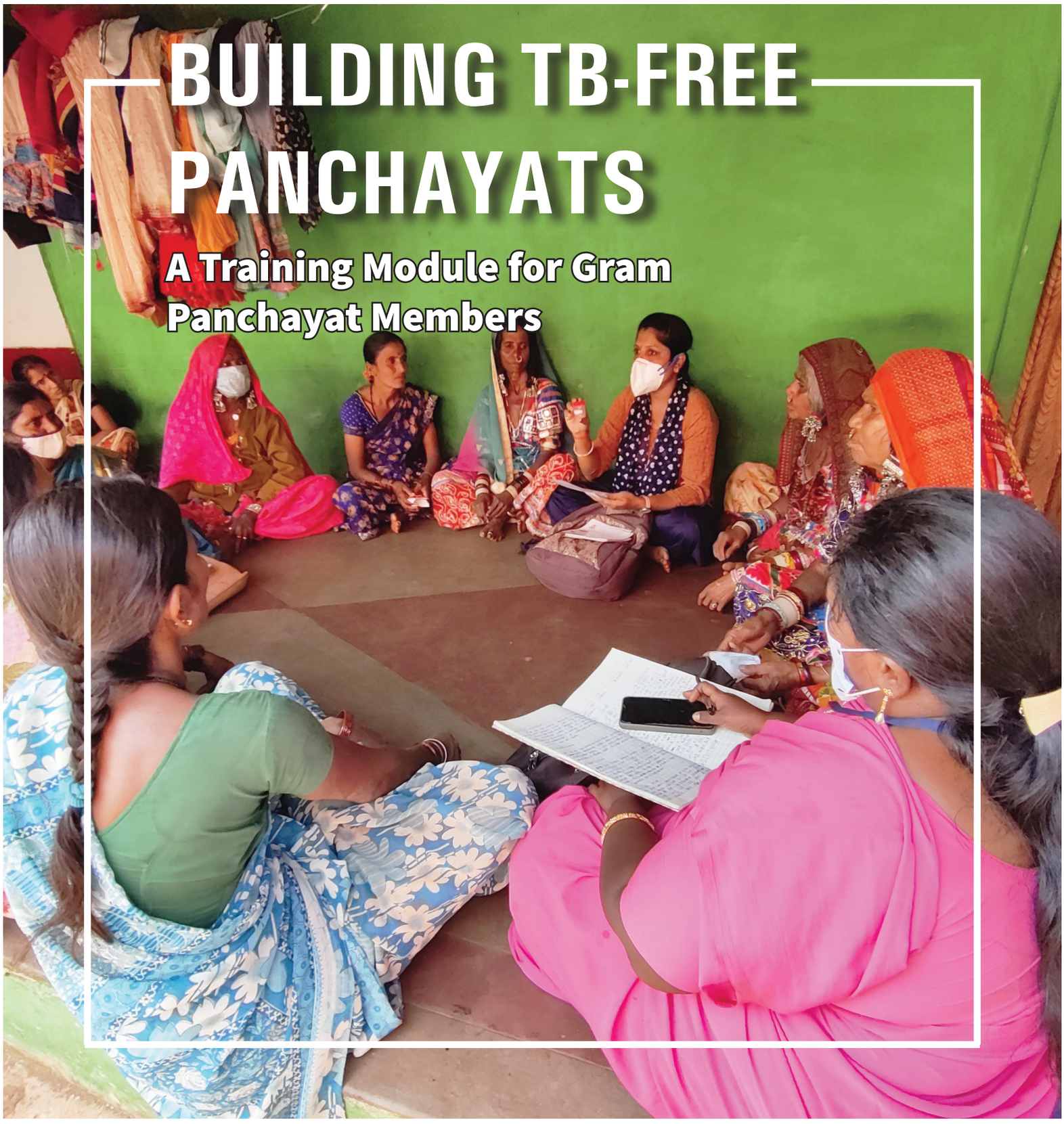
सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

BUILDING TB-FREE PANCHAYATS

A Training Module for Gram Panchayat Members



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NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME

NATIONAL HEALTH MISSION
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KHPT
engage, innovate, empower

ACKNOWLEDGEMENTS

We would like to acknowledge the support of various stakeholders who helped us conceptualize this module and engage with Gram Panchayats to build their understanding of TB and their role in sustaining TB control at the grassroots.

We would like to thank officials of the National Tuberculosis Elimination Programme and the State Tuberculosis Office, Karnataka,whose inputs and encouragement helped us shape this module and pilot it on the ground. We are grateful to the United States Agency for International Development (USAID) for their support in the development and implementation of this module. We appreciate greatly the support of the Gram Panchayat leaders who participated wholeheartedly in the training and whose valuable inputs helped us to make the module more user-friendly. We also acknowledge the significant efforts of the KHPT project staff, including the District TB Leads,Taluka Coordinators and TB Volunteers, who helped in the successful pilot of this module.

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Disclaimer
This module is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of KHPT and do not necessarily reflect the views of USAID or the United States Government.

Sri K.S. Eshwarappa
Honourable Minister
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Government of Karnataka

Dr K. Sudhakar
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Government of Karnataka

Foreword

The Government of India, in its National Strategic Plan for Tuberculosis Elimination (2017-2025), has identified the Panchayats as playing a key role in the prevention and elimination of Tuberculosis (TB).

Programs such as active case finding have been designed to reduce the burden of TB, with the aim of achieving a TB-free India by 2025. The state has developed an action plan to make Karnataka TB-free by 2025 through early case detection and the provision of proper treatment, which will make it possible to prevent persons with TB from facing difficult situations caused by delays.

We can bring awareness on TB prevention at the village levels with greater involvement and coordination with Gram Panchayat members, Self-help Groups, and community-level organizations. Messages on early diagnosis, early treatment initiation, reducing stigma and discrimination, encouraging the completion of TB treatment, as well as supporting persons with TB to get nutritional foods can play a major role in TB elimination and creating a supportive environment for persons with TB.

KHPT and the United States Agency for International Development (USAID), have been supporting the Rural Development and Panchayat Raj Department of the Government of Karnataka to implement the Graama Panchayath Arogya Amrutha Abhiyaana (GPAAA) along with the Gram Panchayat Task Forces and Health and Wellness Centres in the state.

To support this initiative, KHPT has developed this training handbook on developing a TB-free Gram Panchayat. This will help to train Gram Panchayat members and make them part of the TB-free India campaign.

With effective leadership and participation at the Gram Panchayat level, we can make our Gram Panchayats TB-free, followed by a TB-free taluk, district and nation. We requested all departments to support this initiative and take necessary actions on the same.

Honourable Minister
Rural Development and Panchayat Raj Department
Government of Karnataka

Honourable Minister
Health and Family Welfare Services
Government of Karnataka

Foreword

The Panchayat Raj system has been implemented to strengthen India with efficient governance at the grassroots through the decentralization of power. The support of local Panchayat Raj institutions like the village panchayat makes it is possible to provide essential health services at village level to all vulnerable and marginalized communities in rural areas through the effective implementation of National Health Mission programs.

India accounts for more than a quarter of the world's Tuberculosis (TB) cases and the Government of India's vision of a TB-free India by 2025 can only be realized with long term strategies with Gram Panchayat involvement, as they are crucial to improve and encourage community participation in TB prevention programs and to activate TB prevention programs at panchayat level. Through these initiatives, village panchayat task forces can greatly contribute timely screening, diagnosis and treatment initiation.

This module, brought out by KHPT, has been piloted in select district in Karnataka and can be adapted and utilized in different contexts to create TB Mukt Panchayats.

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Foreword

Tuberculosis (TB) is a grave public health challenge, with India carrying more than 25 percent of global TB cases. Prime Minister Modi has set an ambitious target of a TB-Mukt Bharat (TB-free India) by 2025. However, nearly 70 percent of India's population lives in rural areas where communities continue to experience barriers in accessing healthcare services, including for TB. Accessing vulnerable communities and increasing uptake of treatment for TB will be critical to achieving this TB-free goal, requiring a focus on vulnerable and hard-to-reach communities.

