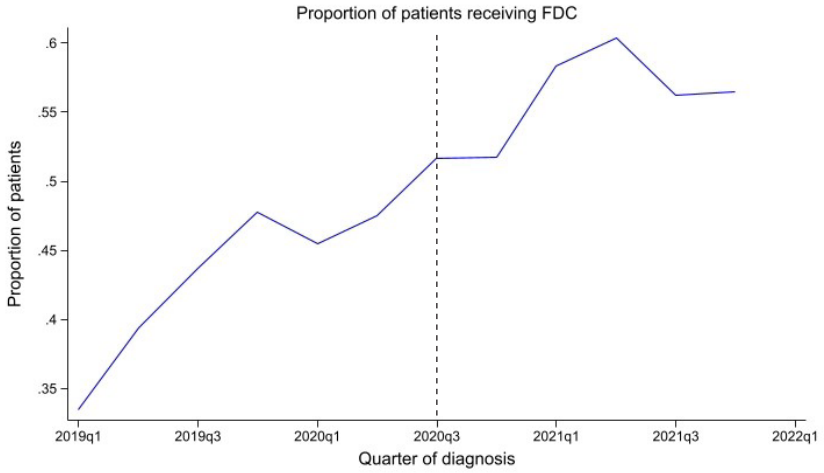
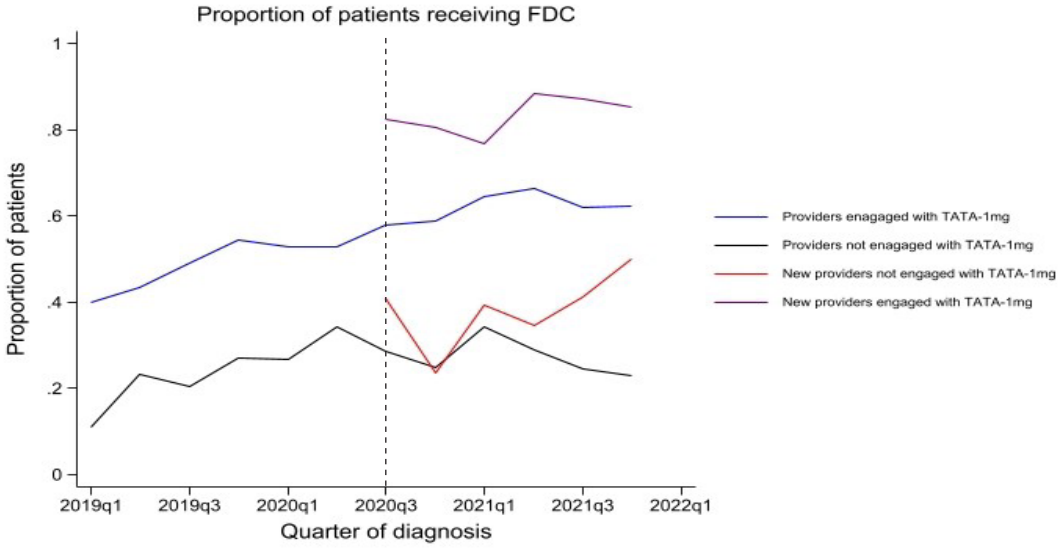


Figure 6 shows the proportion of patients getting government FDCs disaggregated by the provider's engagement status with TATA-1mg in the intervention period. We find that providers who engaged with TATA-1mg in the intervention period were already prescribing government FDCs to a higher proportion of their patients in the pre-period. For these providers, we do not see a sharp increase in the proportion of patients who are prescribed government FDCs. The new providers who engaged with TATA-1mg in the intervention-period, prescribed government FDCs to a substantially higher proportion of their patients.

Figure 6: Proportion of patients receiving government FDCs disaggregated by provider's engagement status

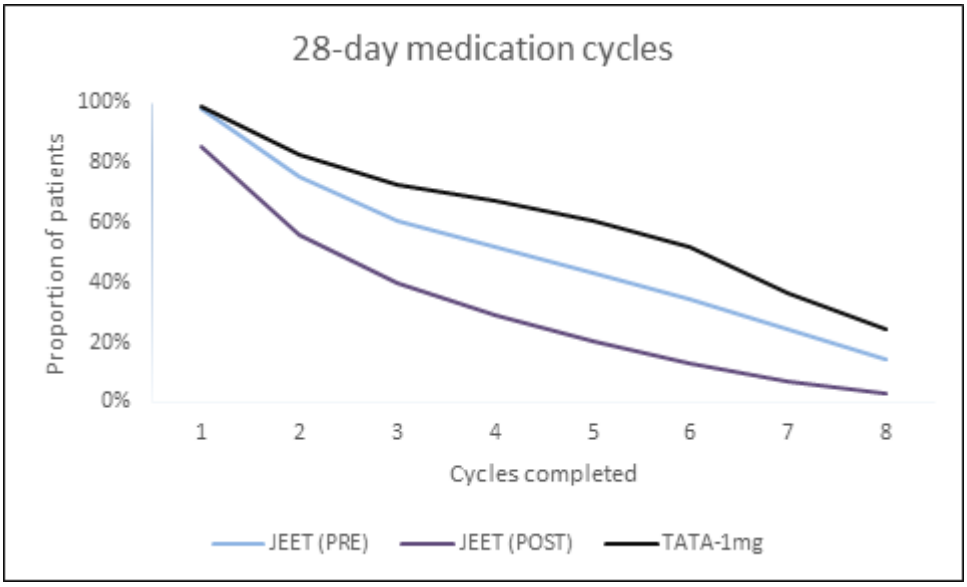


Results from bivariate and regression analysis show a significant increase in the proportion of patients receiving government FDCs in the intervention period (55.87% Vs. 42.46%). The magnitude of this increase is approximately 13% as per the logit model. The DID regression result shows an approximate 8% increase in FDCs that can be attributed to the intervention. The remaining 5% can be attributed to other factors such as learning effect or over the time increase in the acceptability of government FDCs by the providers (Appendix tables 6 through 10).

D) Days without medication

In general, the government provides tuberculosis (TB) medication in strips, typically four strips, which amounts to 28 days of medication. We refer to this 28-day period as a cycle for our analysis. Most TB patients are prescribed medication for six cycles. The analysis for proportion of patients who completed a specific number of cycles and days without medication is based on the medication data from JEET and TATA-1mg. This data does not include information on medication purchase if the patient purchased the medication privately.

We estimated the proportion of patients who completed a specific number of cycles based on their onboarding status, i.e., whether they were onboarded on the TATA-1mg network or not. Among those not onboarded (received standard JEET care), we further divided them into two groups: pre-period and post-period. The figure below illustrates these findings. Notably, approximately 52% of patients who were onboarded on TATA-1mg completed their six 28-day medication cycles. In contrast, the proportion of patients completing six cycles was lower for those not availing TATA-1mg services (13% in the post-period and 34% in the pre-period).



We calculated the mean days without medication for each 28-day cycle for the patients who were onboarded on TATA-1mg and those who were not in the same time period. We removed the first cycle from the analysis as the patients' pick-up their first medication from JEET hub agent. Hence, we assume that there would be no delay in the pick-up. The mean days without medication in the second and the sixth are particularly interesting. In the second cycle, the mean days without medication were less for the onboarded patients (4.90 Vs. 6.83). However, for the fifth and sixth cycle the results flip. It may be asserted that patients who were inconsistent tend to drop out or miss medication pick-ups in the initial cycles, leading to a significant decrease in those picking up their medications. Only consistent patients regularly pick up their medications from the clinic and the days without medication for these patients is lower. The results for the same are presented below in the table.

Table 4: Mean days without medication in every 28-day treatment cycle

Cycles	JEET (Pre-period) [Jan'2019- Jun'2020] [N=3793; 100%]	JEET (Post-period) [Jul'2020 – June' 2021] [N=8492; 100%]	TATA-1mg [Jul'2020 – June'2021] [N=5997; 100%]
1#		-	-
2	12.61 (2,865; 75.73%)	7.70 (4,742; 55.84%)	4.97 (4,969; 82.77%)
3	9.39 (2,298; 60.58%)	5.30 (3,364; 39.61%)	4.82 (4,357; 72.56%)
4	6.86 (1,975; 52.06%)	3.54 (2,426; 28.56%)	3.55 (4,027; 67.06%)
5	5.87 (1,632; 43.02%)	2.83 (1,716; 20.20%)	3.20 (3,647; 60.07%)
6	4.73 (1,306; 34.43%)	1.82 (1,108; 13.04%)	2.65 (3,124; 52.04%)

Since the patients pick up the first medication from the JEET hub agent themselves, we are assuming that the delay in the first cycle would be 0

The OLS regression shows that days without medication across all the cycles was significantly (4 days) less for the patients in the intervention period. However, within the intervention period, we do not see a significant difference in overall days without medication between the patients onboarded onto the TATA-1mg network and those not.

E) Counselling

Figures 14 and 15 show the proportion of patients who received at least one counselling in the pre-and intervention periods and are disaggregated by the provider's engagement status. We observe a slight increase in this proportion.

Figure 7: Proportion of patients ever received counselling

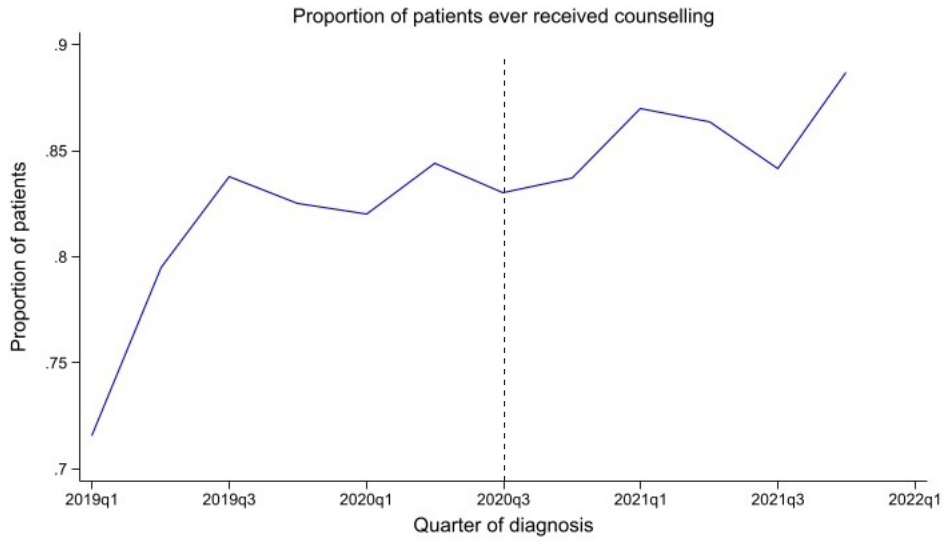
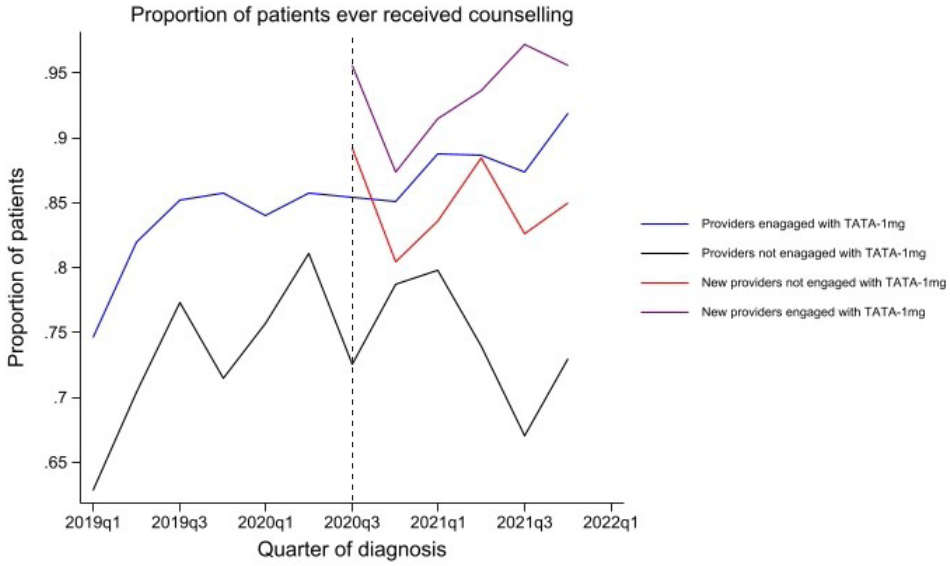


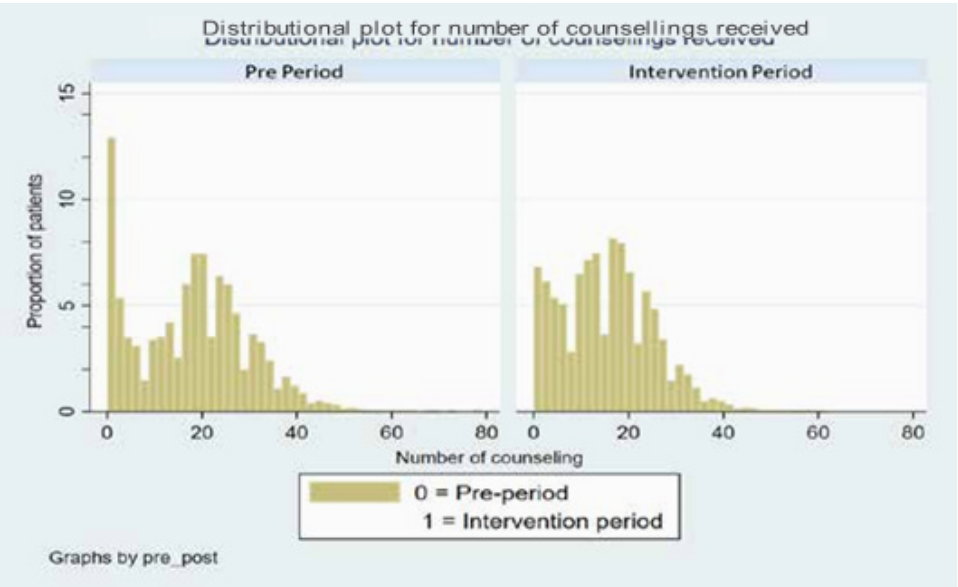
Figure 8: Proportion of patients who ever received counselling disaggregated by provider's engagement status



The bivariate analysis and the two regression models (Logit, and LPM) (appendix table 12,13,14) show a significant 2–3% increase in the proportion of patients who received counselling in the intervention period. The result from the DID analysis showed that this change could be due to other programmatic factors and not necessarily the pilot. This is consistent with the hypothesis that the Drug Delivery pilot might not directly impact the counselling, since the process of counselling remains the same in both the pre- and intervention period.

The graph below presents the distribution of the quantum of counselling that has been received by patients in the pre- and intervention period. It shows that a higher proportion of patients received no counselling in the pre-period as compared to the intervention period.

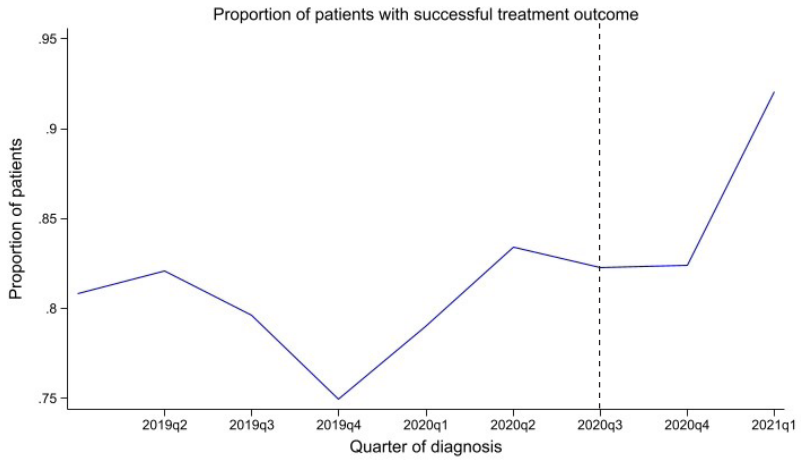
Figure 9: Distributional plot for number of counsellings received



F) Outcomes

The patient's outcome is classified as successful (cured or treatment complete) and unsuccessful (not evaluated, treatment failure, died, and lost to follow-up). Figure 10 below shows the proportion of patients whose treatment outcome is successful by the provider engagement status. It is observed that patients of providers who are engaged with TATA-1mg in the intervention period have better treatment outcomes in the pre-period as well.

Figure 10: Proportion of patients with successful treatment outcomes



These results from bivariate analysis show a significant 2% increase in the proportion of patients whose treatment outcome is successful in the intervention period (88.35% Vs 86.09%). Result from the DID analysis show this change could not be attributed to the pilot (Appendix tables 15 through 18).

The Drug Delivery Pilot where an additional service of doorstep delivery of drugs was provided sees an increase in uptake of both CBNAAT tests for diagnosis and FDCs. Below are the summary results for the Drug Delivery Pilot.

Table 5: Summary results for the Drug Delivery Pilot

Variables of interest/ analysis	Bivariate analysis (Post – pre)	OLS/Linear probability model (for binary variables)	Logit model	Difference-in-difference model
Notifications	0.0013	-	-	-
CBNAAT	0.10***	0.12***	0.11***	0.04***
FDCs	0.13***	0.10***	0.13***	0.08***
Days without medication	-	-4. 16 days	-	-
Counselling	0.03***	0.02**	0.03***	-0.004
Outcomes	0.02***	0.01***	0.01***	-0.03***

*p<0.1; **p<0.05; ***p<0.01

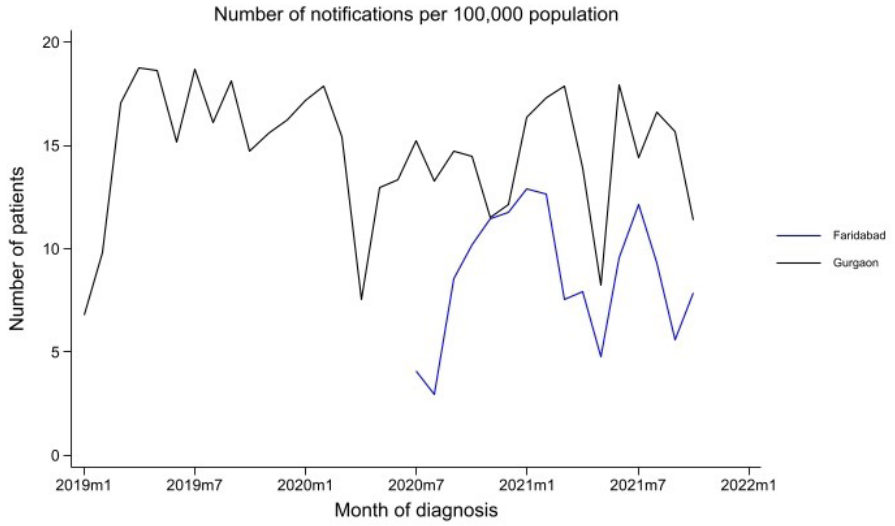
3.3.2 Service and Drug Delivery pilot [Faridabad]

In this sub-section we present the results for the Service and Drug Delivery pilot.

A) Notification

Figure 11 below shows the number of monthly notifications per 100,000 population for the test (Faridabad) and control (Gurugram) geographies. We find that Gurugram has a higher number of notifications for the entire period.

Figure 11: Number of monthly notifications per 100,000 population in Faridabad and Gurugram

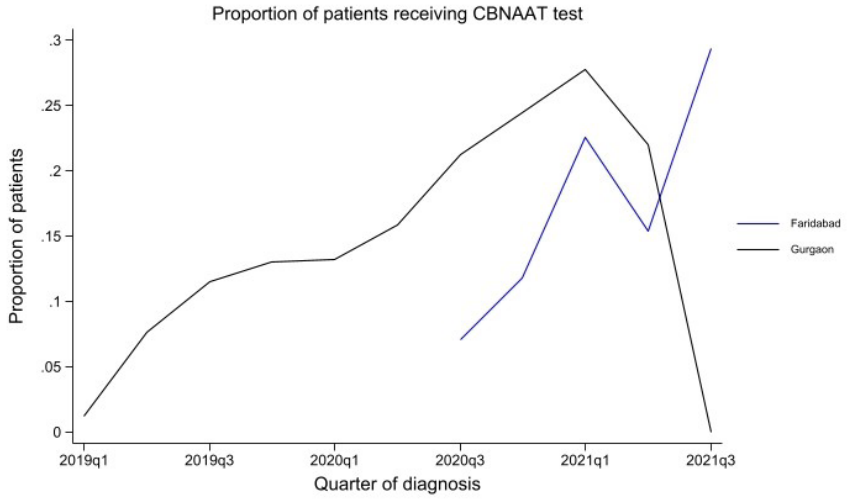


A significant difference is seen between the two with a higher number of average monthly notifications in Gurugram. This can be attributed to multiple factors such as higher prevalence of TB in Gurugram or the settlement period for any PPSA in the initial months of operation. The table with average monthly notifications per 100,000 population in Gurugram and Faridabad is given in appendix 2 table 19.

B) CBNAAT tests

Figure 12 shows the proportion of patients receiving the CBNAAT test in Faridabad and Gurugram. While the proportion is found to be higher in Gurugram, a sharp rise is seen in the proportion of patients who receive the CBNAAT test in Faridabad.

Figure 12: Proportion of patients receiving the CBNAAT test in Faridabad and Gurugram

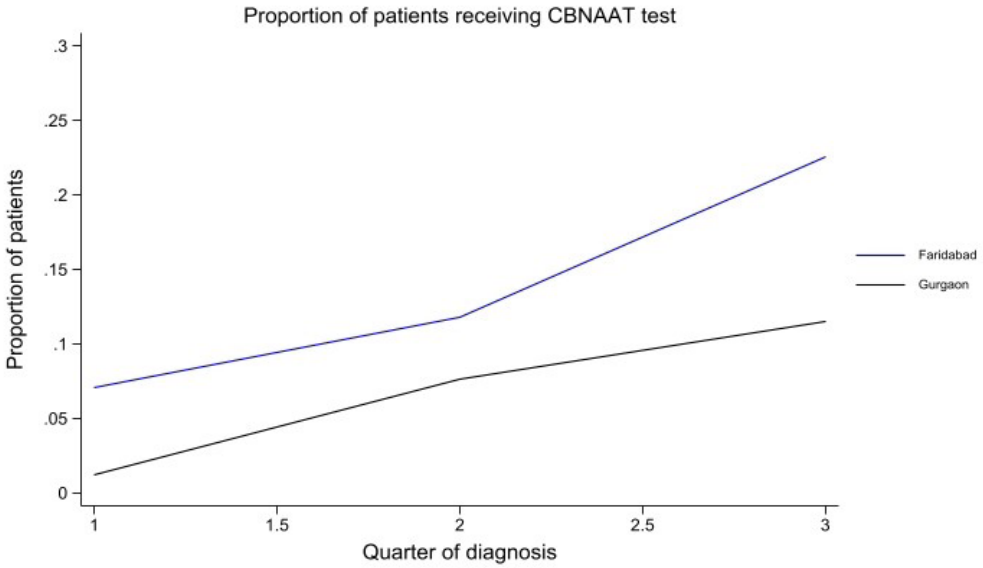


Results from the bivariate and regression models (Appendix table number 20,21,22) show no significant difference in the proportion of patients receiving the CBNAAT test between Faridabad and Gurugram.

According to the programme implementers, there is a settlement period for any PPSA. This settlement period is for establishing trust and rapport and to set up all functions. This could possibly lead to making the estimates not accurately comparable. To account for this, we plotted the first three-quarters of the programme for the Faridabad and Gurugram districts.

Figure 13 shows the proportion of patients receiving CBNAAT tests in the first three-quarters of operations of PPSA in Faridabad and Gurugram [Faridabad– July 2020 to March 2021 | Gurugram– January 2019 to September 2019]. We found that the proportion of patients who received CBNAAT tests is higher in Faridabad as compared to Gurugram.

Figure 13: Proportion of patients receiving the CBNAAT test in Faridabad and Gurugram

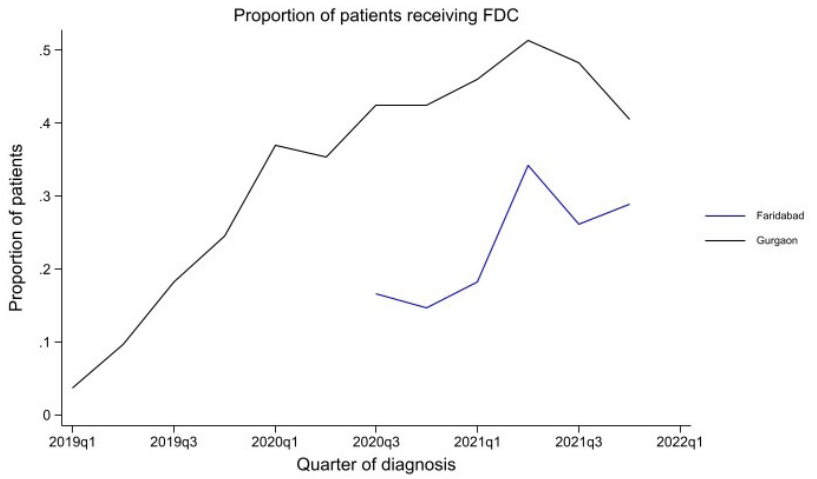


Results from bivariate and regression analysis for patients who are diagnosed during the first three quarters of operations of the PPSA in Faridabad and Gurugram show significantly higher proportion of patients (4% logit model) receiving CBNAAT tests in the test geography. Results are presented in appendix 2 table number 23.

C) Government FDC

Figure 14 shows the proportion of patients receiving the government FDCs in Faridabad and Gurugram. This proportion is higher (32.7% vs. 21.9%) in Gurugram as compared to Faridabad.

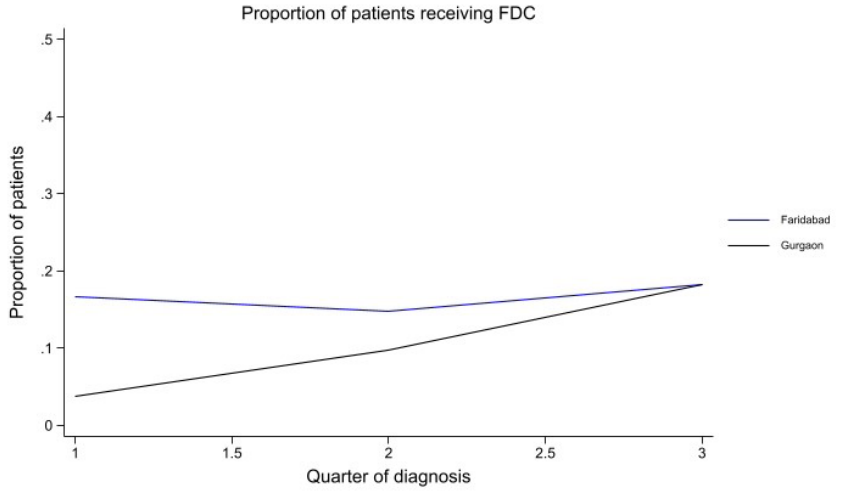
Figure 14: Proportion of patients receiving government FDCs in Faridabad and Gurugram



Results from the bivariate and regression analysis (Appendix table number 24,25,26) show a higher proportion of patients getting government FDCs in Gurugram as compared to Faridabad (32.74% vs. 21.90%).

Taking the settlement period into account and presenting a graph (Figure 15) for the first three-quarters of the operation. We see that the proportion of patients receiving government FDCs is found to be higher in Faridabad as compared to Gurugram. However, the two proportions turned out to be similar by the end of the third quarter.

Figure 15: Proportion of patients receiving government FDCs in the first three quarters of operations of PPSA in Faridabad and Gurugram

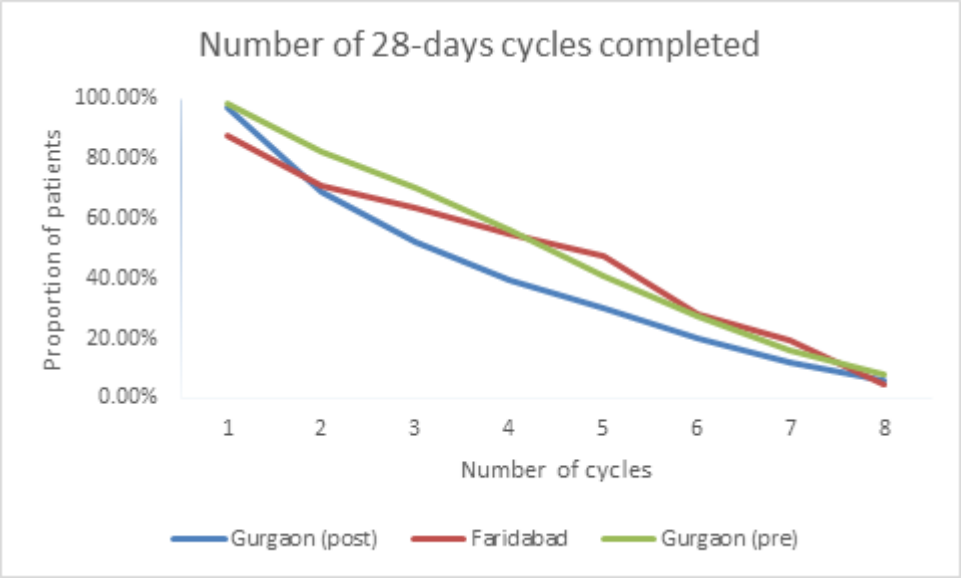


Although the bivariate analysis showed a significantly higher proportion of patients receiving government FDCs in the first three quarters of operations (5% higher proportion) in Faridabad, the result did not remain such in the regression. Results presented in appendix 2 table 27.

D) Days without medication

In general, the government provides tuberculosis (TB) medication in strips, typically four strips, which amount to 28 days of medication. We refer to this 28-day period as a cycle for our analysis. Most TB patients are prescribed medication for six cycles. The analysis for proportion of patients who completed a specific number of cycles and days without medication is based on the medication data from JEET and TATA-1mg. This data does not include information on medication purchase if the patient purchased the medication privately.

We estimated the proportion of patients who completed a specific number of cycles for the patients in Faridabad and Gurugram. We further bifurcated the patients in Gurugram by their date of diagnosis into pre and post-period. Post-period is the same as the Service and Drug Delivery pilot period. It is important to note that we did not have prescription data for all patients. The prescription data was available for 969 of 2520 (38.4%) patients in Faridabad and only 819 of 1980 (41.3%) of patients in Gurugram in the same time period. The results are presented in the figure below. We see that a higher proportion of patients in Faridabad complete their six 28-day medication cycles as compared to those in Gurugram's post-period (27.97% Vs.20.27%). However, when comparing it to Gurugram's pre-period, we see that a similar proportion of patients complete their six cycles of medication (27.97% Vs. 27.51%).



We calculated the mean days without medication for each 28-day cycle for the patients in Faridabad (onboarded on TATA-1mg) and those in Gurugram (JEET) in the same time period. Similar to the Drug Delivery analysis, we do not present the results for the first cycle as the medicines for the first cycle is usually picked up at the clinic.

In the second cycle, the mean days without medication were more for the patients in Faridabad (2.10 Vs. 1.30). The result is similar for the third and fourth cycles. However, for the fifth and sixth cycles, the results flip, although the difference is not significant. The table is presented below.

Table 6: Mean days without medication for every 28-day treatment cycle

Cycles	JEET - Gurugram(Post-period) [Jul'2020 – June' 2021] [N= 819; 100%]	TATA-1mg - Faridabad [Jul'2020 – June'2021] [N= 969; 100%]	Ttest p-value*
1#	-	-	-
2	1.30 (566; 69.10%)	2.10 (687; 70.89%)	0.01
3	0.78 (427; 52.13%)	1.85 (614; 63.36%)	0.00
4	0.34 (326; 39.80%)	2.69 (535; 55.21%)	0.00
5	0.52 (245; 29.91%)	0.31 (461; 47.57%)	0.22
6	0.54 (166; 20.26%)	0.21 (271; 27.96%)	0.15

Since the patients pick up the first medication from the JEET hub agent themselves, we are assuming that the delay in the first cycle would be 0
*p-values are based on ttest of means [TATA-1mg – JEET (post-period)]

E) Counselling

The below graph gives the distribution of the number of counselling sessions received by the patients in Faridabad and Gurugram. It is interesting to note that in Faridabad where TATA- 1mg was involved in counselling and was getting paid on a per counselling basis, all patients received counselling. The number of counselling sessions received in Gurugram were more spread out. A possible reason for this could be that patients who were thought to be more in need of counselling by the Treatment Coordinators were followed-up more than what the protocol suggests, whereas some patients were not followed-up as frequently.

Figure 16: Proportion of patients ever received counselling in Faridabad and Gurugram

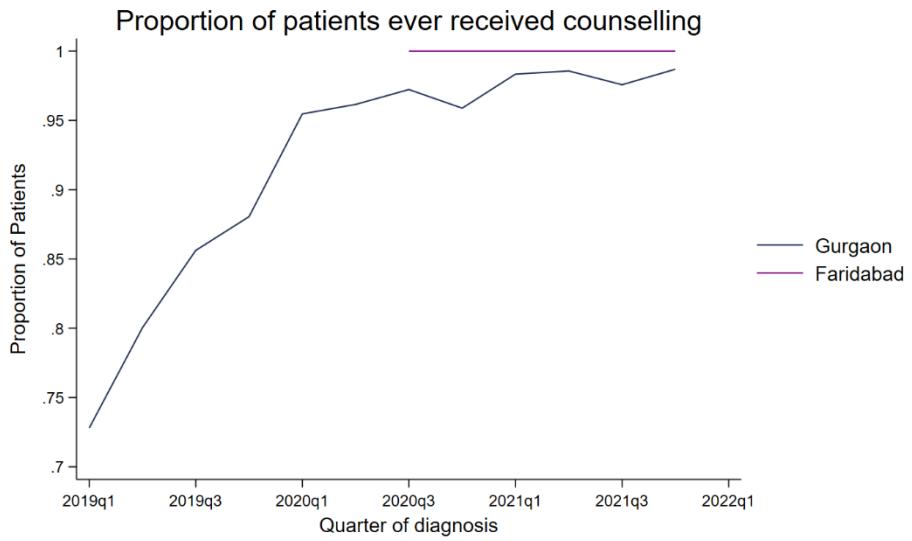
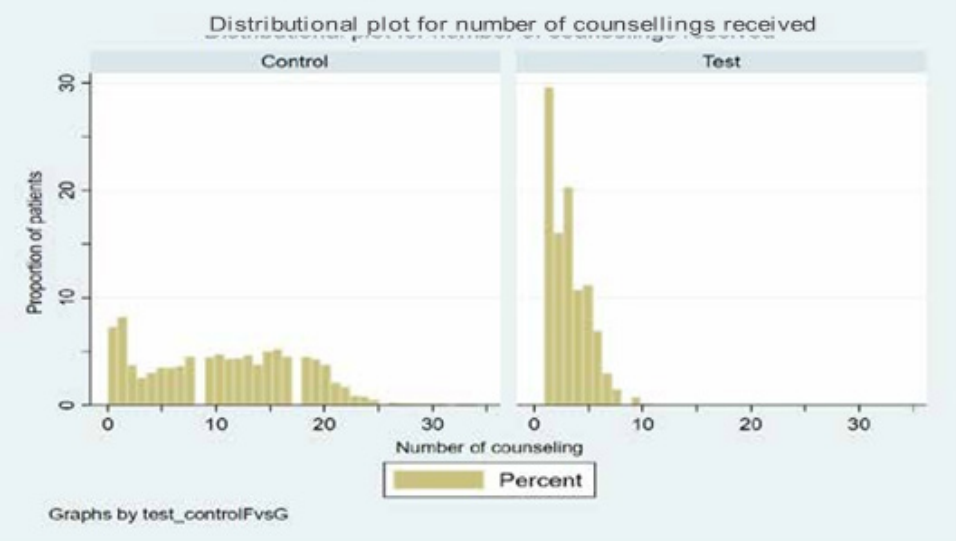


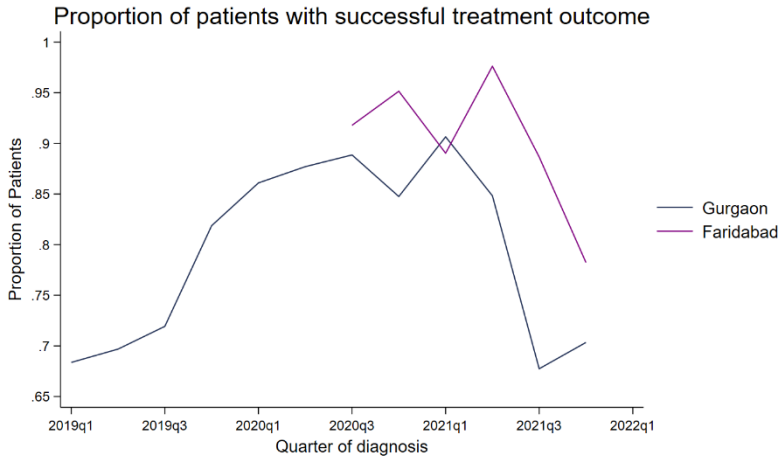
Figure 17: Distributional plot for number of counsellings received



F) Outcomes

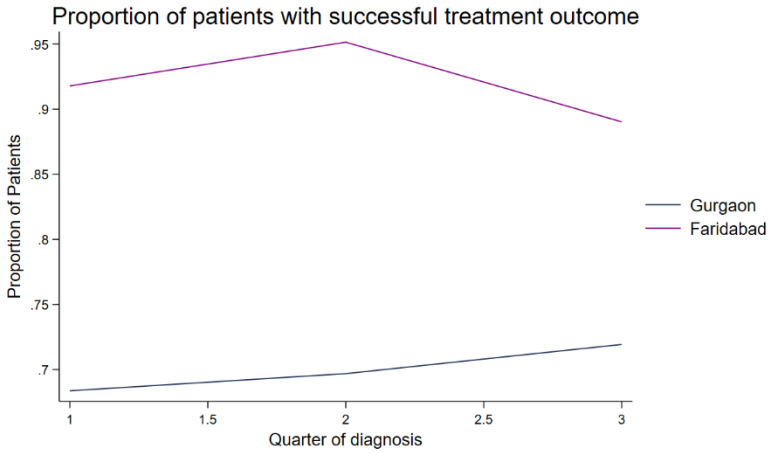
The patient's outcome status was evaluated for Faridabad and Gurugram (Appendix table 32). We see that a significantly higher proportion of patients with treatment outcome successful in Faridabad (91.60% vs. 80.02%). Regression results also adhere to this and show nearly 12% to 14% higher proportion of patients with successful treatment outcomes (appendix table 33 and 34).

