Supplemental Appendices for:
Tuberculosis diagnosis and management in public and private health care sectors in Mumbai, India: A cross-sectional standardized patients study

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Appendix – Reflexivity Statement

1. How does this study address local research and policy priorities?

Tuberculosis is a leading killer of people in India, and no country has a higher TB burden than India. Mumbai city has India’s biggest burden of drug-resistant TB. So, the study does address a key local and national priority.

2. How were local researchers involved in study design?

The study done in partnership with the Mumbai city government (Municipal Corporation of Greater Mumbai – MCGM), and MCGM partners were involved in the design of the study, and in the interpretation and writing of the results. Six MCGM experts are coauthors of the paper, including DS, the second author. The standardized patient (SP) data collection was also conducted by a team in India (ISERDD).

3. How has funding been used to support the local research team?

The local research team in India was funded to conduct the standardized patient research. Apart from paying the SPs, there were no other major expenses.

4. How are research staff who conducted data collection acknowledged?

All MCGM team members who collaborated as included as co-authors, and the ISERDD team that conducted the SP data collection are acknowledged in the paper.

5. Do all members of the research partnership have access to study data?

All members of the partnership have access to data. The data and code can be accessed and cited at https://doi.org/10.5281/zenodo.4441148.

6. How was data used to develop analytical skills within the partnership?

Data analysis was done by the team at Georgetown university. As such, there was no analytical skill development in this specific project.

7. How have research partners collaborated in interpreting study data?

Study results were shared with the MCGM team and multiple teleconferences were held with their lead (DS).

8. How were research partners supported to develop writing skills?

While there was no plan to refine the writing skills, our partners made extensive edits to various iterations of the manuscript.

9. How will research products be shared to address local needs?

This paper will be published as open access. The MCGM team will share the study results within their TB program and use it for quality improvement of services.
10. How is the leadership, contribution and ownership of this work by LMIC researchers recognised within the authorship?

Six MCGM experts are coauthors on the manuscript, with DS being the second author.

11. How have early career researchers across the partnership been included within the authorship team?

The team includes early career and senior authors, in all the institutions involved.

12. How has gender balance been addressed within the authorship?

Eight authors are female and four authors male.

13. How has the project contributed to training of LMIC researchers?

The ISERDD team in India collected the data, and all the SPs were hired as field staff and participated in training and refresher training in order to mitigate any potentially harmful events, such as injections, invasive tests, and consumption of medicines during visits.

14. How has the project contributed to improvements in local infrastructure?

This project has not directly contributed to improvements in local infrastructure.

15. What safeguarding procedures were used to protect local study participants and researchers?

All provider information was treated with confidentiality and not shared in any analysis or report.
Appendix A1

Fieldwork Details

A1.1 Description of SP Case Scenarios

For this study, two tuberculosis (TB) case scenarios were developed to document the level and variation in quality of care for TB among sampled providers. (These two cases have been presented in several of our team’s previous publications.) For each case, both the clinical case presentation and social contexts were developed and agreed upon by a technical advisory group, which included clinicians, economists, anthropologists, experts in international and national TB guidelines, and other stakeholders. The two cases were:

1. **Case 1 (Naïve TB Suspect)** – A classic case of presumptive TB with 2-3 weeks of cough and fever. The SP presents to the providers and begins the interaction with the opening statement: “Doctor, I have a cough that is not getting better and some fever too.”

2. **Case 2 (MDR Suspect)** – A classic case of presumptive TB with 2-3 weeks cough and fever, and, if asked, a history of previous incomplete TB treatment, which would raise the suspicion of multi-drug-resistant TB.

   (a) **When presenting at Private Facility:** The SP begins the interaction by saying: “Doctor, I am suffering from a bad cough. One year earlier, I had the same – and I was treated at a government hospital – they told me it was TB. I took the medicines then and was better but now the cough has returned.”

   (b) **When presenting at Government Facility:** The SP begins the interaction by saying: “Doctor, I am suffering from a bad cough. One year earlier, I had the same – and I was treated by a private practitioner – they told me it was TB. I took the medicines then and was better but now the cough has returned.”

A1.2 SP Recruitment, Script Development, and Training

A1.2.1 SP Recruitment

For this study, 10 individuals (3 women) conducted fieldwork between 28/9/2018 and 17/1/2019 in the private sector and between 25/2/2019 and 14/3/2019 for the public sector. For these interactions, 5 SPs (2 women) were Case 1 and 5 SPs (2 women) were Case 4. Some SPs had prior experience as they had participated in our validation study in Delhi (Das et al. 2015) and/or other SP studies assessing quality for other health conditions aside from TB. SPs were originally from...
Delhi (1) and the Indian States of Bihar (4) and Maharashtra (5). Primary languages spoken by the SPs included: Hindi (6), Marathi (5), Magahi (2), English (1), and Bangali (1).

During the recruitment process, all potential SPs underwent a health screening questionnaire and checkup, and all SPs in the final cohorts were seemingly healthy, which meant they had no apparent health conditions that could confound the case presentation and interaction with providers. The SPs, although recruited specifically to fit each case scenario and corresponding narrative, differed in age, gender, height, and weight. The average age of all the SPs was 35.5 years. The youngest was 25; the oldest was 51. The 7 men weighed 50 to 61 kilograms and were 162 to 178 centimeters tall. The 3 women weighed 50 to 65 kilograms and were 142 to 160 centimeters tall.

**SP Script Development**

The following text is an edited version of the Supplemental Appendices from Kwan et al. (2018) and Das et al. (2015), tailored for this study.

Each SP case scenario described above was coupled with a script. Each script is a narrative that describes the social and family contexts of the patient. The scripts were developed under the guidance of an anthropologist (VD) with active supervisor and SP participation. Together, the case scenarios and scripts were piloted in our validation study in Delhi as presented in Das et al. (2015). They were again refined based on field and data management lessons from Delhi and again during and after training in Patna and Mumbai for the study presented in this paper.

The two most important considerations for script development that were also tightly linked to SP training were: First, the clinical symptoms and case history had to reflect the social and cultural milieu of which the SP was assumed to be a member, and second, the presentation of symptoms and answers to history questions had to be consistent with biomedical facts about the disease.

On the former, SPs brought a lot of socially appropriate understanding of the local vocabularies through which symptoms were to be presented and also about typical life histories that would correspond to the age, gender, caste, religion and class of the character that the SP was portraying. As a simple but crucial example, people among the strata the SPs were drawn from do not often use thermometers to measure temperature but report fever on the basis of the sensation of heat and rapid pulse. The inputs by SPs in script development were crucial from this perspective.

The latter issue was to train SPs to present symptoms and answer questions pertaining to case history that were medically correct. For example, all opening statements and questions pertaining to the type of cough and its duration were standardized. A critical part of the training was to help SPs distinguish between questions to which answers could be improvised but had to be appropriate to the social role of the SP and answers that had to be given using local idioms but in a standardized format without any alterations.

The dual aim of presenting the disease in a manner that was not misleading and avoiding detection were largely successful because the reasoning behind both objectives was carefully and repeatedly explained to the SPs and because of their active involvement in the script development and hands-on training. SP case scripts are available from the authors upon request.

**A1.2.2 SP Training**

The following text is an edited version of the Supplemental Appendices from Kwan et al. (2018) and Das et al. (2015), tailored for this study.

To portray the two SP cases, the individuals recruited as SPs were trained in Mumbai to finalize the case presentation given their knowledge of context, internalize the scripts and cases, be able to
debrief with a supervisor within 1-2 hours of the interaction, and present in clinical settings in a way that would avoid any potentially harmful risks and detection. Thus, SP training was designed with four specific aims:

1. To ensure the SPs correctly present the cases in a standardized way;
2. To ensure the SPs accurately recall the interaction that occurred with health care providers;
3. To ensure SPs avoid both detection or any suspicion that the interaction was not genuine; and
4. To ensure SPs are prepared to avoid potentially harmful risks that can occur to them.

The first two aims were achieved through extensive classroom training in case presentation and recall. Classroom training was complemented with mock interviews and followed by live supervised dry runs in the field at clinics not sampled for the study. Our pilot study in Delhi described in Das et al. (2015) also included the use of tape recorders in a selected subset of interactions, which we used to verify that the results reported on the structured questionnaires were accurate reflections of the clinical interactions.

For the third aim, SPs were carefully instructed to avoid detection by the following methods. First, our recruitment strategy ensured that SPs came from low-income areas or slums from the same cities in which the project was located, so they could easily pass for genuine and local patients, but the areas from which they came were located far from the field sites, so they would not be personally known in the areas they conducted interactions. Second, supervisors for SP fieldwork traveled into the field for 'scoping exercises' before any of the SP interactions were conducted. These scoping exercises helped supervisors to familiarize themselves with landmarks, clinic locations and addresses, general setting, operating hours, length of potential wait time or queues, need for clinic appointments, and other potential issues that could pose challenging to the SP interaction. Based on scoping, the team ensured that SPs were set up to conduct as-successful-as-can-be interactions. Third, during the training, time was organized such that SPs could internalize the characters for each case and the details of their mock stories through which the character was made alive to them. In mock interviews during training, supervisors added unscripted questions with regard to the patient’s family or neighborhood details, which SPs were able to answer spontaneously because they were of the actual social background that was being approximated in the characters they were portraying. Finally, dry runs were conducted in which the supervisor was present in the shop on the pretense of buying something, such as toothpaste or an over-the-counter cough syrup, and thus could watch the interaction and use additional training time to improve the SPs’ presentations of the cases.

For the fourth aim, SPs participated in active discussions on risk mitigation strategies. Together with the supervisors, the SPs brainstormed what they could do to mitigate risks or avoid situations that could be abnormal. They were then extensively trained on these and additional risk mitigation strategies. (Communication on these matters were prioritized and extended into the data collection period. Throughout the data collection period, which was weathered with scorching heat at times above 43°C/110°F, high humidity, annual monsoons, and flooded roads, supervisor and SP meetings would occur near weekly. These meetings provided additional opportunities to discuss potential issues as a team and how to mitigate them as they were encountered in the field.)

All of these individuals took part in a comprehensive and rigorous 10-day training, which included 3 days of dry runs and was held in Mumbai. The entire standard training was done in Hindi, since even Marathi-speaking individuals were expected to encounter doctors speaking in Hindi, and after classroom training, Marathi-speaking SPs went over scripts and exit questionnaires
in Marathi, followed by dry runs in Marathi. Dry runs were conducted outside of the wards selected for the sample. There were several full meetings for SPs and supervisors, and refresher trainings were conducted every time a new schedule was provided to the field team, approximately every three weeks.

A1.2.3 Rationale for Approved Waiver of Provider Informed Consent

Ethics guidelines on health service audit studies state that SPs should be used in cases where the person being sent the SP is providing a service to other people and where other options have been carefully studied but cannot answer the research questions required. In addition, there should be minimal risk to the participants. Based on 10 years of research, we have demonstrated the difficulties of obtaining quality of care data without using SPs (Alderman et al., 2014). In previous SP studies, we have requested and received waivers of informed consent from ethics committees at Johns Hopkins University, Harvard University, and Duke University. Another SP study conducted at the Universidad Peruana Cayetano Heredia has also received waiver of informed consent. These waivers have been granted under the provisions for waiver or alteration of the informed consent requirements under the United States Department of Health and Human Services regulations 45 CFR 46.116(d).

Although the ideal study design would include informed consent, we sought a waiver because (a) we were sending multiple SPs to the same healthcare provider, and (b) we would be carrying out these assessments as part of a quality of care surveillance for a TB program (PPIA) being implemented by PATH in Mumbai. In this case, the consequences of potential detection were very high, as the entire 3-year study could have been jeopardized. Further, as part of the PPIA program, providers who were part of the PPIA network were to attend trainings and workshops together. This added a risk to the SP study - for example, if providers in Mumbai were consented for an SP study, the PPIA networked providers could discuss the identities and personal characteristics of the SPs. The combination of informed consent and congregation of providers at frequent intervention trainings (at times several are scheduled in one week) threatened the validity of our study as reported responses would not reflect the actual quality of care we were aiming to measure, while increasing the risk of SP detection.

We therefore worked closely with Institutional Review Board (IRB) requirements on informed consent, which is handled as per the provisions of the Government of Canada Panel on Research Ethics in the 2nd edition of the Tri-Council Policy Statement of Ethical Conduct for Research. Prior to the current study, we conducted a pilot with informed consent to validate the SP method for tuberculosis in urban India (published as Das et al. (2015) in Lancet Infectious Diseases). The results of the pilot validation study confirmed the decision to seek a waiver of informed consent in the current study. Corresponding to the requirements of Article 3.7, we documented in our pilot study that the SP approach in urban India was no more than minimal risk of participation to the SPs or providers. This was based on the following considerations: Involving Humans’ Article 3.7 entitled “Alteration of Consent in Minimal Risk Research”:

1. Opinion data from providers in the pilot demonstrated that participation in the study did not adversely affect their practice in any way.

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2. No monetary loss was incurred by the providers as the SPs, like real patients, paid the full consultation fee.

3. No added inconvenience was placed on real patients as the SPs were trained to immediately step aside if there were an emergency that demanded the doctor’s attention.

