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BARRIERS AND ENABLERS ASSOCIATED WITH TETANUS DIPHTHERIA VACCINE UPTAKE AMONG PREGNANT AT SIRSI VILLAGE: A FACILITY BASED MIXED METHOD STUDY

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INTRODUCTION

1.0 BACKGROUND

Immunization has been proven to be one of the effective public health interventions to achieve optimum and desired health, and prevent vaccine preventable diseases in a community towards diminishing the mortality and morbidity of the children and pregnant women (1),(2). Maternal vaccines given to the pregnant women in their early pregnancy, second and third trimester have been shown to provide protection from potential infections for the mother, and the newborn through trans-placental maternal antibodies (3).

After 5 years, the introduction of National Immunization program in India, in 1983, TT vaccine for pregnant women was added in the EPI program (4). In 2017, WHO updated the recommendation of the replacement of TT (Tetanus toxoid) vaccine with Tetanus Diphtheria vaccine (TD) for pregnant women (5). Around 133 countries including India have replaced TT with Td vaccine (6), (7).

Tetanus and diphtheria vaccine is a mixture of tetanus and diphtheria with low dose concentration of diphtheria antigen (d) as recommended for children older than 5 years and adults including pregnant women (6), scheduled for Td1 for early pregnancy, Td2 for 4 weeks after Td1, and Td-B given as a booster, if pregnancy occur within 3 years of last pregnancy and Td2 doses were received (8), (6).

In the last two decades, India has made significant progress in improving maternal health indicators by implementing various interventions (9) with the aim to provide assured, dignified, high quality healthcare with free of charge, and no patience for denial of services for any women and children visiting a primary or community health center to eliminate all preventable maternal and newborn deaths (10) (9). An example of the achievements include that India was certified maternal and neonatal tetanus elimination status in 2015 (11). These interventions to improving maternal health indicators led to a significant decline in maternal mortality ratio from 130 per lakh live births in 2014/2016 to 97 per lakh live births in 2018/20 (12), (13).

Despite progress and efforts to improve tetanus diphtheria uptake among pregnant women has been made, including targeted interventions in the sirsi village, there remains a critical need in achieving optimal vaccination coverage.

Various persistent barriers including, unequal accessibility of public health in India (14), inadequate provider information and low trust of the community health workers which effects

the acceptance of community in the facility and reduces the utilization rate of maternal health services (15), logistical issues related to vaccines (16), and sociocultural influences for instance, discrimination due to language barrier or socioeconomic position (17). These barriers continue to hamper the achievement of the desired vaccine uptake rates, posing a significant risks to maternal and neonatal health. Therefore, in this study, we explore the barriers and enablers associated with vaccine uptake among pregnant women at sirsi village, Jaipur, India.