Since 1998, the United States and India have worked together to combat TB through improved patient-centered diagnosis, treatment and prevention, helping treat more than 15 million people with the disease. The U.S. Agency for International Development (USAID), in partnership with Indian health organizations, supports Prime Minister Modi's goal of TB elimination by improving case detection and treatment success rates, addressing multi-drug resistant TB, and leveraging new partnerships, artificial intelligence, and digital health solutions. Importantly, USAID has developed a gender-responsive TB program that disseminates gender-sensitive messaging and builds the capacities of healthcare workers to address gender barriers to TB detection, diagnosis, and treatment.

Through USAID's 'Breaking the Barriers' project, USAID and Karnataka Health Promotion Trust (KHPT) work with Panchayati Raj structures (PRIs) to test for and treat TB among rural poor, tribal, migrants, and industrial workers. With more than 200,000 PRIs in India, harnessing their power and reach, KHPT and USAID work directly with communities to co-design health programs that improve TB outcomes and foster lasting change. Together, we have developed and implemented innovative and effective behavior change models to increase case notification and improve treatment outcomes in drug-sensitive and drug-resistant TB.

The new module, based on 'Building TB Free Panchayats,' will bring together PRIs and TB redressal forums to ensure inclusion of the most vulnerable and marginalized populations. Trained PRI representatives will be skilled and empowered to adapt programs, reduce resistance, and monitor the quality of care among their communities. Importantly, this model ensures the voices of the community are integrated as part of the solutions, which will increase community ownership and ensure services are tailored to community needs. USAID is hopeful that this model will support Panchayat members to fulfill the TB-Mukt Bharat vision and improve the health outcomes of their communities.

Sangita Patel

Sangita Patel
Director, Health Office
United States Agency for International Development (USAID), India
New Delhi, India
May 2022

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OVERVIEW

Gram Panchayats (GPs) are the centres of village administration, development, and health and family welfare with immense potential to provide decentralized services that can improve the health and well-being of their community. This is achieved by gauging public health needs in rural areas, expanding access to healthcare services and leveraging community networks to realize the rights and meet the needs of the most vulnerable and ignored populations.

Article 40 of the Constitution of India incorporates the principle of autonomous self-rule at the local level. It states that, 'States shall take requisite steps to organise village panchayats and endow them with such powers and authority as may be necessary to enable them to work as units of self-governance'. Panchayats, therefore, are the lowest level of local self-government. Today, India has about 253,400 rural local bodies at the village level Gram Panchayats. There are about 3 million elected representatives of these panchayats, out of which 1.3 million are women. Thus, 70 per cent of India's population is covered through these local governance institutions.

Panchayat Raj Institutions (PRIs) are self-governing units at the rural level, with regular elections and flow of funds through the Finance Commission. The organisational structure of PRIs is such that it ensures representation at state and village level, thereby ensuring representatives at the top and bottom. One of the very effective roles that interventions can play is to intensify coordination between community structures, civil society organisations, self-help groups and PRIs. The core function of the PRI is to focus on sectoral issues of education, health and child-care, water and sanitation and community mobilisation in these primary sectors of development. The PRI has several mandated sub-committees to carry out these functions effectively and convergently.

The Government of India's National Strategic Plan for Elimination of Tuberculosis 2017-2025 (NSP) recognizes the strength of the Panchayats, and emphasizes that "to significantly reduce TB burden... intensified case finding will be one of the most important interventions. National "sweep out TB" / "TB Mukt Bharat" campaigns, which are massive, repetitive, intensive and persuasive, for case-finding and community commitment from the panchayat, districts and states, will become centre-stage in the program." The NSP also highlights the importance of mapping socially and clinically vulnerable populations to intensify TB control among key populations, especially in the rural areas. The Panchayat, therefore, plays a key role in India's vision to end TB in 2025.

By involving the members of GPs, there will be a better understanding of the disease from the community perspective, an impetus for the early detection of cases and early initiation of treatment, community support to enable treatment adherence by reducing stigma, and support to nutrition and treatment completion for better outcomes. Fortifying rural areas by empowering GPs and health functionaries is therefore essential to mitigate existing and emerging health threats like TB, COVID-19 and other Non-Communicable Diseases (NCDs) like hypertension and diabetes.

It is only when decentralized healthcare services reach the underserved in rural pockets of the nation that India can hope to achieve universal access to equitable and affordable healthcare, especially for a disease like TB.

This module has been designed for the use of program staff of national health programs, as well as civil society organizations, to enable Gram Panchayats and allied health structures to optimally utilize the resources available to them and strategically plan their approach to achieving a healthy and TB-free panchayat. It has been piloted in Karnataka under the Graama Panchayath Arogya Amrutha Abhiyaana (GPAAA), a first-of-its kind initiative to usher in new synergy among the Gram Panchayats, communities and the health facilities in rural areas of the state and help create a decentralised convergence model for health between both the demand and supply sides among grassroot communities. The initiative involves the coordination of the Karnataka state departments of Rural Development and Panchayat Raj (RDPR), and Health and Family Welfare (HFW), in collaboration with KHPT.

This module has been designed to be adapted by the National Tuberculosis Elimination Programme in alignment with India's goal of TB elimination by 2025, and has the potential to be scaled up across the country.

NOTE TO TRAINERS

The outcome of any training module or workshop hinges on its trainers, or facilitators, who not only facilitate learning but also create the apt learning environment. The approach a trainer takes to actualize this Module will determine its success and while each trainer has their own preferences and interpretation, certain tips can be universally used to better facilitate training. A few such notes have been shared below.

- Facilitators should ensure that the participants are a fair mix of men, women and other genders from the Panchayat and are aware of and sensitive to their local realities and concerns.
- Further, they should ensure that at least five members from each Gram Panchayat (President, Secretary and 2 to 4 members) are represented in the training along with the Panchayat Development Officer (PDO).
- All participants should be treated equally, irrespective of their position in the GP. Facilitators must be cognizant of and avoid any biases that may enter their workshop due to a participant's hierarchical position.
- An environment of participatory learning and self-reflection should be fostered during the workshop.
- Session durations are suggestive and trainers are welcome to edit these as per their requirement.
- Trainers are requested to read the entire module at least once and the have all training materials and aids (or their substitutes) ready for use before commencing training.
- All sessions follow the same outline;

    Session number and name
    Session objectives (the specific aims of a particular session, for the participants)
    Learning (real world understanding or application from a session)
    Materials required to conduct and/or participate in a session
    Process detailing how a session is to be facilitated, as well as its approximate duration
    Key points to summarize learning

- At the end of the training, trainers should use the self-reflection form in Annexure I, which will help them think back over the session and how they can more effectively use the module in the coming sessions.

AGENDA

Session Name	Session duration	Suggested timings
PART I: SETTING THE CONTEXT FOR BUILDING TB-FREE PANCHAYATS		
Pre-training forms	**10 mins**	**09.00-09.10**
Session 1: Why are we important? Introduction and Valuing Our Unique Selves	**20 mins**	**09.10-09.30**
Session 2: Why the Gram Panchayat? Being accountable for people's wellbeing	**30 mins**	**09.30-10.00**
Session 3: Why do inequities exist? Health Inequities and vulnerable populations	**30 mins**	**10.00-10.30**
Session 4: What do we mean by health? Health as Holistic Wellbeing	**30 mins**	**10.30-11.00**
Tea Break – 15 mins (11.00-11.15)		
Session 5: What is Tuberculosis? Understanding the Basics	**30 mins**	**11.15-11.45**
PART II: WORKING TOGETHER TO ELIMINATE TB		
Session 6: How can we harness the power of people? Communities as Assets and Partners	**15 mins**	**11.45-12.00**
Session 7: Who can help us eliminate TB? Working with Community Structures	**30 mins**	**12.00-12.30**
Session 8: What do we have to do? Working towards a TB-Mukt Panchayat	**30 mins**	**12.30-13.00**
Session 9: Who are our major partners? Working with Allied Structures (HWC, JAS, VHSNC)	**30 mins**	**13.00-13.30**
Lunch break – 45 mins (13.30-14.15)		
PART III: FROM LEARNING TO ACTION		
Session 10: How do we get to better know our area? Contextualizing Training A-Micro Planning	**60 mins**	**14.15-15.15**
SESSION 11: Contextualizing Training B-How do we move forward for TB elimination? Creating an Action Plan For A TB-Mukt Panchayat	**90 mins**	**15.15-16.45**
Closing and post-training feedback	**15 mins**	**16.45-17.00**
Tea (17.00-17.15)		

PRE-TRAINING SURVEY

This survey seeks to assess the level of awareness of GP members (participants) before training, in order to establish a baseline which can be compared against the post-training survey. The purpose of the survey is to only evaluate the effectiveness of Training Module and its activities (and not the members or their knowledge). The survey forms may be given out as soon as the participants come in, even before the start of introductions.