4. None of the identities of the providers or their clinics were compromised since we maintained strict anonymity in the information collected and never disclosed the identity of health care providers who participated in the study.

5. From our observations, average consultation times in our pilot were between 3 and 7 minutes, so that would only inconvenience other patients by that time.

Based on these considerations, we requested a waiver of informed consent from the IRB at ISERDD and the Research Ethics Board at McGill University. The requests for a waiver were reviewed and approved by both ethics committees, contingent upon the provision of a letter of full disclosure to be sent to debrief any provider who received an SP at the end of the study. The letter will offer health care providers a chance to further discuss any aspect of the findings or methodology and register any concerns; however, no individual data on any clinic or provider will be disclosed. Because our larger quality of care surveillance study has been extended to December 2019, this letter will be circulated thereafter.

A1.3 Sampling and Case Assignment in Private Sector

A1.3.1 Sampling in Private Sector

During the primary data collection period for this study, a Private Provider Interface Agency (PPIA) in Mumbai (led by PATH) was implementing an urban TB program funded by the Bill and Melinda Gates Foundation (BMGF). As the program began, the PPIA were mapping, recruiting, and enrolling private sector providers into provider networks across Mumbai. At the time of sampling for our study, we decided to stratify our provider sample by PPIA program enrollment. From lane-by-lane mapping exercises conducted by the PPIA, which resulted in a universe list of private sector providers in Mumbai, we obtained lists of enrolled and not-enrolled AYUSH practitioners in the PPIA program and merged them to produce a complete sampling universe stratified by PPIA enrollment status.

We then restricted these lists based on eligibility criteria for the SP study: AYUSH practitioners eligible for the study were those who had not yet been enrolled into the PPIA program as of DD MM YYYY and those who had practices in wards of interest for the PPIA expansion at the time. The description of the program serves to support sampling weights (Table 1) applied to achieve the urban area estimates for Mumbai but stratified findings based on PPIA program enrollment are not presented in this paper.

Between January and June 2014 in Mumbai, PATH contracted out street-by-street mapping activities in Mumbai of private health facilities, originally planned for 12 high TB burden wards and 3 high-slum population wards, which account for 86% of the Mumbai slum population and 70% of the Mumbai population. The mapping activity was done by two community-based organizations (Alert India and Maharashtra Janavikas Kendra (MJK)). Mapping was initiated in G-North (high TB burden), M-East (Chembu slums and presence of Chest Physicians), P-North, and S wards. By June 2014, the exercise resulted in a provider universe of 8897 locations in 18 wards, which were 12 fully mapped wards, partial mapping of H-East, P-South, and R-South wards, and minimal
mapping in the remaining wards. Of the 8897, 2804 were chemists, 3591 were AYUSH practitioners (BAMS, BUMS, BHMS, DAMS, DHMS, LCEH), 671 less than fully qualified allopathic providers, 1290 MBBS, 463 MDs, and 78 chest physicians.

Since the network established by PATH aimed to move with the providers regardless of where and in how many facilities they practiced, the final QuTUB sampling frames were the result of thorough cleaning, scoping, and verification exercises in collaboration with the PATH team. Before fieldwork began, an individual (R) hired by ISERDD together with a representative from AHI (NC), both from Mumbai, heavily scoped the field to check for addresses and to gather additional information that would be useful before the ISERDD field team moved to the city. The information that was gathered included, but was not limited to: identifying potential SP recruits, looking at the transportation systems, reporting the setup of clinics and health facilities, collecting GPS locations of providers, and correcting provider and facility names while capturing consulting fees, first points of contact in a facility, and outpatient department (OPD) timings.

Four wards out of the 15 original focus wards of the PPIA program were selected for the majority of Mumbai SP surveillance to minimize geographical spread of the SP study. This was because increasing the geographic scope of the city would increase logistical difficulties as presented by Mumbai’s transit system and scale. In mid-January 2015, a meeting was conducted between the PATH and QuTUB teams to agree on the four study wards. After assessing upcoming PPIA program efforts, access to transportation, mixture of unregistered and registered slums, and available data on the wards (e.g., total ward population, slum population, and proportion of slum population figures as per the 2011 census), F-North, K-East, L, and P-North were selected. Relative to other mapped wards, these four wards have a higher slum population (with the exception of F-North), and they also have more providers and more networked providers. Together, these wards were a good representation of areas for PPIA Mumbai efforts. As noted in sections below, these wards were used for constructing the AYUSH sample.

In addition to PPIA hubs, there were non-networked private hospitals and single provider private clinics that met the PPIA hub criteria (i.e., in-house or nearby digital X-ray, pharmacy, and chest physician) and could provide a reasonable comparative ‘apples-to-apples’ estimate of the quality of major facilities not enrolled in the program. The list of non-PPIA hubs was created with the assistance of PATH, who verified whether each one would be a comparable candidate for enrollment into the program. The list consisted of health facilities that met the criteria for the PPIA network and located in the four study wards: F-North, K-East, L, and P-North wards. An initial list of eligible but non-PPIA ‘hubs’ was created by PATH in January 2015, and this list was revisited and updated in April 2015. The process of updating the list at the end of April 2015 involved PATH team members and FOs going through the list and removing any facilities that had been networked since July 2015, when SP interactions began for the eligible, yet non-PPIA hubs.

The FOs also went through the full universe list again to make sure the PPIA networking criteria still applied, and any duplicates were removed (at least 12 sets of duplicates or triplicates). The final list was frozen on April 28, 2015, and the QuTUB team flagged facilities that were ineligible for the SP study (i.e., children hospitals) before establishing the sampling frame for non-PPIA hubs. The final list contained 78 eligible, yet non-PPIA hubs, and 11 were excluded from actual SP visits, since they were children or orthopedic hospitals and the SP cases did not reflect pediatric TB or extrapulmonary TB.

Furthermore, we ascertained how PPIA providers (MBBS and higher) practice at PPIA hubs and non-PPIA locations. To expand on this, it was common for individual PPIA providers practicing at PPIA hubs to also have other private practices, which we deem as ‘non-PPIA locations’ or ‘non-networked locations’. These are locations where the providers were confirmed to not be networked regardless of being networked in the PPIA at a different location. To confirm the
PPIA status of these private practices, an initial mapping with verification activities for these ‘non-networked locations’ occurred between April and July 2015. For initial mapping, two PATH team members in collaboration with the QuTUB team procured a list of practices for 150 PPIA providers, who were MBBS, MDs, and MD/Chest Physicians and who were all networked at known PPIA hubs. Of the 150, 136 met the inclusion criteria (i.e., providers who see adult pulmonary patients) for the SP study.

In terms of the process, FOs conducted the non-networked location mapping in two phases. The first phase, which was circulated to the QuTUB team on July 3rd, contained 153 locations for 62 of the 136 eligible providers and was collected from FOs in R South, N, G North, M East, M West, and F North wards (providers were interviewed at their networked location linked to a ward and a corresponding FO). This resulted in a list of non-networked locations for 62 providers where: 18 providers had 1 location; 21 providers had 2 locations; 10 had 3; 6 had 4; 4 had 5; 2 had 6; and 1 had 7. PATH team members reviewed these locations to determine their networked statuses, and AHI and ISERDD teams conducted scoping for eligibility into the SP study (e.g., government facilities were ineligible for the SP study). The second phase contained details for the remaining 74 providers. For the verification activities, ISERDD and AHI (NC) did on-ground scoping to double-check for any government facilities, ensure there were no duplicates, confirm outpatient hours of the providers, and check whether providers had on-call duties at any of the locations. At the time of verification, ISERDD had already completed all PPIA and non-PPIA hub walk-ins, and favorably, the team was also able to map whether or not any of these non-networked locations had already been visited as a non-PPIA hub. If so, facility IDs matching with those non-PPIA hubs were mapped back to the sample and analytically used also for ‘non-networked’ interactions.

A1.3.2 SP Case Assignment in Private Sector

Our sampling was restricted to AYUSH practitioners and to four study wards as agreed with PATH. Engagement statuses of AYUSH were frozen on January 24, 2015. There were three samples that resulted: 1. Uniform-probability random sample of non-PPIA AYUSH in K-East and L wards 2. Uniform-probability random sample of non-PPIA AYUSH in F-North and P-North wards 3. Census of PPIA AYUSH in all four wards
Schedules were given to ISERDD in two groups: AYUSH in K-East and L wards in one group, and AYUSH in F-North and P-North wards in a second group. For both groups, reserves were provided for the non-PPIA practitioners based on ward. All AYUSH interactions were randomly assigned to be conducted either in the morning or evening hours.

Next, general walk-ins without appointments to hubs were conducted by having the SP enter the health facility and go to the doctor suggested by the receptionist or intake nurse, without regard for PPIA status of the provider, at both PPIA-registered facilities and non-PPIA facilities. There were two samples: 1. Non-PPIA hub walk-ins at purposively selected locations in the four wards 2. PPIA hubs walk-ins (census of all PPIA hubs) across 15 wards
All hub walk-ins were conducted during specific times that were given to the field team. For PPIA hubs specifically, walk-ins were conducted during hours any networked doctor were scheduled to practice, unless an appointment was scheduled by the receptionist or intake nurse. If, during the consultation, the SP was told to go to another doctor at that moment, the SP was instructed to do so and any aspect of the interaction was also recorded on the same form. On May 1, 2015, before sending SPs to the field, ISERDD supervisors met with the PATH team to go over all the PPIA hubs, their locations, the facility layout, and the networked providers.

Walk-ins were first conducted among 100 PPIA hubs. Only Case 1 interactions were conducted. Once PPIA hub walk-ins were completed, walk-ins were done at non-PPIA hubs. Since we had
to still confirm whether these facilities would accept a presumptive TB walk-in patient, all non-PPIA hubs were sent an SP portraying Case 1. Only after Case 1 interactions were successfully completed, we randomly assigned half to receive Case 2 and then randomly assigned another half to receive either Case 3 or Case 4. None of the SPs trained as Case 4 carried a sputum report to the non-PPIA hubs. To avoid any risk of the same SP running into the same provider across locations, the following field protocols were put in place: (1) SPs were to remain cognizant and maintain a list of providers they had visited, and (2) supervisors were to review a provider directory when assigning SPs for interactions. At least two PPIA providers were seen by SP1 during the non-PPIA walk-in, while 54 of 93 PPIA facility walk-ins resulted in the SP seeing a PPIA provider.

We then targeted additional PPIA providers at facilities where they practiced as part of the PPIA (see Appendix Figure A1). Updated lists for providers, mostly MDs and MD Chest Physicians, networked by the PPIA were procured in January 2015 and then again in April 2015. A total of 136 providers at PPIA hubs were eligible for the SP study (ineligible providers, such as pediatricians and orthopedist specialists, were excluded) across 100 health facilities, resulting in 98 successful interactions. When scheduling the providers and locations that would receive SPs, our top priority was to maximize the total number of interactions we could conduct while reducing risk of detection. In order to do this, we had to work around three issues: (1) providers who were networked at multiple locations, (2) PPIA hubs that had more than 3 networked providers, and (3) providers selected who had already been seen during the walk-in visits. Selecting the eligible providers was done manually and checked several times.

Among the 136 providers, we were aware of 19 who were networked at multiple locations (13 providers at 2 facilities, 2 at 3, 4 at 4 = 48). To maximize the total number of interactions, we then selected these 19 providers at the facility that had the fewest number of other practicing doctors. Among the PPIA hubs, there were six hubs considered as large, defined as having more than 3 networked providers (2 hubs with 5 providers, 1 with 7, 1 with 9, 1 with 10, 1 with 11 = 57). To avoid detection, we decided that no PPIA hub would receive SPs for more than three providers. In order to select the three providers at the large hubs, we attributed the eligible networked doctors to the number of TB cases they had reported to the PPIA program and ranked them from highest to lowest. We then removed all the providers located at multiple locations since we had already selected another one of their networked locations. Three providers were then selected by taking the highest notifying, the lowest notifying, and a random provider who had not been selected yet and who could be either notifying or not to the program.

All PPIA providers at PPIA hubs received SPs portraying Case 1 (however, if SPs as Case 1 had already seen the networked doctor during a walk-in, we did not assign another Case 1 to this doctor, and the assumption was the walk-in observation for Case 1 could be used for the provider targeted interaction for Case 1). A random half received Case 2. Another random half received Case 3 with a sputum report in addition to Case 4 without a sputum report, with the other half was assigned to not receive Case 3 and to receive Case 4 with a sputum report. To minimize detection risk, the field team conducted interactions at the six large facilities last.

Finally, we specifically targeted PPIA providers at their other practice locations where they were not considered part of the PPIA (non-networked locations or “NNLs”). From the verified list of non-networked locations, NNLs that were government facilities and outside Mumbai city were excluded for sampling. Some of the interactions, though not deliberately scheduled for ISERDD, took place during the walk-ins at non-PPIA locations when providers who also practiced within the network were encountered by chance. Scheduling for ISERDD was done in 4 waves as the mapping was done in parallel to fieldwork, and verification process was also done with SP1 case.