Figure 18: Proportion of patients with successful treatment outcomes



While considering the first three quarters of operations of the PPSA in Faridabad and Gurugram, it was noted that the above results still hold. The proportion of patients whose treatment outcome was successful was significantly higher in Faridabad as compared to Gurugram (92% vs. 70.2%). Results from the bivariate and regression analysis are enumerated below in Figure 18 and Appendix table 35).

Figure 18: Proportion of patients with successful treatment outcomes



The summary results for Service and Drug Delivery pilot wherein PPSA services were outsourced to a third-party agency are presented below.

Table 7: Summary results for the Service and Drug Delivery pilot based on calendar month

Variables of interest/ analysis	Bivariate analysis [Test-Control]	Linear probability model	Logit model
Notifications	0.06***	-	-
CBNAAT	-0.004	-0.06***	-0.05***
FDCs	-0.10***	-0.14***	-0.14***
Counselling	-0.48***	-0.46***	-0.37***
Outcomes	0.11***	0.12***	0.14***

*p<0.1; **p<0.05; ***p<0.01

Table 8: Summary results for the Service and Drug Delivery pilot based on first three quarters of operations

Variables of interest/ analysis	Bivariate analysis [Test-Control]	Linear probability model	Logit model
Notifications	-	-	-
CBNAAT	0.07***	0.04***	0.04***
FDCs	0.05***	0.02	0.02
Counselling	-0.25***	-0.27***	-0.23***
Outcomes	0.21***	0.23***	0.24***

*p<0.1; **p<0.05; ***p<0.01

Section 4

Primary Qualitative Data Research

4.1 Introduction

Whilst the quantitative secondary data analysis helps understand "What" is the impact of the pilot on the uptake and quality of TB care, the qualitative research supports the understanding of the "How" and "Why" of the impact of the TATA-1mg programme. For the qualitative analysis, we conducted in-depth interviews with the patients, providers, and staff members of JEET and TATA-1mg.

4.2 Methodology

4.2.1 Objectives

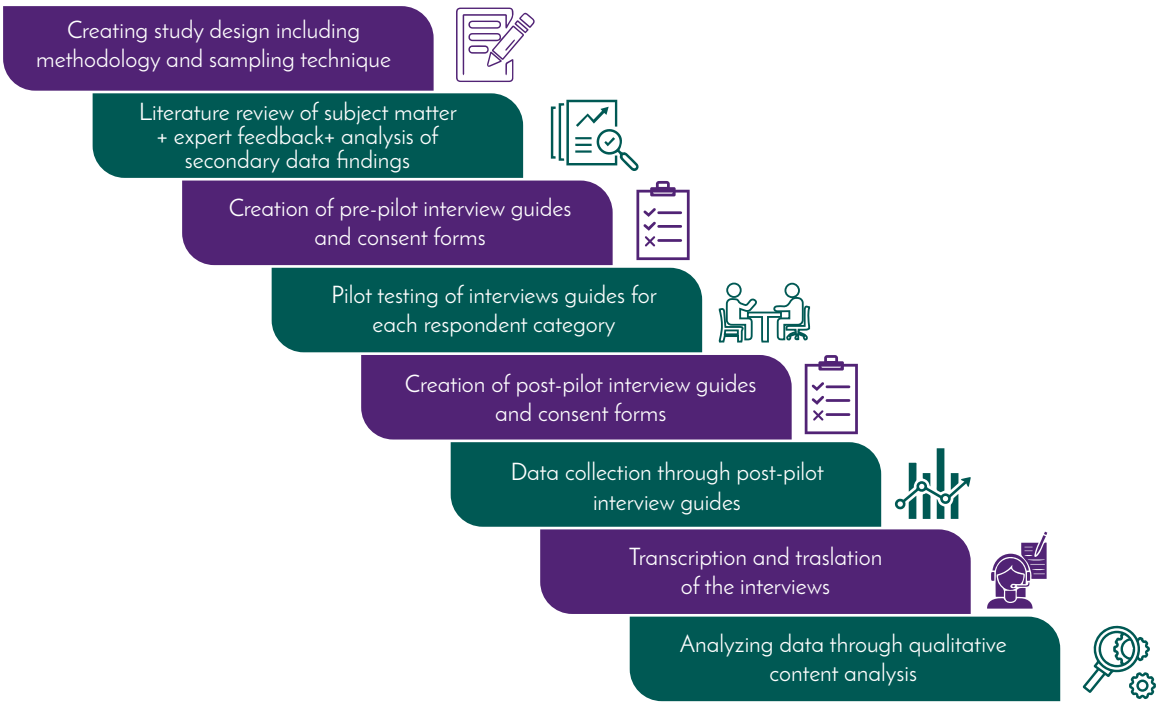
The objective of the qualitative research was to understand how and why the TATA-1mg pilots may have affected the uptake and quality of TB care for private sector patients under the PPSA model.

4.2.2 Research approach

We employed a multiple case study methodology to investigate the barriers and facilitators influencing TB care uptake and quality in the intervention region compared to the control region. We categorized the population into control and intervention groups for the primary qualitative study. In this context, the intervention group comprised patients, providers, and staff engaged with TATA-1mg services. This included patients who availed TATA-1mg services, providers whose patients utilized TATA-1mg services, and the staff involved in providing TATA-1mg services. Conversely, the control group encompassed patients, providers, and staff who did not engage with TATA-1mg. For the Drug Delivery pilot in Surat and Ahmedabad, defining the intervention and control groups within these areas. For the Service and Drug Delivery pilot, the intervention group originated from Faridabad, while the control group is from Gurugram, an adjacent region where JEET 1.0 was already in operation.

4.2.3 Steps for the qualitative study

Figure 19 shows a graphical representation of the step-by-step process followed for the qualitative part of the research.



We initiated the qualitative study by designing the methodology and finalizing the sampling technique. After reviewing existing literature and gathering feedback from experts, guided by the preliminary analysis of secondary programmatic data, we identified possible themes. Subsequently, we created and piloted interview guides for each respondent category to ensure smooth flow of questions, assess interview duration, and gauge respondent comprehension. Post-pilot, we incorporated insights to develop the final interview guides for data collection.

We conducted Qualitative Content Analysis (QCA) using a deductive approach. In addition to the case study tradition, we incorporated insights from literature review and expert interviews to further synthesize results. The themes and sub-themes for this research were derived from variables in the secondary programmatic data analysis, secondary literature review, input from implementors, and researcher intuition.

To code the qualitative data collected from interviews, we designed a categorization matrix (refer to Table 9). This matrix indicates the relevant respondent category for each theme and sub-theme through checkmarks.

Table 9: Categorisation matrix for qualitative study

Themes	Sub-themes	Test (TATA-1mg)			Control (JEET)		
		Patient	Provider	Staff	Patient	Provider	Staff
TB diagnosis and testing	Initial diagnosis and CB-NAAT testing	✓	✓	✓	✓	✓	✓
Medication prescription, consumption and adherence	FDC prescribed by providers	✓	✓		✓	✓	
	E-prescriptions and medication consumption	✓	✓		✓	✓	
	Reminder calls for medication adherence	✓	✓	✓	✓	✓	
Doorstep delivery of other services	Doorstep delivery of FDCs- availed services and preferences	✓	✓	✓			
	Doorstep delivery of FDCs- challenges	✓	✓	✓			
	Doorstep sample collection and report delivery- availed services and preferences	✓	✓	✓			

Themes	Sub-themes	Test (TATA-1mg)			Control (JEET)		
		Patient	Provider	Staff	Patient	Provider	Staff
	Doorstep sample collection and report delivery- challenges	✓	✓	✓			
TB counselling	Counselling provided on treatment adherence by providers	✓	✓	✓	✓	✓	✓
	Nutritional diet counselling and patient's knowledge	✓	✓	✓	✓	✓	✓
Beliefs and perceptions about private sector TB care		✓	✓		✓	✓	

4.2.4 Sampling technique

The research employed purposive sampling to select a total of 131 participants (patients, providers, and staff) following the approach suggested by Hennink and Kaiser (2022). For a heterogenous sample set such as this, a sample size of 15 patients, 3-4 staff and 3-4 providers from each intervention and control location was chosen.

- Control (JEET): Patients that availed of services under JEET 1.0 with further stratification based on age and gender.
- Intervention (TATA-1mg): Patients that availed services under the TATA-1mg programme with further stratification based on age and gender.

For the provider respondent group, we purposively sampled for:

- Control (JEET): Providers that worked with JEET further stratified based on high and low notification and % of CBNAAT tests that were recommended.
- Intervention (TATA-1mg): Providers that worked with TATA-1mg further stratified based on high and low notification and % of CBNAAT tests that were recommended.

Lastly, we purposively sampled one staff type enrolled under JEET/TATA-1mg in all four research geographies. We did so with the goal of obtaining a holistic view of the respondents; hence different respondent categories were deployed for this research. Since the patients happened to be direct consumers of various services provided under the TATA-1mg programme, the highest number of patients were selected for this research. Table 10 below describes the bifurcation of participants for qualitative research.

Table 10: Bifurcation of respondent category for qualitative research

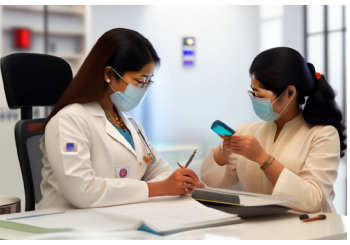
Participant category	Surat (Intervention)	Surat (Control	Ahmedabad (Intervention)	Ahmedabad (Control)	Faridabad (Intervention)	Gurugram (Control)
Patients	15	15	15	15	15	15
Providers	3	3	3	3	3	3
Staff (SCT Agent)	1	1	1	1	1	1
Staff (Hub Agent)	1		1		1	
Staff (Treatment Coordinator)	1		1		1	
Staff (Field Officer)	1		1		1	
Staff (Compounder)	1	1	1	1	1	1
Staff (Tele-caller)	-	-	-	-	1	-
Staff (Delivery Agent)	1	-	1	-	1	-

4.2.5 Research tools

We gathered data using semi-structured interview guides designed for patients, providers, and TATA-1mg or JEET staff in both the control and intervention groups. These guides were developed through a comprehensive literature review and expert interviews to pinpoint the crucial areas to be explored with the stakeholders. Moreover, we integrated insights from the secondary quantitative data analysis to fine-tune the qualitative guides. All study tools underwent field pilot testing and were subsequently refined to enhance their flow, comprehension, reliability, and applicability for the research. The tools are provided in the appendix.

4.2.6 Data collection process

We engaged Outline India, an experienced agency in conducting qualitative interviews in the healthcare sector, for data collection. The process followed a flexible interview protocol supplemented with follow-up questions, probes, and comments to capture open-ended insights into participants' knowledge, beliefs, and ideas about the TB delivery system. The interviewer received a guided list of 10–12 questions, allowing for in-depth exploration of key themes. Interviews were conducted in local languages, Hindi and Gujarati, with translated guides and consent forms vetted by language experts. Enumerators obtained audio consent before recording interviews, which were then transcribed and translated into English for analysis. The overseeing researcher also took detailed field notes.



Each interview lasted 25–35 minutes (except staff interviews, averaging 20 minutes). Patient interviews focused on TB diagnosis, testing, data, doctor visits, counselling, medication adherence, home services, and personal beliefs about private sector TB care. Provider interviews delved into diagnosis, counselling, medication adherence, beliefs, experiences with home services, and personal perceptions of private sector TB care. Staff interviews centered on roles, incentives, training needs, and personal beliefs regarding private sector TB care.

The data, securely stored in password-protected laptops, was de-identified for analysis, managed by the ISB research analyst. Necessary approvals were obtained from the Indian School of Business–Institutional Review Board (protocol number "ISB-IRB 2022– 2043"), and both original and modified Institutional Review Board (IRB) approvals are included in the appendix.

4.2.7 Field visit dates and coverage of respondents

The study team made field visits to conduct and monitor qualitative interviews with patients, providers and staff in Surat and Ahmedabad between 1st March to 17th March 2023. Next, the study team made field visits in Faridabad and Gurugram between 13th March to 25th March 2023. A total of 131 interviews were conducted across Gujarat and Delhi-National Capital Region (NCR).

4.3 Results

The themes from the above categorization matrix were condensed and the results are presented under five broad themes: TB diagnosis and testing, medication behavior and delivery, counselling and treatment adherence, knowledge/awareness about the program, and stigma and taboos.

4.3.1 Drug Delivery pilot

A) TB diagnosis and testing

Under the Drug Delivery pilot, there was no change in the process of sample collection or report delivery of the CBNAAT tests prescribed by the providers for diagnosis. It was the same as followed before the pilot under JEET 1.0.

i) Providers

There was no discernible difference in the prescription of the CBNAAT test between healthcare providers who were engaged with TATA-1mg and those who were not. Seven of the 12 providers reported prescribing the CBNAAT test to their patients. The ones who did not prescribe CBNAAT stated affordability as an issue for patients or not being involved in the diagnosis process.

"(do not prescribe CBNAAT as) We have poor patients, they are not wealthy"

- –35|M|Control

ii) Patients

We do not see a significant difference in CBNAAT testing uptake behaviour between patients of intervention and control groups. 56 of the 60 patients got the tests that were prescribed by their providers. However, in some instances, we did find that the patient denied getting the CBNAAT test done due to the cost of the test.

> *"No, I didn't know (which sample to call it), that's all I had been told, but I had not allowed it. Sir asked me to do all the samples, but I didn't like it. … No, it has been told only once, but they charged Rs 18,000 for it. If we do it at the Civil hospital, we would be charged less. Since I didn't like it, I didn't give it. I feel that god will save me, and god has indeed saved me."*
>
> – 45|F|Intervention

"They asked for an x-ray and sputum sample. After diagnosis, they told me that I have TB and I took a six-mont course. I did what the Dr. told."

– 35|F|Intervention

Patients from both groups expressed differing opinions when asked about their preference for services like sample collection and report delivery at their doorstep. Some found it helpful, but many preferred going to hospitals for these tasks. They believed hospitals/labs would have the necessary equipment for sample collection in case of any issues. Additionally, they valued the ability to consult with a doctor and receive input on their reports if they collected them from the hospital directly.

iii) Staff

After FOs onboarded the providers, hub agents stationed at the provider's clinics or hospitals played a crucial role in connecting with both providers and patients. These hub agents not only dispensed medication but also provided counselling and support to hesitant patients, assisting with sample collection and stressing the importance of taking medication as prescribed.

"Mostly patients complain that their sputum is not generating and they are not coughing, so we have to make them see how to do that. Also, most of the time, patients think it is not necessary, so we have to make them understand why it is so necessary."

32 | M| Hub agent

B) Medication behaviour and delivery

i) Providers

Under the Drug Delivery pilot in Surat and Ahmedabad, all 12 providers in our sample prescribed FDCs to their patients and instructed them to collect the medication from either JEET staff or government centres. However, there was a difference in the follow-up prescription method between the providers who engaged with TATA-1mg and those who did not. The former mentioned sharing e-prescriptions on WhatsApp, whereas in the latter patients had to follow-up in person. It was observed that none of the providers had a structured follow-up mechanism, but those in the intervention group knew that TATA-1mg was reminding patients of their follow-up dates.

"Not over WhatsApp or any online means. There is no online or telemedicine... Nothing like that"

– 47|M|Control

"... JEET foundation (staff) personally call them and ask them if their medicines are finished, and why they did not take medicine. They call them 5 days before (the next provider visit date)."

– 32|M|Intervention

"No (reminder calls). It is written in my prescription, if it is written for one month then the date of the next appointment is written below. It is the patient's responsibility"

– 49|M|Control

ii) Patients

All 60 patients in our intervention group got FDCs delivered at least once, to their doorstep by TATA- 1mg. The patients who availed the doorstep delivery service were either told by the provider or JEET staff who dispensed the first dosage. Patients in the intervention group preferred government medicines and delivery as it saved cost.

> *"...the government person was also sitting there at the hospital. Then he asked us that I will start these medicines for you, and he started my medicines... Saves money, saves fare, I had such a condition that I didn't have money for the medicines"*

- 45|F|Intevention

However, five patients in the intervention group also reported stopping FDCs and moving to private medication. This was done largely due to ADRs or other supply-side issues. Sometimes the patients mentioned getting medicines for more than a month.

Patients who did not avail of the TATA-1mg service were either not told about the doorstep delivery of medicine or refused to take government medicine. The reasons were primarily distrust in the government medicine (FDC), and the long waiting time to collect the medicine or ADRs.

> *"Yes I was told that you can take it from there (government hospital), but I didn't take it .... Who will go there? I don't have time"*

– 50|M|Control

> *"Yes he told me that if you take treatment from the government, then you will receive, all your medicines free of cost for six months. These would be delivered at home. They told us to go to the government facility, but we refused since we had faith in him. They even enrolled us in the Government set up and gave all our bank details to them. However, we refused to go there and instead purchased medicines from the store."*

- 60|F|Control

> *"Xxx (JEET staff) came from Corporation .... He insisted on all the medicines. I said we don't need these medicines because whichever medicines we are taking, he would be giving the same. All our medicines were from a branded company, their medicines were from non-branded, whatever comes in government quota".*

– 64|F|Control

In addition, patients in the intervention group also received reminder calls prior to their scheduled provider visit date. Three patients in the control group received reminder call from the JEET staff. However, it was not uniform across all patients.

> *"I received calls regularly. Before the end of 1.5 months, they reminded us of the doctor's visit. I told them my appointment date etc."*

50|F|Intervention

"They called me before my medicine stock got over and I collected it from there"

32|M|Control

iii) Staff

With the introduction of TATA-1mg's medication delivery service, we were told that there was a reduction in the hub agent's workload. This service enabled patients to receive prescribed medication at their doorstep, eliminating the need to visit the hubs. Nevertheless, field staff remained crucial in ensuring smooth medication delivery. They aided patients in uploading their prescriptions if needed and ensured timely delivery. With TATA-1mg, hub agents were relieved from the responsibility of maintaining medication stock, as patients now received it directly.

"After the 1 mg service, the patient visits the doctor and takes the prescription from them. If the patient is educated then they can WhatsApp the concerned person. However, if the patient is not educated then with the help of the others, they can send us a prescription photo and we upload it so that they get their medicine at home."

29| M|Field Officer

"Earlier, we had to maintain stocks but after TATA- 1mg came into the project, it was directly sent by them."

29|M|Field Officer

TATA-1mg delivery agents while delivering medication maintained the privacy of the patient. The medicine was delivered in discreet packaging and the agents did not tell the neighbours (or anyone else) about the type of medicine being delivered.

"...vendor gives us packed medicine and we deliver it to the patient, but we only tell them about the medicine and not the name of the medicine."

"Some people ask us as to what it is that we bring, so we tell them normally that it is medicine. And if they ask what medicine is it, then we tell them that we don't know what is inside the packet."

43|M|TATA-1mg Delivery Agent

While Delivery Agents did face challenges such as incomplete addresses, it was resolved and did not come out as a major issue

C) Treatment adherence

Under the Drug Delivery pilot, there was no change in the counselling of the patients. Treatment coordinators counselled the patients post their diagnosis as done before the pilot under JEET 1.0.

i) Providers

We observed that providers from both the intervention and control groups conducted preliminary counselling of their patients, which centered on educating them about the disease, potential adverse drug reactions (ADRs), and the importance of adhering to medication. Additionally, providers reported that JEET staff provided counselling to the patients.

"XXX (JEET staff; name not mentioned to maintain anonymity) used to do counselling of patients)"

M|65|Control

ii) Patients

All patients in both the intervention and control groups received counselling.

"...One person from the AMC came home and explained to me. He guided me on what to take in food and what not to take ... the doctor could not spend that much time with you, as he has more patients like us.... They asked about our health in the reminder calls many times."

28|M|Intervention

iii) Staff

The Treatment Coordinators supported the patients throughout their TB treatment. With a follow-up every 15 days by them followed by regular home visits, patients reached out to the TCs regarding any problems faced during the treatment. The TCs not only counselled the patients but also the caregivers.

"...use to call patients and go to their home to make them understand all things including what is TB, what do's and don'ts to follow, what medicine to take and how to be forewarned about side effects of medicine."

"...we go to their home for counselling. That is a good time to do family members' counselling too."

"Doctors only give medicines but we do their counselling and are in touch with them for long. We take care of the patient like a family member."

D) Knowledge/Awareness about the programme

i) Providers

Both intervention and control group providers were well-informed about the JEET program and expressed positive responses towards it. It was evident that JEET staff played a crucial role in establishing relationships with the providers. However, in the control group, two providers were unaware of TATA-1mg, potentially due to being low notifiers or having reservations about sharing information with a for-profit/private organization. One provider specifically mentioned not receiving

information about TATA-1mg. Despite some providers being unclear about the distinctions between the JEET and TATA-1mg programs, they still directed their patients to JEET staff for assistance with TB treatment.

"I send patients to the JEET Foundation so they cooperate with TATA 1 mg and send medicines to the patients" .... "The patient who is taking treatment with JEET Foundation has very good experience since they have very good compliance. Sometimes patients became lazy and that is when the JEET foundation calls and reminds them to take medicines."

32|M|Intervention

"We do not give the data of private individuals in this way. Instead, we directly give all the details to JEET staff."

2|M|Control

"I have TB patients coming there, no doubt, but only twice monthly, once in two months, once in three months, that. Hardly four or five patients a year."

45|M|Control

E) Stigma and Taboo

i) Patients

Both groups of patients exhibited prevalent taboos and stigma regarding the disease. This influenced some patients to choose hospital visits for sample collection and report collection. While most patients were comfortable with their family members knowing about their TB status, some kept it hidden from neighbors and relatives due to fears of isolation and social distancing.

This situation could potentially lead to patients avoiding doorstep services, which may result in delays in treatment initiation or lapses in adherence.

"..because they will start talking about anything, it is good to hide and take medicine on time otherwise people will start making their distance from you. I have a female infant who is about 3-4 months old. I met her after a year so that she might not get affected."

33|M|Control

"...If they come here, the watchman asks us and 2-3 people would know us. Everyone has different nature. As I had this disease, people started staying away from me. Even if it is a normal fever, people get away from you. So, it is better if it is at the hospital, so it remains hidden. Our disease will go away, but people would be afraid of us as we have this disease."

40|F|Intervention

4.3.2 Service and Drug Delivery pilot

A) TB diagnosis and testing

Our result showed that the providers in our sample from Faridabad (test) had limited to no knowledge of either the TATA-1mg or JEET programme.

i) Providers

Due to their lack of knowledge about the programme, providers in Faridabad behaved differently from those in Gurugram with regard to CBNAAT prescription. Providers in Faridabad did not prescribe CBNAAT to all patients and cited affordability and accessibility as issues. In contrast, providers in Gurugram prescribed CBNAAT to their patients.

4.3.2 Service and Drug Delivery pilot

"...we initially conduct GeneXpert test and other tests and find the current situation from there and start the treatment if the person is producing sputum."

M|(age not stated)| Gurgaon

ii) Patients

We found mixed responses about the patients being prescribed CBNAAT test in both the intervention and control groups. While three patients of the 15 in the intervention group and four of 15 in the control group were prescribed CBNAAT tests, others were not. None of the patients in our sample denied getting CBNAAT test after being prescribed by the provider.

"No, sputum testing was not done."

25|M|Control

The majority of patients from both the intervention and control groups favored visiting the hospital for sample testing and report collection. They cited several reasons for this preference. Patients believed that hospitals/labs would offer superior facilities for sample collection, along with the presence of qualified medical professionals. Additionally, there were concerns about the potential risk of other family members contracting the infection during home sample collection. Furthermore, five patients of 30 expressed apprehension about facing social stigma.

"...there are lots of things in a lab or hospital. We don't have all the facilities at home. It's good when we go to a health facility."

22|F|Intervention

"...at home there is a problem, that my family is there and if anyone gets an infection we will all be in trouble. We prefer the clinic so that others are not exposed to risk of infection and sickness."

33|M|Control

Similarly, most patients preferred going to collect the report as it would give them a chance to consult with the doctor and understand their report.

"...because we will have to show the reports to the doctor."

25|M|Control

"Being illiterate, I cannot understand what is written in the report. To get proper consultation from the doctor, I have to go to the hospital."

45|F|Intervention

B) Medication behaviour and delivery

i) Providers

Providers in Faridabad mentioned prescribing loose drugs to patients, while those in Gurugram did not exclusively mention FDCs. Instead, they mentioned drugs being dispensed by JEET staff. We did not find any structured follow-up mechanism, such as reminder calls made by the provider.

"...we used to send the patients to her (JEET staff) and she used to provide medicines as well."

43|F|Gurgaon

ii) Patients

We found that the take-up of doorstep drug delivery service provided by TATA-1mg received mixed responses from patients in the intervention group. While five patients availed of the service and continued getting medication throughout their treatment period, some patients either discontinued the delivery and thereby FDCs due to ADRs or did not opt for it due to stigma around TB.

"...those medicines make me restless and anxious... Don't know...Half the medicines are kept in the box ...I didn't take them."

37|F|Intervention

"it was an issue, people would talk. Neighbours and others would ask why they (Delivery Agents) were coming and what had happened."

22|F|Intervention

"Medicine was delivered at home so that was not a concern. I had ordered there and went for a checkup today and on the third day, the medicines were delivered at home."

35|M|Intervention

Among patients in the control group, we found that most of them took government FDC through a hub agent. Either the hub agent was stationed at their provider's clinic or the hub agent travelled to other provider's clinic to dispense the medication. Furthermore, the hub agent dispensed two months

medication in case the patients requested. Along with the prescription, patients also showed empty medication wrappers before getting a fresh batch of medicines.

"She actually used to sit in the hospital itself. She was from the government but was sitting there."

32|F|Control

"...I used to take a ticket at 9 o'clock for the doctor's but then used to wait till about 2 pm. He used to give medicine for my other ailments for which treatment was going on (diabetes and thyroid). Then madam used to come and medicines were given.

45|F|Control

"... The wrapper of the medicines, I showed to them and told them that it has been one month since I have been taking and my empty wrappers are testimony to my adherence."

42|M|Control

C) Counselling and Treatment adherence

i) Providers

All providers mentioned counselling patients on the disease, adherence, and ADRs. Providers in Gurugram also reported that patients received counselling from JEET staff.

"We also provide counselling. If we have no time, there are coordinators in Gurgaon who do that."

43|F

ii) Patients

Most of the patients in our control group received counselling from JEET staff. The counselling was not just focused on do's and don'ts but also reinforced the importance of drug adherence. If needed, the TCs themselves carried the patient's medicines during home visits.

"At home, ma'am used to come only once or twice when it was starting, as part of their observation, otherwise we had to go there mostly. At the beginning, when my condition was very bad, I could not go, then medicines came once or twice."

32|F|Control

"About this, I was told to take medicines properly for six months and not miss a single dose in between and whatever diet plan you have ensure that fast food and oily food are not consumed. Cold and hot also has to be avoided."

25|M|Control

Contrary to this, only three patients of the 15 from our sample in the intervention group received counselling from a TC. Some patients received reminder calls but most relied on the provider to get information about TB.

"He used to give slips and explain something. However, I would not remember and forget half the things...nobody did anything or visited us."

22|F|Intervention

"They said to take the medicine in the morningand would call and remind me to take it. They would also advice me on my diet."

23|F|Intervention

"Someone on your behalf came to meet once in between and guided me on what all to eat and avoid and also the importance of having a balanced diet."

24|M|Intervention

The above responses show that while patients in the control group were made aware about the disease, ADRs, and others, patients in the intervention group were counselled about the disease or treatment. We noted that this lack of counselling could affect medication adherence among patients in the intervention group.

iii) Staff

The TCs in control group not only provided counselling to patients but also to caregivers, encouraging them to get tested for TB if they showed any symptoms. Furthermore, the TCs facilitated patients' access to medication even when the patient would travel outside of their area of residence.

"...we visit their home and meet them at their house....Or if they (household members) have any symptoms, we counsel them to visit doctors."

24|F|Treatment Coordinator| Control

".... If they want to go somewhere, they should keep the medicines with them. And if they want to go to their village for say two months, we will provide medicine for that period too so that they won't skip any medicine."

24|F|Treatment Coordinator| Intervention

In Faridabad (test), unlike in other locations, there were no field staff apart from FOs. Instead, TATA-1mg tele-callers collaborated with compounders to provide services such as sample collection, report delivery, and medication delivery directly to the patients' doorstep. Our study found that both the tele-caller and compounder were aware of the process.

"...It was uploaded through Google forms which we used to fill with all the details following which the staff (TATA-1mg staff) used to enter them in the Nikshay (portal)..."

53|M|Compounder|Intervention

According to the model, compounders were meant to receive incentives for their assistance. However, the compounder in our sample denied receiving any incentives, and we were unable to confirm this information with others.

"No (incentive) only the salary."

53|M|Compounder|Intervention

D) Knowledge/Awareness about the programme

i) Providers

Providers in Faridabad had limited knowledge or awareness about the programme. However, those in Gurugram had better knowledge and awareness of the JEET programme and this was in some ways similar to the situation in Gujarat. Here, JEET staff played a crucial role in Gurugram, and providers were familiar with the Hub Agents who were stationed at the clinic or hospital.

"... The follow-up that JEET does is, to check whether the patient is taking medicine or not. Other clinical follow-ups are done by us. ...." But we strongly recommend that this JEET initiative by the government should be back in private to streamline things for us. We are doing our jobs, however, when JEET was there it was very helpful. We had a girl from JEET sitting here for a long time, she was very helpful".

– 43|F|Gurgaon

E) Stigma and Taboo

i) Patients

Patients from both the intervention and control groups were comfortable with sharing their TB status with their family but were hesitant to speak with others about it. One patient from the control group was afraid of losing his job if his employers found out that he was suffering from TB.

Some patients were worried that they would be isolated and people would be afraid of coming near them.

"I did not inform them because if we did, they would distance themselves from me."

25|M|Control

"Yes, people shouldn't know I had TB because some of them have misconceptions about ithe disease. Like, we cannot talk to them, we cannot meet people and because of that, I have missed my college for a long time. Unless and until I am well, I won't go to college."

21|F|Intervention

"...fear is that he had TB. Do not go near him. Don't do this, don't do that. This is wrong... this is not untouchability."

60|M|Intervention

The summary of the qualitative insights are presented below.

Drug Delivery Pilot

Providers working with TATA-1mg shared follow-up e-prescriptions with patients, streamlining medication delivery to their doorstep. Moreover, patients using this service received reminder calls before their scheduled provider visit, potentially reducing the days without medication. The existing JEET staff played a crucial role in building trust and maintaining relationships with both providers and patients. While patients were comfortable sharing their TB status with family members after counseling, they hesitated to do so with neighbors due to fear of isolation. Addressing this stigma through counseling could greatly benefit patients. Patients who utilized the TATA-1mg service felt at ease with doorstep medication delivery. TATA-1mg delivery agents prioritized patient privacy, delivering medication in discreet packaging without disclosing the type of medicine to neighbors or anyone else.

Service and Drug Delivery Pilot

In the Service and Drug Delivery pilot, we identified a lack of awareness about the program among both providers and patients, indicating a need for improved engagement. This gap may be attributed to the absence of on-field JEET staff. In this model, compounders played a crucial role in connecting patients with TATA-1mg and were incentivized for their efforts. However, in our sample, one compounder reported not receiving any incentives. The assumption that tele-counselling would be as effective as in-person counseling, and therefore having only one treatment coordinator along with a tele-counselor, did not prove effective in this model. As a result, many patients did not receive counseling. Additionally, the stigma and taboo surrounding TB caused more patients to be hesitant about using doorstep services like sample collection or report delivery.

Section 5

Costing

5.1 Introduction

We estimated the per-case cost of delivering TB care and services for the Drug Delivery and the Service and Drug Delivery pilots vis-à-vis the existing JEET model (JEET 1.0). The methodology and analysis results are presented in the following sections.

5.2 Methodology

5.2.1 Data and method

A retrospective activity-based costing (ABC) approach was used to estimate the cost per case for the three models (two pilots and the existing JEET model). The time period for the analysis of these models was January 2019 to June 2020 (JEET 1.0); July 2020 to June 2022 (Drug Delivery model), and July 2020 to June 2022 (Service and Drug Delivery model).

Activities undertaken by each cadre of staff under all the models were identified through literature and discussions with the WJCF team. A skeleton of the costing tool was created with certain programmatic cost categories based on these activities. This was followed by an in-depth discussion with on-ground individuals involved to understand 'how' the activities were conducted. Based on this understanding, a common cost structure across three models, comprising fixed and variable cost components was developed (details in Table 12). The final costing tools used to conduct the interviews are given in the appendix of the report.

Service and drug delivery pilot, the compounders at the provider's clinics, instead of Hub Agents hired by JEET, were incentivised to notify the patient on the government's Nikshay platform and share consented patient details with TATA-1mg staff. Additionally, under the pilot, the Treatment Coordinator was a TATA-1mg staff, although s/he was trained by the JEET team.

5.2.2 Data collection and analysis

We conducted online primary interviews with staff involved in the three models to understand the costs associated with various activities. These costs were categorized as fixed or variable. For variable costs, we identified a cost driver - the factor influencing changes in cost based on the level of activities. We grouped these costs into different categories. The interviews aimed to estimate the expenses within these defined categories and sub-categories and were recorded. Additionally, we extracted expenses from the budgets provided by the WJCF team for the two pilots and the JEET expenditure sheet. The information detailing cost categories (including sub-categories) and their respective sources is presented in Table 12.

Table 12: Cost categories and sources of data

Activity	Personnel involved	Cost category	Type of cost	Cost driver	Source
General and Administrative	All National Programme Management Units (NPMU) and State Programme Management Unit (SPMU) personnel	Admin JEET: NPMU, SPMU	Fixed	-	Interviews, expenditure sheet, budget documents
	Travel to study site by managerial staff	Travel cost	Fixed	-	
	-	Admin JEET: Others	Fixed	-	
	-	ICT cost	Fixed	-	
	TATA-1mg personnel	Admin TATA-1mg	Variable	Number of patients	
Training of Field Staff	Trainings and review of Field officers	Training and sensitisation	Variable	Number of Field Officers -> Number of providers	Interviews, expenditure sheet
	Training and review of SCT Agents		Variable	Number of SCT Agents -> Number of patients	
Engagement of Providers	Field Officers	Engagement cost	Variable	Number of Field Officer -> Number of Providers	Interviews, expenditure sheet
Training of Providers	Field Officers, Operations Manager, Providers	Training and sensitisation	Variable	Number of Providers	Interview, expenditure sheet

Activity	Personnel involved	Cost category	Type of cost	Cost driver	Source
Notification	Hub Agents, Compounder	Incentive to Compounder	Variable	Number of patients	Expenditure sheet, budget document
Sample collection	SCT Agents, TATA-1mg	Sample collection cost	Variable	Number of patients	Expenditure sheet, budget document
Drug Delivery	TATA-1mg	Drug delivery cost	Variable	Number of patients	Budget document
Counselling	Treatment Coordinators, TATA-1mg	Counselling cost	Variable	Number of patients	Expenditure sheet, budget document
Treatment completion (under SDD)	Compounder	Incentive to Compounder	Variable	Number of patients	Budget document

To estimate the costs under various cost categories, interviews were conducted with staff members involved in the three models. These costs were also cross-referenced using the budgets and expenditure sheet. The sampling details are provided in Table 25.

Table 13: Sample size for the costing exercise

Respondent category	JEET 1.0	Drug delivery	Service and drug delivery
Programme Manager	NA	1	1
State PPM Lead	1	NA	NA
Finance Lead	1	NA	NA
Field Officer	2		1
Hub Agent	1		NA
SCT Agent	2		NA
Treatment Coordinator	3		NA
Total	**13**		

5.2.3 Analysis

We carried out three types of analysis:

- ***Analysis on the current status:*** A per-case cost was estimated at the current level of engagement and uptake of services, under the three models in their respective geographies during the time of implementation.
- **Counterfactual analysis:** A per-case cost if a particular model is implemented in another geography.
- **Marginal analysis:** An estimate was made on a per-case cost in case the models are scaled to geographies with different populations.

5.3 Results

5.3.1 Current per-case cost

To arrive at this cost, we made certain assumptions. These assumptions were verified with the implementation team for their accuracy and are same across all models. The assumptions are listed below:

- Time allocation: The time allocation of the staff at the national level i.e., at the National Programme Management Unit (NPMU) was equal across the different geographies under JEET 1.0 (3.5% per geography).
- Personnel cost: The number of personnel employed and the salaries of both the managerial and field staff were taken as budgeted under the JEET 1.0 model, as there was no change in the number and salaries under the pilots.
- Travel Cost: The travel cost incurred by the managerial staff (airfare, boarding and lodging, F&B, and local travel), was allocated equally to each geography.