Duration

10 minutes

Process

- Once the participants have been welcomed, share printed sheets of the "Pre Training Form" which can be found under "Annexure A," below.
- Explain to the participants that the forms are completely anonymous and are not an academic test but are intended solely to evaluate the training module.The participants may use their name on the form, but if they are not comfortable, you may use an alternative method to ensure that the pre-and-post training surveys have the same identifier so that one participant's pre and post-training surveys can be compared.
- Once the steps above have been completed, request the participants to fill the form to the best of their abilities and within 5 minutes.
- Collect the filled sheets, after everyone has completed the survey.

Session 1: Why are we important?

introduction and valuing our unique selves

Objectives

To help participants introduce themselves and their roles in the Gram Panchayat

Learning

Each member's unique insight and experience makes the GP stronger and more effective

Materials

A bottle which can be comfortably held in the hands

Duration

20 minutes

Process

- Use "The Bottle Game" for a round of introductions by passing a bottle to any participant.
- Ask them to perform or demonstrate some form of action with the bottle (e.g. using it as a chapatti roller, or as a cricket bat, or as a walking stick etc.), and introduce themselves by sharing their name and role in the GP.
- Congratulate the participant on their innovativeness in using the bottle and ask them to pass the bottle around until everyone has introduced themselves.
- Tell the participants that even though everyone had been given the same object (the bottle) and task (perform an action), each person was unique and thought differently about it and that this uniqueness makes the GP members a very effective team. Further, add that these unique insights and valuable experiences must be respected by everyone involved, in order to function as a strong team at the GP level.

Key points

Every GP member's insight and experience is valuable and makes the GP strong and effective.

Session 2: Why the Gram Panchayat?

being accountable for people's wellbeing

Objectives

- To understand the importance of a decentralized body at the grassroots level
- To establish that the GP is accountable to the people and their wellbeing

Learning

- The GP, being an elected body, represents the entire community
- Every individual of the village and their wellbeing is the GP's responsibility

Materials

- A whiteboard or large flipchart to record responses
- A marker or sketch pen to write responses

Duration

30 minutes

Process

- Narrate the following story to the participants:

"Jamun Tree" or "Jamun Ka Ped" by Krishan Chander, 1961

A great storm occurred last night. A jamun tree fell in the lawn of the Secretariat. When the gardener saw it in the morning, he found that a man was pinned down under the tree. The gardener rushed to the peon; the peon rushed to the clerk; the clerk rushed to the superintendent; and the superintendent rushed to the lawn outside. Within minutes a crowd gathered around the man pinned down under the tree.

"The poor jamun tree, how abundantly it bore fruit," a clerk remarked.

"And how juicy its jamuns used to be," the second clerk recalled.

"But this man," the gardener pointed at the crushed man.

"He must have died. If such a heavy trunk were to fall on a person, how can he survive," the second clerk said.

"No, I'm alive," the crushed man said with difficulty, moaning.

"He should be pulled out quickly by having the tree removed," the gardener advised.

"The gardener is right!" many clerks chorused. "Let's try, we're willing."

"Wait!" the superintendent said. "Let me consult the undersecretary."

At lunch time, a few proactive clerks decided to remove the tree on their own without waiting for the decision of the government when the superintendent came running with the file and said, "We on our own cannot remove this tree from here. We are linked to the Trade Department and this is a matter concerning a tree which comes under the care of the Agriculture Department. Therefore, I am marking this file as urgent and sending it to the Agriculture Department. As soon as we receive their response, this tree will be removed."

The next day, the Agriculture Department replied that the tree had fallen in the lawn of the Trade Department, therefore the responsibility of removing the tree or not rested with the Trade Department. The file kept shuttling on the second day as well.

On the third night, a gardener fed rice and pulses to the crushed man. The gardener told the crushed man, "Your file is moving and has been sent to a sub-committee of the Secretariat, hopefully by tomorrow there will be a decision."

The crushed man slowly recited Ghalib's verse with a sigh, I accept that you won't ignore me but; before you hear of my sad plight, I would have died)."

The gardener put his hand over his mouth in amazement, "Are you a poet?"

The crushed man slowly nodded his head.

The next day the gardener told the peon and the peon told the clerk. When it was known that the crushed man was a poet, the sub-committee of the Secretariat decided that since the crushed man was a poet, his file was related to the Culture Department. The Culture Department was requested to decide the matter.

The file reached the secretary of the Literary Academy. The secretary at once went to speak to the man and found that he was a famous poet! Excited, he asked if he was a member of the Literary Academy. The man said he was not.

"Strange!" the secretary exclaimed. "What a mistake we have committed, such a great poet and how he is crushed by obscurity!"

"Crushed by a tree, not by obscurity! Please pull me out from under this tree."

"I will make arrangements presently!" the secretary said and reported to his department immediately.

The next day, the secretary came running to the poet and said, "Congratulations! Our official academy has chosen you to be a member of its central committee!"

"But first pull me out from under this tree," the crushed man said with a groan. He was breathing with great difficulty.

"We have written to the Forest Department, flagging it as urgent," the secretary said.

On the sixth evening, the superintendent himself brought the file to the poet. As soon as he arrived, he shouted, waving the file, "The tree will be cut down! The Forest Department men are here with their saws and axes! Do you hear? Your file is complete today!"

But the poet's face was lifeless, and a long line of ants was going into his mouth. The file of his life had also been completed.

Translated from Urdu by Raza Naeem (abridged)

- After narrating the story, facilitate a self-reflective discussion with the help of the following questions and statements:
- Do you think that these kinds of situations really occur in real life? If so, can you share some examples from your experience?
- Keeping in mind the responses you get, ask the participants:
    - If any incident or mishap occurs in your community, who do you think should be responsible for correcting or fixing it?
    - Imagine that in your village, everybody has contracted a disease and one important family member has died. Who will this death impact? If all young people die, who will it impact? If all women die, who will it impact the most? Lastly, how would something like this impact the panchayat?
- Record and consolidate the responses on a whiteboard or flipchart and conclude this chain of discussion by pointing out that it is the people, who are every panchayat's main resource.
- Next, continue the discussion by asking the following questions:
    - Do you agree with this conclusion? Who do you think should be responsible for protecting this resource?
    - Why does this resource (i.e. people) elect a group of individuals (i.e. the Gram Panchayat)?
- Record and consolidate the participants' responses and conclude this session by stating that it is the duty of the GP to protect its people, and it is the right of the people to expect this from the GP because they are the ones who have elected the participants or GP members.

Key points

- Ensuring the safety, health and wellbeing of the people is the most important responsibility of the panchayat.
- As a decentralized body, it is the GP's responsibility to take relevant and appropriate measures for people's health and wellbeing.
- The GP is answerable to all sections of the community and it cannot transfer the responsibility of people's health and life to anyone else.