PPIA providers at NNLs were scheduled to receive Case 1 before any other cases. This was done to serve as a final verification for location eligibility. Case 1 was randomly assigned to one
Table A1.1: Sampling and SP Case Assignment in Public Sector

<table>
<thead>
<tr>
<th>Level</th>
<th>Total in Universe</th>
<th>Number Sampled</th>
<th>Number of Case 1 visits per facility</th>
<th>Number of Case 2 visits per facility</th>
<th>Total Number of Visits</th>
</tr>
</thead>
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<tr>
<td>Medical colleges</td>
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<td>4</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Peripheral hospitals</td>
<td>16</td>
<td>16</td>
<td>2</td>
<td>2</td>
<td>64</td>
</tr>
<tr>
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<td>175</td>
<td>44</td>
<td>1</td>
<td>1</td>
<td>88</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>195</strong></td>
<td><strong>64</strong></td>
<td><strong>84</strong></td>
<td><strong>84</strong></td>
<td><strong>168</strong></td>
</tr>
</tbody>
</table>

NNL for the providers who SPs visited in the previous sample at a networked location. If the provider was known to have multiple NNLs, we gave preference to the location where he or she was not on-call or working at an actual large PPIA hub before random selection, since large PPIA hubs had already received at least 3 provider-specific SP1s. All on-call locations and other NNLs for each provider was made available as a reserve list to the field team. All PPIA providers at their NNLs were assigned Case 1. The half that did not receive Case 2 at the networked location were assigned to receive them at the NNL. The half that received Case 4 with a sputum report were assigned to receive Case 4 without a sputum report.

A1.4 Sampling and Case Assignment in Public Sector

The public sector sample includes a census of medical colleges managed by MCGM (N = 4), a census of peripheral hospitals managed by MCGM (N = 16), and a random sample of 25% (N = 44 of 175 total) of primary health dispensaries managed by MCGM. This sample was determined by our team in collaboration with MCGM in early 2019 (see Table A1.1). Each medical college or peripheral hospital was assigned two Case 1 and two Case 2 interactions. Each primary health dispensary was assigned one Case 1 and one Case 2 interaction. In all, a total of N = 168 interactions were assigned in the public sector (N = 84 Case 1 visits and N = 84 Case 2 visits; N = 16 in medical colleges, N = 64 in peripheral hospitals, and N = 70 in primary health dispensaries).

A1.5 Medication Coding

After SP interactions were completed with sampled facilities in both cities, a list of all labeled medicines prescribed or offered to the SPs was coded and classified by the team. Medicine received as unlabeled and in loose pills form, such as those received by some AYUSH practitioners in Mumbai, were placed into small plastic bags by the SP field team with one bag for each pill type (defined as same color and shape) and marked as unlabeled on the SP exit questionnaire. The team also determined whether such medicines given included at least one antibiotic or steroid.

In the public sector, medications are given for free as part of the consultation from the facility pharmacy when they are prescribed. In the private sector, practice varies widely. Some providers “bundle” costs; some have attached pharmacies; and some give prescriptions redeemable at outside pharmacies. All costs including medication are included in the statistics reported here. SPs always accepted or purchased medications given during the consultation; in prescription cases, they priced medications at the nearest pharmacy but did not purchase them. When possible, medication costs are individually itemized in the data we provide to accompany the article.
Appendix A2

Standardized Patient Case Scripts
Standardized Case 1: Classic case of suspected TB (with no antibiotics or x-ray)

Ravi (Male)

Ravi is a 35 year old male who has studied up to 10th standard. He is the owner of a small tea shop. Today, in the morning like any other day, when he leaves for his work, his wife Rekha, handing him his lunch box asks, “why are you not eating your lunch properly - you get most of it uneaten every day”? Ravi replies, “I have cough and seem to have lost my appetite”. Ravi’s family is small. It consists of his wife and two children, aged six (daughter) and four (son) and they live in a two room house which he owns. His business at the tea stall is doing well as he is able to earn on average rupees 12000 - 15000 per month. Generally Ravi keeps good health. He has not had any major health problems or any chronic Illness. His wife and children too are in good health. But since last 2-3 weeks he is suffering from cough which is more or less present during early morning and night, and it also has expectoration though that does not have any color in it and is clear. He also has low grade mild fever, on and off, which gets worse during the evening time. But since this problem started he feels a bit tired and also has lost some weight, as his clothes have got a bit loose. He does not suffer from any associated chest or body pain. He smokes 4-5 beedis during the day since last 8-10 years and drinks alcohol once or twice in the month. His relationship with his wife is good. He loves her very much. He has a cheerful and an easy going personality. His business at the tea stall is doing well as he is able to earn on average rupees 12000 - 15000 per month. Generally Ravi keeps good health. He has not had any major health problems or any chronic Illness. His wife and children too are in good health. But since last 2-3 weeks he is suffering from cough which is more or less present during early morning and night, and it also has expectoration though that does not have any color in it and is clear. He also has low grade mild fever, on and off, which gets worse during the evening time. But since this problem started he feels a bit tired and also has lost some weight, as his clothes have got a bit loose. He does not suffer from any associated chest or body pain. He smokes 4-5 beedis during the day since last 8-10 years and drinks alcohol once or twice in the month. His relationship with his wife is good. He loves her very much. He has a cheerful and an easy going personality.

In the morning like any other day, when he leaves for his work, his wife Rekha, handing him his lunch box asks, “why are you not eating your lunch properly - you get most of it uneaten every day”? Ravi replies, “I have cough and seem to have lost my appetite”. Ravi’s family is small. It consists of his wife and two children, aged six (daughter) and four (son) and they live in a two room house which he owns. His business at the tea stall is doing well as he is able to earn on average rupees 12000 - 15000 per month. Generally Ravi keeps good health. He has not had any major health problems or any chronic Illness. His wife and children too are in good health. But since last 2-3 weeks he is suffering from cough which is more or less present during early morning and night, and it also has expectoration though that does not have any color in it and is clear. He also has low grade mild fever, on and off, which gets worse during the evening time. But since this problem started he feels a bit tired and also has lost some weight, as his clothes have got a bit loose. He does not suffer from any associated chest or body pain. He smokes 4-5 beedis during the day since last 8-10 years and drinks alcohol once or twice in the month. His relationship with his wife is good. He loves her very much. He has a cheerful and an easy going personality. His business at the tea stall is doing well as he is able to earn on average rupees 12000 - 15000 per month. Generally Ravi keeps good health. He has not had any major health problems or any chronic Illness. His wife and children too are in good health. But since last 2-3 weeks he is suffering from cough which is more or less present during early morning and night, and it also has expectoration though that does not have any color in it and is clear. He also has low grade mild fever, on and off, which gets worse during the evening time. But since this problem started he feels a bit tired and also has lost some weight, as his clothes have got a bit loose. He does not suffer from any associated chest or body pain. He smokes 4-5 beedis during the day since last 8-10 years and drinks alcohol once or twice in the month. His relationship with his wife is good. He loves her very much. He has a cheerful and an easy going personality.
इसबा देसाना बोलत्या कि "हल्ली असं का होतय की तुम्ही जेवण नीट करत नाही - बहुतांशी अजन्न खाचण नाही? त्यांच्या उपर्युक्त कि "मला खोंकला डाण्याला आहे. आणि भूक पण कमी लागते." रविवर ह्यांचे छोटे कुटूंब आहे, उपयोगांसोबत दोन खोंकंभ आहेत. त्यांच्या बॉलरणुकरणाऱ्या तुम्ही जेलण नीट केली आहे, मुंजल केल्यास वयस्क ६ वर्ष आणि मुंजल त्यां वयस ४ वर्ष आहे. रवि आपल्या परिवारांमध्ये दोन खोंक्यांचा स्वतंत्र्या मालिकी घाताच करतात. त्यांच्या वावून नियत वाचाल्याने उत्तरवण सरासरी १२ ते १५ हजार रुपये दर महिना आहे.

साधारणपणे रवि ह्यांचे आरोग्य चांगले असते, त्यांना कुठल्याही प्रकारच्या त्राव किंवा दीर्घकाळीन आजार नाही आहे. त्यांच्या मुंजल्यांना अफ्ताब फोरल्या कक "शल्री अवां का शोतम की तुम्शी जेलण नीट कयत नाशी – फशुताांळी अन्न खातच नाशी. तलायल यवल उत्तय देतात कक "भरा खोकरा झारा आणण बूक ऩण कभी रागते. यल हमांचे छोटे कुटुांफ आशे, जमाभध्मे तमाांची ऩतनी आणण दोन भुरां आशे जमाचे लम ६ लऴष आणण भुराचे लम ४ लऴष आशे.

रविला अल्लायावोफत दोन खोल्माांच्मा स्लत्च्मा भारकीच्मा घयात याशतात. तमाांचे चशाचे दुकान छान चाररे आशे जमाचे उतऩन्न वयावयी १२ ते १५ शजाय रुऩमे दय भहशना आशे.

वाधायणऩणे यवल हमांचे आयोग्म चाांगरे अवते, तमांना कुठल्यावून प्रकायचा त्राव ककांला दीघषकारीन आजाय नाशी आशे. तमाांच्या ऩतनीांचे आणण भुराांचे आयोग्म व ुद्धा चाांगरे आशे.

रविला भागीर २ -३ आठलडमाांऩावून खोकरा वकाऱी आणण यात्रीच्मा लेऱी जास्त शोतो. तमांना खोकल्माफयोफय खाकया (फेडका) ऩण मेतोम जमाचा कुठराशी यांग नाशी, तो ऩायदळषक आशे.

खोकल्माफयोफय तमांना शरकावा ताऩ चढतो - उतयतो, ऩण अनेकदा वांध्माकाऱ लेऱी ताऩ जास्त शोतो.

जेव्शाऩावून त्राव वुरु झारा तेव्शाऩावून थकला जाणलत आशे.

तमांना अवा लाटतांम कक तमांचा लजन थोडे कभी झारांम कायण तमांना कऩडे वैर झारे आशेत.

तमांना हमांना भागीर १ -२ आठलडमाांऩावून खोकरा वकाऱी आणण यात्रीच्मा लेऱी जास्त शोतो. तमांना खोकल्माफयोफय तमांना शरकावा ताऩ चढतो - उतयतो, ऩण अनेकदा वांध्माकाऱ लेऱी ताऩ जास्त शोतो.

हदलवातून ते ४-५ बिडी मितात आणि हि सवय त्यांना मालिग ८-१० वर्षपासून आहे. महिनातून ते एकदा किंवा दोनदा मदतप्राप्त वसले आहेत. त्यांच्या त्रावांवरील वसले संबंध अनेकता. त्यांच्या त्रावांगे जला उत्तर प्रेम आहे. ते हस्तमुख डरणील्या मस्तिष्क मिस्कुण वागणाऱ्या स्वतंत्र्या व्यक्ति आहेत, पण आज त्यांच्या वेह-यावर खोंकला आणि ताप आल्यामुळे काळजी आहे त्यामुळे त्यां जवळच्या डॉक्टरांनी गेले आहेत.

Rekha (female)

Rekha is a 35 year old female who has studied up to 10th standard. She supplements her family income by stitching clothes at home. She is a little worried today as she has cough and running mild fever and thus does not feel like doing work. Her husband suggests that she should go and see a doctor to day about it. He leaves for work at his tea stall. Rekha’s is a small family unit with her husband and two children aged six (daughter) and four (son) and they live in a two room house. She has been stitching clothes since a few years as her husband’s work does not generate enough income and with her work she is able to earn an extra 4000-5000 rupees in a month. Generally Rekha has been in good health and has not had any major health problems or any chronic illness. Her husband and children too have had good health. But since last 2-3 weeks she has been having cough which is more or less present during early morning and night, and also has expectoration that does not have any color in it and is clear. She is also running low grade mild fever, on and off, which gets worse during the evening time. But since this problem started she feels tired and also has lost some weight, as her clothes have got bit loose. She does not suffer from any associated chest or body pain. Rekha has a cheerful nature and she abscins from alcohol and smoking. Her relationship with her husband is good and she loves him very much but today she is worried about her cough and fever and visits a doctor nearby.