This was done after discussing with implementers as JEET 1.0 expense sheet did not contain expenditure on travel by geography. The budgeted allowances to field personnel (allowances paid to FOs, Hub Agents, SCT Agents, and Treatment Coordinators) were used for the estimation as implementers believe that there wasn't significant difference between the budgeted and actual allowance.

Table 26 shows the per-case cost for the three models in their respective geographies and time periods the level of engagement and uptake of services in that period. The cost is further divided under various programmatic cost categories.

Table 26: Cost per case for the three PPSA models in their respective geography and time periods.

Cost category	Sub-category	Cost per case (JEET 1.0) Surat and Ahmedabad [January 2019 to June 2020]	Cost per case (Drug Delivery Model) Surat and Ahmedabad [July 2020 to June 2022]	Cost per case (Service and Drug Delivery Model) Faridabad [July 2020 to June 2022]
Total cost	-	3222	4513	3872
Admin: JEET Personnel	NPMU	92 (3%)	151 (3%)	**427 (12%)**
	SPMU	193 (6%)	265 (6%)	104 (3%)
	SR	134 (4%)	184 (4%)	NA

Cost category	Sub-category	Cost per case (JEET 1.0) Surat and Ahmedabad [January 2019 to June 2020]	Cost per case (Drug Delivery Model) Surat and Ahmedabad [July 2020 to June 2022]	Cost per case (Service and Drug Delivery Model) Faridabad [July 2020 to June 2022]
Admin: JEET others	Travel	83 (3%)	453 (10%)	308 (8%)
	Maintenance	106 (3%)	146 (3%)	219 (6%)
	Maintenance (SR)	19 (1%)	27 (1%)	NA
	ICT	66 (2%)	68 (1%)	252 (7%)
Admin: TATA-1mg	Personnel	NA	118 (3%)	664 (19%)
Admin: TATA-1mg	Maintenance	NA	30 (1%)	310 (9%)
Field personnel	Field Officers	310 (10%)	358 (8%)	477 (14%)
	Hub Agents	1048 (33%)	1128 (25%)	NA
	SCT Agents	177 (5%)	215 (5%)	NA
	Treatment Coordinator	811 (25%)	1050 (23%)	NA
Training	Field Staff	5 (0.2%)	7 (0.1%)	NA
	Providers	32 (1%)	43 (1%)	20 (1%)
Sample collection	Allowance to SCT Agents	41 (1%)	50 (1%)	NA
	TATA-1mg	NA	NA	37 (1%)
Drug delivery	TATA-1mg	NA	131 (3%)	204 (6%)
Counselling	Allowance to TC	105 (3%)	136 (3%)	NA
	TATA-1mg	NA	NA	691 (20%)
Compounder incentive	TATA-1mg	NA	NA	100 (3%)
		NA	NA	59 (2%)

The estimated per-case cost for the JEET 1.0 operations in Ahmedabad and Surat was Rs.3222. The table shows that more than 70% of the per-case cost can be attributed to the field personnel (FOs, Hub Agents, SCT Agents, and Treatment Coordinators) employed under the JEET 1.0 model.

Table 13 shows the per-case cost for the drug delivery operations in Surat and Ahmedabad from July 2020 to July 2022 (24 months) at the level of engagement and uptake of services prevalent in that period. The cost has been further bifurcated under various programmatic cost categories. The per-case for the drug delivery model in the aforementioned period was calculated as Rs.4513. It was found that nearly 65% of the total cost could be ascribed to the field personnel. Through the interviews, it was noted that nine months into the drug delivery pilot, the field staff was optimised.

Under the Drug Delivery model, the costs paid to TATA-1mg for their services were also incurred. These TATA-1mg costs amounted to nearly 7% of the total cost. Apart from this, a higher per-case cost was attributed to a multitude of factors. These included, case notifications being less in this period as compared to the JEET 1.0 period driving the per-case cost up as well as the different time periods (24 months and 18 months) that drove the overall staff cost for the programme (despite the percentage remaining the same).

The per-case cost for the service and drug delivery pilot in Faridabad for the aforementioned time period was Rs.3872. It was estimated that nearly 60% of this cost could be ascribed to the charges paid to TATA-1mg for their services.

However these costs are not comparable due to the differences in scale and nature of the models. Hence, we also did a counterfactual analysis. To make these costs comparable, we conducted a counterfactual analysis

5.3.2 Counterfactual analysis

Table 14 shows the counterfactual results i.e., how the per-case cost would vary if all three models were applied to Surat and Ahmedabad from July 2020 to July 2021. This was the chosen geography for the Drug Delivery pilot and the time period of the pilot. To arrive at this cost, we made certain assumptions. These assumptions were verified with the implementation team for their correctness and are same across all models. The assumptions are listed below:

- Time allocation: The time allocation of the staff at the national level i.e., at the National Programme Management Unit (NPMU) was equal across the different geographies under JEET 1.0 (3.5% per geography, taking Delhi as one geography).
- Personnel cost: The number of personnel employed and the salaries of both the managerial and field staff were taken as budgeted under the JEET 1.0 model, as there was no change in the number and salaries under the pilots.
- Travel cost : We allocated the total expenditure under travel equally to each geography. This was done after discussing with the implementers as JEET 1.0 expense sheet did not contain expenditure on travel by geography.
- The budgeted allowances to field personnel (allowances paid to FOs, Hub Agents, SCT Agents, and Treatment Coordinators) were used for the estimation as implementers believe that there was no significant difference between the budgeted and actual allowance.

In addition to the above assumptions, for the counterfactuals, we assume:

- The administrative charges paid to TATA-1mg for the services provided would vary proportionately to the number of patients.

- The number of field personnel would vary proportionately with their respective cost drivers. For example, the number of FOs would vary proportionately with the number of providers, while the other field personnel (SCT Agents, Hub Agents, TCs) would vary proportionately with the number of patients.
- The uptake of services (such as drug delivery, and sample collection under the SDD) would vary proportionately with the number of patients. For example, we assume that the same proportion of patients would avail the offered TATA-1mg services for the counterfactuals. The total number of patients, however, would vary.

For the estimation of per-case cost for Surat and Ahmedabad counterfactuals, the number of patients/ case notifications considered would be those of Surat and Ahmedabad in the period of interest.

The administrative cost such as maintenance (office and facility upkeep) would remain the same across the two models (JEET and drug delivery) for the same geography. However, under the SDD model, since there isn't any SR partner required due to the nature of the pilot, the SR partner's facility and upkeep cost would be removed. From the implementing team it was confirmed that this optimisation was not due to the drug delivery pilot but other programmatic factors. Hence, for calculation of counterfactual, the pre- optimisation numbers were used.

The below table gives an overview of how the various cost categories differ by geography and the nature of the pilot. For the Drug Delivery pilot of Surat and Ahmedabad, counterfactuals (JEET1.0 and service and drug delivery) are calculated. It is assumed that cost categories such as 'Admin JEET personnel and travel' would not vary with the nature of the pilot, but with the geography it is implemented in. Since the counterfactuals are calculated for the same geography where the Drug Delivery pilot is implemented, these costs would remain the same as those in the Drug Delivery pilot (actuals).

Table 14: Overview of counterfactual estimates for Surat and Ahmedabad with assumptions.

Cost category	Sub-category	Drug Delivery (Actuals)	JEET 1.0	Service and drug delivery	Assumption
Admin: JEET personnel	NPMU	DD	DD	DD	The managerial cost of NPMU is not dependent on the nature of the pilot but on the geography of implementation. Thus, the managerial staff expenses would remain the same, irrespective of the pilot.
	SPMU	DD	DD	SDD	
	SR Partner	DD	DD	SDD	The SR partner in the geography depends on the nature of the pilot i.e. ,under the SDD pilot, SR partner is not required as TATA-1mg manages most of the activities

Cost category	Sub-category	Drug Delivery (Actuals)	JEET 1.0	Service and drug delivery	Assumption
Admin: JEET others	Travel	DD	DD	DD	The travel cost incurred by the managerial staff is not dependent on the nature of the pilot but on the geography of implementation. Thus, the travel cost would remain the same irrespective of the pilot
	Maintenance	DD	DD	DD – SR cost	The maintenance cost i.e., cost for facility and upkeep would remain the same, irrespective of the pilot. However, in the absence of SR partner under the SDD, that counterfactual would not include the SR partner's maintenance cost
	ICT	DD	DD	DD-SR cost	The ICT cost incurred is not dependent on the nature of the pilot but on the geography of implementation. Thus, it would remain the same, irrespective of the pilot. However, in the absence of SR partner under the SDD, that counterfactual would not include the SR partner's ICT cost
Admin: TATA-1mg	Personnel	DD	NA	SDD cost proportional to the number of notifications in DD	
Admin: TATA-1mg	Maintenance	DD	NA	SDD cost proportional to the number of notifications in DD	

Cost category	Sub-category	Drug Delivery (Actuals)	JEET 1.0	Service and drug delivery	Assumption
Field personnel	Field Officers	DD	Proportional to number of providers in DD	Proportional to number of providers in DD	
	Hub Agents	DD	Proportional to number of patients in DD	NA	
	SCT Agents	DD	Proportional to number of patients in DD	NA	
	Treatment Coordinator	DD	Proportional to number of patients in DD	NA	
Training	Field Staff	DD	DD	DD	Training of the field staff and providers is not dependent on the nature of the pilot
	Providers	DD	DD	DD	
Sample collection	Allowance to SCT Agents	DD	Proportional to number of SCT Agents in DD	NA	
	TATA-1mg		NA	SDD cost proportional to the number of notifications in DD	
Drug delivery	TATA-1mg	DD	Proportional to number of patients in DD	SDD cost proportional to the number of notifications in DD	

Cost category	Sub-category	Drug Delivery (Actuals)	JEET 1.0	Service and drug delivery	Assumption
Counselling	Allowance to TC	DD	Proportional to number of patients in DD NA	NA	
	TATA-1mg		NA	SDD cost proportional to the number of notifications in DD	
Compounder incentive	TATA-1mg	DD	NA	SDD cost proportional to the number of notifications in DD	
		DD	NA	SDD cost proportional to the number of notifications in DD	

The below table gives the per-case cost of all the models if applied to Surat and Ahmedabad in the drug delivery pilot duration.

Table 15: Cost per case of all three models applied to Surat and Ahmedabad in the drug delivery time period (July 2020 to July 2022)

Cost category	Sub-category	Activity	Cost per case (in INR) JEET1.0	Cost per case (in INR) DD (actuals)	Cost per case (in INR) SDD
Total cost	-	-	4230	4513	3652
Admin: JEET Personnel	NPMU	Administrative	127 (3%)	151 (3%)	127 (3%)
	SPMU	Administrative	265 (6%)	265 (6%)	16 (1%)
	SR	Administrative	184 (4%)	184 (4%)	NA

Cost category	Sub-category	Activity	Cost per case (in INR) JEET1.0	Cost per case (in INR) DD (actuals)	Cost per case (in INR) SDD
Admin: JEET others	Travel	Administrative	453 (10%)	453 (10%)	429 (11.8%)
	Maintenance	-	146 (3%)	146 (3%)	168 (5%)
	Maintenance (SR)	-	27 (0.6%)	27 (1%)	NA
	ICT	-	68 (1%)	68 (1%)	54 (1%)
Admin: TATA-1mg	Personnel	Administrative	NA	118 (3%)	664 (18%)
Admin: TATA-1mg	Maintenance	-	NA	30 (1%)	310 (9%)
Field personnel	Field Officers	Engagement with providers	358 (8%)	358 (8%)	779(21%)
	Hub Agents	Notification, drug dispensation	1128 (27%)	1128 (25%)	NA
	SCT Agents	Sample collection	215% (5%)	215 (5%)	NA
	Treatment Coordinator	Counselling	1050 (25%)	1050 (23%)	NA
Training	Field Staff	-	7 (0.2%)	7 (0.1%)	NA
	Providers	-	43 (1%)	43 (1%)	43 (1%)
Sample collection	Allowance to SCT Agents	Sample collection	50 (1%)	50 (1%)	NA
	TATA-1mg		NA	NA	37 (1%)
Drug delivery	TATA-1mg	Drug delivery	NA	131 (3%)	204 (6%)

Cost category	Sub-category	Activity	Cost per case (in INR) JEET1.0	Cost per case (in INR) DD (actuals)	Cost per case (in INR) SDD
Counselling Compounder incentive	Allowance to TC	Counselling	136 (3%)	136 (3%)	NA
	TATA-1mg		NA	NA	691 (19%)
	TATA-1mg	Notifications	NA	NA	100 (3%)
		Treatment completion-notification	NA	NA	59 (2%)

The above results showed that if the Service and Drug Delivery model was implemented in Surat and Ahmedabad instead of the Drug Delivery model, the per-case cost was Rs. 3652, followed by the JEET 1.0 cost of Rs. 4230. The lower cost under SDD can be attributed to the absence of field personnel in the Service and Drug Delivery model who were salaried employees of JEET under the JEET 1.0 and Drug Delivery models. Under the Drug Delivery and JEET 1.0 models, these field personnel contributed to more than 50% of the per case cost. Even with the services of these field personnel, such as the SCT Agent and Treatment Coordinators being outsourced to TATA-1mg, the per-case cost was considerably less.

Table 16 shows counterfactual results for the Faridabad pilot. This relates to how the cost per case would vary if all three models are applied to Faridabad from July 2020 to July 2021 which is the Service and Drug Delivery pilot geography and time period. The assumptions remain same as those for Surat and Ahmedabad.

Table 16: Overview of counterfactual estimates for Faridabad with assumptions

Cost category	Sub-category	JEET 1.0	Drug delivery	Service and drug delivery (Actuals)	Assumption
Admin: JEET Personnel	NPMU	SDD	SDD	SDD	The managerial cost of NPMU is not dependent on the nature of the pilot but on the geography of implementation. Thus, the managerial staff expenses would remain the same irrespective of the pilot.
	SPMU	SDD	SDD	SDD	
	SR	DD	DD	NA	There was no other SR partner than TATA-1mg under the SDD pilot due to the nature of the pilot. However, for DD and JEET1.0 operations, SR partner would be there. For ease of calculation, SR partner cost under the DD pilot is accounted as the time period of operations remains the same under DD and SDD
Admin: JEET others	Travel	SDD	SDD	SDD	The travel cost incurred by the managerial staff is not dependent on the nature of the pilot but on the geography of implementation. Thus, the travel cost would remain the same irrespective of the pilot
	Maintenance	SDD	SDD	SDD	The maintenance cost i.e. cost for facility and upkeep would remain the same, irrespective of the pilot. However, in the presence of SR partner under the DD and JEET, the counterfactuals would include the SR partner's maintenance cost
	Maintenance (SR)	DD	DD	NA	
	ICT	SDD +SR	SDD +SR	SDD	The ICT cost incurred under the JEET and DD models would include the ICT cost for SR partner as well

Cost category	Sub-category	JEET 1.0	Drug delivery	Service and drug delivery (Actuals)	Assumption
Admin: TATA- 1mg	Personnel	NA	Proportional to number of patients	SDD	
Admin: TATA- 1mg	Maintenance	NA	Proportional to number of patients	SDD	
Field personnel	Field Officers	Proportional to number of providers in SDD	Proportional to number of providers in SDD	SDD	
	Hub Agents	Proportional to number of patients in SDD	Proportional to number of patients in SDD	NA	
	SCT Agents	Proportional to number of patients in SDD	Proportional to number of patients in SDD	NA	
	Treatment Coordinator	Proportional to number of patients in SDD	Proportional to number of patients in SDD	NA	
Cost category	Sub-category	JEET 1.0	Drug delivery	Service and drug delivery (Actuals)	Assumption
Training	Field Staff	SDD	SDD	SDD	Training of the field staff and providers is not dependent on the nature of the pilot
	Providers	SDD	SDD	SDD	
Sample collection	Allowance to SCT Agents	Proportional to number of SCT agents in SDD NA	Proportional to number of SCT agents	NA	
	TATA-1mg		NA	SDD	

Cost category	Sub-category	JEET 1.0	Drug delivery	Service and drug delivery (Actuals)	Assumption
Drug delivery	TATA-1mg	NA	DD cost proportional to number of patients in SDD	SDD	
Counselling	Allowance to TC	Proportional to number of patients in SDD NA	Proportional to number of patients in SDD	NA	
	TATA-1mg		NA	SDD	
Compounder incentive	TATA-1mg	NA	NA	SDD	
		NA	NA	SDD	

Table 17: Per-case cost in case all three models get applied to Faridabad in the Service and Drug Delivery time-period

Cost category	Sub-category	Activity	Cost per case (in INR) JEET1.0	Cost per case (in INR) DD	Cost per case (in INR) SDD (actuals)
Total cost	-	-	6091	6450	3872
Admin: JEET Personnel	NPMU	Administrative	427 (7%)	504 (8%)	427 (12%)
	SPMU	Administrative	243 (4%)	243 (4%)	104 (3%)
	SR	Administrative	868 (15%)	868 (14%)	NA
Admin: JEET others	Travel	Administrative	308 (5.1%)	308 (4.8%)	308 (8%)
	Maintenance	-	219 (4%)	219 (4%)	219 (6%)
	Maintenance (SR)		180 (3%)	180 (3%)	NA
	ICT	-	344 (6%)	344 (6%)	252 (7%)
Admin: TATA- 1mg	Personnel	Administrative	NA	118 (2%)	664 (19%)

Cost category	Sub-category	Activity	Cost per case (in INR) JEET1.0	Cost per case (in INR) DD	Cost per case (in INR) SDD (actuals)
Admin: TATA- 1mg	Maintenance	-	NA	30 (0.4%)	310 (9%)
Field personnel	Field Officers	Engagement with providers	477 (8%)	477 (8%)	477 (14%)
	Hub Agents	Notification, drug dispensation	1458 (25%)	1458 (24%)	NA
	SCT Agents	Sample collection	297 (5%)	297 (5%)	NA
	Treatment Coordinator	Counselling	1205 (21%)	1205 (20%)	NA
Training	Field Staff	-	8 (0.1%)	8 (0.1%)	NA
	Providers	-	13 (0.2%)	14 (0.02)	20 (1%)
Sample collection	Allowance to SCT Agents	Sample collection	69 (1%)	69 (1%)	NA
	TATA-1mg		NA	NA	37 (1%)
Drug delivery	TATA-1mg	Drug delivery	NA	133 (2%)	204 (6%)
Counselling	Allowance to TC	Counselling	156 (3%)	156 (3%)	NA
	TATA-1mg		NA	NA	691 (20%)
Compounder incentive	TATA-1mg	Notifications	NA	NA	100 (3%)
		Treatment completion-notification	NA	NA	59 (2%)

The above results showed that the Service and Drug Delivery model implemented in Faridabad had the least per-case cost (Rs 3,872) as compared to a scenario where the drug delivery or JEET 1.0 was implemented in the same geography for the same time period. Here, the per-case cost is estimated to be Rs. 6540 and Rs. 6091 respectively. Similar to the Surat and Ahmedabad counterfactuals, the lower cost under the Service and Drug Delivery pilot can be attributed to the absence of field personnel in the Service and Drug Delivery model who were salaried employees of JEET under the JEET 1.0 and Drug Delivery models. Under the Drug Delivery and JEET 1.0 models, these field personnel contributed to more than 50% of the per-case cost. Even with the services of these field personnel, such as the SCT Agent and Treatment Coordinators being outsourced to TATA-1mg, the cost was considerably less.

5.3.3 Marginal analysis

Under the marginal analysis, we see how the per-case cost would vary with change in population size. To implement the pilots, the fixed costs would remain the same irrespective of the scale of the geography whereas the variable costs would vary with scale of the geography. The fixed and variable costs according to the cost categories and assumptions are presented in the table below:

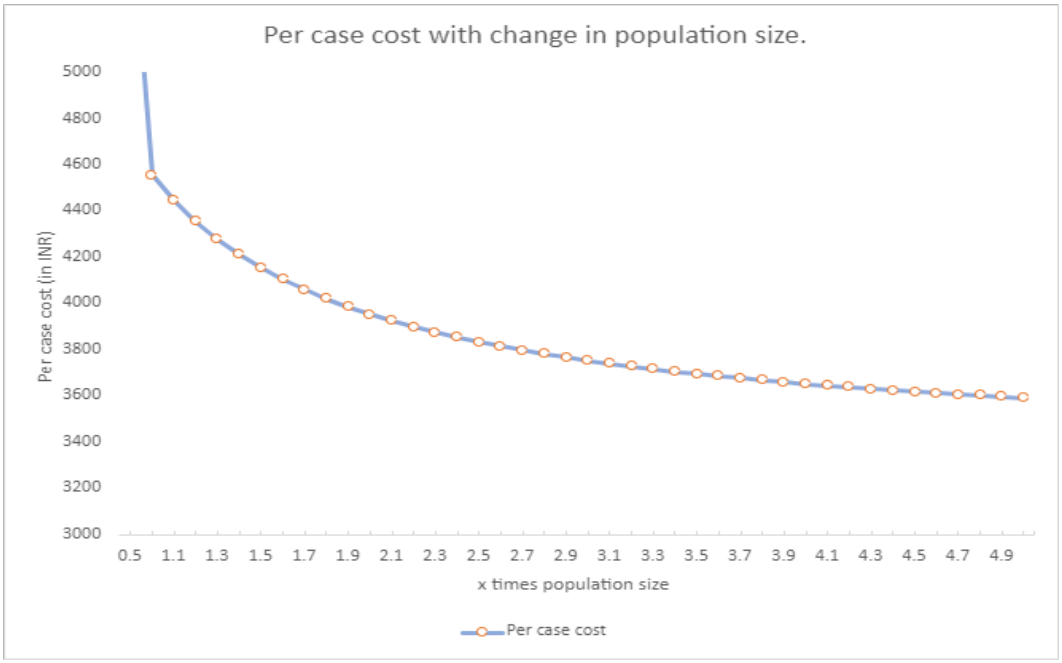
Cost category	Sub-category	Assumption
Admin: JEET personnel	NPMU	Fixed cost. NPMU staff doesn't depend on the population size of the geography where the pilot is implemented
	SPMU	Fixed cost. SPMU staff doesn't depend on the population size where the pilot is implemented but on the nature of pilot
	SR Partner	SR partner manages the field staff. Larger the size of geography, more would be the field staff and more positions like the 'operations lead' would be needed. Thus, this is taken proportional to size
Admin: JEET others	Travel	Travel of the NPMU/SPMU staff would remain the same irrespective of the size of the population
	Maintenance	Maintenance (such as office facility/upkeep cost, etc) would remain the same irrespective of the size of the population
	ICT	ICT cost involves the cost of laptops and equipment of the NPMU/ SPMU staff/office. Would remain the same irrespective of the size of the population
Admin: TATA-1mg	Personnel	Proportional to scale of geography
Admin: TATA-1mg	Maintenance	Proportional to scale of geography
Field personnel	Field Officers	Proportional to scale of geography
	Hub Agents	Proportional to scale of geography
	SCT Agents	Proportional to scale of geography
	Treatment Coordinator	Proportional to scale of geography

Cost category	Sub-category	Assumption
Training	Field Staff	Proportional to scale of geography
	Providers	Proportional to scale of geography + fixed component such as "token to the presenter"
Sample collection	Allowance to SCT Agents	Proportional to scale of geography
	TATA-1mg	Proportional to scale of geography
Drug delivery	TATA-1mg	Proportional to scale of geography
Counselling	Allowance to TC	Proportional to scale of geography
	TATA-1mg	Proportional to scale of geography
Compounder incentive	TATA-1mg	Proportional to scale of geography

Drug Delivery pilot

The below figure shows how the per-case cost under Drug Delivery pilot would vary with scale of geography (other things such as uptake, time period remaining the same). We assume that the number of providers and patients would be proportional to the scale of geography.

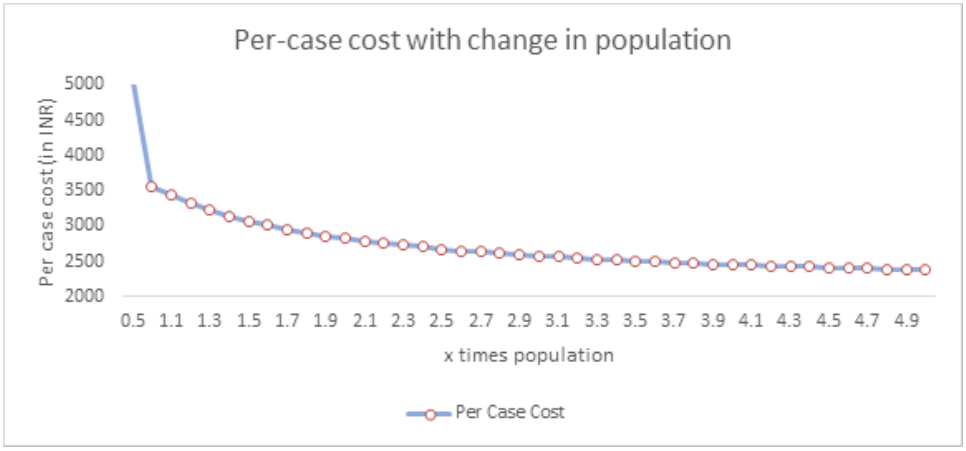
Figure 20: Per-case cost with change in population size



Service and Drug Delivery pilot

The below figure shows how the per-case cost under the Service and Drug Delivery pilot would vary with scale of geography (other things such as uptake, time period remaining the same). We assume that the number of providers and patients would be proportional to the scale of geography.

Figure 21: Per-case cost with change in population



To summarize, the per-case cost at current level of uptake was highest for the Drug Delivery model but the treatment outcomes (as per the programmatic data analysis) was also significantly better under the said model. If the same model is applied to other geography such as Faridabad, the per-case cost still remains the highest. The per-case cost at the current level of uptake was found to be lowest under the Service and Drug Delivery model due to the on-field services being outsourced to a for-profit agency. While the pay-for service under this model yielded the lowest cost, the treatment outcomes are so no clear from the programmatic data analysis.

Conclusion

In this study, we estimated the impact of involving a for-profit organisation (TATA-1mg) on the quality, quality, and cost of TB care under the PPSA model in the private sector in India. For this, we assessed two pilots, a Drug Delivery pilot implemented in Ahmedabad and Surat in Gujarat, and a Service and Drug Delivery pilot implemented in Faridabad.

We assessed the impact of these pilots through a three-fold research methodology wherein programmatic data was analysed to estimate the impact of the pilot on the quantity and quality of TB care. A primary qualitative study was undertaken to understand the mechanisms and reasons for the impact, and a costing analysis was done to estimate the per-case cost of delivering TB care for these pilots vis-à-vis the existing JEET (1.0) model.

Under the Drug Delivery pilot, TATA-1mg was involved in the doorstep delivery of medication (government FDCs). We hypothesised that this would lead to a higher proportion of patients being prescribed government FDCs and we do see the proportion of patients prescribed FDC was higher in the intervention period (55.87% vs. 42.46%). The result from the difference-in-difference analysis also shows that a significant 8% of this 13% can be attributed to the intervention.

Moreover, results from our qualitative interviews also concurred with the same. We saw that the providers who engaged with TATA-1mg were keen on prescribing government FDCs to their patients. However, there was no clear response received from the providers who did not engage with TATA-1mg.

We saw that new providers who engaged with TATA-1mg in the intervention-period, prescribed government FDCs to a substantially higher proportion of their patients. Additionally, the mean days without medication from the 2nd month of treatment and overall average days without medication across six months of treatment were significantly lower for patients who were onboarded on the TATA-1mg than those who were not.

From our interviews with patients, providers, and staff, we could attribute it to three key reasons. Firstly, patients who availed TATA-1mg services received reminder calls for a refill. Secondly, patients who availed of the services of home-delivery of medicines preferred this to collecting the medicines from the clinic as it saved them time and money. Lastly, we found that e-prescriptions were given to patients who availed TATA-1mg service, which meant that they did not necessarily have to travel each time to procure the prescription and subsequently the medication, hence, improving overall consumption and adherence.

Overall, a sense of trust for the TATA-1mg pilot in this geography was observed through the qualitative interviews with providers, and patients, who also believed that this model was doing efficient work, especially for the marginalised section of society.

Under the Service and Drug Delivery pilot, TATA-1mg was involved at every step of the process except onboarding the providers. Patients were given the option to avail of the sample collection and report delivery services at their doorstep. The results for the Service and Drug Delivery pilot are

not so clear. For the analysis, we consider Gurugram, a neighbouring district as a control region. However, Gurugram had a PPSA much earlier than Faridabad. Upon talking to the implementers, we understood that any PPSA has a settlement period. Given this, we conducted two different analyses to estimate the impact, one based on comparing the performance between Faridabad and Gurugram in the same calendar months, other comparing the performance during the first three quarters of operation.

We found that a lower proportion of patients were getting the CBNAAT test in the test geography as compared to the control geography (15.37% vs.15.83%). When comparing for the first three quarters of operation, we find a significantly higher proportion of patients getting the CBNAAT test in the test (15.2%) rather than the control (7.5%) geography.

Results from the qualitative interviews concur with the overall result. Both patients and providers opined that patients in the test geography were not keen on getting the CBNAAT tests done from them since testing was being done in a different centre. This also alludes to the patient's lack of information about TATA-1mg's doorstep sample collection.

FDCs were seen to be prescribed to a higher proportion of patients in the control geography (10.8% higher). However, in the first three operational quarters, a 5% higher proportion of patients in the test geography were prescribed FDCs. Responses from qualitative interviews indicate irregularity in FDC prescription to patients in both test and control geographies. It was also seen that in the early months of treatment, the days without medication for patients in the test geography were significantly lower than those in the control geography. However, no significant difference was found in the later months or overall days in the six months of treatment.

It was hypothesised that reminder calls, a service specific to the TATA-1mg pilot, would positively impact the patient's medication adherence. However, it was observed through the patient interviews in the intervention geography, that they received no reminder call during their treatment process.

Additionally, the providers did not keenly avail of these services either. The patients under the intervention geography expressed their hesitation with the home delivery of medication and stated that they preferred to collect medicines from the provider or clinic directly.

Overall, the knowledge and awareness about the programme among both providers and patients was limited. This could be attributed to less field staff in the intervention geography. It was noted that the intervention location had only one Treatment Coordinator as compared to the control geography which had more than one. This could also help explain the inconsistencies and lack of counselling reflected through the patients' responses.

Under the costing analysis, we calculated a per-case cost for both TATA-1mg operations in the Drug Delivery (Gujarat) and Service and Drug Delivery (Faridabad) pilot and the JEET 1.0 operations in Surat and Ahmedabad. The estimated per-case cost for the JEET 1.0 operations in Ahmedabad and Surat was Rs. 3469. More than 70% of the per-case cost was attributed to the field personnel (FOs, Hub Agents, SCT Agents, and Treatment Coordinators) employed under the JEET 1.0 model. The per-case cost for the Drug Delivery model is estimated to be Rs. 4559. It was found that nearly 65% of the total cost could be ascribed to the field personnel. This increase was hypothesised as under the Drug Delivery model, an additional service of doorstep drug delivery which was provided to the patients while other costs remained the same.

Also, the number of notifications per month has been found to be lower during the Drug Delivery pilot. This leads to a higher per-case cost. In the Service and Drug Delivery model in Faridabad, certain services under the PPSA model were outsourced to TATA-1mg. Here, the per-case cost is estimated to be Rs. 3872.

We also estimated the counter-factual costs i.e., how the per-case cost would vary if all three models were applied to Gujarat and Faridabad respectively from July 2020 to July 2021. If the Service and Drug Delivery model was implemented in Surat and Ahmedabad instead of the Drug Delivery model, the per-case cost was Rs. 3652, followed by the JEET 1.0 cost of Rs. 4230.

When calculated for the Faridabad geography, we saw that the cost of the Drug Delivery model, instead of the Service and Drug Delivery model was Rs. 6146 and that of JEET 1.0 was Rs. 5787. It was seen that the Service and Drug Delivery model implemented in Faridabad had the least per-case cost which stood at Rs. 3872 compared to the other models. We find when certain services of PPSA are outsourced to TATA-1mg, the per-case cost comes down drastically. We could account for the decrease in cost across the models to the absence of field personnel in the Service and Drug Delivery model who were salaried employees of JEET under the JEET 1.0 and Drug Delivery models. However, this decrease in cost is not accompanied with better health outcomes.

Overall, we find that the Service and Drug Delivery pilot performs worse than the JEET 1.0. However, it is not clear if this is due to inherent differences in the two geographies, differences between the two models and their incentive structure, or exposure time. Our study is unable to comment on the reason.

Considering India's high TB burden, further exploration and refinement of such collaborative approach is required to leverage the expertise of both for-profit and non-profit entities for patient management.

Limitations of the study

- Patient medication data available only from JEET programme: The patient's medication data is available only for patients who are in the JEET dataset. The ones who move away from government medication and take private medication are lost from our analysis.
- Self-selection bias whilst sampling: There was a self-selection bias in Surat and Ahmedabad whilst sampling for the study as the providers and patients were given an option to avail or not avail the services offered by TATA-1mg. Because of this bias, there was no pure test and control group for the Drug Delivery pilot in Gujarat. For the Service and Drug Delivery pilot, we tried to find a geography closest to Faridabad to act as control. Gurugram is a nearby district in the same state. However, there seem to be inherent differences between Gurugram and Faridabad. Another issue with comparing Faridabad with Gurugram is that Gurugram had a PPSA much earlier than Faridabad. Post discussion with implementers of the TATA-1mg model under JEET, we understood that there is a settlement period for any PPSA as well as learning effect for later established PPSAs (such as Faridabad). This makes Faridabad and Gurugram not directly comparable geographies.
- Lack of actual costs incurred for travel of managerial staff under JEET 1.0 programme by geography: Under the JEET 1.0 expense sheet, the actual expenditure incurred for travel of the managerial staff for JEET 1.0 operations is not bifurcated by geographies i.e., we did not have the actual cost incurred for travel to Gujarat. Thus, we had to make assumptions to come to this costing.
- The two pilots under the JEET PPSA model show promising signs to provide private sector TB care services in India. However, key improvements are required in sustaining the motivation and trust of providers, improving knowledge around CBNAAT testing and FDC consumption for patients and providers, and optimising cost to patient for seeking TB care in the private sector.