Session 3: Why do inequities exist?

health Inequities and vulnerable populations

Objectives

- To cultivate an awareness and understanding of inequity in the community, especially in accessing healthcare
- To understand how discrimination causes poorer health outcomes

Learning

- Discrimination and oppression of various kinds and at multiple levels exist everywhere, and identifying and remedying it is crucial for improving a GP's health

Materials

- Small paper balls along with a basket or bucket
- A whiteboard or large flipchart/chart paper to record responses
- A marker or sketch pen to write responses

Duration

30 minutes

Process

- Begin by asking the participants, "Are all the people in your community the same? What are some of the differences you can see?"
- Request the participants to share their observations and record them on a whiteboard or chart paper.
- Once done, inform the members that they will now be playing a game. Request for five or six volunteers from among the participants. Conduct the game by using the instructions below:
    - Ask the volunteers to sit one behind each other, in a queue and give each of them a small paper ball.
    - Place a bucket or a basket at a small distance in front of the first participant and instruct all the volunteers to throw their balls into the basket/bucket, one by one. (The ones sitting further away from the bucket will have more difficulty getting their ball into the bucket.)
    - Ask the participants, "Why is this happening? Why are the participants at the back having more difficulty completing the task?"
    - Elicit responses until the long distance from the basket (compared to those in the front of the queue) is mentioned.
    - Highlight this response and begin drawing similarities between the volunteers in the queue and community members/villagers with the help of the following points:

- Explain to the participants how "some people are closer to the basket and have more access to healthcare, while others, do not, due to various vulnerabilities (like age, financial constraints, lack of transportation, lack of caretaker or friend/family member who can accompany them to health facilities etc.)."
- Add that "there are also external factors and situations, and lack of correct information which can prevent certain people from accessing healthcare. Further, people who have power often also have better access to all kinds of services, whereas members of the oppressed castes and economically weaker sections such as women and the transgender community are often marginalized."
- Lastly, summarize by stating, "the privileged, by virtue of caste, class, profession, education and gender are usually positioned to have better access to services and schemes. Those who are marginalized are the ones who require and benefit from such schemes more, but often face numerous barriers in accessing them."

- Expound on this actuality further by providing relevant, real world examples that most participants would have seen or felt around them. For instance, how people with financial and social capital (money and social connections), which are often generational, receive better services at shops and government offices. Similarly, the participants may have found public transportation services to be far better in an upper-caste village and this could be an example of caste-based discrimination and its resulting power imbalance.
- Lastly, explain how this discrimination affects an individual's health by creating inequity.

- "Imagine the condition of a widowed woman living with her son and his family. Her access to anything, from food to clothing and healthcare is determined by her son. If she has a cough for two weeks, she may be unable to go to a healthcare facility because her son works all day, and she has no one else to take her. When the ASHA visits the house and accompanies her to the facility, it is then that she is tested with TB. When the family finds out, they are very upset. They immediately move her belongings to a separate room and forbid contact with her grandchildren. Her son and his wife have daily fights; his wife is being isolated by the other women in the community because her mother-in-law has TB. His wife wants him to send her away. Deprived of any family support, the widowed elderly woman stops taking the treatment, thinking that there is no point in living like this any more. She has no one to turn to for support."

- Conclude by saying,
- "Like this woman, some individuals may already be bearing the burden of such vulnerabilities and marginalization, and having diseases like TB, COVID-19, or diabetes only compounds their struggles and ill health. Such cases need support, and it is the GP who is well positioned and best suited to reach out to them. Therefore, it is the GP's responsibility to seek out and support individuals who may be deprived and underserved, and help them access services to improve their health and quality of life."

Key points

- Our communities and society are not yet equitable. In other words, certain groups of people do not have the power or capacity to access and demand for services like other, privileged groups do.
- As leaders, GP members need to prioritize those people/communities who are overlooked and denied access to services.
- Active participation from these underserved groups in GP planning should be facilitated and promoted to ensure that they are not disenfranchised or silenced, and are instead, empowered.
- The risk of contracting diseases like TB is higher for certain groups of people who are endangered due to their occupation, gender, financial conditions, pre-existing health conditions and habitation. The subsequent burden of any disease is therefore much higher as well. However, highlighting and planning around health and social inequity during a GP's planning, is a positive and critical step in remedying such inequities.

Session 4: What do we mean by health?

health as holistic wellbeing

Objectives

- To foster a multidimensional understanding of health that goes beyond simply being disease-free

Learning

- Health is holistic wellbeing
- A healthy GP is free of stress/fear, discrimination, poverty, malnutrition, abuse and disease

Materials

- Flipchart with illustrations listed in Annexure B
- A whiteboard or large flipchart/chart paper to record responses
- A marker or sketch pen to write responses

Duration

30 minutes

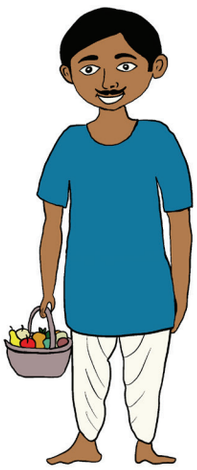
Process

- Begin the session by showing the participants six illustrations on the flipchart (also listed in Annexure B for reference). Introduce the illustrations by saying, "Let's look at six illustrations which depict six different situations that our community members could be in."
- Show only the negative illustration, one at a time and ask the participants to identify the issue/condition/situation in that illustration.
- After acknowledging participants' responses, show and describe the corresponding positive illustration by adding, "this person is disease-free/stress-free/discrimination-free/poverty-free/malnutrition-free/abuse-free."
- Move from one illustration to the next until all six issues have been covered.

Disease-free

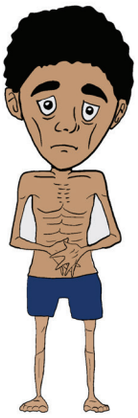
Stress/Fear-free

Discrimination-free



Poverty-free

Malnutrition-free



Risk-free (conflict-free and abuse-free)

- After the illustrations have been shown, ask the participants to choose the condition or situation which they think is most important to address out of the six visuals and their reasons for their choice. List some of their responses on a whiteboard or chart paper.
- Next, pose the following question: "What if you could focus on all of the six conditions at once? Do you think that is possible? Do you think this would help to create a healthy GP?" Proceed to the next step even if there is no response from the members.
- Answer the question from the last step by saying, "it is, in fact, possible to focus on all issues and that is the ideal situation." Give them an example of any person, a man of woman to show how the interplay of several factors can lead to a healthy or unhealth population.

For example, if a man's workplace asks him to leave his job because he has TB, this stigma at the workplace can lead to socio-economic consequences for his family as he cannot earn a livelihood and take care of his family. This can lead to mental health issues such as depression, and lead him to give up trying to take his medication. As a result, the man gets sicker, his children have to drop out of school, and there is a lack of food security in the family.

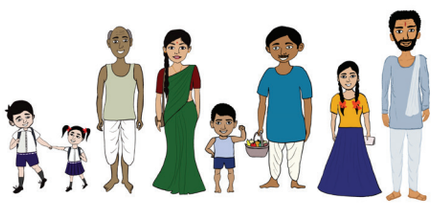
On the other hand, a supportive employer and colleagues in a non-judgemental environment would encourage the man to seek support to complete his treatment. After a few weeks of treatment, he would feel better and rejoin his work and be able to provide for his family. He would be able to afford nutritious food to help his own recovery.

Similarly, a married woman diagnosed with TB could be stigmatized by her family. She could be separated from her children and sent back to her parents' house. The separation of children from their mother could affect their well-being. Their mother, ashamed by the discrimination, could just give up her treatment and risk the health of her own parents. However, if there is an intervention from a panchayat member or an ASHA, or a member of local community structure, the woman's husband could be counselled on TB and encouraged to support his wife rather than break up his family.

The absence or lack of a supportive environment, access to healthcare, and opportunities for care and support, can lead to a non-supportive environment, which affects the health of people and their families.

Reiterate by saying, "A healthy GP is a GP that is free of disease, stress, stigma and discrimination, poverty, malnutrition and abuse!"

- End the session by saying, "Health is holistic wellbeing. A healthy panchayat is a panchayat whose people are physically, mentally, emotionally and socially strong, and where the environment is supportive and encouraging, and gives the people opportunities to grow, develop and flourish. Especially if there are persons with diseases like TB or any other infectious disease, the GP has a role to play in ensuring their overall wellbeing. I am sure you all want a healthy GP, don't you?"



Key points

- There are several factors that contribute to the overall health of communities, such as family support, community support, apart from access to health facilities and services.
- Understanding health holistically, as a multi-dimensional concept is important to make GPs healthy in a true and meaningful sense.