रेखा (महिला)

रेखा पढी-लिखी दसवीं पास 35 साल की महिला है। वह अपने घर के खर्च को पूरा करने के लिये घर में गोल्ड लाई का काम करती है। आज रेखा का मन काम करने का नहीं कर रहा था क्योंकि आज भी उसे खाँची, हल्का दुखार और
कमजोरी उसके पास हो रही थी। वह बात उसने अपने पति को बताई तो उसके पति ने कहा कि उस को तुम आया करो और आज अपनी दौड़र को जरूर दिखा लेना। यह कह कर उसका पति अपनी चाचा की दुकान पर चला गया।

रेखा के पर में उनके पति और दो बच्चे हैं। उलझती की उस 6 साल और उलझती की 4 साल है। रेखा दो कमरे के खुद के मकन में रहती है। रेखा कुछ सालों से पर पर सिलाई का काम कर रही है, क्योंकि उसके पति की चाचा की दुकान से इतनी कमाई नहीं हो पाती और वह अपने काम से महीने में 4 से 5 हज़ार रुपये कमा लेती है।

आमतौर पर रेखा का स्वास्थ्य अच्छा रहता है, उसे किसी भी तरह की तकलीफ और कोई लम्बी बिमारी नहीं है। उसके पति और बच्चों का स्वास्थ्य भी अच्छा है। लेकिन रेखा को पिछले 2-3 हफ्तों से खासी रही है, जो इतना और रात के समय ज्यादा होती है। उसकी खासी के साथ बलगाम भी आता है जिसका कोई रंग नहीं है, जो साफ़ है। उसे हक्का बुखार रहता है जो चढ़ता-उतरता है लेकिन अक्सर शाम के समय ही ज्यादा होता है। जब से उसे यह तकलीफ शुरू हुई है तब से उसे थकावट महसूस हो रही है। उसे बताता है कि उसका कुछ बजन कम हो गया है क्योंकि उसके खाने ध्यान ही गये है। उसने इस तकलीफ में किसी भी तरह की छाती का दर्द और बदन दर्द नहीं है।

रेखा हंसमुख और मिलनसार स्वभाव की महिला है और वह किसी भी प्रकार का कोई नशा नहीं करती। उसके अपने पति के साथ अच्छे सम्बन्ध हैं। वह उसे बहुत प्यार करती है। लेकिन आज उसके बेहतर पर अपनी खासी और बुखार को लेकर शोधों परेशानी है जिससे लेकर वह नज़रदेख डॉक्टर के पास गयी है।

रेखा (महिला)

रेखा सिंहिता-वाचन येंगरी दलवाली पास 35 वर्षीय महिला आहे। त्या आपल्या घर-बांधाची चालवियासाठी घरात शिवण काम करतात। आज रेखांच मने कामावर जाण्यासाठी तयार नव्हेत कारण आज पण त्यांना खोळते, हलकासा ताप आणि अशक्ततपणा बांदू होता, हे गोंडेत त्यांनी आपल्या पतळी सांगणाऱ्या तेथे त्याच्या पतळी त्यांना आराम करतावर सांगितला आणि कोणत्यासाठी डॉक्टरांना दाखवलेला सांगितले। असे बोलून त्यांचे पतळी स्वतःच्या चाहत्या दुकानांना स्वीकार गेले.

रेखाच्या घरी त्यांचे पतळी आणि दोन मुळ आहेत। मुळींचे वय 6 वर्ष आणि मूलाचे वय 4 वर्ष आहेत। रेखा दोन खोळत्याच्या स्वतःच्या मालकीच्या घरात राहतात। रेखा काही वर्षपासून शिवण काम करता आहेत, कारण त्याच्या पतळी चाहत्या दुकानापासून एक्सी कमाई होत नाही आणि त्या आपल्या कामपासून महिल्याच्या 4 ते 5 हजार रुपये कमावतात.

साधारणपणे रेखा ह्यांच्याआरोग्यांचं आसंग आघाडी असते, त्यांना कुठल्याच्या प्रकाराचा वास किंवा दीर्घकाळीन आजार नाही आहे। त्याच्या पतळीचे आणि मूलंचे आरोग्यांचं आसंग आघाडी असते। पण रेखा ह्यांना माणील 2-3 अश्लेषपासून त्यांना खोळते सकाकि आणि रानीप्याच्या वेळी जास्त तीव्र होतो। त्यांना खोळत्याच्या अवलोकनांची त्यांना हलकासा ताप थठत-उतरतो , पण अनेकदा सांद्रकावळ्याच्या वेली ताप जास्त होतो। जेव्हा ह्यांना हा वास सुरू होत तेथे पासून थकवा जाणवत आहे। त्यांना असा वातावर कि त्यांच्या बजन थेड़े कमी झालंय कारण त्यांचे कपडे सैल झाले आहेत। त्यांना ह्या ब्रांडमध्ये कुठल्याच्या प्रकारेचे छाती किंवा अंगदुखी जाणवत नाही.
Opening statement: “Doctor, I have cough that is not getting better and some fever too”

History questions asked by the provider and their answers

Q 1: What is the duration of cough?

Prash 1: Khoka kal tata sahe bhagya la?

Ans 1: 2-3 weeks, more during early morning and night

Prash 1: Khoka kal种子ụn bhagya la?

Uttar 1: 2-3 am, more during early morning and night

Q2: Are you producing sputum (bulgum)?

Prash 2: Aapko bulgum banati hai?

Ans 2: Yes

Q3: Does the sputum contain blood?

Prash 3: Khoka/veeda/duki madhye kahalavu pari?

Ans 3: No

Q 4: How long have you had fever?

Prash 4: Aapko tata sahe bhagya la?

Ans 4: 2-3 weeks, more during early morning and night
Ans 4: Since 2-3 weeks
उत्तर 4: 2-3 हफ्ते हो गये।

Q5: What type of fever do you have?
प्रश्न5: उगमाल कैसा रहता है?
Ans 5: Low grade (mild), on and off, more during evening times.
उत्तर 5: हल्का उगमाल चढ़ा उपर्युक्त होता है, लेकिन ज्यादातर शाम को होता है।

Q 6: Have you taken any medicines for your illness?
प्रश्न 6: क्या आपने इस तकलीफ़ के लिए कोई दवाई ली है?
Ans 6: No.
उत्तर 6: नहीं।

Q 7: Do you get any chest pain?
प्रश्न 7: आपने छाती में दर्द होता है?
Ans 7: No
उत्तर 7: नहीं।

Q 8: Any loss of appetite?
प्रश्न 8: भोजन में कोई कमी?
Ans 8: Yes, loss of appetite.
उत्तर 8: है, भोजन कम हो गया है।

Q 9: Have you lost weight?
प्रश्न 9: वजन कम हुआ है?
Ans 9: I think so; my clothes have become a bit loose.
उत्तर 9: है, मुझे लगता है क्योंकि मेरे कपड़े ढीले हो गये हैं।

Q10: Any wheezing or difficulty in breathing?

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**Q10: श्लाव घेने/वोडताने कुठली अडथण होते का/छाती मधून घरघर (शिटी सारखू) आवाज येतो का?**

**Ans 10:** No

**Q11: व्यायाम वाची-सिगारेट पिता का?**

**Ans 11:** Yes, I smoke beedis. [in case of male SP]

**Q12: How many beedis in a day?**

**Ans 12:** 4-5 beedis, I guess

**Q13: Since when have you been smoking beedis?**

**Ans 13:** Since the last 8 or 10 years

**Q14: Do you drink alcohol?**

**Ans 14:** Yes [in case of male] No [in case of female SP]

**Q15: How often do you drink?**

**Ans 15:** किती पाही लेते हो?
Q 16: Have you been treated for TB in the past?
प्रश्न 16: क्या आपने पहले कभी टी की का इलाज कराया है?
Ans 16: No
उत्तर 16: नहीं।

Q 17: Anyone in your family has TB?
प्रश्न 17: किसी बाबा घर में किसी को टी का आहे का?
Ans 17: No
उत्तर 17: नहीं।

Q 18: Do you have diabetes?
प्रश्न 18: क्या आपको शूगर है?
Ans 18: I do not know
उत्तर 18: जी, मत नहीं।

Q 19: Do you have hypertension?
प्रश्न 19: क्या आपको हाइपरटेशन है?
Ans 19: I do not know
उत्तर 19: जी, मत नहीं।

Q 20: Do you have HIV-AIDS?
प्रश्न 20: क्या आपको HIV-AIDS है?
Ans 20: I do not know
उत्तर 20: जी, मत नहीं।
Q21: Have you ever been tested for these diseases?
Q21: क्या आपने कभी इन बिमारियां के टेस्ट किये हैं?
Ans21: Not been tested
Ans21: कभी टेस्ट किये नहीं हैं।

Q 22: Are you allergic to any drugs?
Q 22: क्या आपको किसी दवा से एलर्जी है?
Ans22: No.
Ans22: नहीं।

Important instructions to be remembered by SP
महत्वपूर्ण बातें जो एस पी को याद रखनी है
एस पी साठी महत्वाच्य सूचना

1. ISERDD staff will identify the facility and/or the provider for the SP, where the SP will present his case alone.
   ISERDD स्टाफ़ फीडबैक ने SP को प्रोवाइडर का क्लिनिक बताया जो SP को अकेले अपना केस करता है।
   ISERDD स्टाफ़ फीडबैक मध्ये SP ला प्रोवाइडरच्या क्लिनिकच्या सांगितले जाते, तर्कद SP ला एकेटेच आपल्या केस सादर कराव्यावी आहेत।

2. SP should remember if the facility and/or the provider was the correct one. (for example, it was the correct location, but the name board did not match the name given or if the assigned provider was not there and the SP saw another provider)
   SP को याद रखावा की दोहो सो प्रोवाइडर का क्लिनिक गायले थे? (उदाहरण के लिए, जन्म सबकी बोर्ड पर लिखा नाम दिये गये नाम से मैथ पूर्व नहीं कर रहा था।
   SP नी सेल्फ़ टेस्ट आहे की ते योग्य प्रोवाइडरच्या क्लिनिकच्या मध्ये गेले होते का? (उदाहरणसाठी जागा बरोबर होती पण बोर्डरचे नाव दिलेल्या नावाची जुडत नव्हते)

3. SP must remember if the provider carried out any of the following examination?
   SP को याद रखावा की प्रोवाइडर ने कोणत्या परीक्षण किये?
   SP नी सेल्फ़ टेस्ट आहे की प्रोवाइडरनी खालीपूर्वी कोणत्या तपासण्या केल्या?
   - Pulse rate नाडी की दर नाहीयाच सम्बन्ध मोजणे
   - Respiratory rate सांस की दर श्वसन दर मोजणे
<table>
<thead>
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| - Auscultation of Chest (Did the provider comment on the auscultation)  
  हदय, केंद्रिय की गति को सुनाना (या प्रोवैडर ने ओर्सकलटेसन करते समय कुछ कहा जैसे आवेज साफ है या अन्य)  
  हदय फुफपुफ संगती होना-या आवेज ऐक्क तपासणे (प्रोवैडर ने ओर्सकलटेसन करताना काय सांगितल का जसे आवेज साफ आहे किंवा अन्य)  
| - Blood Pressure  
  ब्रड प्रेषय / रक्तदब मोजणे  
| - Temperature  
  ताप मापण - थर्मीमीटर  
| - Throat examination  
  गळ्माचे ऩयीषण  
| - Weight  
  लजन भाऩन  
| - Abdomen palpitation  
  पेट दबावणे  
| 4. Did the provider recommend any investigations? का प्रोवैडर ने निम्नलिखित जीवन करावे का कहाचा?  
  प्रोवैडरनी खालीलपैकी कोणतया तपासण्या काया फक्त लांबात झाली?  
  (If yes, SP should ask provider to write the name of the test and the laboratory. And hand over the  
  document to an ISERDD staff.) Write the specific name of lab given by the provider and if no put (-99).  
  (यदि ही, तो SP को प्रोवैडर से टेस्ट और लेब का नाम लिखित में लेना है और उस पर्यंत को ISERDD स्टॉफ को सीप देना है) अगर प्रोवैडर  
  ने किसी विशेष लेब का नाम दिया तो तो वह लिखें, यदि नहीं तो (-99) भरें।  
  (जर हो तर, SP नी प्रोवैडरकडून टेस्ट आणि लेबचे नाव लिहून ध्यानचे आहे अणि व्या कागदाला  
  ISERDD स्टाफला दाबावणे आहे) जर प्रोवैडरनी विशेष लेब ये नाव सुलझवे तर ते लिहून ध्या, जर नाही  
  सांगितले तर (-99) भरा  
| - Chest X-Ray छातीचा एक्स-रे  
  छातीच्या एक्स-रे  
| - CT Scan सी टी स्कॅन  
| - Blood- Total count, differential count- ESR रक्त-टोटल काउंट, डिफिशेशियल काउंट-ई एस आर  
  रक्त टोटल काउंट डिफरेंशियल काउंट - ई एस आर  
| - Blood- HIV test रक्त-एचवी टेस्ट  
  रक्त एच अवी टेस्ट -  
| - Blood- Diabetes test रक्त-सुगर टेस्ट  
  रक्त सुगर टेस्ट -  
| - Blood- TB Gold रक्त - टी बी गोल्ड  
  रक्त टी बी गोल्ड टेस्ट -  
| - Blood-TB ELISA रक्त - टी बी ऐलाइजा  
  रक्त टी बी ऐलाइजा -  
| - Sputum smear examination (Sputum AFB) स्पूटम विषय एक्जामिनेशन  
  स्पूटम स्विम्यर एक्जामिनेशन स्पूटम ए एक वी /  
| - Sputum GeneXpert test स्पूटम जीनएप्सपर्ट टेस्ट  
  स्पूटम जीनएप्सपर्ट टेस्ट  
| - Sputum culture स्पूटम कल्फर  
  स्पूटम कल्फर  
| - Mantoux Test मॉंटूक्स टेस्ट  
  मॉंटूक्स टेस्ट  
| - TB- PCR (not specific) टी बी - पी बी आर (विशिष्ट नाही है)  
  टी बी - पी बी आर (विशेष नाही आहे)  
| - Drug susceptibility test (culture, gene Xpert, line probe assay) ड्रग स्पेक्टिबिलिटी टेस्ट (कल्फर, जीनएप्सपर्ट,  
  लाईन प्रोब एस्से) ड्रग स्पेक्टिबिलिटी टेस्ट (कल्फर, जीनएप्सपर्ट लाईन प्रोब एस्से) |
5. Did the provider give you any vouchers or referral coupons?