OBJECTIVES OF THE STUDY

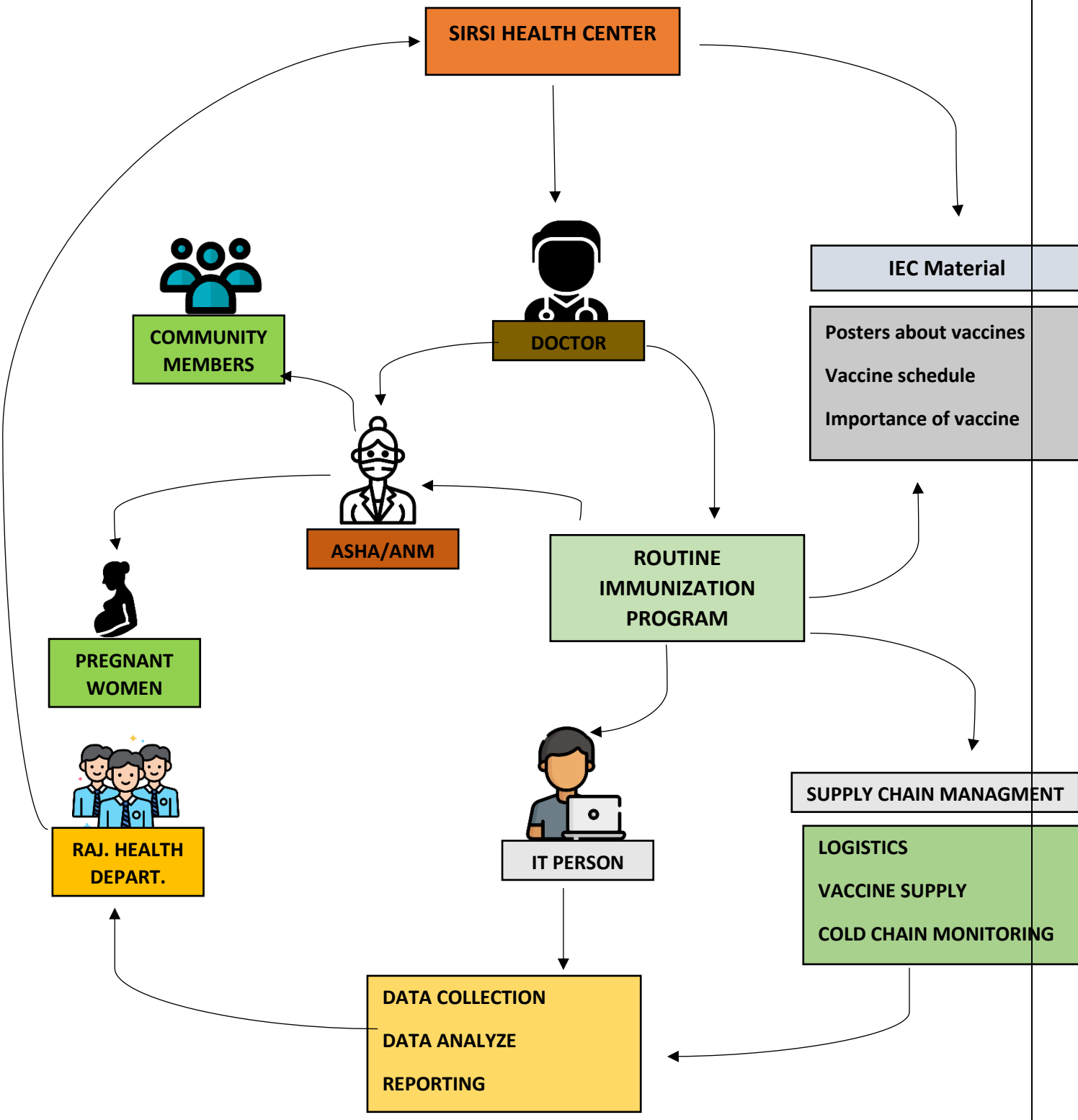
1. To identify the barriers and enablers that may hinder or facilitate tetanus diphtheria vaccine uptake among pregnant women at community level.
2. To describe the system related factors that may delay the vaccine uptake among pregnant women

RESEARCH QUESTION

1. What are the community driven barriers and enablers that may hinder or facilitate tetanus diphtheria vaccine uptake among pregnant women in sirsi village?

2. What are the system related factors that may delay or facilitate the tetanus diphtheria vaccine uptake among pregnant women in sirsi village?

2.0 SCHEMATIC DIAGRAM DEPICTING ROUTINE IMMUNIZATION SERVICE DELIVERY IN SIRSI HEALTH CENTER



3.0 CAPSTONE WORK AREA

The present capstone project aimed to investigate the barriers and facilitators associated with tetanus diphtheria vaccine uptake among pregnant women at sirsi village, located in Jaipur district. The study was a facility based model, conducted at sirsi health center and employed a mixed methods design including both quantitative and qualitative research approaches that was used to examine the barriers and facilitators that may hinder or enable the vaccine uptake.

The quantitative component of the study involved using observation checklists to assess the system related challenges including, the routine immunization program management, quality control, cold chain system, and the supply and stocks of the vaccine. The quantitative component also engaged survey questions for 3 pregnant women. The questions were designed to assess the knowledge and awareness about the tetanus diphtheria vaccine, perceptions of its safety and efficacy, and attitudes towards immunizations among pregnant women. Sociodemographic information such as age, occupation, parity and gravidity of the pregnant women, distant from the center was also collected to identify any potential associations related with the vaccine uptake. The data were analyzed using Excel software.

The qualitative component of the study utilized in-depth interviews with the chief medical officer and ANM to explore their attitudes and experiences related to tetanus diphtheria vaccination, the system related and the sociocultural barriers of the program.

The interviews were conducted in a semi-structured manner, allowing for open ended exploration of the participant's viewpoints. Detailed field notes were taken during the interviews to capture the participant's responses. These field notes were then transcribed for thematic analysis.