Session 5: What is Tuberculosis?

understanding the basics

Objectives

- To understand the basics of TB and the experience of a TB patient who receives support from the Gram Panchayat and community

Learning

- TB is a communicable disease, but with the right drugs at the right dosage taken for the right period of time, it is curable.
- As the closest level of governance to the people, the GP's role is most crucial in mitigating these threats

Materials

- Flipchart on the Basics of TB (see Annexure C)

Duration

30 minutes

Process

- Begin the session by asking the participants, "With all this background, where do we start? Before we can aspire towards a TB Mukt Panchayat, shouldn't we know more about the basics of TB?"
- Facilitate an informative and reflective discussion on TB and the role of Gram Panchayat members, by narrating the story of "Rajappa" In Annexure C

Rajappa is a daily wage labourer, being treated for Tuberculosis.

The frontline health worker contacted a GP member of his village to explore nutrition support.

- Narrate the story till the point where the Community Health Worker (CHW) discusses the problem with the GP member.
- Now, ask the following questions to the participants?

- How do you think, the GP member would react to such a request?
- Should the GP member even get involved in such a matter? Shouldn't this be the responsibility of the Health Department?

The GP member discussed Rajappa's problem in the GP meeting and urged the President to grant some amount from the un-tied fund for Rajappa's nutrition during his treatment period.

Ramaiah the GP member also invited Rajappa to the GP office to receive some collected ration from the members. But Rajappa hesitates and refuses to go over there.

This nutrition support helped Rajappa to recover adequately and completed his treatment successfully.

Rajappa not only recovered, but also regained his confidence in life and went back to work.

- What are the ways in which the Gram Panchayat can help Rajappa?
- Do you think the GP member should have knowledge or information about TB? If you all feel that GP members should have knowledge about TB, then, can you share what you know about the disease?

- As the participants respond, encourage a discussion within the group, and tell them they are free to respond any way they wish. There is no 'incorrect' answer. However, it is important to encourage people to share their points of view, and gently explore why they may respond negatively about helping patients.
- Then use the presentation to show how the GP can actually help the patients.
- Use the presentation to ask the following questions. Take two-three responses for each question before using the presentation to answer the question.

- How does TB spread? What are its symptoms?
- Who is most vulnerable to TB infection?
- How is TB diagnosed? What are the tests for TB?
- How is TB treated?
- Can TB be cured?
- What is a big barrier to treating TB? (STIGMA should be the answer)

- Tell the participants about schemes for which TB patients are eligible at national and state level. TB patients are eligible for Rs 500 per month during the period of treatment for nutrition support under the Nikshay Poshan Yojana from the Government of India. TB patients in tribal areas are also eligible for Rs 750 support towards transportation costs. Some states offer TB patients food baskets and other benefits.
- Ask the participants whether they have any further questions on TB? Have they doubts on the information that has been shared?
- Emphasize the point that TB can happen to anybody regardless of their caste, community, creed and occupation, even as some populations are more vulnerable to developing the disease. It is important to clarify that TB is curable, with the right dosage of the right drugs taken for the right duration of time. It is extremely important that TB patients complete their full course of treatment, and to support them to do the same.

Key points

- Nearly all villages in the country are dealing with major health challenges, of which the most common are diseases like TB and COVID-19.
- The GP's role in ensuring health and wellbeing of its community includes being aware of common health threats, as well as being well versed with their symptoms, tests and treatment options.
- These diseases are not only physically challenging but also impact the social and mental health of patients and care givers. The GP's work is therefore even more crucial in mitigating the effects of these health threats and creating a stigma free environment for patients and their families.

Session 6: How can we harness the power of people?

communities as assets and partners

Objectives

- To understand the power of the community in finding solutions

Learning

- An empowered community is the best asset for the GP. Taking their inputs and encouraging their participation will be useful to the GP to achieve the goal of a healthy panchayat

Materials

- Flipchart with images in Annexure D
- A whiteboard or large chart paper to record responses
- A marker or sketch pen to write responses

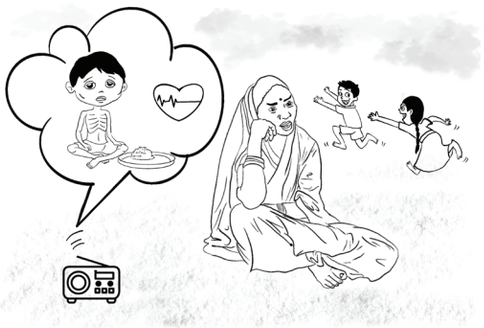
Duration

15 minutes

Process

- Project the presentation on "Community Involvement", and narrate the following, real life story:

Once, in a small village in Tamil Nadu, an old woman was listening to her favorite songs on the radio.



After the songs, the news broadcast came on and began announcing the day's news. The radio blared, "New government data shows that India's children are suffering from serious malnutrition due to lack of nutritious food!" The old woman got worried and looked at her grandchildren and their friends, who were running around with big smiles. When she looked at them carefully though, she grew concerned.

The next morning, like every morning, she went to the milk booth to deposit milk from her cows, like all the other villagers who were standing in a queue, waiting their turn. However, she stopped near the booth and placed a small table next to it. The villagers standing in the queue were amused. "What are you doing amma?" one of them asked. She told them to wait a few minutes.

Then, next to the small table, she placed a big, empty milk canister and finally on the table, she placed a glass full of milk and a placard which said, "FOR OUR CHILDREN."

She then proceeded to put some of the milk from her cows into that empty canister.

The other villagers were still confused! "Why is she putting milk there, instead of depositing it to the booth?" The old lady explained, "Our kids need our help! They may have big smiles on their faces but do they have enough nutrition in their bodies? If we each put even one or two glasses of our milk into the canister for our kids, it won't make much of a difference to us. But, it will make a huge difference in our children's health and wellbeing!"

The people there now understood. They too had heard the news on the radio and noticed their children. Everyone happily agreed to donate one or two glasses of milk every day for the children.

Soon, someone noticed that they could spare a few eggs every day too! So, they put another table with a basket for eggs, next to the milk.

The children grew healthier with the help of this nutrition that the entire village had come together to provide. Soon, word spread around about this novel initiative and government officers came down to see its success for themselves. They were very impressed by the way the community had come together to help their children. Without this daily nutrition, they were at a risk of becoming severely malnourished! From the village, the idea spread to the taluk and later to the entire state and thus, the Midday Meal Scheme was born!

- Give the participants a few minutes to reflect on the story they just heard and ask them what their learning or takeaways were.
- Facilitate a discussion and conclude the story by saying, "People are powerful. If the community wants to change something, they can. So, working with people will always help us find solutions to problems."
- Add that "As a GP, we must also work with our local villagers in order to reach more people with all the services, reach the unreached communities in the panchayat and create a supportive atmosphere for all health-related activities. The more support we have from the local community, the more successful our program will be.

Key points

- The community is intelligent and it can not only identify the problem but also generate solutions.
- The community is the GP's strength. Taking their inputs and encouraging their participation will be useful to the GP to achieve its goals.

Session 7: Who can help us eliminate TB?

working with community structures

Objectives

- To map the different community groups that the GP can work in within their respective areas
- To identify the key informal and formal community structures or groups that the GPs can work with

Learning

- Reaching out to people through local community groups is more efficient than simply targeting individuals as GPs work towards TB elimination.

Materials

- A whiteboard or large chart paper to record responses
- A marker or sketch pen to write responses

Duration

30 minutes

Process

- Ask the participants, now that we have seen the power of the community to generate solutions, do you think that they can help us achieve the goal of TB elimination?
- Next, ask the participants, "Are there any different groups the village community may be a part of? What are the names of some of these groups?"
- Brainstorm with the participants and collate their responses on a whiteboard or chart paper. These responses could include Self-Help Groups, MNREGA groups, caste groups, entertainment groups, youth groups, farmers' unions, labour unions, School Development and Monitoring Committees (SDMC) etc.
- Then ask them the following questions and have a short discussion. Listen to their responses and list them down:
  - Why will the community groups be motivated to partner in this effort?
  - How do you see them contributing towards TB control efforts?
  - What are the steps that need to be involved for engagement of these community groups?
- After the discussion, tell the participants that instead of targeting individuals, the GP must work with groups who are comprised of members from the village community itself, and therefore reach more people, especially populations vulnerable to developing TB, with less effort. Further, by working with these groups, the GP will enjoy the support of communities and be trusted. It is important to engage with structures that already have a welfare mandate, a good reach and connect with vulnerable populations, and which have access to resources for such efforts.