क्या प्रोवाइडर ने SP को कोई वाक्य या रेफरल कूपन दिया?

If yes, SP should retain the voucher or referral coupons and hand over to any ISERDD staff. On the form, supervisors will write the voucher number and name from the stamp.

यदि हो, तो SP को वाक्य या रेफरल कूपन संरक्षित करें और ISERDD के कार्यकर्ता को दें। फॉर्म पर सупरवाइजर के लिए चेक करें।

- Treatment
- Chest X-Ray
- GeneXpert

Please write voucher or referral coupons number and name on the stamp.

कृपया वाक्य या रेफरल कूपन का नंबर और नाम पता चौकी पर लिखें।

6. SP must remember if personal details (Name, Mobile, Address) were given to the provider. If so, what was the full name the SP gave?

SP को याद रखना है कि वह किस वित्तीय मदद के लिए प्रोवाइडर को नाम, फोन नंबर, जीवन जीवन दिया?

Some providers who work with the PPIA will collect this information if they identify the SP as a presumptive TB case, refer you to a lab for sputum or CXR, or refer you to certain providers.

एक कुछ प्रोवाइडर ने SP को आँक दिया जो तुम्हारी याद में रहने जा रहा है।

- SP ने याद किया कि तुम्हारे नाम, मोबाइल, जीवन जीवन दिया?

Please write name and refer to the networked provider/lab list.

कृपया नाम लिखें और नेटवर्क प्रोवाइडर/लेबल लिस्ट में देखें।

7. SP must remember if someone at the facility completed a registration form to register the SP’s personal details such as with a call center. (Some providers who work with the PPIA will make a call to register patients.)

SP को याद रखना है कि कोई केंद्रीय कॉल सेंटर को नाम, मोबाइल, जीवन जीवन दिया?

Some providers who work with the PPIA will make a call to register patients.

एक कुछ प्रोवाइडर ने SP को आँक दिया जो तुम्हारी याद में रहने जा रहा है।

8. ISERDD staff to mark which of the following tests was recommended by a networked provider. (Refer to networked provider/lab list)

ISERDD कर्मचारी के लिए निम्नलिखित टेस्टों में से कौन सा टेस्ट नेटवर्क प्रोवाइडर द्वारा सुझावित था?

Some providers who work with the PPIA will make a call to register patients.

एक कुछ प्रोवाइडर ने SP को आँक दिया जो तुम्हारी याद में रहने जा रहा है।

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</thead>
<tbody>
<tr>
<td>9. SP must collect prescription and/or any medicines given by the provider. SP को प्रोवाइडर द्वारा दी गयी दवाई या दवाई का पव्वा अवर्य लेना है। SP स्पीडी प्रोवाइडर द्वारा दिलेली औषधि आणि औषधचं कागद द्वायलया आवश्यक्रमं आहे।</td>
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<tr>
<td>10. SP must remember if the provider gave any diagnosis. SP को प्रोवाइडर द्वारा दिये गये डायनोसिस को याद रखना है। SP स्पीडी प्रोवाइडर दिलेल्या डायनोसिस सा लक्षात ठेवायलये आहे?</td>
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<tr>
<td>11. SP must remember if the provider recorded the information he took from you. SP को या ध्यान रखना है कि प्रोवाइडर ने आपसे जो जाणकारी ती उसको कौन सा लिखकर रखा। SP स्पीडी प्रोवाइडर दिलेल्या कागद ज्यामध्ये आपल्याकडे संदर्भ माहिती की त्यांनी कुठे लिहून नोंदली का?:</td>
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<td>12. SP should remember if the provider referred to: SP को पदर्यांनी हदरेरा कागद आणण अभारांचे आशेत</td>
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<tr>
<td>- a private provider/ private hospital</td>
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<tr>
<td>- BMC / Municipal hospital वी एम सी / म्युनिसिपल अस्पताल वी एम सी / म्युनिसिपल रूपाणालय</td>
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<tr>
<td>- DOTS centre डॉट्स सेंटर डॉट्स सेंटर</td>
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<tr>
<td>- Other location अन्य स्थान अन्य जागा</td>
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<tr>
<td>and include the name of the provider or health facility you were referred to: ज्या प्रकायचे इंएजेक्शन / इन्लेशन सेटर या नावासे फारसेलीटीचे नाव सामील करा</td>
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<tr>
<td>13. Prescriptions and pills given must be preserved for analysis. SP को पदर्यांनी दिलेल्या कागद आणि औषध-गोड्ब्या एनालिसिससाठी सांभाव्य्या ठेवाच्या आहेत</td>
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<tr>
<td>14. SP should refuse any injections/ invasive tests performed by the provider during this encounter but note down details of what was offered/suggested. SP को या वाहन्यांत देणे विषयवत किसी भी तरी इंजेक्शन/इन्वेसिव टेस्ट लेने से इन्फर्म करना है लेकिन ऐसे किसी भी सुझाव को नोट करवावून बरता तयार</td>
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<tr>
<td>15. If the provider asks any question that is not in the list then the SP should say no or deflect by either saying I don’t know or I don’t remember as is appropriate to the context. यदि प्रोवाइडर कोई ऐसा वाचन पूछता है जो लिस्ट में शामिल नहीं है तो SP को कहना है मुझे पता नहीं या याद नहीं आ रहा (जो उस समय उत्तर दे रहे) जस प्रोवाइडर अपमन्यता असात राय मिलावता जो लिस्ट मध्ये सामील नहीं आहे तर SP नी सांभाव्य्या आहे कि मला माहित नहीं किवा आठवत नहीं (जे त्या वेळी उत्तर देते)</td>
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<td>16. SP should get the prices of the prescribed medicines, labs or consultation fees from the provider. SP को प्रोवाइडर द्वारा परें पर लिखी दवाई, लेख या कनसलटेशन फीस को जाणकारी को याद रखना है।</td>
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<tr>
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<tr>
<td>SPनी प्रोवायडरद्वारा दिलेला कागदवर लिहिलेली औषधिं, लेब किंवा कन्सलटेशन फीज ची माहितीला लक्षात ठेवायचे आहे</td>
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<tr>
<td>17. <strong>Supervisor /SP</strong> should get the prices, brand and generic names of the prescribed medicines. Supervisor/SP को प्रोवायडर द्वारा लिहिलेली दवांका मूल्य, ब्रांड तथा जेनरिक नाम का पता करता हे। Supervisor/SP ला प्रोवायडरद्वारा दिले गेलेल्या औषधांचे मूल्य, ब्रांड आणि जेनरिक नावांची माहिती गोळ्या करायची आहे</td>
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<tr>
<td>• Fill all unlabelled FIRST खुली दवांत लिहिलेल्या विभिन्न औषधांची पहिले लिहिलेली लिहाणे</td>
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<tr>
<td>• In brand: write Unlabelled ब्रांड येथे अनलेबल लिहून ब्रांड मध्ये अनलेबल लिहाणे</td>
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<tr>
<td>• In generic: describe the color + shape जेनरिक मध्ये दवां यांना आकार व रंग जरूरी मध्ये रंग आणि आकार लिहाणे</td>
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Standardized Case 4: A case of suspected MDR-TB (previous history of TB treatment)  

**Suraj (Male)**  

Suraj is a 38 year old male who has studied upto 10th standard while he was living with his uncle (Chacha) in the city. He works in a General Store and earns rupees 14000 to 15000 in a month. He lives in the city in a rented two room house with his wife and three children, aged 13 (boy), 10 (girl) and 6(boy) and all of them are studying in a BMC / Municipal school. His parents are back in the village where his father has a small piece of land.  

Suraj had developed a cough last year for which he went to a BMC / Municipal hospital near his house where after a sputum test and chest x-ray he was diagnosed with TB. He was given 6 or 7 different types of tablets and had to take them on alternate days. (ek din chod kar). He took the treatment for 4 to 5 months and then stopped it as he felt better. But after stopping the medication he had mild cough which used to subside on its own. His family has been keeping well and none of them have ever had any of his symptoms.  

But since last one month he is suffering from cough which is more or less present during early morning and night, and he also has expectoration in which he has seen flecks of blood once or twice in a month. He also has low grade mild fever, on and off, which gets worse during the evening time. But since this problem started he feels a bit tired and also has lost some weight, as his clothes have gotten a bit loose. He does not suffer from any associated chest or body pain. He has tried some home remedies and cough syrup from a local chemist for the problem. However, the cough had not subsided. He has misplaced other medical records.  

He smokes 4-5 beedis during the day since last 10-12 years and drinks alcohol once or twice the month.

Suraj had developed a cough last year for which he went to a BMC / Municipal hospital near his house where after a sputum test and chest x-ray he was diagnosed with TB. He was given 6 or 7 different types of tablets and had to take them on alternate days. (ek din chod kar). He took the treatment for 4 to 5 months and then stopped it as he felt better. But after stopping the medication he had mild cough which used to subside on its own. His family has been keeping well and none of them have ever had any of his symptoms.

But since last one month he is suffering from cough which is more or less present during early morning and night, and he also has expectoration in which he has seen flecks of blood once or twice in a month. He also has low grade mild fever, on and off, which gets worse during the evening time. But since this problem started he feels a bit tired and also has lost some weight, as his clothes have gotten a bit loose. He does not suffer from any associated chest or body pain. He has tried some home remedies and cough syrup from a local chemist for the problem. However, the cough had not subsided. He has misplaced other medical records.

He smokes 4-5 beedis during the day since last 10-12 years and drinks alcohol once or twice the month.

Suraj 38 साल का व्यक्ति है जिसमें शहर में अपने चाचा के पास रहकर 10वीं कक्षा तक पढ़ाई की है। सूरज के माता-पिता के पास गाँव में खेती के लिए छोटी सी जमीन है। सूरज अपनी पत्नी और तीन बच्चों के साथ जिनकी उम्र 13 (लड़का), 10 (लड़की) और 6 (लड़के) साथ की है जो किसानों के दो कमरों के मकन में रहते है। सूरज का किराना की दुकान (जनरल स्टोर) में काम करता है जहाँ उसमें ये 14000 से 15000 रुपये तनख्बान मिलती है। उसके बच्चों की सरकारी स्कूल में पढ़ते है।
छाती और बदन दर्द नहीं है। सुरज ने दिल्ली में महिला कॉमिटी से खाँसी का सिरफ़ और कुछ घरेलू उपचार किये जिससे उसकी खाँसी में कुछ आराम नहीं आया। इसलिए उसे सुबह से काम शुरू करने के लिए वे अपने काम को बदल देते हैं। उसके पास उस की लाइफ स्टाइल के रिपोर्ट भें लेकिन बाकी मेडिकल रिकाउर्ड उससे कहीं ख़ाये गये हैं।

सूरज दिन में 4 से 5 बीड़ी पीता है और उसकी यह आदत पिछले 10-12 सालों से है। महिले में एक या दो बार शराब का सेवन भी कर लेता है।

**सूरज (पुरुष)**

सुरज एक 38 वर्षीय व्यक्ति है जिसे ज्यादा अपना कारकिस्मत रहने 10 वीं परीक्षा पश्चिम पूर्व केंद्र के सुरज ह्या परिवार और किल्ले के नाम से जाने जाते हैं। सुरज ह्या परिवार में एक छोटी बहन एवं दो बड़े बROTHER होते हैं। उन्होंने अपनी पत्नी के साथ दो बच्चे के साथ एक कॉमर्स कार्यालय में काम करते हैं।

पण मगाई एक महिलादा सुरज ह्या परिवार का अध्यक्ष तथा तापाणी तरीके के एक गायक रहता है। उन्होंने अपनी पत्नी से अच्छी दिनों का अनुभव किया है।

जेव्हा पण भागीर एक भागीर होते हैं। उन्होंने अपनी पत्नी से अच्छी दिनों का अनुभव किया है।
Sapna (Female)

Sapna is a 38 year old female, a home maker, who has studied upto 10\textsuperscript{th} standard. Her husband works in a General Store and earns rupees 15000 in a month. She lives in a rented two room house with her husband and three children aged 13 (boy), 10 (girl) and 6 (boy). Her two elder children are studying in a BMC / Municipal school and the youngest is attending a small play school nearby. She is able to manage the household expenses with her husband’s income.

Sapna had developed a cough last year for which she went to a BMC / Municipal hospital near her house where after a sputum test and chest x-ray she was diagnosed with TB. She was given 6 or 7 different types of tablets and had to take them on alternate days. (ek din chod kar). She took the treatment for 4 to 5 months and then stopped it as she felt better. But after stopping the medication she had mild cough which used to subside on its own. Her family has been keeping well and none of them have ever had any of his symptoms.

But since last one month she is suffering from cough which is more or less present during early morning and night, and she also has expectoration in which she has seen flecks of blood once or twice in a month. She does not suffer from any associated chest or body pain. She has tried some home remedies and cough syrup from a local chemist for the problem. However, the cough had not subsided. She has tried some home remedies and cough syrup from a local chemist for the problem. She has misplaced other medical records.
Opening statement: “Doctor, I am suffering from a bad cough – One year ago I had got treatment in the BMC / Municipal hospital, and it had got better. But now again having cough again. I went back to the same hospital and they did sputum test.” Can you see me.