FIELD VISIT DOCUMENTATION

The field visit from this study was conducted at Sirsi community Health Center, Jaipur district, from the period between 20Th of March to 1st April 2023. The visit was involved by the author with the guidance of a research officer. The aim of the field visit was to assess the routine immunization program performance, identify barriers and enablers and ultimately provide recommendations for improvement.

Here, the table shows the coverage and the services of the center

SIRSI CHC	
STAFF	14 Staff including 2 ANM & 1 Medical officer
POPULATION COVERAGE	Previously 21000 pops, but now 50000 to 1 Lakh
CORE SERVICES	OPD service, Immunization, Delivery services, and Minor surgery services, MCN Day,
TIMING & SCHEDUAL	From 8PM to 2PM (6 hours a day)
RI SERVICES	BCG, OPV, Hep B, PENTA, ROTA, IPV, MR, DPT, TD, COVAXIN

The field activities conducted during the field visit include

Activities	**Participants involved**
In-depth interviews	• Healthcare providers including the chief medical officer and ANM who involved in the immunization program. • Pregnant women who attended the health center for ANC consultation
Observations	• Observations on immunization sessions and cold chain system in the center to assess the workflow and overall quality of service delivery.
Record reviews	• Immunization records and information on the vaccination coverage.

The field visit provided an insights in to the routine immunization program at SIRSI Health Community Center.

4.0 RESULTS

4.1 Observation of the immunization center

The observations were taken after we sought permission from the center. At least 2-3 person were present in each department. The observations from tetanus diphtheria immunization services are presented in Table 1. It was observed that the pregnant women attending the center were more likely to take the first dose and miss the second dose. Regarding the immunization session held, the center managed to hold the sessions as intended in 2021 and 2022, and the presence of ASHA on those sessions were promising including this calendar year. There was no any reported cases of adverse event for immunization.

Service statistics	2021	2022	2023
No. of pregnant women who received vaccination (+16weeks)			
A. TD1 (Early pregnancy)	410	421	292
B. TD2 (4 Weeks after TD1)	223	280	220
C. TD Booster (after 2TD doses with the last 3 years)	120	99	39
No. of immunization sessions			
A. Immunization sessions planned	7	8	16
B. Immunization sessions held	7	8	8
C. Immunization sessions where ANM/ASHA were present	7	6	7
Adverse event following immunization (AEFI)	0	0	0
A. No. of cases of AEFI			

Table 4.1 tetanus-diphtheria service statistics in SIRSI CHC

Primary data **(SIRSI CHC)**

4.2 Observations from program management

Regarding the observations from the program management, it was observed that vaccine schedule was planned appropriately with no barriers reported in executing the plan from the center to the sub centers.

Program management	Status
Contents of RI Micro plan (for dependent sub-centers) available	
a) Map of catchment area (Indicating SCs and distances from vaccine stora. points)	**Yes**
b) Estimation of beneficiaries (village/area wise) for current year	**Yes**
c) Estimation of logistics _ Vaccine, syringes, immunization cards etc.	**Yes**
d) ANM Roster/Immunization Calendar	**Yes**
e) Day wise plan for supervisor visits	**Yes**
ANM Roster/Immunization calendar displayed at facility	**Yes**
Coverage Monitoring chart/Drop out chart (TD1, TD2)	**Yes**
Supervisory visits by District Level Gov. Health Officials in the last calendar month	**Yes**

***Primary (*SIRSI CHC)**

4.3 Observations from checklists

Regarding the cold chain and the storage of the vaccines, it was observed that the ILR and deep freezers were set and placed in the standard protocol. The tetanus diphtheria vaccines were placed in the middle section of the ILR at a temperature between (2c and 8c). There were temperature monitors and log books in the cold chain room and the supply stocks was sufficient to supply the center and distribute sub centers.