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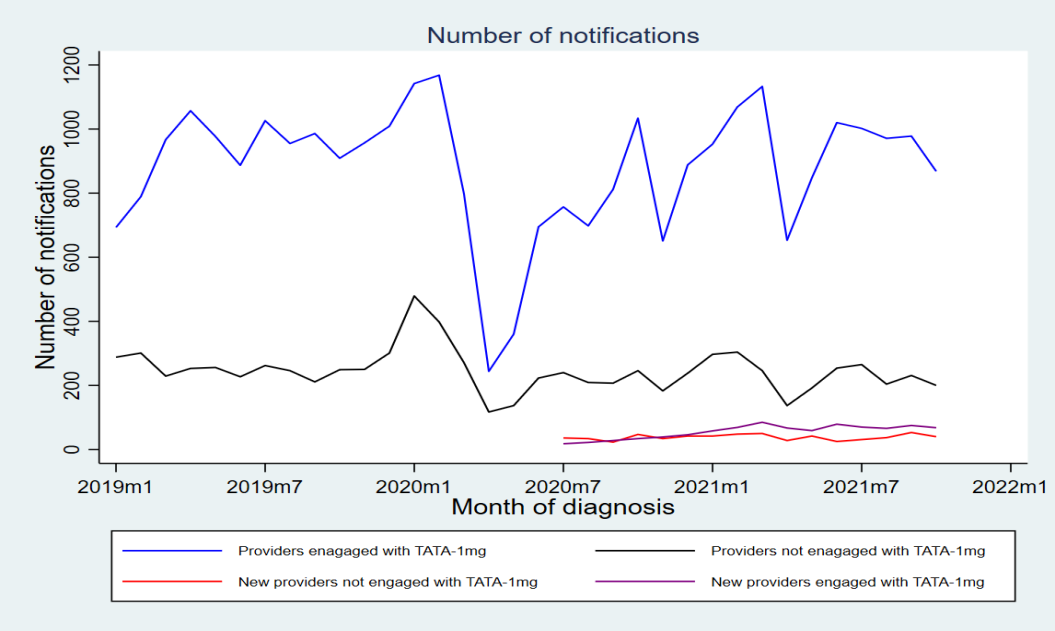
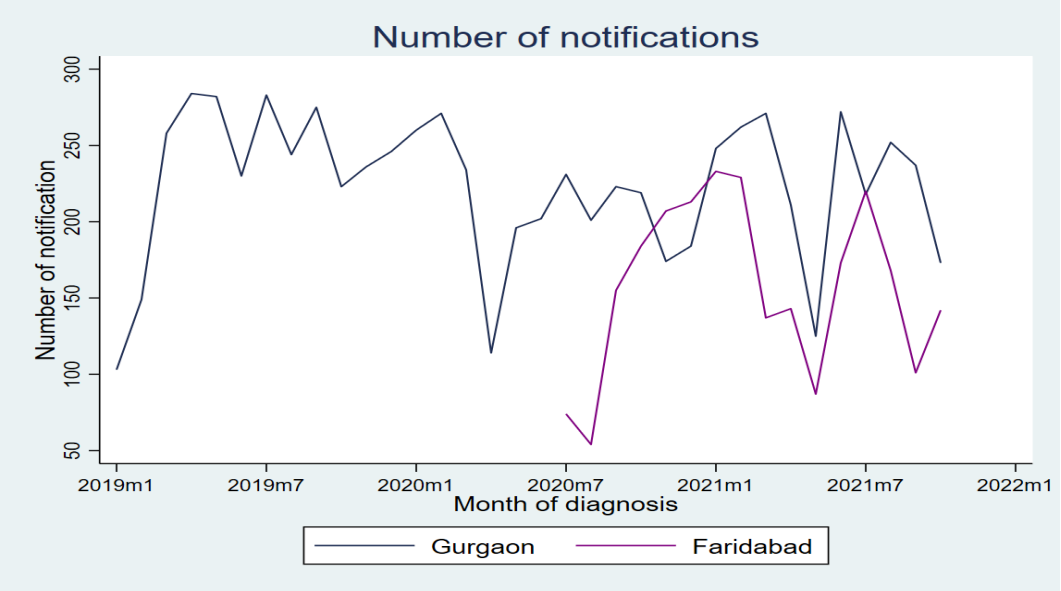
Appendices

Appendix 1: Actual Number of Notifications by Month





Appendix 2: Regression Models

1. Drug Delivery Model (Surat and Ahmedabad)

Total #Providers	1965	Proportion of providers
Number of providers prescribing FDC in the pre-pilot period	1065	54.19%
Number of providers prescribing FDC in the intervention period	1118	56.89%

Logistic Regression (Marginal effects)

Dependent Variable: CBNAAT | No = 0, Yes = 1
Number of obs = 36,605

Covariate	Coefficient	p-value	Confidence interval
Post	0.11	0.00	0.10 – 0.12
Age	-0.00	0.00	-0.001 - -0.000
Sex	0.02	0.00	0.01 – 0.02
Extrapulmonary	-0.19	0.00	-0.20 - -0.18

Linear Probability Model

Dependent Variable: CBNAAT | No = 0, Yes = 1
Number of obs = 36,605

Covariate	Coefficient	p-value	Confidence interval
Post	0.11	0.00	0.10 – 0.12
Age	-0.00	0.00	-0.001 - -0.000
Sex	0.01	0.00	0.01 – 0.02
Extrapulmonary	-0.18	0.00	-0.19 - -0.17

Difference-in-Difference Model

Dependent Variable: CBNAAT | No = 0, Yes = 1
Number of obs = 36,605

Covariate	Coefficient	P-value	Confidence Interval
Post	0.08	0.000	0.06 - 0.10
Test	0.09	0.000	0.07 – 0.10
Interaction (DID coefficient)	*0.04*	*0.001*	*0.01 – 0.06*
Age	-0.0009	0.000	-0.001 - -0.0006
Sex	0.018	0.000	0.009 – 0.028
Extrapulmonary	- 0.18	0.000	-0.19 - -0.17

Logistic Regression (Marginal effects)

Dependent Variable: FDC | No = 0, Yes = 1
Number of obs = 41,692

Covariate	Coefficient	p-value	Confidence interval
Post	0.13	0.000	0.12-0.14
Age	-0.002	0.000	-0.00 – -0.00
Sex	-0.02	0.000	-0.02 - -0.01
Extrapulmonary	0.017	0.001	0.007 – 0.027

Linear Probability Model

Dependent Variable: FDC | No = 0, Yes = 1
Number of obs = 41,692

Covariate	Coefficient	p-value	Confidence interval
Post	0.13	0.00	0.12 – 0.14
Age	-0.002	0.00	-0.002 - -0.002
Sex	-0.02	0.00	-0.02 - -0.01
Extrapulmonary	0.01	0.00	0.00 – 0.02

Difference-in-Difference Model

Dependent Variable: FDC | No = 0, Yes = 1

Number of obs = 41,692

Covariate	Coefficient	P-value	Confidence Interval
Post	0.04	0.00	0.02 - 0.06
Test	0.25	0.00	0.23 – 0.26
Interaction (DID coefficient)	*0.08*	*0.00*	*0.06 – 0.10*
Age	-0.002	0.00	-0.0026 - - 0.0020
Sex	-0.018	0.00	-0.02 - - 0.008
Extrapulmonary	0.02	0.00	0.01 – 0.03

Logistic Regression (Marginal effects)

Dependent Variable: Counselling | No = 0, Yes = 1

Number of obs = 35,888

Covariate	Coefficient	p-value	Confidence interval
Post	0.031	0.00	0.02 – 0.03
Age	-0.0002	0.00	-0.00 - -0.00
Sex	-0.00	0.09	-0.00 – 0.00
Extrapulmonary	0.002	0.199	-0.001 – 0.007

Linear Probability Model

Dependent Variable: Counselling | No = 0, Yes = 1

Number of obs = 35,888

Covariate	Coefficient	p-value	Confidence interval
Post	0.02	0.00	0.02 – 0.03
Age	-0.0002	0.00	-0.00 - -0.00
Sex	-0.003	0.105	-0.007 – 0.000
Extrapulmonary	0.002	0.195	-0.001 – 0.007

Difference-in-Difference Model

Dependent Variable: Counselling | No = 0, Yes = 1

Number of obs = 35,888

Covariate	Coefficient	P-value	Confidence Interval
Post	0.031	0.000	0.021 – 0.040
Test	0.042	0.000	0.035 – 0.049
Interaction (DID coefficient)	*-0.004*	*0.384*	*-0.015 - 0.005*
Age	-0.0002	0.001	-0.0003 - -0.0000
Sex	-0.0018	0.0401	-0.006 – 0.002
Extrapulmonary	0.005	0.018	0.000 – 0.009

Logistic Regression (Marginal effects)

Dependent Variable: Successful Outcome | No = 0, Yes = 1

Number of obs = 36,935

Covariate	Coefficient	p-value	Confidence interval
Post	0.018	0.00	0.01 – 0.02
Age	-0.003	0.00	-0.00 - -0.00
Sex	-0.01	0.00	-0.01 - -0.00
Extrapulmonary	0.04	0.00	0.03 – 0.05

Linear Probability Model

Dependent Variable: Successful outcome | No = 0, Yes = 1

Number of obs = 36,935

Covariate	Coefficient	p-value	Confidence interval
Post	0.018	0.00	0.01-0.02
Age	-0.003	0.00	-0.003 - -0.003
Sex	-0.01	0.00	-0.01 - -0.00
Extrapulmonary	0.04	0.00	0.03 – 0.05

Difference-in-Difference Model

Dependent Variable: Successful outcome | No = 0, Yes = 1

Number of obs = 36,935

Covariate	Coefficient	P-value	Confidence interval
Post	0.046	0.000	0.03 – 0.06
Test	0.017	0.003	0.005 – 0.02
Interaction (DID coefficient)	*-0.033*	*0.000*	*-0.051 – -0.016*
Age	-0.003	0.000	-0.0036 - -0.0032
Sex	-0.0089	0.015	-0.016 – -0.001
Extrapulmonary	0.046	0.000	0.038 – 0.053

2. Service and Drug Delivery Model

Logistic Regression (Marginal effects)

Dependent Variable: CBNAAT | No = 0, Yes = 1

Number of obs = 8,624

Covariate	Coefficient	p-value	Confidence interval
Test	-0.05	0.00	-0.07 - -0.04
Age	-0.001	0.00	-0.001 - -0.000
Sex	0.01	0.08	-0.00 – 0.02
Extrapulmonary	-0.23	0.00	-0.26 - -0.21

Linear Probability Model

Dependent Variable: CBNAAT | No = 0, Yes = 1

Number of obs = 8,624

Covariate	Coefficient	p-value	Confidence interval
Test	-0.06	0.00	-0.08 - -0.04
Age	-0.001	0.00	-0.001 - -0.000
Sex	0.01	0.07	-0.005 – 0.029
Extrapulmonary	-0.18	0.00	-0.20 - -0.16

Logistic Regression (Marginal effects)

Dependent Variable: FDC | No = 0, Yes = 1

Number of obs = 10,107

Covariate	Coefficient	p-value	Confidence interval
Test	-0.14	0.00	-0.16 - -0.12
Age	-0.003	0.00	-0.004 - -0.003
Sex	-0.01	0.04	-0.03 - -0.000
Extrapulmonary	-0.06	0.00	-0.08 - -0.004

Linear Probability Model

Dependent Variable: FDC | No = 0, Yes = 1

Number of obs = 10,107

Covariate	Coefficient	p-value	Confidence interval
Test	-0.14	0.00	-0.16 - -0.11
Age	-0.003	0.00	-0.003 - -0.002
Sex	-0.01	0.04	-0.03 - -0.00
Extrapulmonary	-0.07	0.00	-0.09 - -0.05

Logistic Regression (Marginal effects)

Dependent Variable: Counselling | No = 0, Yes = 1

Number of obs = 10,107

Covariate	Coefficient	p-value	Confidence interval
Test	-0.37	0.00	-0.38 - -0.36
Age	-0.001	0.00	-0.001 - -0.001
Sex	-0.018	0.036	-0.036 - -0.001
Extrapulmonary	0.084	0.00	0.065 – 0.104

Linear Probability Model

Dependent Variable: Counselling | No = 0, Yes = 1

Number of obs = 10,107

Covariate	Coefficient	p-value	Confidence interval
Test	-0.46	0.00	-0.48 - -0.44
Age	-0.001	0.00	-0.002 - -0.001
Sex	-0.01	0.04	-0.03 - -0.00
Extrapulmonary	0.08	0.00	0.06 – 0.10

Logistic Regression (Marginal effects)

Dependent Variable: Successful Outcome | No = 0, Yes = 1

Number of obs = 9,473

Covariate	Coefficient	p-value	Confidence interval
Test	0.14	0.00	0.11 – 0.16
Age	-0.00	0.00	-0.00 – 0.00
Sex	-0.006	0.41	-0.02 – 0.009
Extrapulmonary	0.037	0.00	0.02 – 0.05

Linear Probability Model

Dependent Variable: Successful Outcome | No = 0, Yes = 1

Number of obs = 9,473

Covariate	Coefficient	p-value	Confidence interval
Test	0.12	0.00	0.10 – 0.13
Age	-0.003	0.00	-0.003 - -0.003
Sex	0.004	0.59	-0.01 - -0.01
Extrapulmonary	0.04	0.00	0.02 – 0.05

Appendix 3: Primary Qualitative Research Tools

Patients Interview Guide

Notes to the Interviewer

This is a 'guide' of the themes and questions you might take the help of while interviewing the respondents to understand the barriers and facilitators to the private sector TB care under the PPSA model. We urge you to structure the conversation flow based on the respondent's inputs and not solely based on the sequence listed here.

A. Demography questions (Background)

S No	Questions	Categories/Logic	Notes
1	Which city/village are you originally from?		
2	What best describes your gender?	Female Male Prefer not to say Self-describe ___	
3	What is your current age?		
4	What is your highest educational qualification?	Illiterate (cannot read or write) Literate (can read and write, but do not enter school) Elementary school completed High school completed Senior secondary school completed Graduation Post-graduation and above	
5	What do you currently do for a living?	Farmer Homemaker Private (office) Daily wage worker Not-working Others _____	
6	Are you married?	1. Yes 2. No 3. Separated/divorced	

S No	Questions	Categories/Logic	Notes
7	How many members do you have in your household?		Please check for number of adults and children in household that share the same kitchen
8	When were you diagnosed with TB?		

B. TB diagnosis process and follow-up visits

S No	Questions	Probes/Logic	Notes
1	What were your initial symptoms of TB?	1. Fatigue 2. Joint pain 3. Trepidation (*ghabrahat* in Hindi) 4. Fever 5. Weight loss 6. Night sweats 7. Cold 8. Others (=======)	
2	Can you describe everything that happened when you visited the doctor for the first time with these symptoms?	Probe: Time taken for travel, waiting time, behaviour of doctor/staff with patient, how was patient data recorded, which tests were prescribed, medicines prescribed, were they informed about alternate treatments, money spent by patient on tests and consultation, did they meet/talk to anyone else at the clinic, any other tests (HIV, RBS etc) prescribed	
3	Why did you choose to go to this doctor for TB treatment?	Probes: Distance from home, credibility, cost involved (tests, diagnosis), how many doctors visited before they decided to go ahead with a specific doc for treatment	
4a	Did you go to the same doctor as above for showing your TB test reports?	Yes No	If yes, skip to Q.5
4b	If no, why?		

S No	Questions	Probes/Logic	Notes
5	What happened when you went to the doctor with your report?	Probe on alternate treatments suggested, medicines suggested	
6	Do you go for follow up visits to the doctor?	Yes No Probe on reasons for each	

C. Sample collection

S No	Questions	Probes/Logic	Notes
1a	Was your sample collected for TB testing?		Check on what sample was collected- sputum, urine, blood
1b	If yes, where was your sample collected for TB testing?	Probes: Is the sample collected from home or the clinic?	
2	How many times and when were you asked to provide your sputum sample?		Sputum is collected during initial testing, end of Intensive phase (after 2 months of diagnosis) and end of continuous phase (after 6 months of diagnosis)
3	Would you prefer doorstep sample collection for TB testing or go to a lab or hospital and why?		

D Test reports

S No	Questions	Probes/Logic	Notes
1	How did you receive your TB test reports?	Probes: Are reports delivered at home or collected from clinic/ lab?	
2	Would you prefer doorstep delivery of test reports or go to a lab or hospital to collect it and why?		

E. Fixed dose combination (medicine)

S No	Questions	Probes/Logic	Notes
1	Did you get a monthly prescription of medicines?	Yes No If not, check for how long they got prescription	
2	Do you get medicines only after visiting the doctor?	Probes: Have there been instances where they received medicine without visiting the doctor. Especially, for the intervention group, can a patient get the follow-up medicine from TATA-1mg staff without physically visiting the doctor? Also, can the prescription be given over Whatsapp?	
3	How do you get your TB medicines?	Probes: Are they delivered at home or collected from the clinic?	
4	How frequently do you receive TB medication?		Ideally, medication is to be delivered/ retrieved every month
5a	Do you get four different tablets as medicines or one single tablet?		
5b	If you get single tablet, were you asked by your doctor to shift to four tablets?		
6	Would you prefer getting medicines at the doctor's clinic or delivered at home, and why?	Probe on reasons for each answer	

F. Home delivery of services

S No	Questions	Probes/Logic	Notes
1.a	Are you aware about door-step sample collection and report delivery for TB testing?		If no, skip to Q.4 Only for intervention group in Faridabad
1.b	If yes, have you availed these services?	1. Yes 2. No e	If yes, skip to Q.3
1.c	What are the reasons for refusing these services?		
2	What did you like about doorstep sample collection and report delivery for TB testing?	Probes: Implicit cost---time, effort spent for sample collection from clinic/lab, money spent on travel	Only for the intervention group in Faridabad
3	Were there any challenges faced due to doorstep sample collection and report delivery for TB testing?	Probes: Social stigma around TB, non-availability of patient; previous inhibitions, trust developed	Only for intervention group in Faridabad
4	Have you availed doorstep delivery of medicines?	Yes No	For intervention group in both Gujarat and Faridabad If no, skip to Section G
5	What did you like about doorstep delivery of medicines?	Probes: implicit cost --time, effort spent on getting medicines from clinic, money spent on travel	For intervention group in both Gujarat and Faridabad
6	Were there any challenges faced due to door-step delivery of medicines?	Probes: social stigma around TB, non-availability of patient; previous inhibitions, trust developed only for ASHA workers etc	For intervention group in both Gujarat and Faridabad

G. Treatment counselling support

S No	Questions	Probes/Logic	Notes
1a	Were you explained about TB as a disease?	Probes: what is TB, how do you catch/spread the disease, severeness of the disease, symptoms of the disease, nutritional intake of the patient; mode of this information (telephonic/in-person/ clinic)	If no, skip to 2a
1b	If yes, who explained this to you?		
1c	What did they tell you?		
1d	Was it beneficial for you and your family?		If yes, probe on how it was beneficial
2a	Were you explained about the TB treatment process?	Probes: medication-side-effects and1 adherence, length of treatment, when and who to contact in case of emergency	If no, skip to 3
2b	If yes, who explained this to you?		
2c	What did they tell you?		
2d	Was it beneficial for you and your family?	How was it -beneficial/ not useful	
3	What can be done to improve your knowledge of TB?		
4a	Have you ever missed your medication?	If no, skip 4b.	Ask a base question of how long the treatment process was and then follow up with if they've ever missed medication. Please note that we are interested in knowing the period and not a missing dose for a day or two.
4b	If yes, what did you do to ensure you take medicines next time?		
5a	Did any staff member reminded you for taking your TB medicines?	Yes No	If no, skip to Section H
5b	If yes, who gave you these reminders?		
5c	Are these reminders useful? How?		

H. Beliefs and perceptions

S No	Questions	Probes/Logic	Notes
1	Fears What are some of the fears related to TB care in the private sector?	Probe for in-depth understanding: How has the situation changed since TATA-1mg came into place?	For intervention group in both Gujarat and Faridabad
2a	Fears Do you think you are comfortable in discussing your TB treatment process with family, friends, and neighbours?	Yes No	If yes, skip to 3
2b	Fears If not comfortable, what are the factors that refrain you from telling them?		
3	Trust Define your experience with the following- 1.Doctors 2.Compounders 3. Staff (counsellors, delivery agents, hub agents, TC)	Probe: Ease of access to these stakeholders, knowledge of the stakeholders, trust, availability, behaviour towards patients	
4	Social Norms What has the TB care staff done to remove stigma around TB in your neighbourhood?		
5	Trust Do you think you would recommend other TB patients to take treatment in the private sector? Why/Why not?		Not linked to any research objective but can give interesting insights for the overall research topic

Conclusion

Thank you for your time and much-valued input to the study! As mentioned earlier, we will use these insights to understand the barriers and facilitators of private sector TB care. We will keep all the responses confidential. Your de-identified interview responses will only be shared with research team members.

Is there anything else that you would like to add?
(Answer)
Thank you and have a good day!

Providers Interview Guide

Notes to the Interviewer

This is a 'guide' of the themes and questions you might take the help of while interviewing the respondents to understand the barriers and facilitators to private sector TB care. We urge you to structure the conversation flow based on the respondent's inputs and not solely based on the sequence listed here.

A. Demography questions (Background)

S No	Questions	Categories/Logic	Notes
1	Which city/village are you originally from?		
2	What best describes your gender?	Female Male Prefer not to say. Self-describe ___	
3	What is your current age?		
4	What is your highest educational qualification?	MBBS MD DM BHMS BAMS	
5	What are your total years of experience as a healthcare provider?		
6a	Are you aware of TATA-1mg programme for TB care in your district?	Yes No	For intervention group in Faridabad and Gujarat If yes, skip to Section B
6b	If not, what were the reasons for not working with the TATA-1mg programme?	Open ended- probe for belief in the system, comfort, delegation of work etc	For intervention group in Faridabad and Gujarat

B. First visit to doctor

S No	Questions	Probes/Logic	Notes
1a	What process you follow when new TB suspect patient comes to you?	Probes: How is patient data collected, nikshay notification done, what symptoms alerted them to prescribe tests, were tests prescribed, which tests were prescribed and why, JEET services such as Xpert test/FDC used by doctor, medicines prescribed, were they informed about alternate treatments, money charged for consultation and tests, did they meet/ talk to anyone else at the clinic, any other tests (HIV, RBS etc) prescribed, what was told about TB as a disease and the treatment process to patient	
1b	Did the process change when you worked with TATA-1mg?	Probe: Which elements of the TATA-1mg programme you found challenging? Which elements did you like? Specific probes: How was notification done post TATA-1mg, If they were keeping FDCs; how did that change? , if the doctors prescribed private label FDCs or government FDCs and possibly, reasons for the same, did patients still take meds from them (FDC meds); what %of patients came back to ask for loose drugs ; What led them to prescribe loose drugs instead, has their compounders workload increased since they started working with 1mg	Only for the intervention group Skip this question if provider has not worked with TATA-1mg
2a	Was TB patient's data recorded by the clinic?	Yes No	If no, skip to Section C
2b	If yes, how is a patient's data recorded by the clinic?		
2c	Was there a change in the way data was recorded on Nikshay under the TATA-1mg programme?	Probe on the role of field staff and how this has changed doctor's visibility into patient journey	Only for intervention group Skip this question if provider has not worked with TATA-1mg

C. Sample collection

S No	Questions	Probes/Logic	Notes
1	How is sample collection for TB testing done for patients?	Probes: Is the sample collected from home or the clinic?	
2	How many times do you recommend sample collection and testing of the patients?		Sputum is collected during initial testing, end of Intensive phase (after 2 months of diagnosis) and end of continuous phase (after 6 months of diagnosis)

D. Test reports

S No	Questions	Probes/Logic	Notes
1	What tests do you prescribe to your patients?	Probe on if doctors are prescribing CBNAAT tests If not, why doctors are not prescribing CBNAAT tests to all patients	
121	How do patients receive their TB test reports?	Probes: Are reports delivered at home or collected from clinic?	

E. TB Diagnosis Process and Fixed dose combination (medicine)

S No	Questions	Probes/Logic	Notes
1	What you recommend when patients come back to you with their test report?	Probe on alternate treatments suggested, medicines suggested	
2	How do patients get their TB medication?	Probes: Are they delivered at home or collected from the clinic?	
3	What is the period /frequency of medicine prescription for TB patients?n to a patient?		Ideally, medication is to be delivered/ retrieved every month

F. Home delivery of services

S No	Questions	Probes/Logic	Notes
1	Do you tell patients about door-step sample collection and report delivery for TB testing?	Probe on if the provider is informed about these services to all patients and if no, reasons for the same	Only for intervention group in Faridabad
2	Did you tell the patient about doorstep delivery of medication?	Yes No Probe on if the provider informed about these services to all patients and if no, reasons for the same	For intervention group in both Gujarat and Faridabad If no, skip to Section G
3	Can patients get doorstep delivery of medicines without coming back for their follow-up visit?	Are WhatsApp prescriptions valid?	For intervention group in both Gujarat and Faridabad

G. Follow-up visits to doctor

S No	Questions	Probes/Logic	Notes
1a	Do you or your staff remind the patients for a follow-up visit?		
1b	Do patients regularly visit you for follow-up examinations?	Yes No Probe: Does counselling affect the follow-up visits to doctor TATA-1mg does not delivery medicine without prescription --> patients have to visit the doctor for prescription. question is pivotal to research; please ask specifically for the time duration that TATA-1mg was serving, probe on time taken between prescription and actual delivery of drugs	If yes, skip to 2a
1c	If no, what are the reasons that patient do not regularly come for follow-up examination?	Skip if answer is yes Probe: How has home delivery of drugs, sputum sample collection and reports affected frequency of follow-up visits to the doctor	Only for the intervention group

S No	Questions	Probes/Logic	Notes
2a	Do you think number of follow up visits have changed since the patients have started receiving medicines at home?	Yes No	If no, skip to Section H
2b	If yes, what could be the possible reasons for the same?		

H. Treatment counselling support

S No	Questions	Probes/Logic	Notes
1a	Who explains about TB as a disease and the TB treatment process to patients?		
1b	What do they tell the patients?	Probes: what is TB, how do you catch/ spread the disease, severity of the disease, symptoms of the disease; medication-side-effects, adherence, length of treatment, when and who to contact in case of emergency, counselling on nutritional intake	
2a	Did TATA-1mg change the way counselling of patients is done and how?	Yes No	Only for intervention group in Faridabad Skip this question if provider has not worked with TATA-1mg If no, skip to 3a
2b	If yes, how?		Only for intervention group in Faridabad
3a	Did anyone remind patients about their follow-up visits or medications?		
3b	Is there any difference in the medication adherence for patients since TATA-1mg programme started?		Only for intervention group in Faridabad Skip this question if provider has not worked with TATA-1mg- please only ask in Faridabad district

S No	Questions	Probes/Logic	Notes
4	What could be the challenges if the counselling service are given by TATA-1mg staff		Only for intervention group in Faridabad Skip this question if provider has not worked with TATA-1mg- please only ask in Faridabad district
5	What can be done to improve the overall process for improving TB knowledge for the patients?		

I. Beliefs and perceptions

S No	Questions	Probes/Logic	Notes
1	Fears What are the fears experienced by patients related to TB care in the private sector?	Probe for in-depth understanding: How has the situation changed since TATA-1mg came into place?	
2a	Fears Do you think patients are comfortable in discussing their TB treatment process with their family, friends, and neighbours?	Yes No	If yes skip to Q.3
2b	Fears If not, what are the factors that could refrain them from telling others?		
3	Trust Describe your experience with the following: 1.Patients 2.Compounders 3.TATA-1mg/JEET staff	Probe: Ease of access to these stakeholders, knowledge of the stakeholders, trust, availability, efficacy and efficiency of work Do you think stigma has reduced? How has it reduced--- where/why has it not. Is there a difference in attitude you see between men and women? Does stigma differ by gender?	
4	Motivation Is there a personal motivation to work with a for-profit/private sector provider of TB care?	Probe on the relationship with TATA-1mg/ JEET staff; ease of burden, credibility and factor of trust, specialists assigned for certain role, hence, improve in efficiency	

Conclusion

Thank you for your time and much-valued input to the study! As mentioned earlier, we will use these insights to understand the barriers and facilitators of private sector TB care. We will keep all the responses confidential. Your de-identified interview responses will only be shared with research team members.

Is there anything else that you would like to add?
(Answer)
Thank you and have a good day!

Staff Interview Guide

Notes to the Interviewer

This is a 'guide' of the themes and questions you might take the help of while interviewing the respondents to understand the barriers and facilitators to private sector TB care. We urge you to structure the conversation flow based on the respondent's inputs and not solely based on the sequence listed here.

Please note that Sections I and J are to be shared with all staff categories and their responses recorded.

A. Demography questions (Background)

S No	Questions	Categories/Logic	Notes
1	Which city/village are you originally from?		
2	What best describes your gender?	Female Male Prefer not to say Self-describe ___	
3	What is your current age?		
4	What is your highest educational qualification?	Elementary school completed High school completed Senior secondary school completed Graduation Post-graduation and above	
5	For how many years have you been working as a healthcare worker?		

S No	Questions	Categories/Logic	Notes
6	What is your job title out of the following?	Hub Agent SCT Agent Treatment Coordinator Field Officer TATA-1mg Tele-caller TATA-1mg Delivery Agent Compounder	Skip to the following sections for each staff type- Hub Agent-Section B SCT Agent-Section C Treatment Coordinator-Section D Field Officer- Section E TATA-1mg Tele-caller-Section F TATA-1mg Delivery Agent- Section G Compounder- Section H

B. Hub Agent

S No	Questions	Probes/Logic	Notes
1	Can you explain the activities you do as a hub agent?		
	Elaborate on the process followed for collecting samples from patients?		
3	What challenges are faced during the sample collection of patients in the treatment process?		
4	How do you provide test reports to the patients?	Probe: Are they collected from the hub/ clinic by the patient	
5	How do you capture data for TB patients?		
6a	Do you input details onto the Nikshay platform?	Yes No	If no, skip to question 8.a
6b	Describe your experience with using the Nikshay platform.	Probes: What works well with Nikshay platform Challenges faced with Nikshay platform- technology use and training	
7a	Were you trained to use technology (phone, tablet, computer etc) to upload patients details online?		

S No	Questions	Probes/Logic	Notes
7b	Are you comfortable using technology (phone, tablet, computer etc) to upload patient details online?	Probe on access, intent and ability to use technology	
8a	Do you give medicines to patients?		
8b	What are the challenges faced while giving medicines to patients?	Probes: Drugs suggested by doctor (FDC or loose drugs) and patient perspective on it, beliefs about FDC	
9a	Have you worked with the TATA-1mg programme in your district?	If no, skip 9b	
9b	If yes, how has your workload changed since you started working with TATA-1mg programme?	Probe on why they must share patient details with TATA-1mg	

C. SCT Agent

S No	Questions	Probes/Logic	Notes
1	Can you explain the activities you do as an SCT Agent?		
2	Elaborate on the process followed for sample collection from Hub Agent and report delivery to them?		
3	What challenges are faced by you in the process?		

D. Treatment Coordinator

S No	Questions	Probes/Logic	Notes
1	Can you explain the activities you do as a TC?		
2a	Do you explain about TB as a disease to the patients?		
2b	If yes, what do you explain them?	Probes: What is TB, how do you catch/spread the disease, severeness of the disease, symptoms of the disease, nutritional intake, DBT benefits Can also prove on how this information is conveyed to them- as a conversation or a monologue	

S No	Questions	Probes/Logic	Notes
3a	Do you explain about the TB treatment process to the patients?		
3b	If yes, what do you explain to them?	Probes: Medication-side-effects and adherence, length of treatment, when and who to contact in case of emergency	
4a	Is it beneficial to hire a third-party organisation such as TATA- 1mg for providing counselling to patients?		
4b	What could be the challenges if the counselling service is outsourced to a third-party organisation such as TATA-1mg?		
5	What can be done to improve overall TB knowledge for the patients? Do you think, based on your visits/interactions--- something can be done to improve knowledge around TB?		

E. Field Officer

S No	Questions	Probes/Logic	Notes
1	Can you explain the activities you do as a FO?		
2a	How do you engage doctors with the JEET programme?		
2b	What are their responses?		
3	How was the process of engaging the doctors with TATA- 1mg (in Gujarat & Faridabad) different?	Any extra work required in convincing doctors to engage with a for-profit organisation? Try to capture JEET engagement vs TATA- 1mg engagement	For intervention group in Surat and Ahmedabad

F. TATA-1mg Tele-caller

S No	Questions	Probes/Logic	Notes
1	Can you explain the activities you do as a TATA- 1mg tele-caller?		
2	How do you capture data for TB patients?		Only for intervention group in Faridabad
3a	Do you input details onto the Nikshay platform?	Yes No	Only for intervention group in Faridabad If no, Skip to 4a.
3b	Describe your experience with using the Nikshay platform	Probes: What works well with Nikshay platform? Challenges faced with Nikshay platform- technology use and training?	Only for intervention group in Faridabad
4a	Were you trained to use technology (phone, tablet, computer etc) to upload patients details online?		Only for intervention group in Faridabad
4b	Are you comfortable with using technology (phone, tablet, computer etc) to upload patient details online?	Probe on access, intent and ability to use technology	Only for intervention group in Faridabad
5a	Do you inform the patients about test results?		
5b	If yes, explain the process followed by you.	How do patients respond when you explain them about the process	
6	What do you do to ensure that patients take medicines on time?	Probe on reminder calls	
7a	Did the uptake of medication change when TATA-1mg staff started reminder calls for patients?	What could be the possible reasons for this change?	

G. TATA-1mg Delivery Agent

S No	Questions	Probes/Logic	Notes
1	Can you explain the activities you do as a TATA-1mg Delivery Agent?		
2a	How do you collect samples from the patients?		Only for intervention group in Faridabad
2b	Do you face any challenges whilst collecting samples from the patients?	Probes: Follow-up questions by patients which staff might not be able to answer Stigma/comfort level of the patient Time/ travel issues	Only for intervention group in Faridabad
3a	Where do you deliver the test reports of the patients?		Only for intervention group in Faridabad
3b	Do you face any challenges when you give the patients their test reports?	Probes: Follow-up questions by patients which staff might not be able to answer Stigma/comfort level of the patient Time/ travel issues	Only for intervention group in Faridabad
4	How do patients get their TB medication?	Probe: Do they get medicines only through prescription by doctor)	
5a	Do you think home delivery of medicines is beneficial for patients?		If no, skip to Q6
5b	If yes, how?		
6	What are the challenges faced by you while delivering medicines at home?		
7	Do you ask the patients what they like about home delivery of medicines?		
8	What are the challenges faced by patients in getting medicines delivered at home?	Probes: Social stigma around TB, non-availability	

H. Compounder

S No	Questions	Probes/Logic	Notes
1	Can you explain the activities you do as a compounder?		
2	How do you record patient details?		
3a	Do you give medicines to patients?		
3b	If yes, what are the challenges faced when you give medicines to patients?		
4a	Have you worked with the TATA-1mg programme in your district?		Only for intervention group
4b	If yes, how has your workload changed since you started working with TATA-1mg programme?		Only for intervention group

I. Beliefs and perceptions

S No	Questions	Probes/Logic	Notes
1a	Fears Are there any fears related to TB testing?	Probe for both sputum collection and Chest X-Ray	if no, skip 1b
1b	If yes, can you elaborate		
2a	Fears Do you think patients are comfortable in discussing their TB treatment process with their family, friends, and neighbours?		if yes, skip 2b
2b	Fears If not comfortable, what are the factors that could refrain them from telling others?		
3	Trust Define your experience with the following: 1.Doctors 2.Compounders 3.Patients and their families 4.Other JEET/TATA-1mg staff	Probe: What can be done to improve your relationship with them/build trust with them?	
4	Fear What fears do you have as a healthcare agent in the TB sector?	Probe: Do they wear mask, gloves, fear while collecting sample, concerns from the family about the nature of the job	

S No	Questions	Probes/Logic	Notes
5	Satisfaction How do you feel about your engagement with TATA-1mg?	Probes: Has the workload changed post engagement? do incentives affect their work in a positive manner? is the incentive not enough for the additional work?	

J. Operations

Sno	Questions	Probes/Logic	Notes
1a	Do you receive timely salary payment for your services?		
1b	If not, what are the possible reasons for non-timely payment?		
2a	Do you receive any monetary incentives for your services?		
2b	If yes, how do these incentives affect your overall job satisfaction?	Positive impact or negative	
3a	Are your role and responsibilities as a TATA-1mg/JEET staff clearly defined?	Is there any contract/printed materials/ /orientation about your role	
3b	Did you receive any training before you took up this role?	Ask about any training/workshop to understand and execute the work	
3c	How were the trainings conducted?	In person/ group/ virtual/onsite	
3d	What can be done to take care of your training needs in the future?		

Conclusion

Thank you for your time and much-valued input to the study. As mentioned earlier, we will use these insights to understand the barriers and facilitators of private sector TB care. We will keep all the responses confidential. Your de-identified interview responses will only be shared with research team members.

Is there anything else that you would like to add?

(Answer)

Thank you and have a good day.

Appendix 4: Hindi Translations of Primary Qualitative Research Tools

रोगी साक्षात्कार गाइड

साक्षात्कारकर्ताकेलिएनोट्स -यहउनविषयोंऔरप्रश्नोंकीएक 'गाइड' है, जिसकीमददआपपी.पी.एस.एमॉडलकेतहतनिजीक्षेत्र कीटीबीदेखभालमेंबाधाओंऔरसहायकोंकोसमझनेकेलिएउत्तरदाताओंकासाक्षात्कारकरतेसमयलेसकतेहैं।हमआपसेअनुरोध करतेहैंकिबातचीतकेप्रवाहकोउत्तरदाताकेबातोंकेआधारपरतैयारकरें, नकिकेवलयहांदर्शायेगएक्रमपरआधारित।

कृपयाउत्तरदाताकोअपनापरिचयदेंऔरउन्हेंबताएंकिआपनिजीक्षेत्रकीटीबीदेखभालमेंबाधाओंऔरसहायकोंकोसमझनेकेलिए आउटलाइनइंडियाकीओरसेएकसर्वेक्षणकररहेहैं।

फिर, कृपयाउनसेपूछेंकिक्यावेसर्वेक्षणमेंभागलेनेमेंइच्छुकहैं।यदिहाँ, तोकृपयासर्वेक्षणकेसाथआगेबढ़ें।

यदिवेसर्वेक्षणमेंभागलेनेसेइनकारकरतेहैं, तोकृपयाउन्हेंविवशनकरेंऔरअगलेउत्तरदातापरजाएँ।

क्रमसं	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
Section A		जनसांख्यिकीप्रश्न (पृष्ठभूमि)	
1	आपमूलरूपसेकिसशहर/गांवसेहैं?		
2	आपअपनेलिंगकोकैसेपरिभाषितकरतेहैं ?	स्त्री पुरुष नहीबतानाचाहेंगे स्व-वर्णन ___	
3	आपकीवर्तमानउम्रक्याहै?		
4	आपकाउच्चतमशिक्षास्तरक्याहै?	निरक्षर (पढ़यालिखनहींसकते) साक्षर (पढ़औरलिखसकताहै, लेकिनऔपचारिक (स्कूल) शिक्षानहींप्राप्तकीहै) प्राथमिकविद्यालयउत्तीर्ण (5वी) हाईस्कूलउत्तीर्ण सीनियरसेकेंडरीस्कूलउत्तीर्ण स्नातकस्तरकीपढ़ाईपूर्ण पोस्ट-ग्रेजुएशनऔरउससेऊपर	

क्रमसं	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
5	अपनीजीविका(गुजर -बसर) केलिएआपक्याकरतेहो?	किसान गृहकार्य निजीकार्यालय दिहाड़ीमजदूर कामनहींकररहा(बेरोजगार) अन्य _____	
6	क्याआपशादीशुदाहैं?	1. हाँ 2. नहीं 3. अलग/तलाकशुदा	
7	आपकेघरमेंकितनेसदस्यहैं?		
8	आपकोटीबीहैंइसबातकापताकबचलाथा?		