[Note:- If asked, SP to present with the sputum smear report that is positive for acid fast bacillus].”
ISERDD

SP4-NARRATIVE

QuTub Project - Mumbai

History questions asked by the provider and their answers

Question 1: What is the duration of cough?

Q1: खोकरा कधी झारून आशे?

A1: One Month.

Question 2: When you had cough earlier you went to a BMC / Municipal hospital?

Q2: जेव्हा भागीर लेऱा आऩल्मारा त्माांनी वाांगगतरां शोतां का आऩल्मारा काम झारां शोते ते?

A2: Yes, I did go there.

Question 3: Did you get any tests for the previous episode?

Q3: मागच्या वेळी आपण कुठली टेस्ट केली होती का?

A3: Yes, sputum test and a chest x-ray

Question 4: Did they tell you what you had for the previous episode?

Q4: ते मागच्या वेळी आपण काय झारता ते?

A4: Yes, they told me I had TB
Q 5: What treatment did you get?

Q 6: Do you know what these were?

Q 7: What was the dosage?

Q 8: For how many months did you take the medicine?

Q 9: Did they tell you to stop?

Q 10: Do you have the sputum report or the x-ray from the previous episode?
Q 11: So your cough got better and now it is back?
प्रश्न 11: आपकी छक्की तब तक बेहतर हो गई थी और फिर से बहुत हो गई है?
Ans 11: Yes.
उत्तर 11: है।
उत्तर 11. है।

Q 12: Are you producing sputum (bulgam)?
प्रश्न 2: आपका बलगम बनता है?
Ans 2: Yes
उत्तर 2: है।

Q 13: Does the sputum contain blood?
प्रश्न 13: बलगम में 血 मिलता है?
Ans13: Yes, saw small flecks of blood once or twice in the last month.
उत्तर13: है, एक-दो बार 血 प्रवाह में छोटे क्षतियों का देखा।
उत्तर 13: हो, मानवी मृगन्यात एक-दोन वेळ रक्ताचे रक्ताचे धब्फे हदवरे शोते

Q 14: Do you get fever?
प्रश्न 14: आपका फीबर हो रहा है?
Ans 14: Yes.
उत्तर 14: है।
उत्तर 14. है।

Q 15: How long have you had fever?
प्रश्न15: आपका फीबर कब से है?
Ans 15: One Month.
उत्तर15: एक महीने से।
उत्तर 15: एका महिन्यापासून

Q 16: What type of fever do you have?
Q16: Do you get any tiredness?

प्रश्न 16: ताप कसा असतो?
Ans 16: Low grade (mild), on and off, more during evening times.

उत्तर 16: हलका ताप बदलता उतरता होता है, लेकिन ज्यादातर शाम को होता है।

उत्तर 16: हलका ताप बदलते-उतरते, पण जास्तीकृत संध्याकाळी बाढतो

Q17: Do you get any chest pain?

प्रश्न 17: क्या आपकी छाती में दर्द होता है?
Ans 17: No

उत्तर 17: नहीं।

उत्तर 17: नाही

Q18: Any loss of appetite?

प्रश्न 18: मूंछ में कोई कमी?
Ans 18: Yes, loss of appetite.

उत्तर 18: हो, मूंछ तो कम लगती है।

उत्तर 18: हो, भूक कमी लागते।

Q19: Have you lost weight?

प्रश्न 19: क्या वजन कम हुआ है?
Ans 19: I think so; my clothes have become a bit loose.

उत्तर 19: हों, मुझे लगता है क्योंकि मेरे कपड़े दौड़े हो गये हैं।

उत्तर 19: हो, मला वाढतांबाबत कारण माझे कपडे मला सॉल होत आहेत

Q20: Do you smoke?

प्रश्न 20: क्या आप बीड़ी/सिगरेट पीते हैं?
Ans 20: Yes, I smoke beedis. [in case of male SP]

उत्तर 20: हों, मैं बीड़ी पीता हूं। (मेल SP के लिए)

No [in case of females SP] नाहीं (फीमेल SP के लिए)
उत्तर 20: हो, भी बीडी/सिगारेट (पुरुष एस पी साठी) पिलो, नाही (स्त्री एस पी साठी)

Q 21: How many beedis in a day?
प्रश्न 21: एक दिन में कितनी पीले हो?
प्रश्न 21: एका दिवसात किती बीडी/सिगारेट पिला?
Ans 21: 4-5 beedis, I guess
उत्तर 21: अंदाजे, 4 से 5 बीडी।
उत्तर 21: अंदाजे, 4 ते 5 बीडी/सिगारेट
Q 22: Since when have you been smoking beedis?
प्रश्न 22: कब से बीडी पी रहे हो?
प्रश्न 22: आपण कधीपासून बीडी/सिगारेट वात आहात?
Ans 22: Since the last 10 or 12 years.
उत्तर 22: मागील 10 ते 12 वर्षांपासून
Q 23: Do you drink alcohol?
प्रश्न 23: क्या आप शराब पीते हैं?
प्रश्न 23: आऩण दारू पिलाते का?
Ans 23: Yes [in case of male]  No [in case of female SP]
उत्तर 23: हूँ (मेल SP के लिये), नहीं (फीमेल SP के लिये)
उत्तर 23: हो, भी दारू (पुरुष एस पी साठी) पिलो, नाही (स्त्री एस पी साठी)
Q 24: Does anyone in your family have TB?
प्रश्न 24: क्या आपके परिवार में किसी को टीबी है?
प्रश्न 24: आपल्या कुटुंबामध्ये कोणाला टी बी आहे का?
Ans 24: No.
उत्तर 24: नाही।
उत्तर 24: नाही
Q 25: Have you taken any medicines for your illness in last one month?
प्रश्न 25: क्या पिच्छले एक महीने में आपने इस तकलीफ के लिये कोई दवाई ली है?
प्रश्न 25: मागच्या एका महिन्यात आपत्त्यात झालेल्या ह्या त्रासाबद्ध आपण कोणती औषध घेतली का?
Ans 25: Took home remedies and took cough syrup from a chemist.
उत्तर 25: कुंवा घरच्या उपचार किये और क्षेत्र के कक्षित विकल्प घेतलं होतं
Q26: Do you have diabetes?
Q 26: Do you have diabetes?
प्रश्न 26: क्या आपको शुगर डीआई है?
Ans 26: I do not know
उत्तर 26: जी, पता नहीं।
उत्तर 26: माहित नाही

Q 27: Do you have hypertension?
प्रश्न 27: क्या आपको हाइपरप्रेस्शन है?
Ans 27: I do not know
उत्तर 27: जी, पता नहीं।
उत्तर 27: माहित नाही

Q 28: Do you have HIV-AIDS?
प्रश्न 28: क्या आपको हाइवी एआईएस है?
Ans 28: I do not know
उत्तर 28: जी, पता नहीं।
उत्तर 28: माहित नाही

Q 29: Have you ever been tested for HIV-AIDS, Diabetes and High BP/Hypertension?
प्रश्न 29: आपने कभी एच आई एव डीआई एव शुगर एव एच आईएस/हाइपरप्रेस्शन विमानियां की जाँच या टेस्ट करवाया है?
Ans 29: Not been tested.
उत्तर 29: कभी टेस्ट नहीं करवाया।
उत्तर 29: कभी टेस्ट केल्या नाही
**Important instructions to be remembered by SP**

महत्वपूर्ण बातें जो एस पी की याद रखनी है

एस पी साठी महत्वाच्या सूचना

1. **ISERDD staff will identify the facility and/or the provider for the SP, where the SP will present his case alone.**
   ISERDD स्टाफ़ फील्ड में SP को प्रोवाइडर का क्लिनिकल बतायेगा जहां SP को अपने अपना केस करना है।
   ISERDD स्टाफ़ फील्ड में SP ला प्रोवाइडर चे क्लिनिकल सांगतील जिकडे SP ला एकटच आपले केस सादर करायची आहे।

2. **SP should remember if the facility and/or the provider was the correct one. (for example, it was the correct location, but the name board did not match the name given or if the assigned provider was not there and the SP saw another provider)**
   SP को याद रखना है कि यो सही प्रोवाइडर के क्लिनिकल गये थे? (उदाहरण के लिए, जगह सही थी लेकिन बोर्ड पर लिखा नाम दिये गये नाम से मैच नहीं कर रहा था।
   SPनी लक्षात ठेवायचे आहे कि ते योग्य ते प्रोवाइडरच्या किंसी भिन्न मध्ये गेले होते का? (उदाहरणानुसार जागा बरोबर होती पण बोर्डवरचे नाव दिलेल्या नावशी मैच होत नव्हते)

3. **SP must remember if the provider carried out any of the following examination?**
   SP को याद रखना है कि प्रोवाइडर ने कोणत्या परीक्षण किये?
   SPनी लक्षात ठेवायचे आहे कि प्रोवाइडरला खासीपेक्षी कोणत्या तपासण्या केल्या?
   - Pulse Rate नाडीचे स्नादन
   - Respiratory Rate श्लवन दय
   - Auscultation of Chest (Did the provider comment on the auscultation)
     हृदय, फेफड़ांची गतिका को सुनणा (या प्रोवाइडर ने ऑस्क्युलेशन करते समय कुंठ कहा जसे आवाज साफ हा या अन्य)
     हृदय फुफळे सांगितले होणाऱ्या आवाज़ एकूण तपासणे (प्रोवाइडर ने ऑस्क्युलेशन करताना काय सांगितला का जसे आवाज साफ असेही किंवा अन्य)
   - Blood Pressure ब्लड प्रेशर / रक्तदब गोष्टी
   - Temperature तापमान - थर्मोमीटर ताप मापण - थर्मोमीटरने
   - Throat examination गले का परीक्षण
   - Weight वजन मापण - वजन मापणAbdomen palpitation भोट (वाशकर परीक्षण पोटाचे दाखल परीक्षण करणे)
4. Did the provider recommend any investigations? क्या प्रोवाइडर ने सल्हिदित जीच कराने को कहा?
(If yes, SP should ask provider to write the name of the test and the laboratory. And hand over the
document to an ISERDD staff.) Write the specific name of lab given by the provider and if no put (-99).
(यदि हैं, तो SP को प्रोवाइडर द्वारा टेस्ट और लेख का नाम लिखित में लेना है और उस पर को ISERDD स्टाफ को सौंप देना है) अगर प्रोवाइडर
ने किसी विशेष लेख का नाम दिया है तो वह हिस्से, यदि नहीं हों तो (-99) भरें।
(जर हों, तर SP नी प्रोवाइडरकडून टेस्ट आणण लेखच्या नाव लिहून ध्यानारे आहें आणि त्या कागदात
ISERDD स्टाफला दाखवावे आहें) जर प्रोवाइडरनी विशेष लेख वे नाव सुचवले तर ते लिहू ध्या, जर नाही
सॉगिले तर (-99) भरा
- Chest X-Ray छाती का एक्स-रे छातीया एक्स-रे
- CT Scan सी टी रेन सी टी एरेजन
- Blood- Total count, differential count- ESR रक्त-टोटल काउंट, विभिन्नकारक इ-ई एस आर
- Blood- HIV test रक्त-एचआईटी टेस्ट रक्त-एचआईटी टेस्ट -
- Blood- Diabetes test रक्त-डायबिटीस टेस्ट रक्त-डायबिटीस टेस्ट -
- Blood-TB Gold रक्त- टीबी गोल्ड रक्त- टीबी गोल्ड टेस्ट -
- Sputum smear examination (Sputum AFB) स्पूटम स्मार एफएबी स्पूटम स्मार एफएबी 
- Sputum GeneXpert test स्पूटम जीनएप्टर टेस्ट स्पूटम जीनएप्टर टेस्ट
- Sputum culture स्पूटम कल्चर स्पूटम कल्चर
- Mantoux Test मान्टोक्स टेस्ट मान्टोक्स टेस्ट
- TB- PCR (not specific) टीबी- पीआईएस (स्पेसिफिक) टीबी- पीआईएस (स्पेसिफिक)
- Drug susceptibility test (culture, gene Xpert, line probe assay) ड्रग स्य्पेक्सिबिलिटी टेस्ट (कल्चर, जीनएप्टर, 
लाइन प्रोब एस्वे) ड्रग स्य्पेक्सिबिलिटी टेस्ट (कल्चर, जीनएप्टर, लाइन प्रोब एस्वे)