Table 4.3 cold chain and vaccine supply stock

Cold chain	Status
ILR and Deep Freezers	
a) Placed on wooden blocks and at least 10 cm away from walls and surrounding equipment	**Yes**
b) Dedicated voltage stabilizer for each equipment	**Yes**
c) Functional thermometer inside every ILR and DF	**Yes**

d) No frost or frost less than 5mm inside walls of every ILR	**Yes**
Temperature and Log Books	
a) Twice daily monitoring of temperature in respective log books	**Yes**
b) Periodic checks of log books by facility incharge (signature)	**Yes**
ILRs	
a) Cabinet temperature between +2 - +8c	**Yes**
b) All vaccine vials stored correctly inside cartons (Expiry date, batch)	**Yes**
c) No T-series vaccine kept in the bottom of ILR	**Yes**
DF	
a) Cabinet temperature between -15c – 25c	**Yes**
b) Correct placement of ice packs inside the DF (in cross manner, while freezing)	**Yes**
c) No RI vaccines stored inside DF (including reconstituted vaccines)	**Yes**
SUPLLY AND STOCKS	
a) Available sufficient TD vaccine in the stock with no supply issues	**Yes**
b) All sessions in the last month issued at least one vial each of the vaccine due to supply issues	**No**
AEFI & Reported VPDs	
a) Any AEFI reported in the last 3 calendar months	**No**
b) Any VPD in the last 3 calendar months	**No**

***Primary data* (SIRSI CHC)**

4.4 Identified barriers and enablers

As the table 3.4 shows, we have identified the barriers and enablers based on the in-depth interview from the service users (pregnant women), the health system related and the service provider in the facility.

Table 4.4 Identified barriers and enablers associated with tetanus diphtheria vaccine uptake among pregnant women

Service user identified barriers	Unclear understanding about the benefits of tetanus diphtheria vaccine	***Service user identified enablers***	Strong trust and good faith with the ASHA/ANM and the center
	Pain from the site of the injection		Greater acceptability in attending the center and taking the vaccine
	Inadequate service provider (ASHA/ANM recommendation		Equal access of the services in the facility including the vaccine
Health system identified barriers	Limited health workforce and heavy workload from high demand setting	***Health system identified enablers***	Strictly centralized vaccine tracking and monitoring system
	Difficulties in time, order, access and transportation of vaccine supplies from the warehouse to the center stock and from the center to the sub center		Political will from national and state level on life course maternal immunization
	Poor communication and limited coordination between		Effective HMIS system and data record

	anganwadi centers and the center		
Provider identified barriers	Financial concerns: Inadequate payment and less incentives from ASHA/ANM	***Provider identified enablers***	Clear vaccine guidelines particularly for the pregnant women
	Not enough time for patient education		Effective reminder systems
	Limited training and capacity building		Incentives for the health centers with good coverage
	Inadequate information regarding immunization policies		

In the following table, we have listed the five most important barriers to vaccine uptake among pregnant women in terms of service user identified, system related and service provider identified barriers and we suggested actions to address these barriers. We made feasibility grades and prioritization for each suggestive action in terms of implementation as (SWIFT, CHALLENGING AND DIFFICULT). In the priority section we colored the cells of column based on the degree of the priority with red color being the top priority, yellow color being the intermediate priority and the grey color being low priority.

Problems	**Suggestive Actions**	**Feasibility**	**Priority**
1) Inadequate provider recommendation	• Strengthen patient feedback mechanisms	SWIFT	
	• Form a monthly schedule for community awareness events with including culture of accountability	SWIFT	
	• Establish a community led provider health information mechanism	SWIFT	

2) Limited health workforce and heavy workload in high demand setting	• Recruit volunteers to assist the ANM in high demand settings	CHALLENGING	
	• Increase the work shifts by introducing casual healthcare providers	CHALLENGING	
	• Limit the number of daily admissions in the CHC, and improve the quality of services in the sub centers	SWIFT	
3) Difficulties in time, order, access and transportation of vaccine supplies from the warehouse to the center stock and from the center to the sub center	• Rigorous vaccine inventory management	CHALLENGING	
	• Enhance coordination between the center and other sub centers for on time delivery.	SWIFT	
	• Ensure proper transportation mechanism during vaccine delivery.	SWIFT	
4) Financial concerns including minimal incentivization and less payment particularly for ANM/ASHA	• Introduce regular monthly payment for ASHA workers	CHALLENGING	
	• Update and upgarde existing incentive mechanisms on performance basis	SWIFT	
	• Motivate healthcare staff by introducing rewards and recognition practices for their achievements	SWIFT	
5) Limited training and capacity building	• Reinstate on the job, periodic trainings and capacity building for the healthcare providers	SWIFT	
	• Develop and upgrade web/mobile based application for training of healthcare providers in health centers	SWIFT	
	• Establish intra CHC learning model at district levels	CHALLENGING	

In this table, we have listed the five most important enablers to vaccine uptake among pregnant women and we recommended supporting actions required to sustain the best practices.