- End the discussion by stating that the Government of India and state governments have recognized the importance of community participation to end TB. Many community groups/structures have joined in the Jan Andolan, a mass people's movement to end TB. In many states, Self-Help Groups, Youth Associations, Labour unions and faith-based groups are coming together to make their communities aware of TB, refer them for testing and support them through their treatment period by preventing stigma from the community, helping them access government schemes and even mobilizing support locally. The more community structures we engage with, the faster we will be able to achieve our vision of a TB-free panchayat.

Key points

- Community groups are valuable assets to partner with for TB elimination. In many cases, vulnerable community members are part of informal and formal groups like SHGs, MNREGA groups, Dalit associations, youth groups etc, which are influential and trusted by them. The GP can take the support of these groups to reach underserved communities.
- Community structures have played a significant role in the Government of India's Jan Andolan against TB in many states, and can have a significant impact on raising awareness, supporting patients and caregivers, all of which contribute to a TB-free panchayat.

Session 8: What do we have to do?

working towards a TB-mukt panchayat

Objectives

- To understand the role of the Panchayat leadership in TB elimination
- To understand the potential activities that can be conducted to fulfill these roles

Learning

- GPs can carry out a range of activities for TB prevention, care and support and stigma mitigation.
- GPs must plan their activities according to the needs of their communities

Materials

- A whiteboard or large flipchart to record responses
- Markers or sketch pens of different colours to write responses
- Annexure F (TB Mukt Panchayat)

Duration

30 minutes

Process

- Ask the participants what activities they can undertake to make their panchayat TB-free.
- Start listing them down in different columns using different colour markers
  - One colour for prevention (this will include awareness activities referrals etc)
  - One colour for care and support (patient support, fund mobilization, service linkages, schemes, multi sectoral collaboration etc)
  - One colour for stigma mitigation (special events and meetings, unique efforts any)

Explain the colour-coding to them after the initial listing and ask them if they can think of more activities under each of these categories. Mention that some activities can serve multiple purposes, for example, counselling caregivers about TB and the importance of supporting their loved ones with TB can serve two purposes. One, it will help them care for and support the person with TB better, enabling them to do complete treatment and make a full recovery. Secondly, it will help mitigate the stigma and discrimination against the TB patient from the family themselves.

- Congratulate them on their wonderful suggestions that align very well with what the guidelines say and run them through a simple table of their key roles listed in the TB Mukt Panchayat guidelines. Mention that these guidelines should not limit them, and they should plan their activities in alignment with what the needs of their communities are.

- Creating awareness on TB
- Helping reduce stigma and discrimination towards TB
- Identifying SHGs, TB champions and other community leaders and involve them in TB-related activities
- Ensuring regular contact with the community, TB patients cured and currently on treatment through identified responsible person
- Encouraging self-referral of people with symptoms to the nearest public health facility
- Supporting TB patients with social and livelihood schemes and ensuring treatment adherence among diagnosed TB patients
- Support community-led advocacy
- Supporting de-addiction activities for alcoholics and smokers among persons with TB
- Keeping a track of cross border migration among TB patients and migrants are provided with clinical and social support

Key points

- The Gram Panchayat can carry out numerous activities related to TB prevention, patient care and support and stigma mitigation in alignment with TB Mukt Panchayat guidelines. However, it is important to plan activities according to the needs of the community, and involve community structures in the same.

Session 9: Who are our major partners?

working with allied structures (HWC, JAS, VHSNC)

Objectives

- To establish that the GP is the converging point for every health-related response, service and demand
- To identify and explore the existing allied health structures and their objectives, duties and organization
- To understand existing social schemes for TB patients

Learning

- The HWCs, JASs, and VHSNCs, each with their own functional organization, serve as crucial support providers for the GP
- The GP can coordinate between these healthcare systems to ensure beneficial convergence of these resources at the village level

Materials

- A whiteboard or large flipchart to record responses
- A marker or sketch pen to write responses
- Annexure G ("Understanding Allied Health Structures: HWC, JAS, VHSNC")

Duration

30 minutes

Process

- This session explains the roles, composition, targets and mandated services of three supporting health structures which are available to a Gram Panchayat; Health and Wellness Centres (HWCs), Jan Arogya Samitis (JAS), Village Health Sanitation and Nutrition Committees (VHSNC).
- Begin the session by asking the participants about these structures by saying, "If we are going to work on TB and allied socioeconomic issues mentioned in the previous sessions, we would need some support systems. We already have some really good individuals, support systems and structures. Can you name a few that come to your mind?"
- Record the responses on a chart paper or whiteboard that can be seen by everyone. List all responses which seem relevant to realizing or implementing health initiatives with the GP or village.
- Ask the members to group these as either "Individuals" or "Structures." Mark the responses or re-group them as either of the two categories.
- Highlight the three aforementioned structures (HWCs, JAS, VHSNC) from the list of responses. If any of these three structures have not been mentioned by the participants, then add the missing structures to the list.

- Form and explain the links between responses under the "Individuals" category and those under the "Structures" category. For example, ASHAs are an individual component of the HWCs and the Medical Officer-in-Charge of the HWC is the Member Secretary of the JAS and is therefore both a part of the HWC as well as the JAS. Use the information under "Annexure F" ("Understanding Allied Health Structures: HWC, JAS and VHSNC") to carry out this step.
- Further, show the linkage between these structures and the GP by drawing a visual on a whiteboard or chart paper with "Gram Panchayat" at the center and the structures around it, along with their corresponding individual members (Figure 00, below). Explain to the participants, how the GP has been provided with these numerous support systems to help its members carry out their roles and make their village healthy. Emphasize the point that the GP is the converging point for every health-related response, service and demand.