A. टी .बीनिदानप्रक्रियाऔरफॉलोअपमुलाकात

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	आपकेटीबीकेशुरूआतीलक्षणक्याथे?	-थकान - जोड़ोंकादर्द - घबराहट - बुखार -वजनघटना -रातकोपसीनाआना -सर्दी - अन्य (-------)	
2	क्याआपइनलक्षणोंकेसाथपहलीबारडॉक्टरकेपासजानेपरहुईहरबातकेबारेमेंबतासकतेहैं?	जांच: डॉक्टरकेपासजानेकेलिएलियागयासमय, प्रतीक्षाकासमय, रोगीकेसाथडॉक्टर/ स्टाफकाव्यवहार, कौनसेजांचनिर्धारितकिएगएथे, कौनसीदवाएंबताईगईथीं, क्याउन्हेंवैकल्पिकउपचारकेबारेमेंसूचितकियागयाथा, जांचऔरपरामर्शपररोगीद्वाराखर्चकिएगए पैसे, क्यावेअस्पतालमेंकिसीऔरसेमिले/ बातचीतकीथीक्याकोईऔरजांच (एचआईवी, आरबीएसआदि) निर्धारितकियागयाथा।	

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
3	आपनेटीबीकेइलाजकेलिएइसीडॉक्टरके पासजानेकाचुनावक्योंकिया?	जांच: घरसेकमदूरीपरहोना , विश्वसनीयता, जांचऔरउपचारकाखर्च , इलाजकेलिएएक विशिष्टडॉक्टरकेपासजानेसेपहलेआपकितने औरडॉक्टरकेपासजाचुकेथे ?	
4 क	क्याआपअपनीटीबीजांचरिपोर्टदिखाने केलिएऊपरबताएगएडॉक्टरकेपासहीग एथे?	हाँ नहीं यदिहाँतोप्रश्न 5 परजाएँ	
4 ख	यदि नहीं, तोक्यों?		
5	जबआपअपनीरिपोर्टलेकरडॉक्टरकेपास गएतोक्याहुआ?	सुझाएगएवैकल्पिकउपचारोंऔरजांच, बताईगईदवाएं	
6	क्याआपडॉक्टरकेपासफॉलो-अप(दुबारासलाह) केलिएगएथे?	हाँ नहीं	

B. **नमूनासंग्रह**

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1 क	क्याआपकानमूनाटीबीजांचके लिएलियागयाथा?		
1ख	यदिहां, तोटीबीकीजांचकेलिए आपकानमूनाकिसजगहसेलि यागयाथा?	जांच: क्यानमूनाघरसेयाक्लिनि कसेलियागयाथा ?	
2	आपकोकितनीबारऔरकबअ पनेथूककानमूनादेनेकेलिएक हागयाथा?		
3	क्याआपघरपर (डोरस्टेपसैंपलकलेक्शन) टीबीजांचकेलिएनमूनादेने कोप्राथमिकतादेंगेयाकिसी लैब/अस्पतालजाकरदेना? औरक्यूँ ?		

X. परीक्षणरिपोर्ट

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	आपकोअपनीटीबीजांचरिपोर्टकैसेप्राप्तहुई?	जांच: क्यारिपोर्टघरपर दीजातीहैयाक्लिनिक/ प्रयोगशालासेजाकरलेनीहोतीहै ?	
2	क्याआपघरपर (डोरस्टेपसैंपलकलेक्शन) टीबीजांचरिपोर्टमिलनेकोप्राथमिकतादें गेयाकिसीलैब/अस्पतालजाकरलेनेको ? औरक्यूँ ?		

E .निश्चितखुराकसंयोजन (दवा)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपकोदवाओंकामासिकपर्चामिला था?	हाँ नही	
2	क्याआपकोडॉक्टरकेपासजानेकेबादही दवाएंमिलतीहै?	जांच- क्याऐसेमामलेसामनेआएहैंज बउन्हेंडॉक्टरसेमिलेबिनाहीदवादीग ई।विशेषरूपसे, हस्तक्षेपवालेसमूह, क्याएकमरीजडॉक्टरसेमिलेबिना TATA1-mg स्टाफसेफॉलो-अपदवाप्राप्तकरसकताहै	
3	आपअपनीटीबीकीदवाएंकैसेप्राप्तकर तेहैं?	जांच: क्याउन्हेंघरपरपहुंचायाजाताहैयाक्लि निकसेजाकरलेनाहोताहै?	
4	आपकोकितनीबारटीबीकीदवामिलतीहैं?		
5क	क्याआपकोदवाकेरूपमेंचारअलग-अल गगोलियांमिलतीहैंयाएकहीगोलीमिलती है?		
5 ख	यदिआपकोएकगोलीमिलतीहै, तोक्याआ पकेडॉक्टरनेआपकोचारगोलियोंलेनेके लिएकहाथा ?		
6	क्याआपडॉक्टरकेक्लीनिकसेदवालेनाप संदकरेंगेयाघरपरडिलीवरीकरवानापसं दकरेंगे, औरक्यों?	प्रत्येकउत्तरकेकारणोंकीजांचकरें	

F. **होमडेलिवरीसुविधा**

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1.क	क्याआपघरसे (डोरस्टेप) नमूनाजमाकरनेऔ रघरपररिपोर्टपहुँचानेकीसुविधाकेबारेमेंजानते है ?	यदिउत्तरनहीहैतोप्रश्न 4 परजाएँ	
1.ख	अगरहाँ , तोक्याआपनेइससुविधाकाउपयोगकियाहै ?	हाँ ना	
1. ग	अगरनतो, इससुविधाकोनालेनेकाक्याकारणहै ?		
2.	आपकोघरसेनमूनाजमाकरवानेमेंऔरघरपररि पोर्टदिएजानेकीसुविधामेंक्यापसंदआताहै ?	जांच:क्लिनिकजानेमेंलगनेवालापैसा , समय , औरमेहनत.	
3	क्यानमूनालेनेऔररिपोर्टदेनेकीडोर-स्टेपडिलीवरी(घरपर) कीसुविधाकेकारण आपकोकिसीतरहकीचुनौतियोंकासामनाकर नापड़ा	जांच: टीबीकेलिएसामाजिकउपेक्षा,आ पकाघरपरनहोना ; पिछलेख़राबअनुभ व,केवलआशाकार्यकर्त्तापरविश्वासहोना	
4.	क्याआपनेदवाओकीघरपरडिलेवरीकीसुविधाउ पयोगकीहै ?	हाँ नही	
5.	आपकोघरपरदवादिएजानेकीसुविधामेंक्यापसं दआताहै ?	जांच:क्लिनिकजानेमेंलगनेवालापैसा , समय , औरमेहनत.	
6	क्यादवाओंकीडोर-स्टेपडिलीवरी(घरपर) की सुविधाकेकारणआपकोकिसीतरहकीचुनौतियों कासामनाकरनापड़ा	जांच: टीबीकेलिएसामाजिकउपेक्षा,आ पकाघरपरनहोना ; पिछलेख़राबअनुभ व,केवलआशाकार्यकर्त्तापरविश्वासहोना	

G. उपचारऔरपरामर्शसहायता

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1 क	क्याआपकोटीबी ,एकबीमारीकेरूपमेंबतायागयाथा?	जांच: टीबीक्याहै, आपरोगकोकैसेपकड़ते/फैलातेहैं, रोगकीगंभीरता, रोगकेलक्षण, रोगीकेखानपानऔरपरहेज ; इसजानकारीकोप्राप्तकरनेकरतरीका (टेलीफोनिक/व्यक्तिगत /क्लिनिक)	
1ख	यदिहाँतोआपकोइसकेबारेमेंकिसनेबताया ?		
1 ग	उन्होंनेआपकोक्याबताया ?		
1घ	क्यायहआपकेऔरपरिवारकेलिएलाभदायक था ?		
2. क	क्याआपकोटीबीउपचारप्रकियाकेबारेमेंबता यागयाथा ?	जांच: दवाओंकेदुस्प्रभाव , उपचारकीअवधि , परहेजऔरकिसीगं भीरस्थितिमेंकिससेबातकरनाहै ?	
2 ख	यदिहाँतोकिसनेउन्हेंइसकेबारेमेंबताया ?		
2. ग	उन्होंनेआपकोक्याबताया ?		
2घ	क्यायहआपकेऔरपरिवारकेलिएलाभदायक था ?		
3	टीबीकेबारेमेंआपकीसमझकोऔरबेहतरबना नेकेलिएक्याकियाजासकताहै ?		
4 क	क्याआपकभीअपनीदवाकोलेनेमेंचूकेहैं /?		
4 ख	यदिहां, तोआपनेयहसुनिश्चितकरनेकेलिएक्या कियाकिआपअगलीबारदवाएंलेंगे ?		
5क	क्याआपकोकिसीस्टाफनेआपकीटीबीकीदवा एंलेनेकेलिएयाददिलाया?	हाँ नही यदिनहींतोसेक्शन H परजाएँ	
5 ख	अगरहां, तोआपकोयेरिमाइंडर(याददिलाना) किसनेदिए?		
5c	क्यायहरिमाइंडरउपयोगीथा ? कैसे		

H.विश्वासऔरधारणाएं

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1 क	आशंका निजीक्षेत्रमेंटीबीदेखभालसेसंबंधितकुछडर/संकोचक्याहैं?	जांचकरेकीहोमडिलीवरीकीसुविधासेकोईबदलावआयाहैक्या ?	
2अ	आशंका क्याआपकोलगताहैकिआपपरिवार, दोस्तोंऔरपड़ोसियोंकेसाथअपनीटीबीउपचारप्रक्रियापरचर्चाकरनेमेंसहजहैं?		
2 ख	आशंका यदिसहजनहींहैतो,वेकौनसेकारणहैंजोआपकोउन्हेंबतानेसेरोकतेहैं?		
3	विश्वास आपअपनीटीबीउपचारप्रक्रियामेंनिम्नलिखितव्यक्तियोंकेबारेमेंक्यापसंद/नापसंदकरतेहैं- 1.डॉक्टर 2. कंपाउंडर 3. कर्मचारी (परामर्शदाता(काउंसलर), डिलीवरीएजेंट, हबएजेंट, टीसी)	जांच: इनहितधारकोंतकपहुंचनेमेंआसानी, हितधारकोंकाज्ञान, विश्वास, उपलब्धता, रोगियोंकेप्रतिव्यवहार	
4	सामाजिकआदर्श आपकेक्षेत्रमेंटीबीसेजुड़ेउपेक्षाकोदूरकरनेकेलिएटीबीदेखभालस्टाफनेक्याकियाहै?		
5	विश्वास क्याआपकोलगताहैकिआपअन्यटीबीरोगियोंकोनिजीक्षेत्रमेंइलाजकरानेकीसलाहदेंगे? क्यों, क्योंनहीं?		

निष्कर्ष

आपकेसमयऔरअध्ययनकेलिएमूल्यवानइनपुटकेलिएधन्यवाद! जैसाकिपहलेउल्लेखकियागयाहै, हमनिजीक्षेत्रकीटीबीदेखभालकीबाधाओंऔरसहायकोंकोसमझनेकेलिएइनजानकारियोंकाउपयोगकरेंगे।हमसभीजवाबोंकोगोपनीयरखेंगे।आपकेडी-आइडेंटिफाइडइंटरव्यूकेजवाबकेवलरिसर्चटीमकेसदस्योंकेसाथसाझाकिएजाएंगे।

क्याकुछऔरहैजिसेआपबतानाचाहेंगे?
(जवाब)
धन्यवादऔरआपकादिनशुभरहे!

प्रदाताओं के साथ साक्षात्कार के लिए प्रश्न गाइड

साक्षात्कारकर्ताकेलिएनोट्स - यहउनविषयोंऔरप्रश्नोंकीएक 'गाइड' है, जिनकीमददआपनिजीक्षेत्रकीटीबीदेखभालमेंबाधाओं औरसहायकोंकोसमझनेकेलिएउत्तरदाताओंकासाक्षात्कारलेतेसमयलेसकतेहैं।हमआपसेअनुरोधकरतेहैंकिबातचीतकेप्रवाह कोउत्तरदाताकेइनपुटकेआधारपरतैयारकरें, नकिकेवलयहांसूचीबद्धअनुक्रमपरआधारित।

कृपयाउत्तरदाताकोअपनापरिचयदेंऔरउन्हेंबताएंकिआपनिजीक्षेत्रकीटीबीदेखभालमेंबाधाओंऔरसहायकोंकोसमझनेकेलिए आउटलाइनइंडियाकीओरसेएकसर्वेक्षणकररहेहैं।

फिर, कृपयाउनसेपूछेंकिक्यावेसर्वेक्षणमेंभागलेनेमेंइच्छुकहैं।यदिहाँ, तोकृपयासर्वेक्षणकेसाथआगेबढ़ें।

यदिवेसर्वेक्षणमेंभागलेनेसेइनकारकरतेहैं, तोकृपयाउन्हेंविवशनकरेंऔरअगलेउत्तरदातापरजाएँ।

क्रम. सं.	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
Section A		जनसांख्यिकीप्रश्न (पृष्ठभूमि)	
1	आपमूलरूपसेकिसशहर/गांवसेहैं?		
2	आपअपनेलिंगकोकैसेपरिभाषित करतेहैं ?	महिला पुरुष नहीबतानाचाहेंगे। स्व-वर्णन ___	
3	आपकीवर्तमानउम्रक्याहै?		
4	आपकाउच्चतमशिक्षास्तरक्याहै?	1.एमबीबीएस 2.एमडी 3.डीएम 4. बीएचएमएस 5. बीएएमएस	
5	स्वास्थ्यसेवाप्रदाताकेरूपमेंआपकोकुल कितनेवर्षोंकाअनुभवहै ?		
6क	क्याआपको TATA1-mg प्रोग्रामकेतहतआपकेजिलेमेंटी .बीकेलिए कियेगयेप्रयासोंकीजानकारीहै ?	हाँ नही	
6 ख	यदिनहीतो, TATA1-mg प्रोग्रामकेसाथका मनाकरनेकाक्याकारणहै ?	जांचकरे : उनकीसहूलियत, व्यवस्था, कामकरनेकेतरीकेकोजाने	

क्रम. सं.	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
Section B. डॉक्टरसेपहलीमुलाकात			
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1क	जबआपकेपासकोईनयाटीबीसंदिग्धरोगी आताहैतोआपक्याप्रक्रियाअपनातेहै ?	जांचकरे : किनलक्षणोंनेउन्हेंजांच निर्धारितकरनेकेलिएसचेतकिया, क्याजांचनिर्धारितकिएगएथे, कौन सेजांचनिर्धारितकिएगएथेऔरक्यों , जेईईटीसेवाएंजैसेकिविशेषज्ञजांच /एफडीसीद्वारा, निक्षयडाटादर्ज/ डॉक्टरद्वाराउपयोगकीगईं, कौनसीदवाइयांदीगयी, क्याउन्हेंवै कल्पिकउपचारकेबारेमेंसूचितकि यागयाथा, क्यापरामर्श(काउंसलिंग) औरजांचकेलिएशुल्कलियागया, क्यावेक्लिनिकमेंकिसीऔरसेमिले/ बातचीतकी, क्याकोईअन्यजांच (एचआईवी, आरबीएसआदि) निर्धारितकियागया, टीबीकोएकबीमा रीकेरूपमेंऔररोगीकोउपचारप्रक्रि याकेबारेमेंक्याबतायागया?	
1ख	जबआपने TATA1-mg केसाथकामकिया तोक्याप्रक्रियाबदलगई?	जांचकरे : TATA1-mg प्रोग्रामकेकौनसेपहलू आपकोचुनौतीपूर्णलगे? आपकोकौनसेपहलूपसंदआए? विशिष्टजांच: अगरवेएफडीसीरखरहेथे; वहकैसेबदलगया? , क्याडॉक्ट रनिजीलेबलएफडीसीयासरका रीएफडीसीनिर्धारितकरतेहैंऔ रइसकेसंभवतःक्याकारणहैं, क्यारोगीतबभीउनसेदवाएंलेतेहैं (एफडीसीदवाएं); कितने % रोगीखुलीदवाएँमाँगनेवापसआए ;एफडीसीकीदवाईकीजगहपर खुलीदवाएंलिखनेकेलिएआपको किसचीज़नेप्रेरितकिया, क्याउन केकंपाउंडर्सकाकामकाबोझब ढ़गयाहैक्योंकिउन्होंने TATA-A केसाथकामकरनाशुरूकरदियाहै.	

क्रम. सं.	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
2क	क्याक्लिनिकद्वाराटीबीरोगीकाडेटारिकॉर्ड कियागयाथा?	हाँ नही यदिउत्तरनहीहैतोसेक्शन c मेंजाएँ	
2ख	यदिहां, तोक्लिनिकद्वारारोगीकाडेटाकैसेद र्जकियाजाताहै?		
2ग	क्या TATA- 1mg प्रोग्रामकेतहत 'निक्षय' परडेटादर्जकरनेकेतरीकेमेंकोईबदलाव आयाथा??	फील्डस्टाफकीभूमिकाकीजांचकरें औरकैसेरोगउपचारकीप्रक्रियाडॉक्ट रकेलिएपारदर्शितहुईहैउसेजान्नेकी कोशिशकरे .	
Section C		नमूनासंग्रह	
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	रोगियोंकाटीबीजांचकेलिएनमूनाकैसेलि याजाताहै?	आगेजांचकरें : क्यानमूनाघरयाक्लि निकसेलियागयाहै?	
2	आपकितनीबाररोगियोंकानमूनालेतेहैंऔर जांचकीसलाहदेतेहैं?		
Section D		जाँचरिपोर्ट	
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	आपअपनेरोगियोंकेलिएकौनसेजाँचनिर्धा रितकरतेहैं ?	इसबातकीजांचकरेंकिडॉक्टरसभी रोगियोंकोसीबीएनएएटीटेस्टक्योंनहीं लिखरहेहैं?	
2	रोगीअपनीटीबीजांचरिपोर्टकैसेप्राप्तकर तेहैं?	आगेजांचकरें : क्यारिपोर्टघरपरपहुं चाईजातीहैयाक्लिनिकसेजाकरलेना होताहै	
Section E	टीबीनिदानप्रक्रियाऔरनिश्चितखुराकसंयोजन (दवा)		
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	जबरोगीअपनीजाँचरिपोर्टलेकरआपकेपा सवापसआतेहैंतबआपकेद्वाराक्यासुझाव दिएजातेंहै ?	सुझाएगएवैकल्पिकउपचारों, सुझाईगईदवाओंपरजांचकरे	

क्रम. सं.	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
2	रोगियोंकोउनकीटीबीकीदवाकैसेमिलती है?	आगेजांचकरें : क्याउन्हेंउनकेघरपर पहुंचायाजाताहैयाउन्हेंदवाकोक्लिनिकसेजाकरलेनाहोताहै?	
3	आपकितनेअवधिकेलिएटीबीकीदवालिखतेहैं?	आदर्शरूपसे, दवाहरमहीनेवितरित/पुनर्प्राप्तिकीजानीहै	
Section f		होमडिलेवरीसेवाएँ	
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपरोगियोंकोटीबीकीजांचकेलिए डोर-स्टेपसैंपलकलेक्शन (घरसेनमूनालेने) औररिपोर्टडिलीवरीकेबारेमेंबतातेहैं?	जांचकरेंकिक्याप्रदातानेइनसेवाओंके बारेमेंसभीरोगियोंकोसूचितकियाऔर यदिनहीं, तोइसकेक्याकारणथे?	
2	क्याआपनेरोगीकोदवाकीडोरस्टेपडिलीवरी(घरपरपहुचाने) केबारेमेंबताया?	हाँ नही जांचकरेंकिक्याप्रदातानेइनसेवाओंके बारेमेंसभीरोगियोंकोसूचितकियाऔर यदिनहीं, तोइसकेक्याकारणथे?	
3	क्यारोगीअपनेफॉलो-अपमुलाक़ातकेलिए वापसआएबिनादवाओंकीहोमडिलीवरीप्राप्तकरसकतेहैं?	क्याव्हात्सप्प(whatsapp) पेलिखेपर्चेमान्यहै /	
Section G		डॉक्टरकेपासफॉलोअपमुलाकात	
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1क	क्याआपयाआपकास्टाफरोगियोंकोफॉलो-अपमुलाक़ातकेलिएयाददिलातेहै?		

क्रम. सं.	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
1ख	क्यारोगीनियमितरूपसेफॉलो-अपजांचकेलिएआपकेपासआतेहैं?	जांचकरे : क्यापरामर्शचिकित्सा (काउंसलिंग)फॉलो-अपमुलाकातोंकोप्रभावितकरताहै? TATA1-mg डॉक्टरकेपर्चेकेबिनादवाईनहींदेता -->रोगियोंकोपर्चेकेलिएडॉक्टरकेपासजानापड़ताहै।प्रश्नअनुसंधानकेलिएमहत्वपूर्णहै; कृपयाविशेषरूपसेउससमयअवधिकेबारेमेंपूछेंजबप्रदाता TATA- 1mg प्रोग्राममेंथा , पर्चादेनेऔरदवाओंकीवास्तविकडिलीवरीकेबीचलगनेवालेसमयकीजांचकरें।	
1ग	यदिनहीं, तोक्याकारणहैंकिरोगीफॉलो-अपजांचकेलिएनियमितरूपसेनहींआतेहैं?	यदिपिछलेसवालकाउत्तरहांहै, तोयहसवालनकरें आगेजांचकरें: दवाओं, थूककेनमूनेकासंग्रहऔररिपोर्टकीहोमडिलीवरीनेडॉक्टरकेपासफॉलोअपकेदौरेकोकैसेप्रभावितकियाहै	
2क	क्याआपकोलगताहैकिजबसेरोगियोंकोघरपरदवाएंमिलनीशुरूहुईहैं, तबसेफॉलो-अपमुलाकातोंकीसंख्यामेंकोईबदलावआयाहै?	1.हाँ 2. नही	
2ख	यदिहाँ, तोइसकेसंभावितकारणक्याहोसकतेहैं?		
Section H		उपचारपरामर्शसमर्थन	
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1क	टीबीकोएकबीमारीकेरूपमेंऔररोगियोंकोटीबीकेउपचारकीप्रक्रियाकेबारेमेंकौनसमझाताहै?		

क्रम. सं.	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
1ख	टीबीरोगियोंकोक्याबतायाजाताहै ?	आगेजांचकरें: टीबीक्याहै, आपकोरोगकैसेहोताहै , आपरोगकैसेफैलातेहै ./, रोगकीगंभीरता, रोगकेलक्षण; दवा-दुष्प्रभाव, अनुपालन, उपचारकीअवधि, गंभीरस्थितिमेंकब औरकिससेसंपर्ककरनाहै?	
2क	क्या TATA1-mg नेरोगियोंकीकाउंसलिंग केतरीकेकोबदलदिया? औरकैसे?	हाँ नही यदिउत्तरनाहैंतोजाएँप्रश्न 3 .कपर	
2ख	अगरहाँतोकैसे?		
3क	क्याकिसीनेरोगियोंकोउनकीफॉलो-अपमुलाकातोंयादवाओंकेबारेमेंयाददिलाया?		
3ख	क्या TATA1-mg प्रोग्रामशुरूहोनेकेबाद सेरोगियोंकेलिएदवाकेपालनमेंकोईअंतर आयाहै?	यहप्रश्ननपूछेअगरउत्तरदाताइ TATA1- mg केसाथकामनहीकियाहै ?	
4.	यदि TATA1-mg स्टाफद्वारापरामर्श (कॉउंसिलिंग) सेवादीजातीहैतोक्याचुनौतियांहोसकतीहैं?	यहप्रश्ननपूछेअगरउत्तरदाताइ TATA1- mg केसाथकामनहीकियाहै ?	
5.	रोगियोंमेंटीबीकेबारेमेंऔरसमझविकसितकरनेकेलिएपूरेप्रक्रियामेंक्यासुधारकियाजासकताहै?		
Section I		विश्वासऔरधारणाएँ	
क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1क	आशंका निजीक्षेत्रमेंटीबीकीदेखभालसेजुड़ेरोगियोंकोकिसतरहकेडर / संकोचहोतेहैं?	गहनसमझकेलिएजाँच: TATA1-mg केअस्तित्वमेंआनेकेबादसेस्थितिकैसेबदलीहै??	
2क	आशंका क्याआपकोलगताहैकिरोगीअपनेपरिवारऔरदोस्तोंकेसाथअपनीटीबीउपचारप्रक्रियापरचर्चाकरनेमेंसहजहैं?		

क्रम. सं.	प्रश्न	श्रेणियाँ / तर्क	प्रगणककेलिएनोट्स
2ख	आशंका यदिनहीं, तोफिरवेकौनसेकारणहैंजोउन्हें दूसरोंकोबतानेसेरोकतेहैं?	हाँ नही यदिउत्तरहाँहैतोप्रश्न 3 परजाएँ	
3	विश्वास टीबीदेखभालमेंशामिलनिम्नलिखितव्यक्तियोंकेबारेमेंआपक्यापसंद/नापसंदकरतेहैं- 1. रोगी 2. कंपाउंडर 3.TATA1-mg/JEET स्टाफ	आगेजांचकरे : इनहितधारकोंतकपहुंचनेमेंआसानी, हितधारकोंकाज्ञान, विश्वास, उपलब्धता, उनकाकार्यक्षेत्रमेंप्रभाव औरकार्यकुशलता	
4	प्रेरणा क्याटीबीदेखभालकेलिएनिजीक्षेत्रकेप्रदाताकेसाथकामकरनेकेलिएकोईव्यक्तिगत प्रेरणाहै?	TATA1-mg/JEET स्टाफ़केसाथसंबंधोंकीजांच; कार्यआसनहोना , विश्वसनीयताऔरभरोसा , निश्चितभूमिकाकेलिएविशेषज्ञ, गुणवत्तामेंसुधारहोताहै?	

निष्कर्ष

आपकेसमयऔरअध्ययनकेलिएमूल्यवानइनपुटकेलिएधन्यवाद! जैसाकिपहलेउल्लेखकियागयाहै, हमनिजीक्षेत्र कीटीबीदेखभालकीबाधाओंऔरसहायकोंकोसमझनेकेलिएइनजानकारियोंकाउपयोगकरेंगे।हमसभीजवाबोंको गोपनीयरखेंगे।आपकेडी-आइडेंटिफाइडइंटरव्यूकेजवाबकेवलरिसर्चटीमकेसदस्योंकेसाथसाझाकिएजाएंगे।

क्याकुछऔरहैजिसेआपबतानाचाहेंगे?
(जवाब)
धन्यवादऔरआपकादिनशुभरहे!

कर्मचारी साक्षात्कार गाइड

साक्षात्कारकर्ताकेलिएनोट्स

यहउनविषयोंऔरप्रश्नोंकीएक 'गाइड' है, जिसकीमददआपनिजीक्षेत्रकीटीबीदेखभालमेंबाधाओंऔरसहायकोंकोस मझनेकेलिएउत्तरदाताओंकासाक्षात्कारलेतेसमयलेसकतेहैं।हमआपसेअनुरोधकरतेहैंकिबातचीतकेप्रवाहकोउत्त-रदाताकेबातोंकेआधारपरतैयारकरें, नकिकेवलदर्शायेंगएक्रमपरआधारित।

कृपयाध्यानदेंकि**अनुभाग I और J सभीकर्मचारियोंकीश्रेणियोंसेपूछेजानेहैं**।

कृपयाउत्तरदाताकोअपनापरिचयदेंऔरउन्हेंबताएंकिआपनिजीक्षेत्रकीटीबीदेखभालमेंबाधाओंऔरसहायकोंकोसमझनेकेलिए आउटलाइनइंडियाकीओरसेएकसर्वेक्षणकररहेहैं।

फिर, कृपयाउनसेपूछेंकिक्यावेसर्वेक्षणमेंभागलेनेमेंइच्छुकहैं।यदिहाँ, तोकृपयासर्वेक्षणकेसाथआगेबढ़ें।

यदिवेसर्वेक्षणमेंभागलेनेसेइनकारकरतेहैं, तोकृपयाउन्हेंविवशनकरेंऔरअगलेउत्तरदातापरजाएँ।

A. **जनसांख्यिकीप्रश्न (पृष्ठभूमि)(सभीसेपूछे)**

क्रमसं	प्रश्न	श्रेणियाँ / तर्क	टिप्पणियाँ
1	आपमूलरूपसेकिसशहर/गांवसेहैं?		
2	आपअपनेलिंगकोकैसेपरि भाषितकरतेहैं ?	महिला पुरुष नहींबतानाचाहेंगे स्व-वर्णन ___	
3	आपकीवर्तमानउम्रक्याहै?		
4	आपकाउच्चतमशिक्षास्तरक्याहै?	प्राथमिकविद्यालयउत्तीर्ण हाईस्कूलउत्तीर्ण सीनियरसेकेंडरीस्कूलउत्तीर्ण स्नातककीपढ़ाई पोस्ट-ग्रेजुएशनयाउससेऊपर	
5	आपकितनेवर्षोंसेएकस्वास्थ्यकार्यकर्ताकेरूप मेंकामकररहेहैं?		

क्रमसं	प्रश्न	श्रेणियाँ / तर्क	टिप्पणियाँ
6	निम्नलिखितमेंसेआपका जॉबटाइटल(पद) क्याहै?	हबएजेंट एससीटीएजेंट ट्रीटमेंटकोऑर्डिनेटर (उपचारसमन्वयक) फील्डऑफिसर TATA-TATA1-mg टेली-कॉलर TATA1-mg डिलीवरीएजेंट कंपाउंडर	

B. **हबएजेंट(केवलसंबंधितसे)**

क्रमसं	प्रश्न	श्रेणियाँ / तर्क	टिप्पणियाँ
1	क्याआपहबएजेंटकेरूपमेंकीजानेवालीगतिविधियोंकीव्याख्याकरसकतेहैं?		
2	रोगियोंसेनमूनेजमाकरनेकेलिएअपनाईजानेवालीप्रक्रियाकेबारेमेंविस्तारसेबताएं?		
3	उपचारप्रक्रियामेंरोगियोंकेनमूनाजमाकरनेकेदौरानकिनचुनौतियोंकासामनाकरनापड़ताहै?		
4	आपरोगियोंकोजांचरिपोर्टकैसेप्रदानकरतेहैं?	जांच:क्यावेरोगीद्वाराहब/ क्लिनिकमेंकिएगएहैं	
5	आपटीबीरोगियोंकेलिएडेटाकैसेप्राप्तकरते हैं?		
6 क	क्याआपनिक्षयप्लेटफॉर्मपरविवरणदर्जकरतेहैं?	हाँ नहीं	
6 ख	निक्षयप्लेटफॉर्मकाउपयोगकरनेकेअपनेअनुभवकावर्णनकरें।	जांच: निक्षयप्लेटफॉर्मकेसाथकामकरनेमें क्यापसंदआताहै? निक्षयमंचकेसामनेआनेवालीचुनौतियाँ-प्रौद्योगिकीकाउपयोगऔरप्रशिक्षण	
7 क	क्याआपकोमरीजोंकेविवरणऑनलाइनअपलोडकरनेकेलिएप्रौद्योगिकी (फोन, टैबलेट, कंप्यूटरआदि) काउपयोगकरनेकेलिएप्रशिक्षितकियागयाथा?	हाँ नहीं जांच:क्याआपनेकिसीप्रकारकाप्रशिक्षणप्राप्तकियाहै?प्रशिक्षणकिसनेप्रदानकिया? क्याउन्हेंनयापाठ्यक्रमप्रदानकियाजाता है?	
7 ख	क्याआपरोगीविवरणऑनलाइनअपलोडकरनेकेलिएतकनीक (फोन, टैबलेट, कंप्यूटरआदि) काउपयोगकरनेमेंसहजहैं?	प्रौद्योगिकीकाउपयोगकरनेकीपहुंच, इरादाऔरक्षमतापरजांच	
8 क	क्याआपमरीजोंकोदवाएंदेतेहैं?	हाँ नहीं	

क्रमसं	प्रश्न	श्रेणियाँ / तर्क	टिप्पणियाँ
8 ख	मरीजोंकोदवादेतेसमयकिनचुनौतियोंकासामनाकरनापड़ताहै?	जांच: डॉक्टरद्वारासुझाईगईदवाएं (एफडीसीयाढीलीदवाएं) औरउसपररोगीकानजरिया , एफडीसीकेबारेमेंमान्यताएं	
9 क	क्याआपनेअपनेजिलेमें TATA1-mg प्रोग्रामकेसाथकामकियाहै?	हाँ नही जांच:आपकबसेइसप्रोग् रामकेसाथकामकररहेहैं? क्याआपनेएकहीस्थानपरकार्यकियाहै? यदिउत्तरनहीहैतोप्रश्न 9 खछोड़दें	
9 ख	यदिहां, तोकैसेहै TATA1-mg प्रोग्रामकेसाथ कामकरनाशुरूकरनेकेबादसेआपकावर्कलोडबदलगयाहै?	जांचकरेंकिक्यों- उन्हें TATA1-mg केसाथरोगीकाडाटासाझाकरनाचाहिए?	

X. एससीटीएजेंट (केवलसंबंधितसे)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपउनगतिविधियोंकेबारेमेंबतासकतेहैं जोआपएक SCT एजेंटकेरूपमेंकरतेहैं?	जांच:आपने SCT एजेंटकेरूपमेंकितनेसमयतककार्यकियाहै? क्याआपनेशुरूसेएकहीस्थानपरकामकियाहै?	
2	हबएजेंटसेनमूनाजमाकेलिएअपनाईजानेवालीप्रक्रियाकेबारेमेंविस्तारसेबताएंऔरउन्हेंरिपोर्ट कैसेदेतेहैंउसकेबारेमेंबताएं ?	जांच: आपकोनमूनाभेजेजानेकेबाद रिपोर्टतैयारकरनेमेंकितनासमयलगताहै? नमूनासंग्रह (सिलेक्टकरने) सेलेकररिपोर्टवितरणतककीप्रक्रियाकैसीलगतीहै?	
3	इसप्रक्रियामेंआपकेसामनेक्याचुनौतियाँहैं?	जांच: प्रशासनिकचुनौतियाँ, तकनीकीचुनौतियाँ, फॉलो-अप (अनुवर्ती) चुनौतियाँ	

Δ. ट्रीटमेंटकोऑर्डिनेटर (उपचारसमन्वयक)(केवलसंबंधितसे)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपट्रीटमेंटकोऑर्डिनेटर (उपचारसमन्वयक) केरूपमेंआपकेद्वाराकीजा नेवालीगतिविधियोंकीकेबारेमेंबतासकतेहैं?	जांच:आपनेट्रीटमेंटको ऑर्डिनेटर (उपचारसमन्वयक) केरूपमेंकितनेसमयतककामकियाहै? क्याआपनेशुरूसेएकहीजगहकामकियाहै?	
2 क	क्याआपमरीजोंकोटीबीकेबारेमेंएकबीमारीके रूपमेंसमझातेहैं?	हाँ नही	
2 ख	यदिहाँ, तोआपउन्हेंक्यासमझातेहैं?	जांच: टीबीक्याहै, आपरोगकोकैसेपकड़ते/ फैलातेहैं, रोगकीगंभीरता, रोगकेलक्षण, पोषणकासेवन, डीबीटीलाभ क्याइसबारेमेंभीबतासकतेहैंकीयेजानकारी आपउन्हेंकैसेदेतेहैं	
3 क	क्याआपरोगियोंकोटीबीउपचारप्रक्रियाकेबारेमें समझातेहैं?	हाँ नही	
3 ख	अगरहाँतोआपउन्हेंक्यासमझातेहैं?	जांच: दवाके - दुष्प्रभावऔरपालन, उपचारकीअवधि, गंभीरस्थितिमेंकबऔर किससेसंपर्ककरनाहै	
4 क	क्यामरीजोंकोकाउंसलिंग (परामर्श) प्रदानकरनेकेलिए TATA- 1mg जैसेसंगठनको साथमेंलेनाफायदेमंदहै?	हाँ नही जांच:परामर्शप्रदानकरनेकेलिएकिसीतीस रेपक्षकेसंगठनकोकामपररखनेकेक्यानुक सानहोसकतेहैं, यदिकोईहैं?	
4 ख	यदिकाउंसलिंग (परामर्श)सेवा TATA1-mg जैसेकिसीसंगठनकोआउटसोर्स(उनकेद्वारा) कीजातीहै, तोक्याचुनौतियाँहोसकतीहैं?	जांच:क्या TATA1-mg केसाथसाझेदा रीकरनेकेबादसेआपकाकामआसान/ अधिककठिनहोगयाहै?	
5	मरीजोंकेलिएसमग्रटीबीज्ञानमेंसुधारकेलिएक्या कियाजासकताहै? क्याआपकोलगताहै, आपकीदौरे / बातचीतकेआधारपर--- किटीबीकेबारेमें ज्ञानमेंसुधारकेलिएकुछकियाजासकताहै।/ बातचीतकेआधारपर--- किटीबीकेबारेमेंज्ञान	जांच: आपटीबीकेबारेमेंलोगोंद्वाराप्राप्तजान कारीकेबारेमेंक्यासोचतेहैं,क्यावेअपनेस्वास्थ् यकोगंभीरतासेलेतेहैं? जागरूकतामेंसुधा रकेलिएकिसतरहकासरकारीहस्तक्षेपकि याजासकताहै? सामाजिकपरिवेशऔरचि कित्साउद्योगकैसेटीबीज्ञानऔरसंवेदनशील ताकोबढ़ानेमेंमददकरसकतेहैं?	

E. **फील्ड**ऑफिसर (केवलसंबंधितसे)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपफील्डऑफिसरके रूपमेंआपकेद्वाराकीजानेवा लीगतिविधियोंकेबारेमेंबतास कतेहैं?		
2 क	आपजेईईटी(JEET) कार्यक्र मकेसाथडॉक्टरोंकोकैसेजो ड़तेहैं?	जांच: क्यावे JEET केबारेमेंजानतेहैं? औसत नकितनेलोगकार्यक्रमकेबारेमेंजानतेहैं?	
2 ख	उनकीप्रतिक्रियाक्याहैं?	जांच: कार्यक्रमकेलिएडॉक्टरकितनेग्रहणशी लहैं? क्यावेसक्रियरूपसेकार्यक्रमसेजुड़ेहुए हैं? क्यावेरोगियोंकोगुणवत्तापूर्णटीबीदेखभा लप्रदानकरनेमें JEET कीयोग्यताकोदेखते/ समझतेहैं? यदिनहीं, तोसर्वोत्तमटीबीदेखभा लकेबारेमेंउनकीक्याधारणाहै?	
3	TATA1-mg (गुजरातऔरफरीदाबादमें) के साथडॉक्टरोंकोजोड़नेकीप्रक्रि याकैसेअलगथी?	किसीअतिरिक्तकार्यकीआवश्यकताहै? क्याआसानथा? क्यामुश्किलथा?	