Best Practices	**Supporting actions required to sustain the best practices**
1) Strong trust and good faith with the ASHA/ANM and the center	Strengthen ASHA/ANM technical skills and competencies
	Encourage support and supervision by ASHA/ANM to the households and communities
	Establish culture of community ownership in the center
2) Equal access and free of charge services in the facility to the communities	Ensure all individuals in the community have the same equal chance to access better health services
	Encourage community participation and local solidarity
	Focus on the vulnerable and underserved communities
3) Strictly cold chain monitoring system	Upgrade the cold chain with the latest technologies
	Improve the competence of technicians who are involved in handling the cold chain
	Ensure continuous electricity services without power outage
4) Political will from national and state level on life course maternal immunization	Strengthen political commitment at state and district level to sustain universal immunization
	Encourage MP constituents in the area to attend during immunization campaigns
	Use political and celebrity figures voices to reach the unreachable
5) Effective HMIS & RCH portal system and data record	Ensure availability and completeness of data
	Fasten transformation from paper based to digitalization of data in the facility
	Improve data quality and governance

5.0 RECOMMENDATIONS AND CONCLUSIONS

The barriers and enablers associated with vaccine uptake among pregnant women at Sirsi Village highlight the need for a multifaceted approach to overcome barriers to achieve the desired coverage. While many barriers such as limited access to provider information, health system logistic related gaps, and inadequate policy measures exist, there are also enablers like community trust and the potential for collaborative efforts.

We recommend that

1) To improve access to provider information: This can be achieved by targeting developed educational campaigns and materials to raise awareness among pregnant women about the importance of vaccination during pregnancy. This role can be done by ASHA and other assigned volunteers.
2) To address issues related with vaccine logistics and transportation mechanisms: This can be done by establishing a vigorous vaccine inventory systems and enhancing the coordination between established collaborators to avoid any delay or vaccine damage.
3) Addressing issues related with financial concerns particularly from ASHA workers: This can be achieved by improving and upgrading the existing incentive schemes designed for ASHA workers. This may improve their self-esteem and increase their performance.
4) Reinstate on the job, periodic trainings and capacity building for the healthcare providers, particularly for ANM and ASHA workers: This can be achieved by developing a new and/or upgrading early existing web/mobile based application for training of healthcare providers in health centers.

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ANNEXES

ROUTINE IMMUNIZATION

Group No: _____

Student Name: _____

Facility Visited: _____

Number of Visits in total: _____

Dates of Visits (in dd/mm/yyyy): _____

Capstone Work Area: _____

Routine Immunization Program (RI)

PART I- Service Statistics (This needs to be filled in by the concerned facility)

Name of the Institution : _____

	2020	2021	2022	Remarks
I. Pregnant Immunization (+16 weeks)				
Number of pregnant who received vaccination				
a. TT1 (Early Pregnancy				
b. TT2 (4 weeks after TT1)				
c. TT Booster (if received 2TT doses in a pregnancy with the last 3 years				
II. Number of Immunization Sessions				
a. Immunization Sessions Planned				
b. Immunization Sessions Held				
c. Number of Immunization Sessions where ASHAs were present				
V. Adverse Event Following Immunization (AEFI)				
Number of cases of AEFI –				

PART II

Provisions & Organization of Services (Observation and Assessment Checklist)