5. Did the provider give you any vouchers or referral coupons? क्या प्रोवाइडर ने SP को कोई वॉचर या रेफरल कूपन दिया?
(If yes, SP should retain the voucher or referral coupons and hand over to any ISERDD staff. On the form,
supervisors will write the voucher number and name from the stamp.)
(यदि हैं, तो SP को वॉचर/रेफरल कूपन समावेश कर सकता है और ISERDD स्टाफ के हाथों में सौंपना है)
(जर हों, तर SP नी वॉचर/रेफरल कूपन सामावेश कर आणू हो आणि ISERDD स्टाफ च्या हातात
दाखवावे आहें)
- Treatment उपचार उपचार
- Chest X-Ray छाती का एक्स-रे छातीया एक्स-रे
- GeneXpert जीनएप्टर टेस्ट जीनएप्टर टेस्ट
Please write voucher or referral coupons number and name on the stamp.
(कृपया वॉचर/रेफरल कूपन का नम्बर तथा नाम निपटे)
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 6. | **SP must remember if personal details (Name, Mobile, Address) were given to the provider. If so, what was the full name the SP gave? (Some providers who work with the PPIA will collect this information if they identify the SP as a presumptive TB case, refer you to a lab for sputum or CXR, or refer you to certain providers.)**  
SP must remember if personal details (Name, Mobile, Address) were given to the provider. If so, what was the full name the SP gave? (Some providers who work with the PPIA will collect this information if they identify the SP as a presumptive TB case, refer you to a lab for sputum or CXR, or refer you to certain providers.) |
| 7. | **SP must remember if someone at the facility completed a registration form to register the SP's personal details such as with a call center. (Some providers who work with the PPIA will make a call to register patients.)**  
SP must remember if someone at the facility completed a registration form to register the SP's personal details such as with a call center. (Some providers who work with the PPIA will make a call to register patients.) |
| 8. | **ISERDD staff to mark which of the following tests was recommended by a networked provider.**  
ISERDD staff to mark which of the following tests was recommended by a networked provider. |
| 9. | **SP must remember if the provider gave any diagnosis.**  
SP must remember if the provider gave any diagnosis. |
| 10. | **SP must remember if the provider recorded the information he took from you.**  
SP must remember if the provider recorded the information he took from you. |
| 11. | **SP should remember if the provider referred to:**  
SP should remember if the provider referred to:  
- a private provider/ private hospital  
- a BMC / Municipal hospital  
- DOTS centre  
- Other location |

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BMJ Global Health  
| 12. | **SP should refuse any injections/ invasive tests performed by the provider during this encounter but note down details of what was offered/suggested.**  
   **SP** कों इन्हें बातचीत के दौरान किसी भी तरह का इन्जेक्शन/इन्वेसिव टेस्ट लेने से इनकार करना है लेकिन ऐसे किसी भी सुझाव को नोट करके बताना है।  
   **SP** नी संभाषण दर्शनां कृदंतभाषी प्रकारसे इन्जेक्शन / इन्वेजिव टेस्ट ध्यायला नकार द्यायचा आहे आणि अष्ट्र प्रकारच्या सुचना नोट करून ठेवायच्या आहेत। |
| 13. | **If the provider asks any question that is not in the list then the SP should say no or deflect by either saying I don’t know or I don’t remember as is appropriate to the context.**  
   **यदि प्रोवाइडर कोई ऐसा सवाल पूछता है जो सिस्ट में शामिल नहीं है तो SP को कहना है मुझे पता नहीं या याद नहीं आ रहा (जो उस समय ज्ञात लगे)  
   जर प्रोवाइडर अपव्ययां सामान्य मार्ग विचारता जो सिस्ट मध्ये सामान्य नाही आहे तर **SP** नी सांगावयो आहे कि मला माहित नाही किवा आठवत नाही (जे त्या चीज उचित बतेल ते)** |
| 14. | **SP must collect prescription and/or any medicines given by the provider.**  
   **SP** कों प्रोवाइडर द्वारा दी गेली दवा या दवा का पर्या आपण लेना है।  
   **SP** नी प्रोवाइडरला दिलेल्या ऑषधी आणि ऑषधीचं कागद ध्यायला आवश्यक आहेत। |
| 15. | **SP should get the prices of the prescribed medicines, labs or consultation fees from the provider.**  
   **SP** कों प्रोवाइडर द्वारा पर्या पर्यंत दवा, लेब या कनसलटेशन फीस की जाणकारी को माही आहे।  
   **SP** नी प्रोवाइडरद्वारा ऑषधीसाठी दिलेल्या कागदावर लिहिलेली ऑषधी, लेब किंवा कनसलटेशन फीज ची माहिती सह सांगावयो आहेत। |
| 16. | **Supervisor / SP should get the prices, brand and generic names of the prescribed medicines.**  
   **Supervisor/SP** कों प्रोवाइडर द्वारा दिलेली दवांच्या मूल्य, ब्रांड तथा जेनरिक नाव का पता करता है।  
   **Supervisor/SP** नी प्रोवाइडरद्वारा दिलेली गेलेल्या ऑषधींचे मूल्य, ब्रांड आणि जेनरिक नावांची माहिती गोळ्या करायची आहे।  
   - Fill all unlabelled FIRST लूकूळ दवांमध्ये पहले लिहिलेखणी ऑषधी फार्मील पहिले लिहिलेखणी।  
   - In brand: write Unlabelled ब्रांड मध्ये अनमोलबल्ड लिखिलेखणी ।  
   - In generic: describe the color + shape जेनरिक मध्ये दवाचा आकार व रंग लिहिलेखणी जेनरिक मध्ये रंग आणि आकार लिहिलेखणी। |
| 17. | **Prescriptions and pills given must be preserved for analysis.**  
   **SP** कों दवा आणि दवांमध्ये एनालिसिस करण्यासाठी संग्रहालय करता है।  
   **SP** नी डॉक्टरांनी ऑषधीसाठी दिलेल्या कागद आणि ऑषधी-गोळ्या एनालिसिससाठी सांगावलेली ठेवायच्या आहेत। |
### Table A1. History question completion

<table>
<thead>
<tr>
<th>Exams</th>
<th>Public Dispensary</th>
<th>Public Hospital</th>
<th>Private Sector</th>
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<tbody>
<tr>
<td>Pulse</td>
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<td>13.2%</td>
<td>59.1%</td>
</tr>
<tr>
<td>Auscultation</td>
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<td>42.7%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Provider commented on auscultation</td>
<td>50.0%</td>
<td>66.7%</td>
<td>66.2%</td>
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<tr>
<td>Temperature</td>
<td>0.0%</td>
<td>1.3%</td>
<td>20.2%</td>
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<tr>
<td>Throat Exam</td>
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<td>2.6%</td>
<td>40.9%</td>
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<tr>
<td>Blood Pressure</td>
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<td>65.5%</td>
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<tr>
<td>Weight</td>
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<td>0.0%</td>
<td>37.9%</td>
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<tr>
<td>Abdomen palpitation</td>
<td>1.1%</td>
<td>0.0%</td>
<td>33.5%</td>
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<table>
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<th>Public Dispensary</th>
<th>Public Hospital</th>
<th>Private Sector</th>
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<tr>
<td>Duration of Cough</td>
<td>95.5%</td>
<td>92.1%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Sputum</td>
<td>54.5%</td>
<td>57.9%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Past TB</td>
<td>29.5%</td>
<td>60.5%</td>
<td>43.4%</td>
</tr>
<tr>
<td>Family TB</td>
<td>15.9%</td>
<td>34.2%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Blood in Sputum</td>
<td>15.9%</td>
<td>10.5%</td>
<td>27.9%</td>
</tr>
<tr>
<td>Cough Throughout Day</td>
<td>20.5%</td>
<td>15.8%</td>
<td>61.7%</td>
</tr>
<tr>
<td>Fever</td>
<td>79.5%</td>
<td>78.9%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Fever Type</td>
<td>29.5%</td>
<td>34.2%</td>
<td>73.7%</td>
</tr>
<tr>
<td>Family or Family with Similar Symptoms</td>
<td>2.3%</td>
<td>10.5%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>11.4%</td>
<td>18.4%</td>
<td>37.4%</td>
</tr>
<tr>
<td>Loss of Appetite</td>
<td>13.6%</td>
<td>23.7%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Lost Weight</td>
<td>13.6%</td>
<td>21.1%</td>
<td>51.7%</td>
</tr>
<tr>
<td>Wheezing</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Difficulty Breathing</td>
<td>4.5%</td>
<td>26.3%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Smoking</td>
<td>6.8%</td>
<td>2.6%</td>
<td>25.7%</td>
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<tr>
<td>Alcohol History</td>
<td>9.1%</td>
<td>2.6%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Taken Medicines for Illness</td>
<td>38.6%</td>
<td>26.3%</td>
<td>71.2%</td>
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<tr>
<td>Diabetes</td>
<td>2.3%</td>
<td>15.8%</td>
<td>20.9%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>0.0%</td>
<td>2.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Age</td>
<td>86.4%</td>
<td>76.3%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Duration of Cough</td>
<td>93.2%</td>
<td>94.7%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Sputum</td>
<td>38.6%</td>
<td>65.8%</td>
<td>86.8%</td>
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</table>

<table>
<thead>
<tr>
<th>Case 2 Questions</th>
<th>Public Dispensary</th>
<th>Public Hospital</th>
<th>Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Taken Last Month for Present Illness</td>
<td>18.2%</td>
<td>15.8%</td>
<td>33.2%</td>
</tr>
<tr>
<td>Visited Governmental Hospital for Previous Illness</td>
<td>52.3%</td>
<td>42.1%</td>
<td>32.8%</td>
</tr>
<tr>
<td>Treatment for Previous Illness</td>
<td>50.0%</td>
<td>57.9%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Sputum or X-Rays Done for Previous Illness</td>
<td>15.9%</td>
<td>23.7%</td>
<td>33.6%</td>
</tr>
<tr>
<td>Diagnosis Given by Governmental Hospital</td>
<td>40.9%</td>
<td>55.3%</td>
<td>43.2%</td>
</tr>
<tr>
<td>Past TB Treatment</td>
<td>61.4%</td>
<td>57.9%</td>
<td>50.4%</td>
</tr>
<tr>
<td>For How Long Past TB Treatment</td>
<td>81.8%</td>
<td>86.8%</td>
<td>52.8%</td>
</tr>
<tr>
<td>Reason for Stopping</td>
<td>75.0%</td>
<td>71.1%</td>
<td>45.2%</td>
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<tr>
<td>Previous Treatment Medical Records</td>
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<td>36.8%</td>
<td>34.8%</td>
</tr>
<tr>
<td>Blood in Sputum</td>
<td>2.3%</td>
<td>13.2%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Cough Throughout Day</td>
<td>4.5%</td>
<td>21.1%</td>
<td>46.6%</td>
</tr>
<tr>
<td>Fever</td>
<td>43.2%</td>
<td>76.3%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Fever Type</td>
<td>25.0%</td>
<td>39.5%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Similar Symptoms Before</td>
<td>6.8%</td>
<td>2.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Family TB</td>
<td>2.3%</td>
<td>10.5%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>6.8%</td>
<td>13.2%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Loss of Appetite</td>
<td>15.9%</td>
<td>18.4%</td>
<td>55.4%</td>
</tr>
<tr>
<td>Lost Weight</td>
<td>11.4%</td>
<td>18.4%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Wheezing</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Difficulty in Breathing</td>
<td>2.3%</td>
<td>5.3%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Smoking</td>
<td>11.4%</td>
<td>13.2%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>9.1%</td>
<td>7.9%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4.5%</td>
<td>5.3%</td>
<td>29.7%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>2.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>High Blood Pressure or Hypertension</td>
<td>2.3%</td>
<td>2.6%</td>
<td>22.9%</td>
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<tr>
<td>Presence of Children</td>
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<td>5.3%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Age</td>
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### Table A2. Regression comparison of public vs private sector