Φ. **TATA-1mg टेलीकॉलर (केवलसंबंधितसे)**

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपउनगतिविधियोंकीव्याख् याकरसकतेहैंजोआप TATA1-mg टेलीकॉलरकेरूपमेंकरतेहैं?	**जांच:** एकदिनमेंकॉलकीसंख्या?	
2	आपटीबीरोगियोंकेलिएडेटाकैसेप्राप्तकरतेहैं?	**जांच:** क्यायहप्रक्रियासामान्यडेटासंग्र हसेभिन्नहै?	
3 क	क्याआपनिक्षयप्लेटफॉर्मपरविवरणदर्जकरतेहैं?	हाँ नहीं	
3 ख	निक्षयप्लेटफॉर्मकाउपयोगकरनेकेअपनेअनुभव केबारेमेंबताये।	जांच: निक्षयप्लेटफॉर्मकेसाथक्याअच्छा कामकरताहै निक्षयप्लेटफार्मकेसाम नेआनेवालीचुनौतियाँ- प्रौद्योगिकीकाउपयोगऔरप्रशिक्षण	

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
4 क	क्याआपकोमरीजोंकेविवरणऑनलाइनअप लोडकरनेकेलिएप्रौद्योगिकी (फोन, टैबलेट, कंप्यूटरआदि) काउपयोगकरनेकेलिएप्रशिक्षित कियागयाथा?	हाँ नही **जांच:** क्याआपनेप्रशिक्षणप्राप्तकिएहै? प्रशिक्षणकिसनेप्रदानकिया? क्याउनकोपुनश्चर्या (नवीनतम) पाठ्यक्रमप्रदानकिएजातेहैं?	
4 ख	क्याआपरोगियोंकाविवरणऑनलाइनअप लोडकरनेकेलिएतकनीक (फोन, टैबलेट, कंप्यूटरआदि) काउपयोगकरनेमेंसहजहैं?	**जांच:** प्रौद्योगिकीकाउपयोगकरनेकीपहुंच, इरादाऔरक्षमतापरजांच	
5 क	क्याआपमरीजोंकोजांचकेपरिणामोंकेबारेमेंसूचि तकरतेहैं?	हाँ नही	
5 ख	यदिहां, तोआपकेद्वाराअपनाईजानेवालीप्रक्रिया केबारेमेंबताएं।	**जांच:** जबआपउन्हेंप्रक्रियाकेबारेमेंसम झातेहैंतोमरीजकैसेप्रतिक्रियादेतेहैं	
6	आपयहसुनिश्चितकरनेकेलिएक्याकरतेहैंकिरोगी समयपरदवाएँलें?	अनुस्मारक (फॉलो-अप) कॉलपरजांचकरें	
7	जब TATA1-mg स्टाफ़नेमरीजोंकेलिएरिमाइंड रकॉलकरनाशुरूकियातोक्यादवाओंकेसेवनकर नेमेंबदलावआया?	हाँ नही इसबदलावकेसंभावितकारणक्याहोस कतेहैं?	

Γ. TATA-1mg डिलीवरीएजेंट (केवलसंबंधितसे)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपउनगतिविधियोंकेबारेमें बतासकतेहैंजोआप TATA1-mg डिलीवरीएजेंटकेरूपमेंकरतेहैं?		
2 क	आपमरीजोंसेनमूनेकैसेजमाकरतेहैं?	जांच: क्यानमूने (सैंपल) घर/ क्लिनिकसेएकत्रकिएजातेहैं? घरसेनमूनेलेनेकीप्रक्रियाकैसीहै?	

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
2 ख	क्याआपकोरोगियोंसेनमूनेजमाकरनेमें किसीचुनौतीकासामनाकरनापड़ताहै?	**जांच:** मरीज़ोंकेउनसवालोंकाफ़ॉलोअप लेंजिनकाशायदकर्मचारीजवाबदेनेमेंसक्षमनहों रोगीकीउपेक्षा /आरामस्तर समय/यात्राकेमुद्दे	
3 क	आपमरीजोंकीजांचरिपोर्टकहांपहुंचा तेहैं?	**जांच:** क्याआपकोइसेमरीजोंकेघर, याक्लीनिकलेजानाहै? दोनोंमेंसेसबसेअ धिकबारक्याहोताहै?	
3 ख	जबआपमरीजोंकोउनकीजांचरिपोर्टदे तेहैंतोक्याआपकोकिसीचुनौतीकासाम नाकरनापड़ताहै?	जांच: मरीज़ोंकेउनसवालोंकाफ़ॉलोअपलेंजिन काशायदकर्मचारीजवाबदेनेमेंसक्षमनहों रोगीकीउपेक्षा /सुलभता समय/यात्राकेमुद्दे	
4	मरीजोंकोउनकीटीबीकीदवाकैसेमिल तीहै?	**जांच:** क्याआपमरीजोंकेघरजातेहैं? यात्रा/समयकीकमीऔरअंतराल।क्याआ पसमयपरदवाएंदेपारहेहैं?	
5 क	क्याआपकोलगताहैकिदवाओंकीहोम डिलीवरीमरीजोंकेलिएफायदेमंदहै?	हाँ नही	
5 ख	अगरहाँतोकैसे?	**जांच:**क्याहोमडिलीवरीकेकारणमरीजों कोसमयपरदवालेनेमेंआसानीहोतीहै?	
6	घरपरदवाइयाँपहुँचातेसमयआपकेसा मनेकौन-सीचुनौतियाँआतीहैं?	**जांच:** समय/यात्राकेमुद्दे।रोगीकीउपेक्षा / आरामस्तर।वितरणअंतराल?	
7	क्याआपमरीजोंसेपूछतेहैंकिउन्हेंदवा ओंकीहोमडिलीवरीकेबारेमेंक्यापसं दहै?	हाँ नही	
8	घरपरदवाइयांमंगवानेमेंमरीजोंकोकिन चुनौतियोंकासामनाकरनापड़ताहै?	**जांच:** टीबीकेलिएसामाजिकउपेक्षा, अनुपलब्धता	

H. कंपाउंडर(केवलसंबंधितसे)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1	क्याआपउनगतिविधियोंकेबारेमेंबतासकते हैंजोआपएककंपाउंडरकेरूपमेंकरतेहैं?		
2	आपरोगीविवरणकैसेरिकॉर्डकरतेहैं?	टलरूपसे? आपदोनोंमेंसेकिसकाउपयोग करनाआसानसमझतेहैं?	
3 क	क्याआपमरीजोंकोदवाएंदेतेहैं?	हाँ नही	
3 ख	यदिहां, तोरोगियोंकोदवादेतेसमयकिनचु नौतियोंकासामनाकरनापड़ताहै?	**जांच:** रोगियोंकेउनप्रश्नोंकाअनुसरणकरें जिन्हेंवेबीमारी, दवाओं, उपचार, भविष्यके दौरेआदिकेबारेमेंनहींसमझपाएहोंगे। रोगीकीउपेक्षा/आरामस्तर	
4 क	क्याआपनेअपनेजिलेमें TATA1-mg प्रोग्रामकेसाथकामकियाहै?	हाँ नही **जांच:** आपकितनेसमयसेका र्यक्रमकेसाथकार्यकररहेहैं? क्याआपनेएकहीस्थानपरकार्यकियाहै?	
4 ख	यदिहाँ, तो TATA1-mg प्रोग्रामकेसाथका मकरनाशुरूकरनेकेबादसेआपकाकार्यभा र(जवाबदेही) कैसेबदलाहै?	जांचकरेंकिक्यों- उन्हें TATA1-mg केसाथरोगीकाविवरणसाझाकरनाचाहिए	

I. विश्वासऔरधारणाएं (सभीसेपूछे)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1 क	आशंका क्याटीबीजांचसेसंबंधितकोईडर/संकोचहै?	थूकसंग्रहऔरचेस्टएक्स-रेदोनोंकेलिएजांच यदिउत्तरनहीहैतोप्रश्न 1 खनपूछें	
1 ख	यदिहाँ, तोक्याइसकेबारेमेंबतासकतेहैं	जांच: रोगीकीउपेक्षा, आराम, जागरूकता	
1 ग	TATA1-mg केअस्तित्वमेंआनेकेबादसेस्थिति कैसेबदलीहै?	Yes No जांच: कैसे? क्याबदलावदेखेगएहैं?	

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
2 क	आशंका क्याआपकोलगताहैकिमरीजअपनेपरिवार, दोस्तोंऔरपड़ोसियोंकेसाथअपनीटीबीउपचारप्रक्रियापरचर्चाकरनेमेंसहजहैं?	हाँ नही	
2 ख	आशंका सहजनहींहैं , वेकौनसेकारणहैंजोउन्हेंदूसरोंकोबतानेसेरोकसकतेहैं?		
3	विश्वास टीबीउपचारप्रक्रियामेंनिम्नलिखितव्यक्तियोंकेबारेमेंआपक्यापसंद/नापसंदकरतेहैं- 1.डॉक्टर 2. कंपाउंडर(स्टाफ) 3.मरीजऔरउनकेपरिवार 4.अन्य JEET/TATA1-mg स्टाफ	जांच: उनकेसाथअपनेसंबंधसुधारने/उनकेसाथविश्वासबनानेकेलिएक्याकियाजासकताहै?	
4	डर टीबीक्षेत्रमेंएकस्वास्थ्यसेवाएजेंटकेरूपमेंआपकोक्याडर/संकोचहै?	जांच: क्यावेनिशानपहचानतेहैं, नमूनाएकत्रकरतेसमयडर, नौकरीकीप्रकृतिकेबारेमेंपरिवारसेचिंता	
5	संतुष्टि आप TATA1-mg केसाथअपनेजुड़ावकेबारेमें कैसामहसूसकरतेहैं?	जांच:क्याजुड़नेकेबादकामकाबोझबदलगयाहै? क्याप्रोत्साहनउनकेकामकोसकारात्मकतरीकेसेप्रभावितकरतेहैं? क्याअतिरिक्तकार्यकेलिएप्रोत्साहनपर्याप्तनहींहै?	

संचालन (सभीसेपूछे)

क्रमसं	प्रश्न	जांच / तर्क	टिप्पणियाँ
1 क	क्याआपकोअपनीसेवाओंकेलिएसमयपरवेतन प्राप्तहोताहै?	हाँ नही	
1 ख	यदिनहीं, तोसमयसेभुगताननहोनेकेसंभावित कारणक्याहैं?		
2 क	क्याआपकोअपनीसेवाओंकेलिएकोईप्रोत्साहन राशिमिलताहै?	हाँ नही	
2 ख	यदिहां, तोयेप्रोत्साहनराशिआपकीनौकरीसेसं तुष्टिकोकैसेप्रभावितकरतेहैं?		
3 क	क्या TATA1-mg/JEET स्टाफ़केरूपमेंआप कीभूमिकाऔरउत्तरदायित्वस्पष्टरूपसेपरिभा षितहैं?	हाँ नही क्याकोईलिखितअनुबंधहै \ कोईदस्तावेजहै \ कहींप्रकाशितहै ?	
3 ख	क्याआपनेयहभूमिकानिभानेसेपहलेकोईप्रशिक् षणप्राप्तकियाथा?	हाँ नही कोईसभाहुईहै ? कोईफील्डट्रेनिंग ?	
3 ग	प्रशिक्षणकैसेआयोजितकिएगएथे?	जांच:किसकेद्वारा? घरसेदूर / घरकेकरीब? प्रशिक्षणलेनेकेलिएप्रोत्साहन? सत्रकीसंख्या?	
3 घ	आपकीप्रशिक्षणआवश्यकताओंकीदेखभालके लिएक्याकियाजासकताहै?	जांच: कामकेस्थान/ रहनेकेकरीब? प्रोत्साहनदें? नौकरीकीगारंटी?	

निष्कर्ष

आपकेसमयऔरअध्ययनकेलिएमूल्यवानइनपुटकेलिएधन्यवाद! जैसाकिपहलेउल्लेखकियागयाहै, हमनिजीक्षेत्रकीटीबीदेखभा लकीबाधाओंऔरसहायकोंकोसमझनेकेलिएइनजानकारियोंकाउपयोगकरेंगे।हमसभीप्रतिक्रियाओंकोगोपनीयरखेंगे।आपके डी-आइडेंटिफाइडइंटरव्यूकेजवाबकेवलरिसर्चटीमकेसदस्योंकेसाथसाझाकिएजाएंगे।

क्याकुछऔरहैजिसेआपजोड़नाचाहेंगे?

(उत्तर)

धन्यवादऔरआपकादिनअच्छाहो!

Appendix 4: Gujarati Translations of Primary Qualitative Research Tools

Patients Interview Guide

Notes to the Interviewer

PPSA મોડલહેઠળખાનગીક્ષેત્રમાંટીબીસંભાળમાટેઊભાથતાંઅવરોધોઅનેતેનાસહાયકોનેસમજવામાટેઉત્ત-રદાતાઓનોઇન્ટરવ્યુલેતીવખતેતમેજેવિષયોઅનેપ્રશ્નોનાનિરાકરણમાટેમદદલઈશકોછોતેદર્શાવતીઆએક 'માર્ગદર્શિકા' છે. અમેતમનેફક્તસૂચિબદ્ધક્રમપરઆધારિતનહી, પરંતુઉત્તરદાતાનાઇનપુટ્સનાઆધારેવાર્તા-લાપનીરચનાકરવાવિનંતીકરીએછીએ.

Demography Questions (Background)

S No	Questions	Categories/Logic	Notes
1	તમેમૂળકયાશહેર/ગામનાછો?		
2	તમારાલિંગનુંવિશિષ્ટવર્ણનશુંછે?	સ્ત્રી પુરુષ કહેવાનથીમાંગતા સ્વ-વર્ણન ___	
3	તમારીહાલનીઉંમરકેટલીછે?		
4	તમારીઉચ્ચતમશૈક્ષણિકલાય-કાતશુંછે?	1. નિરક્ષર (વાંચીકેલખીશકતાનથી) 2.સાક્ષર (વાંચીઅનેલખીશકેછે, પરંતુશાળામાંપ્રવેશતાનથી) 3.પ્રાથમિકશાળાપૂર્ણકરેલ 4.હાઇસ્કૂલપૂર્ણકરેલ 5. વરિષ્ઠમાધ્યમિકશાળાપૂર્ણકરેલ 6.સ્નાતક 7.અનુસ્નાતકઅનેતેથીવધુ	
5	તમેહાલમાંઆજીવિકામાટેશુંક-રોછો?	1. ખેડૂત 2. ગૃહિણી 3. ખાનગી (ઓફિસ) 4. દૈનિકવેતનકામદાર 5.બેરોજગાર 6.અન્ય _____	
6	શુંતમેપરિણીતછો?	1. 1Yes 1. હા2. ના 3. છૂટાથયેલ / છૂટાછેડાલીધેલ	
7	તમારાઘરમાંકુલકેટલાસભ્યોછે?		કૃપાકરીનેએકજરસોડેખાતા-પીતાઘ-રનાપુખ્તવયનાસભ્યોઅનેબાળકો-નીસંખ્યાતપાસો
8	તમનેટીબીનુંનિદાનક્યારેથયું?		

TB diagnosis process and follow up visits

S No	Questions	Probes/Logic	Notes
1	તમનેટીબીથયોત્યારેપરારંભિકલક્ષણોશું હતા?	-થાકલાગતો - સાંધાનોદુખાવો ગભરાટથતો(હિન્દીમાંગભરાહટ) - તાવ -વજનમાંઘટાડો - રાતરેપરસેવો -ઠંડીલાગવી - અન્ય (_____)	
2	જ્યારેતમેઆલક્ષણોનેકારણેપર્થમવખત ડૉક્ટરનીમુલાકાતલીધીત્યારેજેબન્યુંતેબધું શુંતમેવણર્વીશકોછો?	તપાસ: મુસાફરીમાટેનોસમય, રાહજોવાનોસમય, દદીર્સાથેડૉક્ટર/સ્ટાફનુંવતર્ન, દર્ દીનોડેટાકેવીરીતેરેકોડર્કરવામાંઆવ્ યો, કયાપરીક્ષણોસૂયવવામાંઆવ્યા, દવાઓસૂયવવામાંઆવી, શુંતેમનેવૈકલ્ પિકસારવારવિશેજાણકરવામાંઆવી, દર્ દીદ્વારાપરીક્ષણોઅનેપરામશર્પરખ યર્વામાંઆવેલાનાણાં, શુંતેઓમળ્યા/ ક્લિનિકમાંઅન્યકોઇપણસાથેવાતકરો, અન્યકોઇપણપરીક્ષણો (એચઆઇવી, આરબીએસવગેરે) સૂયવવામાંઆવેછે	
3	તમેટીબીનીસારવારમાટેઆડૉક્ટરપાસેજ વાનુંકેમપસંદકયુર્?	તપાસ: ઘરથીઅંતર, વિશ્વસનીયતા, ખચર્સામેલછે (પરીક્ષણો, નિદાન), સારવારમાટેયોક્કસ ડોકટરનીસારવારલેવાનુંનક્કીકરતાપહેલાકે ટલાડોકટરોનીમુલાકાતલીધીહતી	
4a	શુંતમેતમારાટીબીનાટેસ્ટરિપોટ્સર્બતા વવામાટેઉપરદશાર્વેલડૉક્ટરપાસેગયાછો?	1. હા 2. ના	જોહા, તો Q.5 પરજાઓ
4b	જોના, તોશમાટે?		

S No	Questions	Probes/Logic	Notes
5	તમેતમારોરિપોટર્લઇનેડૉક્ટરપાસેગયાત્યારેશુંથયું?	સૂચવેલવૈકલ્પિકસારવારોવિષેતપાસ, દવાઓસૂચવવામાંઆવી	
6	શુંતમેડૉક્ટરનીઅનુવતીર્મુલાકાતોમાટેજાઓછો?	1. હા 2. ના દરેકમાટેનાકારણોવિષેતપાસકરો	

Sample collection

S No	Questions	Probes/Logic	Notes
1a	શુંતમારાનમૂનાટીબીનાપરીક્ષણમાટેલેવામાંઆવ્યાહતા?		શેનોનમૂનોલેવામાંઆવ્યોહતોતેતપાસો - ગળફા, પેશાબ, લોહી
1b	જોહા, તોટીબીપરીક્ષણમાટેતમારોનમૂનોક્યાંથીલેવામાંઆવ્યોહતો?	ચકાસો: નમૂનાઘરેથી-અથવાક્લિનિકમાંથી-એકત્રિતકરવામાંઆવ્યાછે?	
2	તમનેકેટલીવારઅનેક્યારેતમારાસ્પુટમસેમ્પલઆપવામાટેકહેવામાંઆવ્યુંહતું?		પ્રારંભિકપરીક્ષણદરમિયાનગળફોએકત્રિતકરવામાંઆવેછે, સઘનતબક્કાનાઅંતમાં (નિદાનના 2 મહિનાપછી) અનેસતતતબક્કાનાઅંતમાં (નિદાનના 6 મહિનાપછી)
3	શુંતમેટીબીનાપરીક્ષણમાટેલેબઅથવાહોસ્પિટલમાંજવાનુંપસંદકરશોકેઘરેઆવીનેનમૂનાનેએકત્રિતકરવાનુંપસંદકરશોઅનેશામાટે?		

Test reports

S No	Questions	Probes/Logic	Notes
1	તમનેતમારાટીબીટેસ્ટરિપોર્ટ્સકેવીરીતેપ્રા-પ્તથયા?	ચકાસો: રિપોર્ટ્સઘરેપ-હોંચાડવામાંઆવેછેકે-ક્લિનિક/લેબમાંથીએક-ત્રિતકરવામાંઆવેછે?	
2	શુંતમેટેસ્ટરિપોર્ટનીડોરસ્ટેપડિલિવરીપસંદકરશો-અથવાતેનેએકત્રકરવામાટેલેબઅથવાહોસ્પિટલ-માંજવાનુંપસંદકરશોઅનેશામાટે?		

E. Fixed dose combination (medicine)

S No	Questions	Probes/Logic	Notes
1	શુંતમનેદવાઓનુંમાસિકપ્રિસ્ક્રિપ્શનમળ્યુંછે?	1. હા 2. ના જોના, તોતપાસોકેતેમ-નેકેટલાસમયમાટેપ્રિ-સ્ક્રિપ્શનમળ્યુંછે	
2	શુંતમનેડૉક્ટરનીમુલાકાતલીધાપછીજદવાઓમ-ળેછે?	તપાસ- એવાકિસ્સા-ઓછેકેજ્યાંડૉક્ટરની-મુલાકાતલીધાવિનાતે-મનેદવામળીગઈહોય. ખાસકરીને, મધ્ય-સ્થીજૂથપાસેથી, શુંદર્દીડૉક્ટરનીમુલા-કાતલીધાવિનાસ્ટા-ફપાસેથીફોલો-અપ TATA-1mg દવામેળ-વીશકેછે, શુંદવાનુંપ્રિ-સ્ક્રિપ્શન whatsapp પરઆપીશકાયછે?	
3	તમેતમારીટીબીનીદવાઓકેવીરીતેમેળવશો?	તપાસો: શુંતેઘરેપ-હોંચાડવામાંઆવેછેકે-તેનેક્લિનિકમાંથીએક-ત્રિતકરવામાંઆવેછે?	

S No	Questions	Probes/Logic	Notes
4	તમેટીબીનીદવાકેટલીવારમેળવોછો?		આદર્શરીતે, દવાદર-મહિનેપહોંચાડવાની/ પુનઃપ્રાપ્તકરવાની-હોયછે
5a	શુંતમનેદવાતરીકેચારઅલગ-અલગટેબ્લેટમળે-છેકેએકજટેબ્લેટ?		
5b	જોતમનેસિંગલટેબ્લેટમળેછે, તોશુંતમનેત-મારાડોક્ટરેચારટેબ્લેટલેવાનુંકહ્યુંહતું?		
6	શુંતમેડોક્ટરનાક્લિનિકમાંથીદવાઓલેવા-નુપસંદકરશોકેઘરેપહોંચાડવાનુંપસંદકરશો-અનેશામાટે?	દરેકજવાબમાટેકાર-ણોતપાસો	

F. Home delivery of services

S No	Questions	Probes/Logic	Notes
1a	શુંતમેટીબીપરીક્ષણમાટેડોર-સ્ટેપ સેમ્પલકલેક્શનઅનેરિપોટર્ડિલિવ રીવિશેમાહિતગારછો?		જોના, તોQ.4 પરજાઓ. માતરફરીદબાદમાંમધ્ય સ્થીજુથમાટે
1b	જોહા, તોશુંતમેઆસેવાઓનોલાભલીધોછે?	1. હા 2. ના	જોહા, તો 3 પરજાઓ.
1c	આસેવાઓનેનકારવાનાકારણોશુંછે?		
2	ટીબીપરીક્ષણમાટેડોર-સ્ટેપસેમ્પલ કલેક્શનઅનેરિપોટર્ડિલિવરીબાબતે તમનેશુંગમ્યું?	તપાસો: ગભિરતખયર્---સમય, ક્લિનિક/લેબમાંથીનમૂનાએક તર્કરવામાટેખયર્વામાંઆવેલ પર્યત્નો, મુસાફરીપરખયર્વા માંઆવેલનાણાં	માતરફરીદાબાદમાં મધ્ય સ્થીજૂથમાટે
3	શુંડોર-સ્ટેપસેમ્પલકલેક્શનઅનેટી બીટેસ્ટિંગમાટેરિપોટર્ડિલિવરીબા બતેકોઈપડકારોનોસામનોકરવોપડ્ યોહતો?	તપાસો: ટીબીપર્ત્યેસામાજિકકલંક, દદીર્નીબિનઉપલબ્ધતા; અગાઉનાઅવરોધો, વિશ્વાસવિકસિતથવો.	માતરફરીદાબાદમાંમધ્ય સ્થીજૂથમાટે

S No	Questions	Probes/Logic	Notes
4	તમનેડોરસ્ટેપદવાઓનીડિલિવરીવિશેકહેવામાંઆવ્યુંહતું?	હા ના	ગુજરાતઅનેફરીદાબાદબંનેમાંમધ્યસ્થીજૂથમાટે જોના, તોસેકશનGપરજાઓ.
5	ડોરસ્ટેપદવાઓનીડિલિવરીવિશેતમનેશુંગમ્યું?	ચકાસો: ગભિરતખચર્ --સમય, ક્લિનિકમાંથીદવાઓમેળવવામાટેકરેલપર્યત્નો, સાફરીમાટેખચર્વામાંઆવેલનાણાં	ગુજરાતઅનેફરીદાબાદબંનેમાંમધ્યસ્થીજૂથમાટે
6	શુંદવાઓનીડોર-સ્ટેપડિલિવરીનેકારણેકોઈતકલીફોનોસામનોકરવોપડ્યોહતો?	તપાસો: ટીબીપર્ત્યેસામાજિકકલંક, દદીર્નીબિનઉપલબ્ધતા; અગાઉનાનિષેધ, વિશ્વાસમાતર્ આશાકાયર્કરોપર્ત્યેકેળવવામાં આવ્યોહતો, વગેરે	ગુજરાતઅનેફરીદાબાદબંનેમાંમધ્યસ્થીજૂથમાટે

G. Treatment counselling support

S No	Questions	Probes/Logic	Notes
1a	શુંતમનેટીબીનેએકરોગતરીકેસમજાવવામાંઆવ્યોહતો??	ચકાસો: ટીબી-કોનેકહેવાયછે, તમનેઆરોગકેવીરીતેપ્રદાનથવો/તેનોફેલાવો, રોગનીતીવ્રતા, રોગનાલક્ષણો, દદીદ્વારાપોષણયુક્તખોરાકનુંસેવન; આમાહિતીપહોંચડવાનોમોડ (ટેલિફોનિક/વ્યક્તિગત/ક્લિનિક)	જોના, તો 2a પરજાઓ.
1b	જોહા, તોતમનેઆકોણેસમજાવ્યું?		
1c	તેમણેતમનેશુંકહ્યું?		
1d	શુંતેતમારામાટેઅનેતમારાકુટુંબમાટેફાયદાકારકહતું?		જોહા, તોતેકેવીરીતેફાયદાકારકહતુંતેનીતપાસકરો

S No	Questions	Probes/Logic	Notes
2a	શુંતમનેટીબીનીસારવારનીપ્રક્રિયાવિશેસમજાવવામાંઆવ્યુંહતું?	ચકાસો: દવાઅનેતેનીઆડઅસરઅનેતેનુંપાલન, સારવારમાટેનોસમયગાળો, ઊભીથતીકટોકટીનાકિસ્સામાંક્યારેઅનેકોનોસંપર્કકરવો	જોના, તો 3 પરજાઓ.
2b	જોહા, તોતેતમનેકોણેસમજાવ્યુંહતું?		
2c	શુંતેતમારીમાટેઅનેતમારાકુટુંબમાટેફાયદાકારકહતું?		
2d	શુંતેતમારીમાટેઅનેતમારાકુટુંબમાટેફાયદાકારકહતું?	તેકેવુંફાયદાકારક/નુકશાનદાયકહતું	
3	ટીબીવિશેનાતમારાજ્ઞાનમાંસુધારોકરવામાટેશુંકરીશકાય?		
4a	શુંતમેક્યારેયતમારીદવાલેવાનુંચૂકીગયાછો?	જોનાતો4bપરજાઓ	સારવારનીપ્રક્રિયાકેટલીલાંબીચાલીહતીતેનાઆધારેપ્રશ્નપૂછોઅનેપછીજોતેઓક્યારેયદવાચૂકીગયાહોયતોતેનુંઅનુસરણકરો. મહેરબાનીકરીનેનોંધકરોકેઅમનેતમેએકકેબેદિવસદવાલેવાનુંચૂકીગયાહોયતોતેજાણવામાંરસનથીપરંતુદવાનોસમયગાળોજાણવામાંરસછે
4b	જોહા, તોતમેઆગલીવખતેદવાઓલોછોતેનીખાતરીકરવામાટેતમેશુંકર્યું?		
5a	શુંકોઈસ્ટાફમેમ્બરેતમનેતમારીટીબીનીદવાઓલેવામાટેયાદકરાવ્યુંછે?	1. હા 2. ના	જોના, તોસેકશનI-પરજાઓ.
5b	જોહા, તોતમનેઆરિમાઈન્ડર્સકોણેઆપ્યા?		
5c	શુંઆરીમાઇન્ડર્સઉપયોગીછે? કેવીરીતે?		

H. Beliefs and perceptions

S No	Questions	Probes/Logic	Notes
1	ભય ખાનગીક્ષેત્રમાંટીબીનીસંભાળનેલગતાકેટલાકભ-યશું છે?	ઊંડાણપૂર્વકનીસ-મજણમાટેતપાસ: TATA-1mg અમલ-માંઆવ્યાપછીપરિસ્થિ-તિકેવીરીતેબદલાઈછે?	ગુજરાતઅનેફરીદાબા-દબંનેમાંમધ્યસ્થીજૂ-થમાટે
2a	ભય શું તમનેલાગેછેકેપરિવાર, મિત્રોઅનેપડોશીઓસા-થેતમારીટીબીસારવારપ્રક્રિયાનીચર્ચાકરવામાટે-તમેઅનુકૂળછો?	1. હા 2. ના	જોહા, તો 3 પરજાઓ.
2b	જોઅનુકૂળનહોય, તોકયાપરિબળોછેજેતમનેતેમ-નેજણાવવાનુંટાળેછે?		
3	વિશ્વાસ નીચેઆપેલવ્યક્તિઓસાથેતમારાઅનુભવનેવર-ણવો- 1.ડોક્ટરો 2.કમ્પાઉન્ડર્સ 3. સ્ટાફ (કાઉન્સેલર્સ, ડિલિવરીએજન્ટ્સ, હબએજ-ન્ટ્સ, ટીસી)	તપાસ: આહિસ્સેદારો-સુધીપહોંચવાનીસરળ-તા, હિસ્સેદારોનુંજ્ઞાન, વિશ્વાસ, ઉપલબ્ધતા, દર્દીઓપ્રત્યેનુંવર્તન	
4	સામાજિકઘોરણો તમારાપડોશમાંટીબીપ્રત્યેનાકલંકનેદૂરકરવામાટે-ટીબીસંભાળસ્ટાફેશું કર્યું છે?		
5	વિશ્વાસ શું તમનેલાગેછેકેતમેટીબીનાઅન્યદર્દીઓનેખાન-ગીક્ષેત્રમાંસારવારલેવામાટેભલામણકરશો? શામાટે/શામાટેનહીં?		કોઈપણસંશોધનઉદ્દે-શ્યસાથેજોડાયેલુંનથી-પરંતુસમગ્રસંશોધન-વિષયમાટેરસપ્રદસૂ-ઝઆપીશકેછે

Conclusion

તમારાસમયઅનેઅભ્યાસમાટેખૂબમૂલ્યવાનઇનપુટબદલઆભાર! અગાઉસૂચવ્યામુજબ, અમેઆઆંતરદૃષ્ટિ-નોઉપયોગખાનગીક્ષેત્રનીટીબીસંભાળનાઅવરોધોઅનેસુવિધાકર્તાઓનેસમજવામાટેકરીશું. અમેતમામપ્રતિ-ભાવોગુપ્તરાખીશું. તમારાબિન-ઓળખાયેલઇન્ટરવ્યુપ્રતિસાદોફક્તસંશોધનટીમનાસભ્યોસાથેજશેરકરવા-માંઆવશે.

શું બીજુંકંઈછેજેતમેઉમેરવામાંગોછો?

(જવાબ)

તમારોઆભારઅનેતમારોદિવસશુભરહે!

Providers Interview Guide

Notes to the Interviewer

આવિષયોઅનેપ્રશ્નોવિષેની 'માર્ગદર્શિકા' છેજેનીમદદતમેખાનગીક્ષેત્રનીટીબીસંભાળદરમ્યાનઆવતાઅ-વરોધોઅનેસહાયકોનેસમજવામાટેઉત્તરદાતાઓનોઇન્ટરવ્યુલેતીવખતેલઈશકોછો. અમેતમનેફક્તઅ-હીંસૂચિબદ્ધક્રમપરઆધારિતનહીં, પરંતુઉત્તરદાતાનાઇનપુટ્સનાઆધારેવાર્તાલાપનીરચનાકરવાવિનંતી-કરીએછીએ.

Demography Questions (Background)

S No	Questions	Categories/Logic	Notes
1	તમેમૂળકયાશહેર/ગામનાછો?		
2	તમારાલિંગનુંવિશિષ્ટવર્ણનશુંછે?	સ્ત્રી પુરુષ કહેવાનથીમાંગતા. સ્વ-વર્ણન ___	
3	હાલમાંતમારીઉંમરકેટલીછે?		
4	તમારીઉચ્ચતમશૈક્ષણિકલાયકાતશુંછે?	1. એમબીબીએસ એમડી ડીએમ બીએચએમએસ બીએએમએસ	
5	હેલ્થકેરપ્રદાતાતરીકેતમનેકુલકેટલાવર્ષ-નોઅનુભવછે?		
6a	શુંતમેતમારાજિલ્લામાંટીબીસંભાળમાટેના TATA-1mg પ્રોગ્રામથીવાકેફછો?	હા ના	ફરિદાબાદઅનેગુજરા-તમાંમધ્યસ્થીજૂથમાટે જોના, તોવિભાગ B પરજાઓ
6b	જોના, તો TATA-1mg પ્રોગ્રામમાટેકામ-નકરવાનાંકારણોશુંહતા?	ઓપનએન્ડેડ- સિસ્ટ-મમાંવિશ્વાસ, આરામ, કામસોંપણીવગેરેની-તપાસ	ફરિદાબાદઅનેગુજરા-તમાંમધ્યસ્થીજૂથમાટે

First visit to doctor

S No	Questions	Probes/Logic	Notes
1a	જ્યારેટીબીનોનવોશંકાસ્પદદર્દીતમારીપાસેઆવેછે-ત્યારેતમેકઇસારવારપ્રક્રિયાઅનુસરોછો?	ચકાસો: દર્દીનોડેટાકેવીરીતેએકત્રિતકરવામાંઆવેછે, નિક્ષયસૂચનાઆપવામાંઆવેછે, તેમાંનાકયાલક્ષણોતેમનેપરીક્ષણોકરવામાટેચેતવણીઆપેછે, કયાપરીક્ષણોસૂચવવામાંઆવ્યાહતાઅનેશામાટે, JEET સેવાઓજેમકેએક્સપર્ટટેસ્ટ/FDC ડૉક્ટરદ્વારાઉપયોગમાંલેવાયછેઅનેદવાઓસૂચવવામાંઆવીહતી, તેઓનેઆબાબતેજાણકરવામાંઆવીહતી. વૈકલ્પિકસારવાર, પરામર્શઅનેપરીક્ષણોમાટેવસૂલવામાંઆવતાનાણાં, શુંતેઓક્લિનિકમાંઅન્યકોઇનેમળ્યા/વાતકરી, અન્યકોઇપણપરીક્ષણો (એચઆઇવી, આરબીએસવગેરે) સૂચવવામાંઆવ્યા, ટીબીનેરોગતરીકેઅનેદર્દીનેસારવારનીપ્રક્રિયાવિશેશુંકહેવામાંઆવ્યુંહતું	
1b	જ્યારેતમે TATA-1mg સાથેકામકર્યુંત્યારેશુંપ્રક્રિયાબદલાઈગઇહતી?	તપાસ: TATA-1mg પ્રોગ્રામનાકયાતત્વોતમનેપડકારજનકલાગ્યા? તમનેકયાતત્વોગમ્યા? ચોક્કસચકાસણીઓ: TATA-1mg પછીસૂચનાકેવીરીતેકરવામાંઆવી, જોતેઓ FDC રાખતાહતા; તેકેવીરીતેબદલાયું? જોડોકટરોએખાનગીલેબલ FDCs અથવાસરકારી FDCs સૂચવ્યાહોયઅનેસંભવતઃ, તેનામાટેનાકારણો, શુંદર્દીઓહજુપણતેમનીપાસેથીદવાઓલેતાહતા (FDC દવાઓ); કેટલા % દર્દીઓછૂટકદવાઓમાંગવાપાછાઆવ્યા; જેનાબદલેતેમનેછૂટકદવાઓસૂચવવામાટેપ્રેરિતકર્યા, શુંતેમણે□□□□-1mg સાથેકામકરવાનુંશરૂકર્યુંત્યારથીતેમનાકમ્પાઉન્ડસપરકામનુંભારણવધીગયુંછે.	માત્રમધ્યસ્થીજુથમાટે જોપ્રદાતાએ TA-TA-1mg સાથેકામકર્યુંનહોયતોઆપ્રશ્નછોડીદો
2a	શુંટીબીનાદર્દીનોડેટાક્લિનિકદ્વારારેકોર્ડકરવામાંઆવ્યોહતો?	હા ના	જોના, તોસેક્શનC-પરજાઓ.
2b	જોહા, તોક્લિનિકદ્વારાદર્દીનોડેટાકેવીરીતેરેકોર્ડકરવામાંઆવેછે?		
2c	શું TATA-1mg પ્રોગ્રામહેઠળનિક્ષયપરડેટારેકોર્ડકરવાનીરીતમાંકોઇફેરફારથયોહતો?	ફિલ્ડસ્ટાફનીભૂમિકાપરતપાસકરોઅનેઆનાથીદર્દીનીસારવારમાંડૉક્ટરનીદૃશ્યતાકેવીરીતેબદલાઈગઈછે	માત્રમધ્યસ્થીજુથમાટે જોપ્રદાતાએ TA-TA-1mg સાથેકામનકર્યુંહોયતોઆપ્રશ્નછોડીદો

Sample collection

S No	Questions	Probes/Logic	Notes
1	દર્દીઓમાટેટીબીપરીક્ષણમાટેનમૂનાનેકેવીરીતેએકત્રિતકરવામાંઆવેછે?	ચકાસો: નમૂનાઘરેથીઅથવાક્લિનિકમાંથીએકત્રિતકરવામાંઆવ્યાછે?	
2	તમેકેટલીવારદર્દીઓનાનમૂનાએકત્રિતકરવાઅનેપરીક્ષણકરવાનીભલામણકરોછો?		પ્રારંભિકપરીક્ષણદરમિયાનગળફોએકત્રિતકરવામાંઆવેછે, સઘનતબક્કાનાઅંતમાં (નિદાનના 2 મહિનાપછી) અનેસતતચાલીરહેલાતબક્કાનાઅંતમાં (નિદાનના 6 મહિનાપછી)

Test reports

S No	Questions	Probes/Logic	Notes
1	તમેતમારાદર્દીઓનેકયાપરીક્ષણોસૂચવોછો?	ડોકટરો CBNAAT પરીક્ષણોલખીરહ્યાછેકેકેમતેનીતપાસકરો જોના, તોશામાટેડોકટરોતમામદર્દીઓને CBNAAT પરીક્ષણોસૂચવતાનથી	
121	દર્દીઓતેમનાટીબીટેસ્ટરિપોર્ટકેવીરીતેમેળવેછે?	તપાસો: રિપોર્ટ્સઘરેપહોંચાડવામાંઆવેછેકેક્લિનિકમાંથીએકત્રિતકરવામાંઆવેછે?	