A	Programmme Management	Consult Facility Incharge and Records
1	Contents of RI Microplan (for dependent sub-centres) available	Yes ☐ No ☐
	a. Map of Catchment Area (Indicating SCs and distances from vaccine storage point)	Yes ☐ No ☐
	b. Estimation of beneficiaries (village / area wise) for current year	Yes ☐ No ☐
	c. Estimation of Logistics – Vaccines, syringes, Immunization Cards etc (Village wise)	Yes ☐ No ☐
	d. ANM Roster / Immunization Calendar	Yes ☐ No ☐
	e. Day wise plan for supervisor Visits	Yes ☐ No ☐
2	ANM Roster / Immunization Calendar displayed at Facility	Yes ☐ No ☐
3	Coverage Monitoring Chart / Drop out Chart (BCG-Measles or DPT 1-3) displayed at facility	Yes ☐ No ☐
4	Supervisory visits by District Level Govt Health Officials in the last calendar month	Yes ☐ No ☐
B	**COLD CHAIN (Observe)**	**Consult SN/ MO and Records**
1	ILR and Deep Freezers	
	a. Placed on wooden blocks and at least 10 cm away from walls and surrounding equipment	Yes ☐ No ☐
	b. Dedicated Voltage Stabilizer for each equipment	Yes ☐ No ☐
	c. Functional Thermometer inside every ILR and DF	Yes ☐ No ☐
	d. No frost or Frost less than 5 mm inside walls of every ILR	Yes ☐ No ☐
2	Temperature and Log Books	
	a. Twice daily monitoring of temperature in respective log books	Yes ☐ No ☐
	b. Periodic checks of log books by facility incharge (Signatures)	Yes ☐ No ☐
3	ILRs	
	a. Cabinet Temperature between +2 - +8^{o}C	Yes ☐ No ☐
	b. All Vaccine vials stored correctly inside cartons (Expiry date, batch)	Yes ☐ No ☐
	c. No T – series or Hepatitis vaccines are kept in the bottom of ILR	Yes ☐ No ☐
4	DF	
	a. Cabinet Temperature between +2 - +8^{o}C	Yes ☐ No ☐
	b. Correct placement of ice packs inside the DF (in cress cross manner, while freezing)	Yes ☐ No ☐
	c. No RI vaccines stored inside DF (including reconstituted vaccines)	Yes ☐ No ☐

C	Supply and Stocks	Consult SN/ MO and Records		
a)	BCG/OPV/DPT/DT/**TT**/ Hep B (Check for any one vaccine)	Available Yes ☐ No ☐	Current Stock _____	Supply Issues / Stockouts in Past (Ask) Yes ☐ No ☐
b)	All sessions in last month issued at least one vial of each vaccine	Available Yes ☐ No ☐	Current Stock _____	Supply Issues / Stockouts in Past (Ask) Yes ☐ No ☐
c)	Doses administered (Cumulative for last three months)	(i) DPT1 _____	(ii) DPT3 _____	Drop out rate = DPT 1 – DPT 3 /DPT 1 x 100 _____
d)	Any AEFI Reported in last 3 months	Yes ☐ No ☐		If Yes Details _____
e)	Any VPD in last 3 calendar months	Yes ☐ No ☐		If Yes Details _____

Part III.A – Provider Interaction

A. Provider Interaction – Medical Officer

I. Demographics

1. **Age**: _____Yrs 2. Gender:

3. **Current affiliation and designation**: _____

4. **What kind of responsibilities you have under the RI program**

_____

_____

_____

5. **Tell me a little about RI**

_____

_____

_____

_____

6. **Have you undergone any specific training related to RI, under the program? If yes, when was it and what was the duration?**

II Context and Challenges

1. **Were there any major factors (political, social, economic, technical, and legal) that affected the implementation of RI?**

Political: Lack of government recognition, political structure non-conducive to coordinated action

Social: Communities are non-accepting and/or resistant to the intervention

Economic: Insufficient revenue sources, inadequate funding? Dedicated budget?

Technical: Slow or limited advances of technologies used in implementing program activities, Technological and infrastructural challenges affecting vaccine supply and surveillance

Geographical: Inability to reach population due to difficult terrain, hard to reach population

Any Other: awareness among all stakeholders? Coordinating mechanisms?

2. **How did these changes *hinder* implementation? Did you used any strategies to address the challenge?**

3. **Were there any health system factors that affected implementation of RI? For example, changes to service delivery, health workforce shortages, heavy Workload? How did these factors affect implementation? Did you used any strategies to address the challenge?**

4. Were there any Operational challenges that affected implementation of RI Program? For example? Logistical challenge? Did you used any strategies to address the challenge?

5. Were there any challenges related to process of Program Implementation that affected implementation of RI?

Planning: Implementation schemes/methods not planned in advance

Execution: Failing to carry out activities according to plan due to accountability mechanism, environment disruption, geographical challenges

Engaging: Difficulty identifying appropriate stakeholders to engage given diverse administrative structures, cultural norms • Community mistrust

Reflecting & Evaluating: Difficulty monitoring program progress and quality, including lack of regular debriefing about progress and experience

PART III B. Provider Interaction – ANM

I. Demographics

1. Age: _____Yrs

2. Current affiliation and designation: _____

3. आप राष्ट्रीय टीकाकरण कार्यक्रम के अंतर्गत क्या कार्य कर रहे है? / What work are you doing under the National Immunization Program?