<table>
<thead>
<tr>
<th>Comparison vs Private Sector</th>
<th>Difference</th>
<th>Standard Error</th>
<th>T-Statistic</th>
<th>P-Value</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
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<tbody>
<tr>
<td><strong>Family 1</strong></td>
<td></td>
<td></td>
<td></td>
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<td>STCI Management: Public Dispensaries</td>
<td>-0.188</td>
<td>0.066</td>
<td>-2.864</td>
<td>0.004</td>
<td>-0.317</td>
<td>-0.059</td>
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<td>STCI Management: Public Hospitals</td>
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<td>0.064</td>
<td>-0.283</td>
<td>0.777</td>
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<td>0.108</td>
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<tr>
<td>MGGM Protocol: Public Dispensaries</td>
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<td>0.060</td>
<td>6.180</td>
<td>0.000</td>
<td>0.253</td>
<td>0.489</td>
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<td>MGGM Protocol: Public Hospitals</td>
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<td>0.071</td>
<td>4.768</td>
<td>0.000</td>
<td>0.198</td>
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<td>0.000</td>
<td>-0.228</td>
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<td>-5.507</td>
<td>0.000</td>
<td>-0.206</td>
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<td>0.437</td>
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<td>Sputum AFB: Public Hospitals</td>
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<td>-0.129</td>
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<td>0.000</td>
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<td>Referred Away: Public Dispensaries</td>
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<td>0.034</td>
<td>0.015</td>
<td>0.988</td>
<td>-0.065</td>
<td>0.067</td>
</tr>
<tr>
<td>Referred Away: Public Hospitals</td>
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<td>0.031</td>
<td>0.978</td>
<td>0.329</td>
<td>-0.031</td>
<td>0.092</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Started TB Treatment: Public Dispensaries</td>
<td>0.006</td>
<td>0.018</td>
<td>0.335</td>
<td>0.738</td>
<td>-0.029</td>
<td>0.041</td>
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<td>0.009</td>
<td>-1.739</td>
<td>0.083</td>
<td>-0.035</td>
<td>0.002</td>
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<tr>
<td>Fluoroquinolones: Public Dispensaries</td>
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<td>0.031</td>
<td>-0.145</td>
<td>0.885</td>
<td>-0.057</td>
<td>0.066</td>
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<td>Fluoroquinolones: Public Hospitals</td>
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<td>0.021</td>
<td>-1.321</td>
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<td>-0.069</td>
<td>0.014</td>
</tr>
<tr>
<td>Other Antibiotic: Public Dispensaries</td>
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<td>0.064</td>
<td>2.422</td>
<td>0.016</td>
<td>0.029</td>
<td>0.281</td>
</tr>
<tr>
<td>Other Antibiotic: Public Hospitals</td>
<td>0.242</td>
<td>0.069</td>
<td>3.487</td>
<td>0.001</td>
<td>0.105</td>
<td>0.378</td>
</tr>
<tr>
<td>Steroids: Public Dispensaries</td>
<td>-0.023</td>
<td>0.008</td>
<td>-2.788</td>
<td>0.006</td>
<td>-0.039</td>
<td>-0.007</td>
</tr>
<tr>
<td>Steroids: Public Hospitals</td>
<td>-0.022</td>
<td>0.008</td>
<td>-2.837</td>
<td>0.005</td>
<td>-0.037</td>
<td>-0.007</td>
</tr>
<tr>
<td><strong>Family 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SP Subjective Rating (1-10): Public Dispensaries</td>
<td>0.186</td>
<td>0.203</td>
<td>0.914</td>
<td>0.361</td>
<td>-0.214</td>
<td>0.586</td>
</tr>
<tr>
<td>SP Subjective Rating (1-10): Public Hospitals</td>
<td>0.128</td>
<td>0.227</td>
<td>0.564</td>
<td>0.573</td>
<td>-0.319</td>
<td>0.575</td>
</tr>
<tr>
<td>Provider Used Cell Phone: Public Dispensaries</td>
<td>0.022</td>
<td>0.047</td>
<td>0.473</td>
<td>0.637</td>
<td>-0.071</td>
<td>0.115</td>
</tr>
<tr>
<td>Provider Used Cell Phone: Public Hospitals</td>
<td>-0.051</td>
<td>0.027</td>
<td>-1.868</td>
<td>0.063</td>
<td>-0.104</td>
<td>0.003</td>
</tr>
<tr>
<td>Other People Were In Room: Public Dispensaries</td>
<td>0.014</td>
<td>0.034</td>
<td>0.417</td>
<td>0.677</td>
<td>-0.053</td>
<td>0.081</td>
</tr>
<tr>
<td>Other People Were In Room: Public Hospitals</td>
<td>0.370</td>
<td>0.079</td>
<td>4.702</td>
<td>0.000</td>
<td>0.215</td>
<td>0.525</td>
</tr>
<tr>
<td>Provider Had A TV On: Public Dispensaries</td>
<td>-0.002</td>
<td>0.002</td>
<td>-0.977</td>
<td>0.329</td>
<td>-0.007</td>
<td>0.002</td>
</tr>
<tr>
<td>Provider Had A TV On: Public Hospitals</td>
<td>-0.003</td>
<td>0.003</td>
<td>-0.990</td>
<td>0.323</td>
<td>-0.008</td>
<td>0.003</td>
</tr>
<tr>
<td>SP Liked The Provider: Public Dispensaries</td>
<td>0.041</td>
<td>0.023</td>
<td>1.762</td>
<td>0.079</td>
<td>-0.005</td>
<td>0.088</td>
</tr>
<tr>
<td>SP Liked The Provider: Public Hospitals</td>
<td>0.011</td>
<td>0.027</td>
<td>0.409</td>
<td>0.683</td>
<td>-0.043</td>
<td>0.065</td>
</tr>
<tr>
<td>SP Would Go To This Provider: Public Dispensaries</td>
<td>0.052</td>
<td>0.024</td>
<td>2.193</td>
<td>0.029</td>
<td>0.005</td>
<td>0.099</td>
</tr>
<tr>
<td>SP Would Go To This Provider: Public Hospitals</td>
<td>0.022</td>
<td>0.027</td>
<td>0.810</td>
<td>0.418</td>
<td>-0.032</td>
<td>0.076</td>
</tr>
<tr>
<td>Provider Created A Private Environment: Public Dispensaries</td>
<td>0.049</td>
<td>0.045</td>
<td>1.090</td>
<td>0.276</td>
<td>-0.039</td>
<td>0.137</td>
</tr>
<tr>
<td>Provider Created A Private Environment: Public Hospitals</td>
<td>-0.493</td>
<td>0.063</td>
<td>-7.827</td>
<td>0.000</td>
<td>-0.617</td>
<td>-0.369</td>
</tr>
<tr>
<td>Provider Seemed Knowledgeable About Illness: Public Dispensaries</td>
<td>0.043</td>
<td>0.057</td>
<td>0.759</td>
<td>0.448</td>
<td>-0.069</td>
<td>0.156</td>
</tr>
<tr>
<td>Provider Seemed Knowledgeable About Illness: Public Hospitals</td>
<td>-0.017</td>
<td>0.056</td>
<td>-0.301</td>
<td>0.763</td>
<td>-0.126</td>
<td>-0.092</td>
</tr>
<tr>
<td>Provider Addressed Worries Seriously: Public Dispensaries</td>
<td>-0.033</td>
<td>0.062</td>
<td>-0.531</td>
<td>0.596</td>
<td>-0.155</td>
<td>0.089</td>
</tr>
<tr>
<td>Provider Addressed Worries Seriously: Public Hospitals</td>
<td>-0.012</td>
<td>0.060</td>
<td>-0.201</td>
<td>0.841</td>
<td>-0.130</td>
<td>0.106</td>
</tr>
<tr>
<td>Provider Explained SP Condition: Public Dispensaries</td>
<td>-0.085</td>
<td>0.019</td>
<td>-4.408</td>
<td>0.000</td>
<td>-0.123</td>
<td>-0.047</td>
</tr>
<tr>
<td>Provider Explained SP Condition: Public Hospitals</td>
<td>-0.016</td>
<td>0.038</td>
<td>-0.426</td>
<td>0.670</td>
<td>-0.091</td>
<td>0.058</td>
</tr>
<tr>
<td>Provider Explained SP Treatment Plan: Public Dispensaries</td>
<td>0.047</td>
<td>0.062</td>
<td>0.678</td>
<td>0.498</td>
<td>-0.080</td>
<td>0.164</td>
</tr>
<tr>
<td>Provider Explained SP Treatment Plan: Public Hospitals</td>
<td>-0.122</td>
<td>0.051</td>
<td>-2.410</td>
<td>0.016</td>
<td>-0.222</td>
<td>-0.023</td>
</tr>
</tbody>
</table>

**Notes:** This figure reports the results of a series of regressions using both the public hospital interactions (N=76) and private hospital interactions (N=633). Each point reports the real-valued coefficient for the indicator variable of the private sector and the corresponding confidence interval. Estimates are controlled for individual SP ID and the case scenario; standard errors are clustered by facility. The measures are grouped into four families for illustrative purposes.
Figure A1. Case management with private sector split by MD specialist qualifications

Notes: This figure reports the proportion of interactions in each study strata that resulted in the indicated outcome for an SP presenting Case 1 or Case 2 as indicated. The STCI management measure is defined as each Case 1 interaction that received a referral, a chest X-ray, a sputum AFB test, or an Xpert CBNAAT test or other drug-susceptibility test; and for each Case 2 interaction that received a referral or an Xpert CBNAAT test or other drug-susceptibility test. TB: tuberculosis, AFB: acid-fast bacillus; Xpert MTB/RIF: CBNAAT mycobacterium tuberculosis / rifampicin sensitivity testing. Medications from each interaction were ex-post coded by name to correspond to ATC code classifications. Fluoroquinolone antibiotics were defined as ATC codes beginning with J01M; steroids were defined as ATC codes beginning with H02, R01, or R03.
Figure A2. Regression comparison of public vs private sector non-MD providers

Notes: This figure reports the results of a series of regressions using both separately comparing the different types of public sector facilities with private sector non-MD providers. Each point reports the coefficient for the indicator variable of the private sector and the corresponding confidence interval. All measures are standardized to mean 0 and standard deviation 1 for illustration purposes. Estimates are controlled for individual SP ID and the case scenario; standard errors are clustered by facility. The measures are grouped into four families: Family 1 are the appropriate clinical management outcomes; Family 2 are the medication use outcomes; Family 3 are the subjective experience measures; and Family 4 are the unassociated characteristics. Each family’s confidence intervals are extended to the appropriate Bonferroni interval for the number of simultaneous hypothesis; and the p-values are considered significant if they satisfy the Benjamini-Hochberg step-up procedure (including values that may not be considered significant under their own Bonferroni interval). Measures are sorted by the magnitude and direction of the estimated coefficient.
Figure A3. Regression comparison of public vs private sector MD specialists

Case 1: Favors Public Disparities | Case 2: Favors Public Disparities
---|---
| Favors Private MBBS+MD Providers → | Favors Private MBBS+MD Providers → |
| +2 SD | +1 SD | 0 | +1 SD | +2 SD |
| | | | | |
| Provider Seemed Knowledgeable About Illness [F3] | Provider Seemed Knowledgeable About Illness [F3] |
| Provider Created A Private Environment [F3] | Provider Created A Private Environment [F3] |
| Provider Explained SP Treatment Plan [F3] | Provider Explained SP Treatment Plan [F3] |
| Provider Addressed Worries Seriously [F3] | Provider Addressed Worries Seriously [F3] |
| Provider Explained SP Condition [F3] | Provider Explained SP Condition [F3] |
| Other People Were In Room [F3] | Other People Were In Room [F3] |
| Provider Subjective Ratings About Room [F3] | Provider Subjective Ratings About Room [F3] |
| Provider创建了私人环境 [F3] | Provider创建了私人环境 [F3] |
| Provider解释了患者的治疗计划 [F3] | Provider解释了患者的治疗计划 [F3] |
| Provider认真处理了患者的担忧 [F3] | Provider认真处理了患者的担忧 [F3] |
| Provider解释了患者的状况 [F3] | Provider解释了患者的状况 [F3] |
| 其他人在房间内 [F3] | 其他人在房间内 [F3] |
| 医生主观评价房间 [F3] | 医生主观评价房间 [F3] |

Colored markers indicate significant Benjamini-Hochberg p values at FDR α = .05.

Case 1: Favors Public Hospitals | Case 2: Favors Public Hospitals
---|---
| Favors Private MBBS+MD Providers → | Favors Private MBBS+MD Providers → |
| +2 SD | +1 SD | 0 | +1 SD | +2 SD |
| | | | | |
| Provider Seemed Knowledgeable About Illness [F3] | Provider Seemed Knowledgeable About Illness [F3] |
| Provider Created A Private Environment [F3] | Provider Created A Private Environment [F3] |
| Provider Explained SP Treatment Plan [F3] | Provider Explained SP Treatment Plan [F3] |
| Provider Addressed Worries Seriously [F3] | Provider Addressed Worries Seriously [F3] |
| Provider Explained SP Condition [F3] | Provider Explained SP Condition [F3] |
| Other People Were In Room [F3] | Other People Were In Room [F3] |
| Provider Subjective Ratings About Room [F3] | Provider Subjective Ratings About Room [F3] |
| Provider创建了私人环境 [F3] | Provider创建了私人环境 [F3] |
| Provider解释了患者的治疗计划 [F3] | Provider解释了患者的治疗计划 [F3] |
| Provider认真处理了患者的担忧 [F3] | Provider认真处理了患者的担忧 [F3] |
| Provider解释了患者的状况 [F3] | Provider解释了患者的状况 [F3] |
| 其他人在房间内 [F3] | 其他人在房间内 [F3] |
| 医生主观评价房间 [F3] | 医生主观评价房间 [F3] |

Colored markers indicate significant Benjamini-Hochberg p values at FDR α = .05.

Notes: This figure reports the results of a series of regressions using both separately comparing the different types of public sector facilities with private sector MD specialist providers. Each point reports the coefficient for the indicator variable of the private sector and the corresponding confidence interval. All measures are standardized to mean 0 and standard deviation 1 for illustration purposes. Estimates are controlled for individual SP ID and the case scenario; standard errors are clustered by facility. The measures are grouped into four families: Family 1 are the appropriate clinical management outcomes; Family 2 are the medication use outcomes; Family 3 are the subjective experience measures; and Family 4 are the unassociated characteristics. Each family's confidence intervals are extended to the appropriate Bonferroni interval for the number of simultaneous hypothesis; and the p-values are considered significant if they satisfy the Benjamini-Hochberg step-up procedure (including values that may not be considered significant under their own Bonferroni interval). Measures are sorted by the magnitude and direction of the estimated coefficient.
Figure A4. Time dimensions of interactions

Notes: This figure summarizes temporal characteristics of interactions with various types of providers for illustration purposes. The left panels display the time of day of all interactions that SPs were able to successfully complete in each sector. Histogram bars each cover a half-hour time interval and are reported as the percentage of interactions occurring in each time slot. The right panels summarize the time waiting for each interaction and the time with each provider (in minutes), presented as a box plot with the 5th, 25th, 50th, 75th, and 95th percentiles marked.
Figure A5. Public sector sample and administrative data