TB Diagnosis Process and Fixed dose combination (medicine)

S No	Questions	Probes/Logic	Notes
1	જ્યારેદર્દીઓતેમનાટેસ્ટરિપોર્ટસાથેતમારી-પાસેપાછાઆવેત્યારેતમેતેમનેશુંસૂચવોછો?	સૂચવેલવૈકલ્પિક-સારવારોપ્રમાણેત-પાસ, દવાઓસૂચ-વવામાંઆવેછે	
2	દર્દીઓનેટીબીનીદવાકેવીરીતેમળેછે?	ચકાસો: શુંતમનેદ-વાઘરેપહોંચાડવા-માંઆવેછેઅથવા-ક્લિનિકમાંથીએક-ત્રિતકરવામાંઆ-વેછે?	
3	ટીબીનાદર્દીઓમાટેદવાનાપ્રિસ્ક્રિપ્શનનોસમ-યગાળો/આવર્તનકેટલુંહોયછે?		આદર્શરીતે, દવા-દરમહિનેવિતરિત/પ્રાપ્તકરવાનીહોયછે

Home delivery of services

S No	Questions	Probes/Logic	Notes
1	શુંતમેદર્દીઓનેટીબી-પરીક્ષણમાટેડોર-સ્ટે-પસેમ્પલકલેક્શનઅ-નેરિપોર્ટડિલિવરીવિ-શેકહોછો?	પ્રદાતાએતમામદર્દીઓનેઆસેવા-ઓવિશેજાણકરીછેકેકેમતેનીતપા-સકરોઅનેજોના, તોતેનાકારણો-જાણો	માત્રફરીદબાદમાંમધ્યસ્થીજુથમાટે
2	શુંતમેદર્દીનેદવાનીડોરસ્ટેપડિલિ-વરીવિશેકહ્યુંહતું?	હા ના પ્રદાતાએતમામ-દર્દીઓનેઆસેવા-ઓવિશેજાણકરી-છેકેકેમતેનીતપા-સકરોઅનેજોનહીં, તોતેનાકારણોજાણો	ગુજરાતઅનેફરીદ-બાદબંનેમાંમધ્યસ્થી-જુથમાટે જોના, તોસેકશનG-પરજાઓ.
3	શુંદર્દીઓતેમનીફોલો-અપમુલાકા-તમાટેપાછાઆવ્યાવિનાદવાઓ-નીડોરસ્ટેપડિલિવરીમેળવીશકેછે?	શું WhatsApp પ્રિસ્ક્રિ-પ્શન્સમાન્યછે?	ગુજરાતઅનેફરીદ-બાદબંનેમાંમધ્યસ્થી-જુથમાટે

Follow-up visits to doctor

S No	Questions	Probes/Logic	Notes
1a	શું તમે અથવા તમારો સ્ટાફ દર્દીઓને ફોલો-અપ મુલાકાત માટે યાદ કરાવો છો?		
1b	શું દર્દી ઓ ફોલો-અપ પરીક્ષણ માટે નિયમિત પણે તમારી મુલાકાત લે છે?	હા ના તપાસ: શું કાઉન્સેલિંગ ડૉક્ટર ની અનુવર્તી મુલાકાતો ને અસર કરે છે TATA-1mg પ્રિસ્ક્રિપ્શન વિના દવા પહોંચાડતી નથી -->દર્દી ઓ એ પ્રિસ્ક્રિપ્શન માટે ડૉક્ટર ની મુલાકાત લેવી પડે છે. પ્રશ્ન સંશોધન માટે મુખ્ય છે: કૃપા કરીને ખાસ કરીને TATA-1mg દ્વારા આપવામાં આવતા સમય માટે પૂછો, પ્રિસ્ક્રિપ્શન અને દવાઓ ની વાસ્તવિક ડિલિવરી વચ્ચે લેવાયેલા સમય નીતપાસ કરો	જો હા, તો 2a પર જાઓ.
1c	જો ના, તો કયા કારણો સર દર્દી નિયમિત પણે ફોલો-અપ તપાસ માટે આવતા નથી?	જો જવાબ હા હોય તો છોડી દો તપાસ: દવાઓ ની હોમ ડિલિવરી, ગળફા નું સેમ્પલ કલેક્શન અને રિપોર્ટ્સ ડૉક્ટર ની ફોલો-અપ મુલાકાત ની આવર્તન ને કેવી રીતે અસર કરી છે	માત્ર મધ્યસ્થી જુથ માટે
2a	શું તમને લાગે છે કે દર્દી ઓ ને ઘરે થી દવાઓ મળવા નીશરૂઆત થઈ ત્યારથી ફોલો-અપ મુલાકાતો માં કોઈ ફેરફાર થયો નથી?	હા ના	જો ના, તો સેકશન G પર જાઓ.
2b	જો હા, તો તે ના માટે સંભવિત કારણો શું હોઈ શકે?		

Treatment counselling support

S No	Questions	Probes/Logic	Notes
1a	ટીબીનેરોગતરીકેઅનેટીબીનીસારવારનીપ્રક્રિયા-દર્દીઓનેકોણસમજાવેછે?		
1b	તેઓદર્દીનેશુંકહેછે?	ચકાસો: ટીબીશુંછે, તમેરોગકેવીરીતેપકડો/ફેલાવોછો, રોગનીતી-વ્રતા, રોગનાલક્ષણો; દવા-આડ-અસર, પાલન, સારવારનો-સમયગાળો, કટોક-ટીનાકિસ્સામાંક્યારે-અનેકોનોસંપર્કકરવો, પોષકખોરાકનાસેવ-નઅંગેપરામર્શ	
2a	શું TATA-1mg એદર્દીઓનુંકાઉન્સેલિંગકરવાની-રીતમાંફેરફારકર્યોછેઅનેકેવીરીતે?	હા ના	માત્રફરીદબાદમાંમ-ધ્યસ્થીજુથમાટે જોપ્રદાતાએ TA-TA-1mg સાથેકામક-ર્યુંનહોયતોઆપ્રશ્નછો-ડીદો જોના, તો3a પરજાઓ.
2b	જોહા, તોકેવીરીતે?		માત્રફરીદબાદમાંમ-ધ્યસ્થીજુથમાટે
3a	શુંકોઈએદર્દીઓનેતેમનીફોલો-અપમુલાકાતોઅ-થવાદવાઓવિશેયાદઅપાવ્યુંહતું?		
3b	TATA-1mg પ્રોગ્રામશરૂથયોત્યારથીદર્દીઓમાટે-દવાઓનાપાલનમાંકોઈફેરફારથયોછે?		માત્રફરીદબાદમાંમ-ધ્યસ્થીજુથમાટે જોપ્રદાતાએ TATA-1mg સાથે-કામનકર્યુંહોયતોઆ-પ્રશ્નનેછોડીદો- કૃપાક-રીનેમાત્રફરીદાબાદજિ-લ્લામાંજપૂછો
4	જોકાઉન્સેલિંગસેવા TATA-1mg સ્ટાફદ્વારાઆપ-વામાંઆવેતોપડકારોશુંહોઈશકે?		માત્રફરીદબાદમાંમ-ધ્યસ્થીજુથમાટે જોપ્રદાતાએ TATA-1mg સાથે-કામનકર્યુંહોયતોઆ-પ્રશ્નનેછોડીદો- કૃપાક-રીનેમાત્રફરીદાબાદજિ-લ્લામાંજપૂછો
5	દર્દીઓમાટેટીબીવિષેનુંજ્ઞાનસુધારવામાટેસમગ્ર-પ્રક્રિયામાંસુધારોકરવાશુંકરીશકાય?		

Beliefs and perceptions

S No	Questions	Probes/Logic	Notes
1	ભય ખાનગીક્ષેત્રમાંટીબીનીસંભાળનેલગતાદર્દીઓદ્વારાશુંડરઅનુભવાયછે?	ઊંડાણપૂર્વકનીસમજણમાટેતપાસ: TATA-1mg પ્રોગ્રામઅમલમાંઆવ્યાપછીપરિસ્થિતિકેવીરીતેબદલાઈછે?	
2a	ભય શુંતમનેલાગેછેકેદર્દીઓતેમનાપરિવાર, મિત્રોઅનેપડોશીઓસાથેતેમનીટીબીસારવારપ્રક્રિયાવિષેનીચર્ચાકરવામાટેઅનુકૂળછે?	હા ના	જોહા, તો 3 પરજાઓ.
2b	ભય જોના, તોએવાકયાપરિબળોછેજેતેમનેઅન્યનેકહેવાથીદૂરકરીશકેછે?		
3	વિશ્વાસ નીચેનાસાથેતમારાઅનુભવનુંવર્ણનકરો: 1.દર્દીઓ 2.કમ્પાઉન્ડર્સ 3.TATA-1mg/JEET સ્ટાફ	પ્રોબ: આહિસ્સેદારોસુધીપહોંચવાનીસરળતા, હિતધારકોનુંજ્ઞાન, વિશ્વાસ, ઉપલબ્ધતા, કાર્યક્ષમતાઅનેકાર્યબાબતેઆવડત શુંતમનેલાગેછેકેકલંકઓછુંથયુંછે? તેકેવીરીતેઘટ્યું--- ક્યાં/શામાટેનહી. શુંતમેપુરુષોઅનેસ્ત્રીઓવચ્ચેનાવલણમાંકોઈતફાવતજુઓછો? શુંલિંગપ્રમાણેકલંકઅલગપડેછે?	
4	પ્રેરણા શુંટીબીસંભાળનાનફાકારક/ખાનગીક્ષેત્રનાપ્રદાતાસાથેકામકરવામાટેકોઈવ્યક્તિગતપ્રેરણામળેલછે?	TATA-1mg/JEET સ્ટાફસાથેનાસંબંધવિષેતપાસ: બોજનીસરળતા, વિશ્વસનીયતાઅનેવિશ્વાસનુંપરિબળ, ચોક્કસભૂમિકામાટેનિયુક્તનિષ્ણાતો, આમ, કાર્યક્ષમતામાંસુધારો	

Conclusion

તમારાસમયઅનેઅભ્યાસમાટેખૂબમૂલ્યવાનઇનપુટઆપવાબદલઆભાર!

અગાઉસૂચવ્યામુજબ, અમેઆઆંતરદૃષ્ટિનોઉપયોગખાનગીક્ષેત્રનીટીબીસંભાળદરમ્યાનઆવતાઅવરોધોઅનેસહાયકોનેસમજવામાટેકરીશું. અમેતમામપ્રતિભાવોગુપ્તરાખીશું. તમારાબિન-ઓળખાયેલઇન્ટરવ્યુપ્રતિસાદોફક્તસંશોધનટીમનાસભ્યોસાથેજશેરકરવામાંઆવશે.

શુંબીજુંકંઈછેજેતમેઉમેરવામાંગોછો?

(જવાબ)

તમારોઆભારઅનેતમારોદિવસશુભરહે!

Staff Interview Guide

Notes to the Interviewer

આથીમ્સઅનેપ્રશ્નોની'માર્ગદર્શિકા' છેજેનીતમેખાનગીક્ષેત્રનીટીબીસંભાળમાંઅવરોધોઅનેસહાયકોનેસમજવા-માટેઉત્તરદાતાઓનોઇન્ટરવ્યૂલેતીવખતેમદદલઈશકોછો.અમેતમનેઉત્તરદાતાનાજવાબનાઆધારેવાર્તાલા-પકરવાવિનંતીકરીએછીએઅનેફક્તઅહીંયાદીક્રમપરઆધારિતનથી.

મહેરબાનીકરીનેનોંધકરોકેવિભાગ I અને J તમામસ્ટાફશ્રેણીઓનેપૂછવામાંઆવશે

Demography Questions (Background)

S No	Questions	Categories/Logic	Notes
1	તમેમૂળકયાશ-હેર/ગામનાછો?		
2	લિંગ	સ્ત્રી પુરુષ કહેવાનુંપસંદનથી. સ્વ-વર્ણન ___	
3	તમારીહાલની-ઉંમરકેટલીછે?		
4	તમારીઉચ્ચત-મશૈક્ષણિકલા-યકાતશુંછે?	પ્રાથમિકશાળાપૂર્ણકરી હાઈસ્કૂલપૂર્ણકરી ઉચ્ચમાધ્યમિકશાળાપૂર્ણ ગ્રેજ્યુએશન અનુસ્નાતકઅનેતેથીવધુ	
5	તમેકેટલાવર્ષો-થીહેલ્થકેરવર્ક-રતરીકેકામક-રીરહ્યાછો?		
6	નીચેનામાંથી-તમારીનોકરી-નુંશીર્ષકશુંછે?	હબએજન્ટ SCT એજન્ટ સારવારસંયોજક ફિલ્ડઓફિસર TATA-1mg ટેલિ-કોલર TATA-1mg ડિલિવરીએજન્ટ કમ્પાઉન્ડર	નીચેનાવિભાગોનાદરેકપ્રકારનાસ્ટાફનેઅવગણો- 1. હબએજન્ટ-વિભાગ B 2. SCT એજન્ટ-વિભાગ C 3. સારવારસંયોજક-વિભાગ D 4. ક્ષેત્રઅધિકારી- વિભાગ E 5. TATA-1mg ટેલિ-કોલર- વિભાગ F 6. TATA-1mg ડિલિવરીએજન્ટ- વિભાગ G 7. કમ્પાઉન્ડર- વિભાગ H

S No	Questions	Probes/Logic	Notes
1	તમેહબએજન્ટતરીકેજેપ્રવૃત્તિઓકરોછોતેસમજા-વીશકોછો?		
2	દર્દીઓપાસેથીનમૂનાઓએકત્રકરવામાટેઅનુસરવા-માંઆવતીપ્રક્રિયાવિશેવિગતવારજણાવો?		
3	સારવારપ્રક્રિયામાંદર્દીઓનાનમૂનાએકત્રકરતીવખ-તેકયાપડકારોનોસામનોકરવોપડેછે?		
4	તમેદર્દીઓનેટેસ્ટરિપોર્ટકેવીરીતેઆપોછો?	તપાસ: શુંતેદર્દીદ્વારાહબ/ક્લીનિકમાંથીએકત્રિતક-રવામાંઆવ્યાછે	
5	તમેટીબીનાદર્દીઓમાટેડેટાકેવીરીતેમેળવોછો?		
6a	શુંતમેનિક્ષયપ્લેટફોર્મપરવિગતોદાખલકરોછો?	હા ના	જોનાહોય, તોપ્રશ્ન 8.a પરજાઓ
6b	નિક્ષયપ્લેટફોર્મનોઉપયોગકરવાનાતમારાઅનુભવ-નુંવર્ણનકરો.	તપાસ: નિક્ષયપ્લેટફોર્મ-કઈરીતેકામકરેછે નિક્ષયપ્લેટફોર્મ- ટેક્નો-લોજીનોઉપયોગઅનેપ્ર-શિક્ષણસામેપડકારો	
7a	શુંતમનેદર્દીઓનીવિગતોઓનલાઈનઅપલોડકર-વામાટેટેક્નોલોજી (ફોન, ટેબ્લેટ, કોમ્પ્યુટરવગેરે) નોઉપયોગકરવાનીતાલીમઆપવામાંઆવીહતી?		
7b	શુંતમનેદર્દીનીવિગતોઓનલાઈનઅપલોડકરવામા-ટેટેક્નોલોજી (ફોન, ટેબ્લેટ, કોમ્પ્યુટરવગેરે)નોઉપ-યોગકરવામાંઆવડેછે?	એક્સેસ, ઉદ્દેશ્યઅનેટે-ક્નોલોજીનોઉપયોગકર-વાનીક્ષમતાઅંગેતપાસ	
8a	શુંતમેદર્દીઓનેદવાઓઆપોછો?		
8b	દર્દીઓનેદવાઓઆપતીવખતેકયાપડકારોનોસામ-નોકરવોપડેછે?	તપાસ: ડૉક્ટરદ્વારાસૂચ-વવામાંઆવેલીદવાઓ (FDC અથવાછૂટકદ-વાઓ) અનેતેનાપરદર્દી-નુંમંતવ્ય, FDC વિશેની-માન્યતાઓ	
9a	શુંતમેતમારાજિલ્લામાં TATA-1mg પ્રોગ્રામસાથેકા-મકર્યુંછે?	જોના, તો 9bનેઅવગણો	
9b	જોહા, તોતમે TATA-1mg પ્રોગ્રામસાથેકામકરવા-નુંશરૂકર્યુંત્યારથીતમારુંવર્કલોડકેવીરીતેબદલાયુંછે?	શામાટેતપાસ- તેઓએદ-ર્દીનીવિગતો TATA-1mg સાથેશેરકરવીઆવશ્યકછે	

SCT Agent

S No	Questions	Probes/Logic	Notes
1	SCT એજન્ટતરીકેતમેજેપ્રવૃત્તિઓકરોછોતેતમેસમજાવીશકોછો?		
2	હબએજન્ટપાસેથીસેમ્પલકલેક્શનમાટેઅનુસરવામાંઆવતીપ્રક્રિયાવિશેવિગતવારજણાવોઅનેતેમનેડિલિવરીનીજાણકરો?		
3	પ્રક્રિયામાંતમનેકયાપડકારોનોસામનોકરવોપડીરહ્યોછે?		

Treatment coordinator

S No	Questions	Probes/Logic	Notes
1	સારવારસંયોજકતરીકેતમેજેપ્રવૃત્તિઓકરોછોતેતમેસમજાવીશકોછો?		
2a	શુંતમેટીબીવિશેદર્દીઓનેએકરોગતરીકેસમજાવોછો?		
2b	જોહા, તોતમેતેમનેશુંસમજાવોછો?	તપાસ: ટીબીશુંછે, તમેઆરોગનેકેવીરીતેઓળખશો/ફેલાયછે, રોગનીતીવ્રતા, રોગનાલક્ષણો, પોષણનુંસેવન, ડીબીટીનાફાયદા આમાહિતીતેમનેકેવીરીતેસમજાવવામાંઆવેછે - વાતચીતઅથવાએકપાત્રીનાટકતરીકે	
3a	શુંતમેદર્દીઓનેટીબીનીસારવારનીપ્રક્રિયાવિશેસમજાવોછો?		
3b	જોહા, તોતમેતેમનેશુંસમજાવશો?	ચકાસણીઓ: દવા-આડઅસરઅનેપાલન, સારવારનોસમય, કટોકટીનાકિસ્સામાંક્યારેઅનેકોનોસંપર્કકરવો	
4a	શુંદર્દીઓનેકાઉન્સેલિંગઆપવામાટે TATA-1mg જેવીતૃતીય-પક્ષસંસ્થાનેભાડેરાખવીફાયદાકારકછે?		
4b	જોકાઉન્સેલિંગસેવા TATA-1mg જેવીતૃતીય-પક્ષસંસ્થાનેઆઉટસોર્સકરવામાંઆવેતોશુંપડકારોહોઈશકે?		

S No	Questions	Probes/Logic	Notes
5	દર્દીઓમાટેએકંદરેટીબીનાજ્ઞાનમાંસુધારોકરવાશુંકરીશકાય? શુંતમનેલાગેછેકે, તમારીમુલાકાતો/પરસ્પરક્રિયાપ્રતિક્રિયાઓનાઆધારે---કેટીબીવિશેનાજ્ઞાનનેસુધારવામાટેકંઈકકરીશકાયછે.		

Field officer

S No	Questions	Probes/Logic	Notes
1	ફિલ્ડઓફિસરતરીકેતમેજેપ્રવૃત્તિઓકરોછો-તેતમેસમજાવીશકોછો?		
2a	તમેડોકટરોને JEET પ્રોગ્રામસાથેકેવીરીતેજોડશો?		
2b	તેમનાપ્રતિભાવોશુંછે?		
3	TATA-1mg (ગુજરાતઅનેફરીદાબાદમાં) સાથેડોકટરોનેજોડવાનીપ્રક્રિયાકેવીરીતે-અલગહતી?	ડોકટરોનેનફાકારક-સંસ્થાસાથેજોડાવામાટે-થઇનેસમજાવવાજરૂરી-કોઈપણવધારાનુંકામ JEET જોડાણવિરુદ્ધ TATA-1mg જોડાણમેળવવાનોપ્રયાસકરો	સુરતઅનેઅમદાવાદમાંહસ્તક્ષેપજૂથમાટે

TATA-1mg tele-caller

S No	Questions	Probes/Logic	Notes
1	શુંતમે TATA-1mg ટેલીકોલરતરીકેપ્રવૃત્તિકરોછો-તેસમજાવીશકોછો?		
2	તમેટીબીનાદર્દીઓમાટેડેટાકેવીરીતેમેળવોછો?		માત્રફરીદાબાદમાંહસ્તક્ષેપજૂથમાટે
3a	શુંતમેનિક્ષયપ્લેટફોર્મપરવિગતોદાખલકરોછો?	હા ના	માત્રફરીદાબાદમાંહસ્તક્ષેપજૂથમાટે જોના, તો 4a પરજાઓ.

S No	Questions	Probes/Logic	Notes
3b	નિક્ષયપ્લેટફોર્મનોઉપયોગકરવાનાતમારાઅનુભવનુંવર્ણનકરો.	તપાસ: નિક્ષયપ્લેટફોર્મકઈરીતેકામકરેછે નિક્ષયપ્લેટફોર્મટેક્નોલોજીનોઉપયોગઅનેપ્રશિક્ષણસામેપડકારો	માત્રફરીદાબાદમાંહસ્તક્ષેપજૂથમાટે
4a	શુંતમનેદર્દીઓનીવિગતોઓનલાઈનઅપલોડકરવામાટેટેક્નોલોજી (ફોન, ટેબ્લેટ, કોમ્પ્યુટરવગેરે) નોઉપયોગકરવાનીતાલીમઆપવામાંઆવીહતી?		માત્રફરીદાબાદમાંહસ્તક્ષેપજૂથમાટે
4b	શુંતમનેદર્દીનીવિગતોઓનલાઈનઅપલોડકરવામાટેટેક્નોલોજી (ફોન, ટેબ્લેટ, કોમ્પ્યુટરવગેરે) નોઉપયોગકરવામાંઆવડેછે?	એક્સેસ, ઉદ્દેશ્યઅનેટેક્નોલોજીનોઉપયોગકરવાનીક્ષમતાઅંગેતપાસ	માત્રફરીદાબાદમાંહસ્તક્ષેપજૂથમાટે
5a	શુંતમેદર્દીઓનેપરીક્ષણપરિણામોવિશેજાણકરોછો?		
5b	જોહ, તોતમારાદ્વારાઅનુસરવામાંઆવતીપ્રક્રિયાસમજાવો.	જ્યારેતમેતેમનેપ્રક્રિયાવિશેસમજાવોછોત્યારેદર્દીઓકેવોપ્રતિભાવઆપેછે	
6	દર્દીઓસમયસરદવાઓલેતેનીખાતરીકરવાતમેશુંકરશો?	રીમાઇન્ડરકોલ્સપરતપાસકરો	
7a	જ્યારે TATA-1mg સ્ટાફેદર્દીઓમાટેરિમાઇન્ડરકોલ્સશરૂકર્યાત્યારેશુંદવાલેવામાંબદલાવથયો?	આપરિવર્તનનાસંભવિતકારણોશુંહોઈશકે?	

TATA-1mg Delivery Agent

S No	Questions	Probes/Logic	Notes
1	શુંતમે TATA-1mg ડલિવિરીએજન્ટતરીકેપ્રવૃતઓકરોછોતેસમજાવીશકોછો?		
2a	તમેદર્દીઓપાસેથીનમૂનાઓકેવીરીતેએકત્રિતકરોછો?		માત્રફરીદાબાદમાંહસ્તક્ષેપજૂથમાટે
2b	દર્દીઓપાસેથીનમૂનાઓએકત્રતિકરતીવખતેતમારેકોઈપડકારોનોસામનોકરવોપડેછે?	તપાસ: દર્દીઓદ્વારાફોલોઅપપ્રશ્નોકેજેનાજવાબસ્ટાફકદાચઆપીશકશેનહી દર્દીનાલક્ષણ/દર્દીનાઆરામનુંસ્તર સમય/પ્રવાસનીસમસ્યાઓ	માત્રફરીદાબાદમાંહસ્તક્ષેપજૂથમાટે

S No	Questions	Probes/Logic	Notes
3a	તમેદર્દીઓનાટેસ્ટરપિોર્ટક્યાંપહોચાડોછો?		માત્રફરીદાબાદમાંહ-સ્તક્ષેપજૂથમાટે
3b	જ્યારેતમેદર્દીઓનેતેમનાટેસ્ટરપિોર્ટઆપોછો-ત્યારેશુંતમનેકોઈપડકારોનોસામનોકરવોપડેછે?	તપાસ: દર્દીઓદ્વારાફોલો-અપપ્રશ્નોકેજેનાજ-વાબસ્ટાફકદાચઆપી-શકશેનહી દર્દીનાલક્ષણ/ દર્દીનાઆરામનુંસ્તર સમય/પ્રવાસનીસમ-સ્યાઓ	માત્રફરીદાબાદમાંહ-સ્તક્ષેપજૂથમાટે
4	દર્દીઓનેતેમનીટીબીનીદવાકેવીરીતેમળેછે?	તપાસ: શુંતેઓનેમા-ત્રડૉક્ટરનાનર્દિે-શઅનુસારજદવાઓ-મળેછે	
5a	શુંતમનેલાગેછેકેદવાઓનીહોમડલિવિરીદર્દીઓ-માટેફાયદાકારકછે?		જોના, તો Q6 પરજાઓ
5b	જોહા, તોકેવીરીતે?		
6	ઘરેદવાઓપહોચાડતીવખતેતમનેકયાપડકારો-નોસામનોકરવોપડેછે?		
7	શુંતમેદર્દીઓનેપૂછોછોકેતેઓનેદવાઓનીહોમ-ડલિવિરીવશિશુંગમેછે?		
8	દવાઓઘરેપહોચાડવામાંઆવેછેતેમાંદર્દીઓને-કયાપડકારોનોસામનોકરવોપડેછે?	તપાસ: ટીબીનાલીધેસામાજકિ-લાંછન,	

Compounder

S No	Questions	Probes/Logic	Notes
1	તમેકમ્પાઉન્ડરતરીકેજેપ્રવૃત્તિઓકરોછોતેસમજા-વીશકોછો?		
2	તમેદર્દીનીવિગતોકેવીરીતેનોંધોછો?		

S No	Questions	Probes/Logic	Notes
3a	શુંતમેદર્દીઓનેદવાઓઆપોછો?		
3b	જોહા, તોતમેદર્દીઓનેદવાઓઆપોત્યારેકયાપડકારોનોસામનોકરવોપડેછે?		
4a	શુંતમેતમારાજિલ્લામાં TATA-1mg પ્રોગ્રામસાથેકામકર્યુંછે?		માત્રહસ્તક્ષેપજૂથમાટે
4b	જોહા, તોતમે TATA-1mg પ્રોગ્રામસાથેકામકરવાનુંશરૂકર્યુંત્યારથીતમારુંવર્કલોડકેવીરીતેબદલાયુંછે?		માત્રહસ્તક્ષેપજૂથમાટે

Beliefs and Perceptions

S No	Questions	Probes/Logic	Notes
1a	ભય શુંટીબીપરીક્ષણસંબંધિતકોઈભયછે?	ગળફાનોસંગ્રહઅનેછાતીનોએક્સ-રેબંનેનીતપાસ	જોના, તો 1b અવગણો
1b	જોહા, તોતમેવિસ્તારથીજણાવીશકોછો?		
2a	ભય શુંતમનેલાગેછેકેદર્દીઓતેમનાપરિવાર, મિત્રોઅનેપડોશીઓસાથેતેમનીટીબીસારવારપ્રક્રિયાનીચર્ચાકરવામાટેઅનુકુળછે?		જોહા, તો 2b અવગણો
2b	ભય જોઅનુકુળનહોય, તોકયાપરિબળોછેજેતેમનેઅન્યલોકોનેકહેવામાંસંકોચઅનુભવાયછે?		
3	વિશ્વાસ નીચેનાસાથેતમારાઅનુભવનેવ્યાખ્યાયિતકરો- 1. ડોક્ટરો 2. કમ્પાઉન્ડર્સ 3. દર્દીઓઅનેતેમનાપરિવારો 4. અન્ય JEET/TATA-1mg સ્ટાફ	તપાસ: તેમનીસાથેનાતમારાસંબંધોસુધારવા/તેમનીસાથેવિશ્વાસવધારવાશુંકરીશકાય?	
4	ભય ટીબીસેક્ટરમાંહેલ્થકેરએજન્ટતરીકેતમનેશુંડરછે?	તપાસ: શુંતેઓમાસ્કપહેરેછે, નમૂનાએકત્રિતકરતીવખતેડરલાગેછે, નોકરીનીપ્રકૃતિવિશેપરિવારનીચેતા	

S No	Questions	Probes/Logic	Notes
5	સંતોષ TATA-1mg સાથેતમારાજોડાણવિશેતમનેકે-વુંલાગેછે?	તપાસ: શુંજોડાણપ-છીકાર્યભારબદલાઈ-ગયોછે? શુંપ્રોત્સાહનોતેમનાકા-ર્યનેહકારાત્મકરીતેઅ-સરકરેછે? શુંવધારાનાકામમાટે-પ્રોત્સાહનપૂરતુંનથી?	

Operations

Sno	Questions	Probes/Logic	Notes
1a	શુંતમનેતમારીસેવાઓમાટેસમયસરપગારમળેછે?		
1b	જોના, તોસમયસરચુકવણીનથવાનાસંભવિતકાર-ણોશુંછે?		
2a	શુંતમનેતમારીસેવાઓમાટેકોઈપ્રોત્સાહનમળેછે?		
2b	જોહા, તોઆપ્રોત્સાહનોતમારીએકંદરનોકરીનાસંતો-ષનેકેવીરીતેઅસરકરેછે?	સકારાત્મકઅસરઅથ-વાનકારાત્મકઅસર	
3a	શું-1mg/JEET સ્ટાફતરીકેતમારીભૂમિકાઅનેજવાબ-દારીઓસ્પષ્ટરીતેવ્યાખ્યાયિતછે?		
3b	શુંતમેઆભૂમિકાનિભાવતાપહેલાકોઈતાલીમલીધી-હતી?		
3c	તાલીમકેવીરીતેહાથધરવામાંઆવીહતી?		
3d	ભવિષ્યમાંતમારીતાલીમનીજરૂરિયાતોનીકાળજીલે-વામાટેશુંકરીશકાય?		

ઉપસંહાર

તમારાસમયઅનેઅભ્યાસમાટેખૂબમૂલ્યવાનપ્રત્યુત્તરબદલઆભાર!

અગાઉજણાવ્યામુજબ, અમેઆઆંતરદૃષ્ટિનોઉપયોગખાનગીક્ષેત્રનીટીબીસંભાળનાઅવરોધોઅ-નેસહાયકોનેસમજવામાટેકરીશું. અમેતમામપ્રતિભાવોગુપ્તરાખીશું. તમારાબિન-ઓળખાયેલઇ-ન્ટરવ્યુનાજવાબોફક્તસંશોધનટીમનાસભ્યોસાથેજવહેંચવામાંઆવશે.

શુંબીજુંકંઈછેજેતમેઉમેરવામાંગોછો?

(જવાબ)

તમારોઆભારઅનેતમારોદિવસશુભરહે!

Appendix 5: Consent Forms for Patients, Providers and Staff

ISB | Max Institute of Healthcare Management

INDIAN SCHOOL OF BUSINESS CONSENT FORM FOR PATIENTS

Thank you for agreeing to participate in this study conducted by the Indian School of Business (ISB), India.

In this study, we want to understand the current TB care in the private sector in India. For this, we will interview you to know about your knowledge and experience regarding TB care. You will be asked questions about the TB testing process, sample collection, medicine delivery, treatment counselling support and your beliefs and perceptions about the entire TB care process.

Each interview will last between 45 minutes and 1 hour and will happen at a location convenient to you. The interview is completely voluntary. If there is any question you do not want to answer you can ask to skip the question. At any point you can ask to end the interview.

To better understand and use the data collected, we will audio record the interview. The data will be used by the researchers at ISB to help analyse the findings from the interviews. All personal information will be removed from the interview before analysing the responses. There are no known risks associated with your participation in this research beyond those of everyday life. There will be no compensation for your participation.

Your responses are important. Your participation will help in understanding and improving TB care in India. We request you to provide us with honest responses to all questions.

If you have questions or wish to report a research-related problem, you may contact the Principal Investigator: Sarang Deo at phone + 91 4023187378 or email at the sarang_deo@isb.edu, Indian School of Business, Gachibowli, Hyderabad – 500032, India.

For questions about your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB) at ISB: Professor Ashwini Chhatre at 040-2318-7134 or email ashwini_chhatre@isb.edu at the Indian School of Business, Gachibowli, Hyderabad – 500111, India.

Do you have any questions?

Currently, do you consent to participating in this survey? Yes No

PARTICIPANT SIGNATURE DATE

ISB | Max Institute of Healthcare Management

INDIAN SCHOOL OF BUSINESS

CONSENT FORM FOR PROVIDERS

Thank you for agreeing to participate in this study being conducted by the Indian School of Business, India.

In this study, we want to understand the current TB care in the private sector in India. For this, we will interview you to know about your knowledge and experience regarding TB care. You will be asked questions about services provided to you such as testing, sample collection and medicine delivery, treatment counselling support and your beliefs and perceptions about TB care process.

Each interview will last between 45 minutes and 1 hour and will happen at a location convenient to you. The interview is completely voluntary. If there is any question you do not want to answer you can ask to skip the question. At any point you can ask to end the interview.

To better understand and use the data collected, we will audio record the interview. The data will be used by the researchers at ISB to help analyse the findings from the interviews. All personal information will be removed from the interview before analysing the responses. There are no known risks associated with your participation in this research beyond those of everyday life. There will be no compensation for your participation.

Your responses are important. Your participation will help in understanding and improving TB care in India. We request you to provide us with honest responses to all questions.

If you have questions or wish to report a research-related problem, you may contact the Principal Investigator: Sarang Deo at phone + 91 4023187378 or email at the sarang_deo@isb.edu, Indian School of Business, Gachibowli, Hyderabad – 500032, India.

For questions about your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB) at ISB: Professor Ashwini Chhatre at 040-2318-7134 or email ashwini_chhatre@isb.edu at the Indian School of Business, Gachibowli, Hyderabad – 500111, India.

Do you have any questions?

Currently, do you consent to participating in this survey? Yes No

PARTICIPANT SIGNATURE DATE

ISB | Max Institute of Healthcare Management

INDIAN SCHOOL OF BUSINESS

CONSENT FORM FOR STAFF

Thank you for agreeing to participate in this study being conducted by the Indian School of Business, India.

In this study, we want to understand the current TB care in the private sector in India. For this, we will interview you to know about your knowledge and experience regarding TB care. You will be asked questions about the TB testing process, sample collection, medicine delivery, treatment counselling support and your beliefs and perceptions about TB care and your relationship with other stakeholders.

Each interview will last between 45 minutes and 1 hour and will happen at a location convenient to you. The interview is completely voluntary. If there is any question you do not want to answer you can ask to skip the question. At any point you can ask to end the interview.

To better understand and use the data collected, we will audio record the interview. The data will be used by the researchers at ISB to help analyse the findings from the interviews. All personal information will be removed from the interview before analysing the responses. There are no known risks associated with your participation in this research beyond those of everyday life. There will be no compensation for your participation.