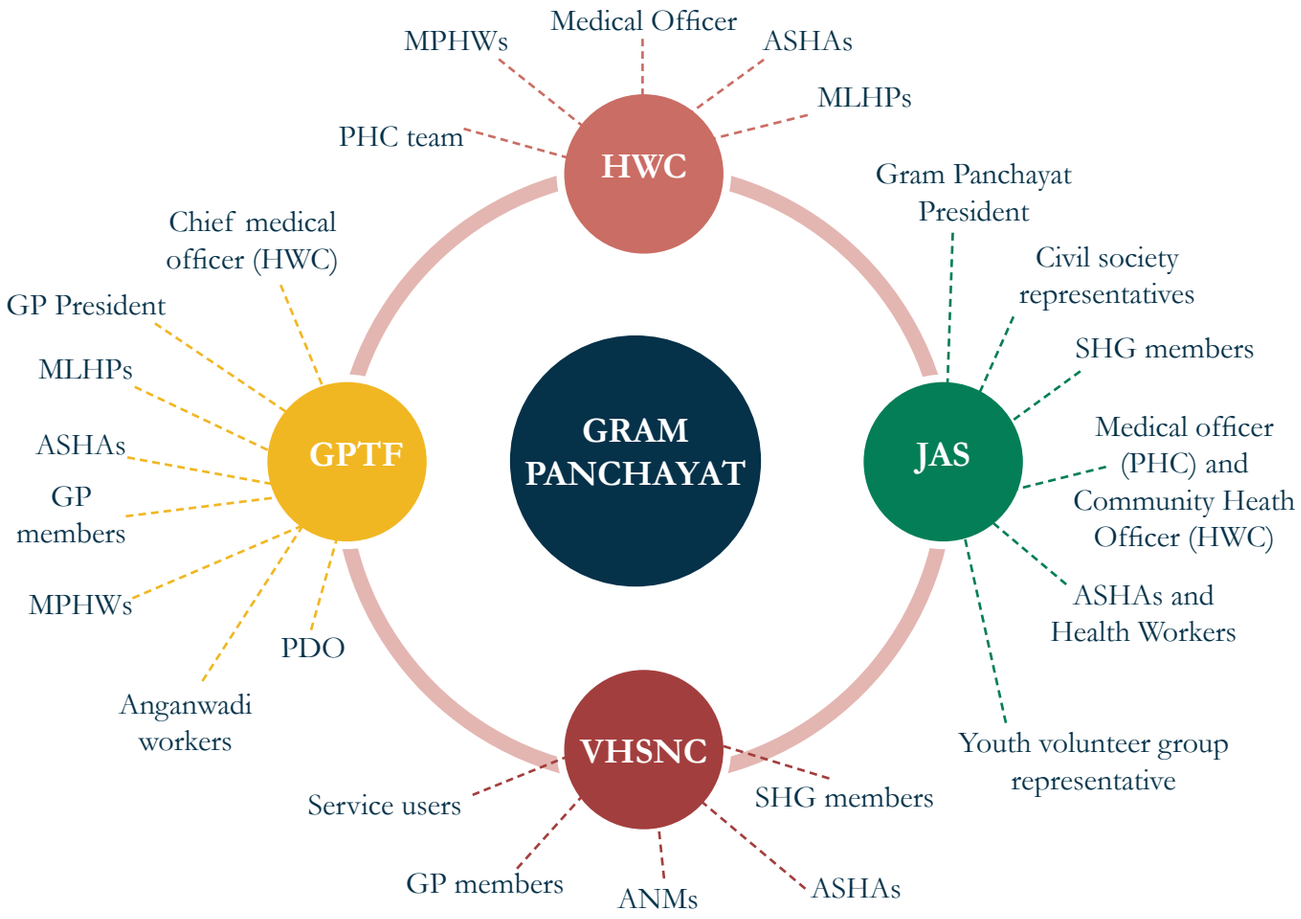


Fig. 2: Example of graphic showing allied health structures and individuals

- Lastly, conclude by adding that the allied structures are support systems given to the GP by the government to ensure the physical, mental and financial health of its people.

Key points

- GPs can leverage and streamline the various existing systems and individuals of HWCs, JAS, VHSNCs and to provide a comprehensive response to any and all health concerns of the people.
- GPs should identify potential opportunities for the involvement of allied structures to end TB, in collaboration with the community groups mentioned earlier.

Session 10: How do we get to better know our area?

contextualizing training a-micro planning

Objectives

- To assess and document village demography, health and resource availability
- To understand the process of micro-planning

Learning

- Microplanning tools can be used to create actionable plans for a TB-free Panchayat

Materials

- A whiteboard or chart paper
- A marker or sketch pen

Duration

60 minutes

Process

- Begin the session by introducing micro-planning to the participants. You may do this by using the following instructions:
  - Let's create a micro-plan of your village with the information that you already have. We will first map all the resources our village has and then create a plan later.
  - A resource map will help us gather information on specific social, monetary and geographical resources, along with their information on their access. We can then use this information to plan initiatives or create smaller goals and plans for our GP.
- Next, divide the participants according to their GPs and ask them to create a map of the resources that are available in their villages, as well as other indicators, by saying:
  - Now, the first thing we need to do, is to formulate a social resources map. We can use symbols for certain resources from our village, like houses, water sources, health facilities/ services etc. to create this.
- Share the list of indicators and mapping tips given below with the participants. They should first attempt to visualize and draw a map of their GP with their chosen indicators ("Resources to Map") and then tabulate the information gathered ("Resources for Tabulation with Properties"), specifying the count or size of each indicator. The information will thus be both in the form of a visual map (with symbols), as well as specific tables.

LIST OF RESOURCES

(May be modified for different villages)

1. Houses
2. SC/ST thandas
3. Houses with pregnant, lactating women or women who were just pregnant
4. Traditional healer's house
5. Dai's house
6. District hospitals (private and government)
7. ANM's house
8. ASHAs's house
9. PHC or HWCs
10. Taluk hospitals (private and government)
11. Anganwadi
12. Primary schools and secondary schools
13. Panchayat office
14. Community hall
15. Milk dairy
16. Temple
17. PDS shop
18. SHGs office or meeting place
19. MNREGA groups
20. Youth or community groups office or meeting place
21. Offices/meeting places of occupational associations
22. Water sources
23. Waste dumps
24. Common land
25. Occupational areas/sites such as labour addas, beedi rolling plants, factories brick kilns, etc.

Fig. 3: List of resources to be mapped

Population-Specific Indicators

DEMOGRAPHIC BY AGE AND SEX		
AGE	**SEX**	**COUNT**
0 – 5 years	Male	
	Female	
	Transgender	
6 – 14 years	Male	
	Female	
	Transgender	
15 years and above	Male	
	Female	
	Transgender	
65 years and above	Male	
	Female	
Total		

Household Population Indicators

i. Houses with people over 70 years of age

ii. Houses with TB patient(s)

iii. Houses with HIV patients

iv. Houses with migrant workers

Fig. 4: List of population-specific indicators to be tabulated

- Once this map has been created and tabulated, the participants can now begin to draft a plan on the groups of people they should reach.
- Ask them to look at the map to see if
  - They can find clusters of vulnerable populations?
  - Do some populations have less access to healthcare facilities because of distance?
  - Do the TB patients form clusters in any particular area?
- Then ask them to fill the below table to understand the reach of the different community structures in their GP area

Community Structure Indicators

Sl. No.	Type of Community Structure	Point Person	Total Reach
1	Cement Factory Union	Union President, Supervisor, Manager & HR Manager	1500
2			
3			
4			
5			
6			

Fig. 5: Community structure indicators to be tabulated

- Tell the participants that they will need to update the map periodically and it will help them to plan their activities for TB elimination systematically, and allow them to reach out to the most vulnerable groups in their community.

Key points

- Mapping or documenting village resources (environmental, civic or social) can be helpful to take stock of both advantages and needs of the community.

Session 11: Contextualizing Training B-How do we move forward for TB elimination?

creating an action plan for a TB-mukt panchayat

Objectives

- To develop an action plan for the GP

Learning

- Knowledge of diseases, micro-planning, and enlisting the support of community structures is paramount for planning for and working towards community's wellbeing

Materials

- Action plan template (on whiteboard/chart paper or as printed sheets)
- Writing aids for participants (notebooks/blank pages and pens/pencils)

Duration

90 minutes

Process

- The participants will remain in the same groups (according to GP) as they were for the previous session. Each group will have 60 minutes to complete the activities, and 30 minutes for presentation and feedback.
- Ask the participants to brainstorm and create a plan for particular vulnerable populations by using the table given below. This plan will help the GP members make an action plan in the next part of the activity You may draw this on a whiteboard or chart paper for easier comprehension. The table below may be modified as per the needs of the GP.

WHO TO REACH	HOW	WHERE	SERVICES TO OFFER
Pregnant women and new mothers	Through frontline workers, SHG leaders	SHG meetings, VHSNC meetings, village festivals	Awareness generation, testing services
Families with Children			
Elderly			
Adolescents			
TB patients			
Persons Living with HIV			
Migrants			
Daily wage labourers			
Different occupational groups			

Fig. 6: Table of vulnerable populations to be listed during action plan

- Once the groups have mapped out the populations to reach and the opportunities through which they can be reached, provide a simple template (see Figure below) to each group and request them to discuss the key activities they will undertake to actualize their plans for their GP (from the previous sessions) and create an action plan for one year with the following details:

ACTIVITY

The key activities that they intend to undertake

TIME PERIOD

The dates (day/month) or duration between which an activity will be conducted

LOCATION

Site(s), area or type of location (door to door, temple etc.) where the activity will be conducted

SUPPORTING BODIES

The missions, programs, community structures, or individuals whose support the GP members would need to take, in order to conduct an activity

TOTAL BUDGET

Monetary requirement for the entire activity, if needed

SL NO.	ACTIVITY	TIME PERIOD	LOCATION(S)	SUPPORTING BODIES	TOTAL BUDGET (IF ANY)
(E.g.) 1	Awareness campaign on TB - auto speaker activity	April 1-5	• Hosahalli • Rampura • Srinivasapura • Mathahalli	Auto union	Rs. 20,000
(E.g.) 2.	Health camp for facilitating referrals	April 10-15	• Hosahalli • Rampura • Srinivasapura • Mathahalli	• Village PHCs • FLWs like ASHAs • Youth associations • SHGs	Rs. 10,000
(E.g.) 3.	Supporting TB patients- creating a fund to support patients in need	Continuous	• Hosahalli • Rampura • Srinivasapura • Mathahalli	• SHGs • Local leaders	Rs. 20,000

Figure 7: Action plan template with examples

- Each group will then present their action plan to the rest of the participants and request feedback from them.
- Bring out the unique points from each of the plans and encourage the groups to take ideas from each other.
- After the discussion has closed, thank the participants for their time and contributions and especially their commitment to creating a TB-Mukt Panchayat.
- Hand out the post-training survey to the participants and collect them after they have been filled.