_____

_____

_____

4. इस कार्यक्रम के बारे में आप क्या जानती हैं? कुछ बताएं।/ What do you know about this program? Tell me something

_____

_____

_____

_____

5. इस कार्यक्रम के अंतर्गत क्या सहयोग प्रदान करतीं हैं? (MCHN/VHND गतिविधियाँ, ड्यू लिस्ट, टीकाकरण के प्रति जागरूकता आदि पर चर्चा करें।)/ What support do you provide under this program? (Discuss MCHN/VHND activities, due list, immunization awareness, etc.)

6. आप का इस कार्यक्रम में और क्या योगदान रहता है? / What is your contribution to this program?

7. इस कार्यक्रम के कार्य में आपको कभी कोई कठिनाई महसूस होती है? अगर हाँ तो ज्यादा विस्तार में बताएं।/ Do you ever find any difficulty in working with this program? If yes, then tell in more detail.

8. How do you get the vaccine? What are the system associated challenges you usually observe when receiving the vaccines and other supplies? Time? Access? Transportation?

9. इस कार्यक्रम को और बेहतर करने के लिए आप क्या सुझाव देंगे? / What suggestions would you give to improve this program?

CAPSTONE PROJECT

Interview With ASHA/ANM/AWW Working In the Community/ समुदाय में कार्यरत आशा/एएनएम/आंगनवाड़ी कार्यकर्ता के साथ साक्षात्कार

CONSENT FORM/ सहमति पत्र

Introduction: I am _____, a student of IIHMR University, Jaipur. This is a university where I am currently enrolled as a Master of Public Health (Implementation Science) student. This interview is a part of my Capstone project which is needed to be completed for course curriculum. My capstone topic is _____. The purpose of this interview is to determine the work done by the ASHA/ANM/AWW working in this community on the health program _____. I am going to ask you a few questions. Your participation in this interview is completely voluntary. You may choose to not answer a question at any point during the interview. You can ask me to repeat the question if you come across anything which may be confusing. There is no to minimal risk for you if you decide to participant in the study. Your name and personal information will be kept confidential and will not be revealed to anyone else other than the person conducting this interview. In case of any query, you may reach me at _____.

परिचय: नमस्ते। मेरा नाम _____ है, और मैं आईआईएचएमआर यूनिवर्सिटी, जयपुर का छात्र हूं। मैं इस विश्वविद्यालय में मास्टर ऑफ पब्लिक हेल्थ (इम्प्लीमेंटेशन साइंस) का छात्र हूं। यह साक्षात्कार मेरी कैपस्टोन प्रोजेक्ट का एक हिस्सा है जिसे पाठ्यक्रम के लिए पूरा करने की आवश्यकता है। मेरा कैपस्टोन विषय _____ है। इस साक्षात्कार का उद्देश्य इस समुदाय में स्वास्थ्य कार्यक्रम _____ पर काम करने वाली आशा/एएनएम/आंगनवाड़ी कार्यकर्ता के काम को समझना है।। मैं आपसे कुछ सवाल पूछने जा रहा हूं। इस साक्षात्कार में आपकी भागीदारी पूरी तरह स्वैच्छिक है। आप साक्षात्कार के दौरान किसी भी समय किसी प्रश्न का उत्तर नहीं देना चुन सकते हैं। यदि कोई ऐसा सवाल हो जो आपको समझ ना आये, तो आप मुझसे प्रश्न दोहराने के लिए कह सकते हैं। यदि आप अध्ययन में भाग लेने का निर्णय लेते हैं तो आपके लिए कोई जोखिम नहीं है। आपका नाम और व्यक्तिगत जानकारी गोपनीय रखी जाएगी और इस साक्षात्कार को आयोजित करने वाले व्यक्ति के अलावा किसी और के सामने प्रकट नहीं की जाएगी। किसी भी प्रश्न के मामले में, आप मुझसे _____ पर संपर्क कर सकते हैं।

I_____*(agree/disagree)* to take part in this study.

मैं इस अध्ययन में भाग लेने के लिए _____(सहमत/असहमत) हूँ।

Date/ दिनांक: _____ Signature of participant/ प्रतिभागी के हस्ताक्षर:_____