Your responses are important. Your participation will help in understanding and improving TB care in India. We request you to provide us with honest responses to all questions.

If you have questions or wish to report a research-related problem, you may contact the Principal Investigator: Sarang Deo at phone + 91 4023187378 or email at the sarang_deo@isb.edu, Indian School of Business, Gachibowli, Hyderabad – 500032, India.

For questions about your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB) at ISB: Professor Ashwini Chhatre at 040-2318-7134 or email ashwini_chhatre@isb.edu at the Indian School of Business, Gachibowli, Hyderabad – 500111, India.

Do you have any questions?

Currently, do you consent to participating in this survey? Yes No

PARTICIPANT SIGNATURE DATE

Appendix 6: Hindi Translations of Consent Forms for Patients, Providers and Staff

ISB | Max Institute of Healthcare Management

इंडियन स्कूल ऑफ बिजनेस सहमतिपत्र

इंडियनस्कूलऑफबिजनेस (आईएसबी), भारतद्वाराआयोजितइसअध्ययनमेंभागलेनेकेलिएधन्यवाद।

इसअध्ययनमें, हमभारतमेंनिजीक्षेत्रमेंटीबीकीवर्तमानदेखभालकोसमझनाचाहतेहैं।इसकेलिएहमआपकासाक्षात्कारकरेंगेऔर टीबीकीदेखभालकेबारेमेंआपकेज्ञानऔरअनुभवकेबारेमेंजानेंगे।आपसेटीबीपरीक्षणप्रक्रिया, नमूनासंग्रह, दवावितरण, उपचार परामर्शसहायताऔरसंपूर्णटीबीदेखभालप्रक्रियाकेबारेमेंआपकीधारणाओंऔरधारणाओंकेबारेमेंप्रश्नपूछेजाएंगे।

प्रत्येकसाक्षात्कार 45 मिनटऔर 1 घंटेकेबीचचलेगाऔरआपकेलिएसुविधाजनकस्थानपरहोगा।साक्षात्कारपूरीतरहसेस्वैच्छिक है।यदिकोईप्रश्नहैजिसकाआपउत्तरनहींदेनाचाहतेहैंतोआपप्रश्नछोड़नेकेलिएकहसकतेहैं।आपकिसीभीसमयसाक्षात्कारसमाप्त करनेकेलिएकहसकतेहैं।

एकत्रकिएगएडेटाकोबेहतरढंगसेसमझनेऔरउपयोगकरनेकेलिए, हमसाक्षात्कारकाऑडियोरिकॉर्डकरेंगे।डेटाकाउपयोग ISB केशोधकर्ताओंद्वारासाक्षात्कारोंकेनिष्कर्षोंकाविश्लेषणकरनेमेंमददकेलिएकियाजाएगा।प्रतिक्रियाओंकाविश्लेषणकरनेसे पहलेसाक्षात्कारसेसभीव्यक्तिगतजानकारीहटादीजाएगी।रोज़मर्किजीवनसेपरेइसशोधमेंआपकीभागीदारीसेजुड़ाकोईज्ञातजो खिमनहींहै।आपकीभागीदारीकेलिएकोईमुआवजानहींहोगा।

आपकेजवाबमहत्वपूर्णहैं।आपकासहयोगभारतमेंटीबीकीदेखभालकोसमझनेऔरसुधारनेमेंमददकरेगा।हमआपसेसभीप्रश्नोंके लिएईमानदारजवाबदेनेकीअनुरोधकरतेहैं।

यदिआपकेकोईप्रश्नहैंयाआपशोधसेसंबंधितसमस्याकीरिपोर्टकरनाचाहतेहैं, तोआपप्रधानअन्वेषकसेसंपर्ककरसकतेहैं: सारंगदेवफोन + 4023187378 91 परयाsarang_deo@isb.edu, इंडियनस्कूलऑफबिजनेस, गाचीबोवली, हैदराबाद - 500032, भारतपरईमेलकरें। .

एकशोधभागीदारकेरूपमेंअपनेअधिकारोंकेबारेमेंप्रश्नोंकेलिए, आपआईएसबीमेंइंस्टीट्यूशनलरिव्यूबोर्ड (आईआरबी) केअध्यक्षसेसंपर्ककरसकतेहैं: प्रोफेसरअश्विनीछत्रेसे 7134-2318-040 परयाइंडियनस्कूलऑफबिजनेस, गाचीबोवलीमेंashwini_chhatre@isb.eduपरईमेलकरें। , हैदराबाद - 500111, भारत।

क्याआपकेपासकोईप्रश्नहैं?
वर्तमानमें, क्याआपइससर्वेक्षणमेंभागलेनेसेसहमतहैं? हाँनहीं

सहभागीहस्ताक्षरतारीख

इंडियनस्कूलऑफबिजनेससहमतिपत्र

इंडियनस्कूलऑफबिजनेस (आईएसबी), भारतद्वाराआयोजितइसअध्ययनमेंभागलेनेकेलिएधन्यवाद।

इसअध्ययनमें, हमभारतमेंनिजीक्षेत्रमेंटीबीकीवर्तमानदेखभालकोसमझनाचाहतेहैं।इसकेलिएहमआपकासाक्षात्कारकरेंगे औरटीबीकीदेखभालकेबारेमेंआपकेज्ञानऔरअनुभवकेबारेमेंजानेंगे।आपसेआपकोप्रदानकीजानेवालीसेवाओंजैसेपरीक्षण, नमूनासंग्रहऔरदवावितरण, उपचारपरामर्शसहायताऔरटीबीदेखभालप्रक्रियाकेबारेमेंआपकीधारणाओंऔरधारणाओंकेबारे मेंप्रश्नपूछेजाएंगे।

प्रत्येकसाक्षात्कार 45 मिनटऔर 1 घंटेकेबीचचलेगाऔरआपकेलिएसुविधाजनकस्थानपरहोगा।साक्षात्कारपूरीतरहसेस्वैच्छिक है।यदिकोईप्रश्नहैजिसकाआपउत्तरनहींदेनाचाहतेहैंतोआपप्रश्नछोड़नेकेलिएकहसकतेहैं।आपकिसीभीसमयसाक्षात्कारसमाप्त करनेकेलिएकहसकतेहैं।

एकत्रकिएगएडेटाकोबेहतरढंगसेसमझनेऔरउपयोगकरनेकेलिए, हमसाक्षात्कारकाऑडियोरिकॉर्डकरेंगे।डेटाकाउपयोग ISB केशोधकर्ताओंद्वारासाक्षात्कारोंकेनिष्कर्षोंकाविश्लेषणकरनेमेंमददकेलिएकियाजाएगा।प्रतिक्रियाओंकाविश्लेषणकरनेसे पहलेसाक्षात्कारसेसभीव्यक्तिगतजानकारीहटादीजाएगी।रोज़मर्राकेजीवनसेपरेइसशोधमेंआपकीभागीदारीसेजुड़ाकोईज्ञातजो खिमनहींहै।आपकीभागीदारीकेलिएकोईमुआवजानहींहोगा।

आपकेजवाबमहत्वपूर्णहैं।आपकासहयोगभारतमेंटीबीकीदेखभालकोसमझनेऔरसुधारनेमेंमददकरेगा।हमआपसेसभीप्रश्नोंके लिएईमानदारजवाबदेनेकीअनुरोधकरतेहैं।

यदिआपकेकोईप्रश्नहैंयाआपशोधसेसंबंधितसमस्याकीरिपोर्टकरनाचाहतेहैं, तोआपप्रधानअन्वेषकसेसंपर्ककरसकतेहैं: सारंगदेवफोन + 4023187378 91 परयाsarang_deo@isb.edu, इंडियनस्कूलऑफबिजनेस, गाचीबोवली, हैदराबाद - 500032, भारतपरईमेलकरें। .

एकशोधभागीदारकेरूपमेंअपनेअधिकारोंकेबारेमेंप्रश्नोंकेलिए, आपआईएसबीमेंइंस्टीट्यूशनलरिव्यूबोर्ड (आईआरबी) केअध्यक्षसेसंपर्ककरसकतेहैं: प्रोफेसरअश्विनीछत्रेसे 7134-2318-040 परयाइंडियनस्कूलऑफबिजनेस, गाचीबोवलीमेंashwini_chhatre@isb.eduपरईमेलकरें। , हैदराबाद - 500111, भारत।

क्याआपकेपासकोईप्रश्नहैं?

वर्तमानमें, क्याआपइससर्वेक्षणमेंभागलेनेसेसहमतहैं? हाँनहीं

सहभागीहस्ताक्षर

ISB | Max Institute of Healthcare Management

इंडियनस्कूलऑफबिजनेससहमतिपत्र

इंडियनस्कूलऑफबिजनेस (आईएसबी), भारतद्वाराआयोजितइसअध्ययनमेंभागलेनेकेलिएधन्यवाद।इसअध्ययनमें, हमभारत मेंनिजीक्षेत्रमेंटीबीकीवर्तमानदेखभालकोसमझनाचाहतेहैं।इसकेलिएहमआपकासाक्षात्कारकरेंगेऔरटीबीकीदेखभालकेबारेमें आपकेज्ञानऔरअनुभवकेबारेमेंजानेंगे।आपसेटीबीपरीक्षणप्रक्रिया, नमूनासंग्रह, दवावितरण, उपचारपरामर्शसहायताऔरटीबी देखभालकेबारेमेंआपकीधारणाओंऔरधारणाओंऔरअन्यहितधारकोंकेसाथआपकेसंबंधोंकेबारेमेंप्रश्नपूछेजाएंगे।

प्रत्येकसाक्षात्कार 45 मिनटऔर 1 घंटेकेबीचचलेगाऔरआपकेलिएसुविधाजनकस्थानपरहोगा।साक्षात्कारपूरीतरहसेस्वैच्छिक है।यदिकोईप्रश्नहैजिसकाआपउत्तरनहींदेनाचाहतेहैंतोआपप्रश्नछोड़नेकेलिएकहसकतेहैं।आपकिसीभीसमयसाक्षात्कारसमाप्त करनेकेलिएकहसकतेहैं।

प्रयदिआपकेकोईप्रश्नहैंयाआपशोधसेसंबंधितसमस्याकीरिपोर्टकरनाचाहतेहैं, तोआपप्रधानअन्वेषकसेसंपर्ककरसकतेहैं: सारंगदेवफोन + 4023187378 91 परयासारंग_deo@isb.edu, इंडियनस्कूलऑफबिजनेस, गाचीबोवली, हैदराबाद - 500032, भारतपरईमेलकरें। .

एकशोधभागीदारकेरूपमेंअपनेअधिकारोंकेबारेमेंप्रश्नोंकेलिए, आपआईएसबीमेंइंस्टीट्यूशनलरिव्यूबोर्ड (आईआरबी) केअध्यक्षसेसंपर्ककरसकतेहैं: प्रोफेसरअश्विनीछत्रेसे 7134-2318-040 परयाइंडियनस्कूलऑफबिजनेस, गाचीबोवलीमेंashwini_chhatre@isb.eduपरईमेलकरें। , हैदराबाद - 500111, भारत।

क्याआपकेपासकोईप्रश्नहैं?

वर्तमानमें, क्याआपइससर्वेक्षणमेंभागलेनेसेसहमतहैं? हाँनहीं

सहभागीहस्ताक्षरतारीख

Appendix 7: Gujarati Translations Consent Forms for Patients, Providers and Staff

ISB | Max Institute of Healthcare Management

ઇન્ડિયનસ્કૂલઓફબિઝનેસકન્સેન્ટફોર્મ

ઈન્ડિયનસ્કૂલઓફબિઝનેસ (ISB), ભારતદ્વારાઆયોજિતઆઅભ્યાસમાંભાગલેવામાટેસંમતથવાબદલઆભાર.

આઅભ્યાસમાં, અમેભારતનાખાનગીક્ષેત્રનીવર્તમાનટીબીસંભાળનેસમજવામાંગીએછીએ. આમાટે, અમેટીબીસંભાળઅંગેનાતમારાજ્ઞાનઅનેઅનુભવવિશેજાણવામાટેતમારોઇન્ટરવ્યુકરીશું. તમનેટીબીપરીક્ષણપ્રક્રિયા, નમૂનાસંગ્રહ, દવાનીડિલિવરી, સારવારપરામર્શસહાયઅને,સમગ્રટીબીસંભાળપ્રક્રિયાવિશેનીતમારીમાન્યતાઓ,અનેધારણાઓવિશેપ્રશ્નોપૂછવામાંઆવશે.

દરેકઇન્ટરવ્યુતમારામાટેઅનુકૂળસ્થાનપર45 મિનિટઅને1 કલાકનીવચ્ચેચાલશે. ઇન્ટરવ્યુસંપૂર્ણપણેસ્વૈચ્છિકછે. જોકોઈપ્રશ્નનોતમેજવાબઆપવામાંગતાનહોવતોતમેપ્રશ્નછોડવામાટેકહીશકોછો. કોઈપણસમયેતમેઇન્ટરવ્યુસમાપ્તકરવાનુંકહીશકોછો.

એકત્રિતકરવામાંઆવેલડેટાનેવધુસારીરીતેસમજવાઅનેતેનોઉપયોગકરવામાટે, અમેઇન્ટરવ્યુનેઓડિયોરેકોર્ડકરીશું. ડેટાનોઉપયોગISB ખાતેનાસંશોધકોઇન્ટરવ્યુમાંથીમળેલાતારણોનુંવિશ્લેષણકરવામાટેકરશે. પ્રતિસાદોનુંવિશ્લેષણકરતાપહેલાઇન્ટરવ્યુમાંથીબધીવ્યક્તિગતમાહિતીદૂરકરવામાંઆવશે. રોજિંદાજીવનનીબહાર,આસંશોધનમાંતમારીસહભાગિતાસાથેસંકળાયેલાકોઈજાણીતાજોખમોનથી. તમારીસહભાગિતામાટેકોઈવળતરરહેશેનહીં.

તમારાપ્રતિભાવોમહત્વપૂર્ણછે. તમારીસહભાગિતાભારતમાંટીબીનીસંભાળનેસમજવાઅનેસુધારવામાંમદદકરશે. અમેતમનેવિનંતીકરીએછીએકેઅમનેબધાપ્રશ્નોનાપ્રમાણિકજવાબોઆપો.

જોતમારીપાસેપ્રશ્નોહોયઅથવાસંશોધન-સંબંધિતસમસ્યાનીજાણકરવામાંગતાહોય, તોતમેમુખ્યતપાસકર્તા: સારંગદેવનોતેમનાફોનનંબર+ 91 4023187378 પરઅથવાઈમેલsarang_deo@isb.edu, ઇન્ડિયનસ્કૂલઓફબિઝનેસ, ગાચીબવલી, હૈદરાબાદ - 500032, ભારતપરસંપર્કકરીશકોછો.

સંશોધનસહભાગીતરીકેતમારાઅધિકારોવિશેનાપ્રશ્નોમાટે, તમેISB પરસંસ્થાકીયસમીક્ષાબોર્ડ (IRB) નાઅધ્યક્ષનોસંપર્કકરીશકોછો: પ્રોફેસરઅશ્વિનીછત્રેનોતેમનાફોનનંબર2040-2318-7134 પરઅથવાઈમેલashwini_chhatre@isb.eduઇન્ડિયનસ્કૂલઓફબિઝનેસ, ગચીબોવલી,હૈદરાબાદ - 500111, ભારતપરસંપર્કકરીશકોછો.

શુંતમનેકોઈપ્રશ્નોછે?

હાલમાં, શુંતમેઆસર્વેક્ષણમાંભાગલેવામાટેસંમતિઆપોછો? હાના

સહભાગીહસ્તાક્ષર તારીખ

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ઇન્ડિયનસ્કૂલઓફબિઝનેસકન્સેન્ટફોર્મ

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આઅભ્યાસમાં, અમેભારતમાંખાનગીક્ષેત્રમાંવર્તમાનટીબીસંભાળનેસમજવામાંગીએછીએ. આમાટે, અમેટીબીસંભાળઅંગેનાતમારાજ્ઞાનઅનેઅનુભવવિશેજાણવામાટેતમારોઇન્ટરવ્યુકરીશું. તમનેપૂરીપાડવામાંઆવતીસેવાઓજેમકેપરીક્ષણ, નમૂનાસંગ્રહઅનેદવાનીડિલિવરી, સારવારપરામર્શસહાયઅનેટીબીસંભાળપ્રક્રિયાવિશેતમારીમાન્યતાઓઅનેધારણાઓવિશેતમનેપ્રશ્નોપૂછવામાંઆવશે.

દરેકઇન્ટરવ્યુતમારામાટેઅનુકૂળસ્થાનપર45 મિનિટઅને1 કલાકનીવચ્ચેચાલશે. ઇન્ટરવ્યુસંપૂર્ણપણેસ્વૈચ્છિકછે. જોકોઈપ્રશ્નનોતમેજવાબઆપવામાંગતાનહોવતોતમેપ્રશ્નછોડવામાટેકહીશકોછો. કોઈપણસમયેતમેઇન્ટરવ્યુસમાપ્તકરવાનુંકહીશકોછો.

એકત્રિતકરવામાંઆવેલડેટાનેવધુસારીરીતેસમજવાઅનેતેનોઉપયોગકરવામાટે, અમેઇન્ટરવ્યુનેઓડિયોરેકોર્ડકરીશું. ડેટાનોઉપયોગISB ખાતેનાસંશોધકોઇન્ટરવ્યુમાંથીમળેલાતારણોનુંવિશ્લેષણકરવામાટેકરશે. પ્રતિસાદોનુંવિશ્લેષણકરતાપહેલાઇન્ટરવ્યુમાંથીબધીવ્યક્તિગતમાહિતીદૂરકરવામાંઆવશે. રોજિંદાજીવનનીબહાર,આસંશોધનમાંતમારીસહભાગિતાસાથેસંકળાયેલાકોઈજાણીતાજોખમોનથી. તમારીસહભાગિતામાટેકોઈવળતરરહેશેનહીં.

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જોતમારીપાસેપ્રશ્નોહોયઅથવાસંશોધન-સંબંધિતસમસ્યાનીજાણકરવામાંગતાહોય, તોતમેમુખ્યતપાસકર્તા: સારંગદેવનોતેમનાફોનનંબર+ 91 4023187378 પરઅથવાઈમેલsarang_deo@isb.edu, ઇન્ડિયનસ્કૂલઓફબિઝનેસ, ગાચીબવલી, હૈદરાબાદ - 500032, ભારતપરસંપર્કકરીશકોછો.

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સહભાગીહસ્તાક્ષર તારીખ

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ઇન્ડિયનસ્કૂલઓફબિઝનેસકન્સેન્ટફોર્મ

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દરેકઇન્ટરવ્યુતમારામાટેઅનુકૂળસ્થાનપર45 મિનિટઅને1 કલાકનીવચ્ચેચાલશે. ઇન્ટરવ્યુસંપૂર્ણપણેસ્વૈચ્છિકછે. જોકોઈપ્રશ્નનોતમેજવાબઆપવામાંગતાનહોવતોતમેપ્રશ્નછોડવામાટેકહીશકોછો. કોઈપણસમયેતમેઇન્ટરવ્યુસમાપ્તકરવાનુંકહીશકોછો.

એકત્રિતકરવામાંઆવેલડેટાનેવધુસારીરીતેસમજવાઅનેતેનોઉપયોગકરવામાટે, અમેઇન્ટરવ્યુનેઓડિયોરેકોર્ડકરીશું. ડેટાનોઉપયોગISB ખાતેનાસંશોધકોઇન્ટરવ્યુમાંથીમળેલાતારણોનુંવિશ્લેષણકરવામાટેકરશે. પ્રતિસાદોનુંવિશ્લેષણકરતાપહેલાઇન્ટરવ્યુમાંથીબધીવ્યક્તિગતમાહિતીદૂરકરવામાંઆવશે. રોજિંદાજીવનનીબહાર,આસંશોધનમાંતમારીસહભાગિતાસાથેસંકળાયેલાકોઈજાણીતાજોખમોનથી. તમારીસહભાગિતામાટેકોઈવળતરરહેશેનહીં.

તમારાપ્રતિભાવોમહત્વપૂર્ણછે. તમારીસહભાગિતાભારતમાંટીબીનીસંભાળનેસમજવાઅનેસુધારવામાંમદદકરશે. અમેતમનેવિનંતીકરીએછીએકેઅમનેબધાપ્રશ્નોનાપ્રમાણિકજવાબોઆપો.

જોતમારીપાસેપ્રશ્નોહોયઅથવાસંશોધન-સંબંધિતસમસ્યાનીજાણકરવામાંગતાહોય, તોતમેમુખ્યતપાસકર્તા: સારંગદેવનોતેમનાફોનનંબર+ 91 4023187378 પરઅથવાઈમેલsarang_deo@isb.edu, ઇન્ડિયનસ્કૂલઓફબિઝનેસ, ગાચીબવલી, હૈદરાબાદ - 500032, ભારતપરસંપર્કકરીશકોછો.

સંશોધનસહભાગીતરીકેતમારાઅધિકારોવિશેનાપ્રશ્નોમાટે, તમેISB પરસંસ્થાકીયસમીક્ષાબોર્ડ (IRB) નાઅધ્યક્ષનોસંપર્કકરીશકોછો: પ્રોફેસરઅશ્વિનીછત્રેનોતેમનાફોનનંબર2040-2318-7134 પરઅથવાઈમેલashwini_chhatre@isb.eduઇન્ડિયનસ્કૂલઓફબિઝનેસ, ગચીબોવલી,હૈદરાબાદ - 500111, ભારતપરસંપર્કકરીશકોછો.

શુંતમનેકોઈપ્રશ્નોછે?

હાલમાં, શુંતમેઆસર્વેક્ષણમાંભાગલેવામાટેસંમતિઆપોછો?? હાના

સહભાગીહસ્તાક્ષર તારીખ

Appendix 8 : Costing Exercise Tools

Leveraging E-Pharmacy to Improve Quality of TB Care in the Private Sector

Costing Tool

Faridabad Model

Introduction:

Thank you for agreeing to participate in this interview. We are from the Indian School of Business, Hyderabad, and are interviewing you to better understand the cost incurred in delivering TB-related services and treatment if a for-profit organisation is leveraged to deliver services such as sample collection and TB drugs at doorstep. In this regard, I would like to ask you questions about various activities undertaken and the cost associated with them.

The information that you provide us will only be used for non-commercial research purposes. Participation in this study is voluntary and we completely respect your decision and willingness to participate in this study. The interview should take 30 to 35 minutes. All responses will be kept confidential; your de-identified interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time and for any reason. Are there any questions about what I have just explained? Is it ok if I record the interview?

Programme Duration (in months) =

Section 1: Rapport building/ Ice-breaking

1. Can you list down the activities undertaken by:

Managerial staff category	Designations	Activities	% of time allocated to the activity in a month *Note:* Incase of difficulty in answering, ask "# of hours spent doing the activity per week"
Category 1	Programme Manager		
Category 2	Analyst		
State Programme Management Unit/ Category 3	State PPM Lead		
	Operations Manager		
Field Officers			

Section 2: Human Resource and Salaries

Type of resource	Number of resources	Salary per month	Number of months	% of time allocated in a month
Managerial Staff				
Category 1[1]				
Category 2 [2]				
Category 3[3]				
Category 4 [4]				
Field officers				
Others				
*Formula: [# of managerial staff *(salary/month*% of time allocated in a month)* # month] + [# field staff *(salary/month*% of time allocated in a month)* # month] +...*				

[1] Programme Manager
[2] Analyst
[3] State Programme Management Unit

Field officers	Questions	Response
	What was the provider coverage for Faridabad model? (*Proportion of providers engaged)*	
	How many visits in a month did the field officer make?	
	What was the duration of each visit?	
	What was the average travel time between the two providers?	
Formula: *On field time required per month / Available time per field officer per month*		
*On field time required per month = (duration of each visit + avg. travel time) * number of visits * proportion of providers engaged.*		

Section 1.1: Travel and reimbursement for managerial staff

Number of days spent on office/programme related travel in a year	
Category 1	
Category 2	

- How are these trips reimbursed?

Head	Per day individual cost	Number of individuals per visit
Domestic Travel		
Food and beverage		
Local conveyance		
Lodging		
Other applicable		
Formula: [(∑Per day individual cost # individuals) * Number of days spent travelling for programme related activities in a year]*		

Section 2: Training and sensitisation

2.1 Training of Field Officers

Field Officers were trained (at the beginning of the programme) virtually by the CHAI staff (such as operations manager).

2.2 Training of Providers (CMEs)

Question	Response
On an average how many individuals are present in 1 CME meeting?	
How many CME meetings are conducted in a year?	

Activity	Cost per session	Cost per individual	Type of cost/ driven by
Printing invitation cards	NA		Variable / Number of individuals invited
Venue (includes AV tech such as projector, mics etc)		NA	Fixed
Food and Beverage	NA		Variable/ Number of individuals present
Token of appreciation to chief guest (such as bouquet, shawl etc)		NA	Fixed
Hard copies of resource material	NA		Variable/Number of participants
*Formula: [(venue cost + token cost) * (number of CMEs per year) + per unit (print cost (invitation) + food and beverage + print cost (resource) * (number of individuals per CME)]*			

Section 3: Sample collection, diagnosis, and treatment

Activity	Cost per sample collected	Number of samples collected in the programme duration
Sputum Collection (Includes the consumables)		
HIV sample collection (includes the consumables)		
*Formula: [Σ (cost per sample collected * # of samples collected in the programme duration]*		

Section 4: Incentive to compounder

Activity	Incentive per patient notified/treatment completed	Number of patients notified/treatment completed in the programme duration
Patient notification		
Treatment completion		
*Formula: [∑ (incentive per unit * # of units in programme duration]*		

Number of engaged compounders:

Section 5: Delivery and counselling

Activity	Cost per delivery	Number of deliveries in the programme duration
Drug delivery		
In-person counselling		
Telephonic counselling		
*Formula: [∑ (cost per unit * # of units in the programme duration]*		

Section 6: Other fixed costs budgeted by TATA-1mg

Question	Response
Other costs budgeted by TATA-1mg (personnel cost, management cost)	

Section 7: Administrative cost

Heads	Cost for programme duration
Printing	
Stationary	
Office supplies	
Facility costs	
Upkeep and maintenance	
Other costs	
Formula: [∑cost for programme duration]	

Section 8: ICT cost

Heads	Number of units	Cost per unit
Laptops		
Computer equipment (*such as printers, projector screens etc)*		
Mobile phones		
Other applicable costs		
*Formula: [(# laptops * cost per unit) + (#mobile phones * cost per unit) +...]*		

Leveraging E-Pharmacy to Improve Quality of TB Care in the Private Sector

Costing Tool

Drug Delivery Pilot

Introduction:

Thank you for agreeing to participate in this interview. We are from the Indian School of Business, Hyderabad, and are interviewing you to better understand the cost incurred in delivering TB-related services and treatment in case a for-profit organisation is leveraged for doorstep delivery of TB drugs. In this regard, I would like to ask you questions about various activities undertaken and the cost associated with them.

The information that you provide us will only be used for non-commercial research purposes. Participation in this study is voluntary and we completely respect your decision and willingness to participate in this study. The interview should take 30 to 35 minutes. All responses will be kept confidential; your de-identified interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time and for any reason. Are there any questions about what I have just explained? Is it ok if I record the interviews?

Programme Duration (in months) =

Section 1: Rapport building/ Ice-breaking

1. Can you list down the activities undertaken by:

Managerial staff category	Designation	Activities	% of time allocated for the project in a month *Note:* In case of difficulty in answering, ask "# of hours spent doing the activity per week"
Category 1	Programme Manager		
Category 2	Analyst		
State Programme Management Unit/ Category 3	State PPM Lead		
	Operations manager		
Category 4	Data entry op-erator		
Field Officers			

Managerial staff category	Designation	Activities	% of time allocated for the project in a month *Note:* In case of difficulty in answering, ask "# of hours spent doing the activity per week"
SCT Agents			
Treatment Coordinators			

Section 2: Human Resource and Salaries

Type of resource	Number of resources	Salary per month	Number of months	% of time allocated in a month
Managerial Staff				
Category 1[1]				
Category 2 [2]				
Category 3[3]				
Category 4[4]				
Field Officers				
Hub Agents				
SCT agent				
Treatment Coordinators				
Others				
*Formula: [# of managerial staff *(salary/month*% of time allocated in a month)* # month] + [# field staff *(salary/month*% of time allocated in a month)* # month] +...*				

[1] Programme Manager
[2] Analyst
[3] State Programme Management Unit
[4] Data Entry Operator

Section 2.1: Travel and reimbursement for managerial staff

Number of days spent on office/programme related travel in a year	
Category 1	
Category 2	
Category 3	
Category 4	

- How are these trips reimbursed?

Head	Per day individual cost	Number of individuals per visit
Domestic travel		
Food and beverage		
Local conveyance		
Lodging		
Other applicable		
Formula: [(∑Per day individual cost # individuals) * Number of days spent travelling for programme related activities in a year]*		

Section 3: Delivery and Counselling

Activity	Cost per unit	Number of units in the programme duration
FDC delivery		
Pick up of MERM boxes		
Packaging of MERM boxes		
Delivery of MERM boxes		
*Formula: [∑ (cost per unit * # of units in programme duration)]*		

Section 4: Other costs budgeted by TATA-1mg

Question	Response
Other costs budgeted by TATA-1mg (includes personnel cost, management cost, maintenance cost etc)	

Section 5: Administrative cost

Heads	Cost for programme duration
Printing	
Stationary	
Office supplies	
Facility costs	
Upkeep and maintenance	
Other costs	
Formula: (∑Cost for programme duration)	

Section 6: ICT cost

Heads	Number of units	Cost per unit
Laptops		
Computer equipment (*such as printers, projector screen etc)*		
Mobile phones		
Other applicable costs		
*Formula: [(# laptops * cost per unit) + (#mobile phones * cost per unit) +...]*		

Leveraging E-Pharmacy to Improve Quality of TB care in the Private Sector

Costing Tool

JEET 1.0 Model

Introduction:

Thank you for agreeing to participate in this interview. We are from the Indian School of Business, Hyderabad, and are interviewing you to better understand the cost incurred by the PPSA in delivering TB-related services and treatment depending on the context i.e. ownership of delivery channel and the location of the delivery point (facility-based or home delivery-based). I would like to ask you questions about various activities undertaken and the cost associated with them.

The information that you provide us will only be used for non-commercial research purposes. Participation in this study is voluntary and we completely respect your decision and willingness to participate in this study. The interview should take 30 to 35 minutes. All responses will be kept confidential; your de-identified interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time and for any reason. Are there any questions about what I have just explained? Is it ok if I record the interview?

Programme Duration (in months) =

Section 1: Rapport building/ Ice-breaking

1. Can you list down the activities undertaken by:

Managerial staff category	Designation	Activities	% of time allocated in a month for each activity (number of hours per week spent on each activity)
Category 1 / National Programme Management Unit	Project Director		
Category 2	Finance Lead		
	Operations Lead		
	M&E and Analytical lead		

Managerial staff category	Designation	Activities	% of time allocated in a month for each activity (number of hours per week spent on each activity)
Category 3	Finance Officer		
	HR and Admin Officer		
	Analytics Associate		
	IT/MIS lead		
State Programme Management Unit/Category 4	State PPM Lead		
	Operations Manager		
Hub Agent			
Field Officers			
SCT Agents			
Treatment Coordinators			

Section 2: Human resource and salaries

*Formula: [# of managerial staff *(salary/month*% of time allocated in a month)* # month] + [# field staff *(salary/month*% of time allocated in a month)* # month] +...*

Type of resource	Number of resources	Salary per month	Number of months	% of time allocated in a month for this programme
Managerial Staff				
Category 1[1]				
Category 2 [2]				
Category 3 [3]				
Category 4 [4]				
Category 5 [5]				
Field Officers				

Type of resource	Number of resources	Salary per month	Number of months	% of time allocated in a month for this programme
Hub Agents				
SCT Agents				
Treatment Coordi-nators				
Others				

[1] Project Director,
[2] Finance Lead, Operations Lead, M&E and Analytical lead,
[3] Finance Officer, HR and Admin Officer, Engagement Officer, Analytics Associate, IT/MIS lead
[4] State PPM Lead, Operations Manager,
[5] Data Entry Operator

Field Officers	Questions	Response
	What was the provider coverage for JEET 1.0? (*Proportion of providers engaged)*	
	How many visits in a month did the field officer make?	
	What was the duration of each visit?	
	What was the average travel time between the two pro-viders?	
	Is there any allowance that you get apart from the basic salary? Can you elaborate	
Formula: *On field time required per month / Available time per field officer per month*		
*On field time required per month = (duration of each visit + avg. travel time) * number of visits * proportion of providers engaged.*		

Field Officers	Questions	Response
Hub Agents – *From our discussion, Hub agents notify the patients on Nikshay, provide FDC as per 1st and subsequent follow-up prescription.*		
Formula: *Number of Hub Agents = number of high notifying providers.*		

SCT Agents	QuestioAn	Response
	How many samples does a SCT Agent transport in a day?	
	On an average how many presumptive patients come to the sample collection site in a day?	
	How many samples are collected per patient?	
	Travel time to transport the sample from collection site to lab	
Formula: *Number of SCT Agents required = (av. Presumptive patients per month * #samples per patient) / #transported by one SCT Agent per month*		

Treatment coordinator	Question	Response
	How many sessions of tele-counselling are needed per patient per month?	
	What is an average duration of tele-counselling?	
	How many sessions of F2F counselling are needed per patient per month?	
	What is the average travel time from one patient's location to another? (in minutes)	
	What is an average duration of F2F counselling?	
	How much time does one TC spend in counselling per month?	
Formula: [*(# tele sessions*av. Duration of 1 tele-session) + (#F2F sessions*Av duration of 1 F2F session) + (travel time from one patient location to another)] * Number of patients in programme duration / time spent by 1 TC counselling per month.*		

Section 1.1: Travel and reimbursement for managerial staff

Number of days spent on office/programme related travel in a year	
Category 1	
Category 2	
Category 3	
Category 4	
Category 5	

*Categories same as defined in above section.

How are these trips reimbursed?

Formula: [(∑Per day individual cost # individuals) * Number of days spent travelling for programme related activities in a year]*

Head	Per day individual cost	Number of individuals per visit
Domestic travel		
Food and beverage		
Local conveyance		
Lodging		
Other applicable		

Section 2: Training and sensitisation

Sr. No.	Activity	Cost per unit	Average Number of resources trained per session	Maximum number of resources who can be trained in one session	Number of units per month
1	Training of Field Officers				
1.1	Food and refreshment cost				
1.2	Stationary cost				
1.3	Printing (training material) cost				
2	Training of SCT Agents				
2.1	Food and beverage cost				
2.2	Stationery cost				
2.3	Printing (training material) cost				
3	**CME meetings**				
3.1	Printing of invitations for providers				
	Venue				
3.2	Food and refreshment cost				
3.3	Incentive to the presenter at the meeting				
3.4	Stationery cost				
3.5	Printing (of training material) cost				
*Formula: [((Σ Cost per unit) * Number of trainings for FOs per month) + ((Σ Cost per unit) * Number of trainings for SCT Agents) + ((Σ Cost per unit) * Number of CME meetings)]*					

Section 3: Sample collection, diagnosis, and treatment

Name of items	Cost per unit	Number of units per patient	Estimated number of patients in the programme duration
Consumable (such as falcon tubes)	-		
X-ray cost/subsidy	-		
CBNAAT cost/subsidy	-		
FDC cost/subsidy	-		
Any other applicable cost	-		
*Formula: [(# units required/patient * # of patients in programme duration) * (cost per unit)]*			

Section 4: Administrative cost

Heads	Cost for programme duration
Printing	
Stationary	
Office supplies	
Facility costs	
Upkeep and maintenance	
Other costs	
Formula: [∑cost for programme duration]	

Section 5: ICT cost

Heads	Number of units	Cost per unit
Laptops		
Computer equipment (*such as printers, projector screens etc)*		
Mobile phones		
Other applicable costs		
*Formula: [(# laptops * cost per unit) + (#mobile phones * cost per unit) +...]*		

Appendix 9: Consent form for costing Exercise

Indian School of Business

Consent Form

Thank you for agreeing to participate in this study being conducted by the Indian School of Business, India.

In this interview, we would ask you programme specific information such as activities undertaken by various cadres of staff, their salary structure, various services provided under the programme etc.

Please note that the information that you provide us will only be used for non-commercial research purposes. The interview should take approximately half an hour to forty minutes depending on how much information you would like to share. All answers will be kept confidential by separating the information you provide from your personal information. Nobody other than the research team will know what you answered. We request you to provide us with honest responses to all questions. There are no known risks associated with your participation in this research beyond those of everyday life. Your participation will help the research since your insights are important.

Participation in the research is completely voluntary. If there is any question you don't want to answer or if at any point you feel uncomfortable with the study, you have the option of quitting the study. There will be no consequences for not answering any question or not taking part in the study. You may decline to answer any question or stop the interview at any time and for any reason. There is no compensation for your participation in the study.

If there is anything about the study or your participation that is unclear or that you do not understand, or if you have questions or you wish to report a research related problem, you may contact the Principal Investigator: Sarang Deo via email (sarang_deo@isb.edu) at the Indian School of Business, Gachibowli, Hyderabad – 500032, India.

For questions about your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB) at ISB: Professor Ashwini Chhatre at 040-2318-7134 or email ashwini_chhatre@isb.edu at the Indian School of Business, Gachibowli, Hyderabad – 500111, India.

At this time, do you consent to participate in this survey?	Yes	No
Is it okay if I record the interview?	Yes	No

PARTICIPANT SIGNATURE

_____

DATE : _____