Key points

- Planning for an ideal GP involves being aware and well-versed with disease symptoms, treatment, management and prevention, government programs or missions, rights of the people, challenges faced by vulnerable communities, and also the demographics and resources available of the village.
- Detailed action plans can be useful to implement the changes that GP members and GP leaders envision for their community.

ANNEXURE

ANNEXURE A: PRE-TRAINING SURVEY

Name/Code.....

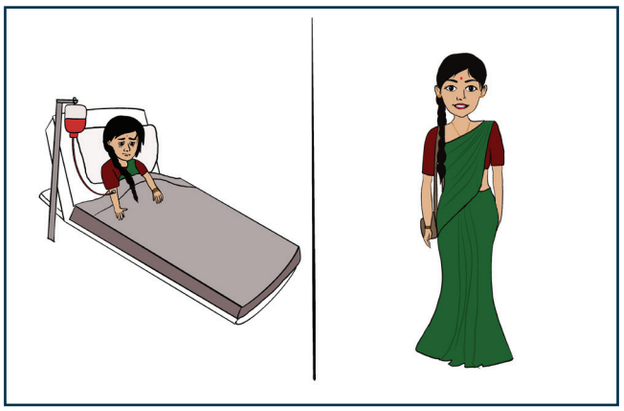
Date.....Place.....

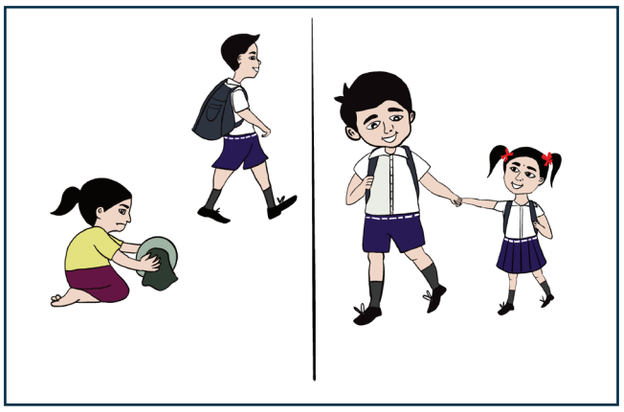
Please answer the following honestly and to the best of your abilities by choosing the appropriate emotion:

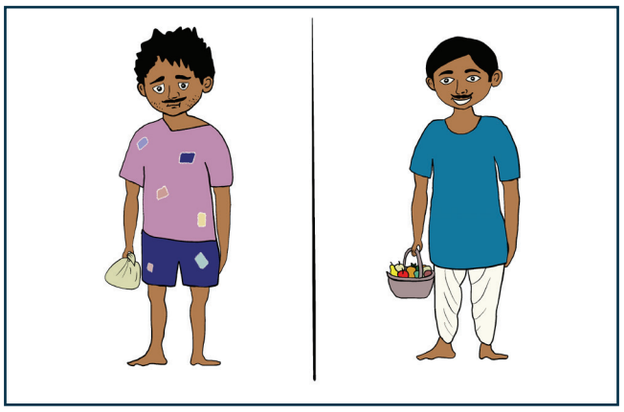
	Yes	No	Don't know
I know TB is a curable disease			
The most common symptom of TB is a persistent cough for more than two weeks			
There are many people in my area who are susceptible to developing TB because they already have other diseases such as HIV and diabetes			
Ending TB in my community is the responsibility of the health system			
My role in the fight to eliminate TB in my village/ area is clear to me			

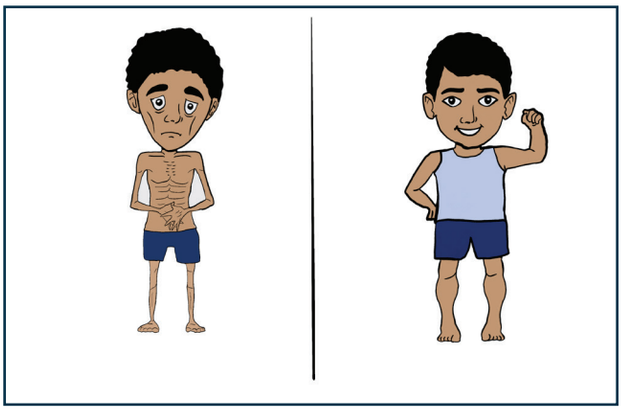
Please note: If the participants do not wish to use their names, the trainer may use an alternative suitable method for coding the forms. It is important that each form has a unique code that can be compared before and after the training.

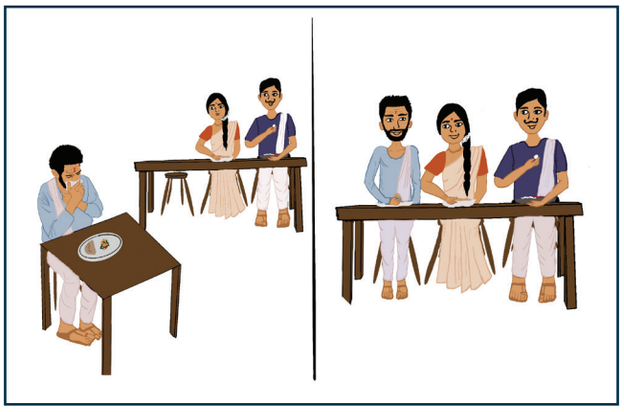
ANNEXURE B: IMAGES FROM HOLISTIC WELL-BEING SESSION











ANNEXURE C: FLIPCHART WITH RAJAPPA'S STORY AND BASICS OF TB

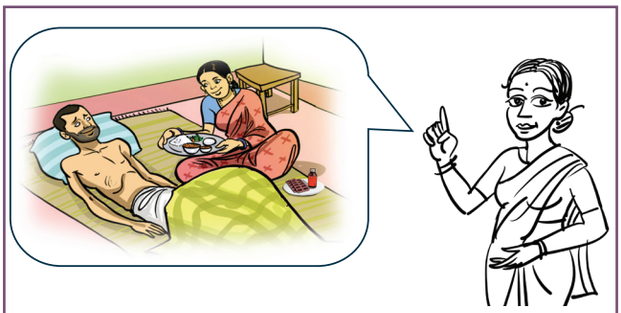
Rajappa is a daily wage labourer, being treated for Tuberculosis.

He was taking his medicines regularly.

However, he still felt weak and tired.

Why do you think Rajappa continued to feel weak and tired?

He shared his problem with the frontline health worker.



She advised him to take good nutrition along with medicine.

He was unable to take good nutrition as he was poor and couldn't afford nutritious food. As a result, his condition became serious.

The frontline health worker contacted a GP member of his village to explore nutrition support.

How do you think, the GP member would react to such a request?

Should the GP member even get involved in such a matter?

Shouldn't this be the responsibility of the Health Department?

The GP member discussed Rajappa's problem in the GP meeting and urged the President to grant some amount from the un-tied fund for Rajappa's nutrition during his treatment period.

Ramaiah the GP member also invited Rajappa to the GP office to receive some collected ration from the members. But Rajappa hesitates and refuses to go over there.

Why do you think Rajappa did not want to collect his rations from the GP office?

Many patients like Rajappa, and often their family members, fear stigma and discrimination from the community, and thus do not want anyone to know about their TB status.

Stigma and discrimination can be a barrier to treatment adherence and completion, and prevent a patient's full recovery.

Finally, the ASHA collects it and delivers it to Rajappa's home.

What are the ways in which the Gram Panchayat can help Rajappa?

The GP member Ramaiah also discussed with the TB staff of the Taluk to facilitate for the Nikshay Poshan Yojana amount to be credited to his account.

This nutrition support helped Rajappa to recover adequately and completed his treatment successfully.

Rajappa not only recovered, but also regained his confidence in life and went back to work.

Do you think the GP member should have knowledge or information about TB?

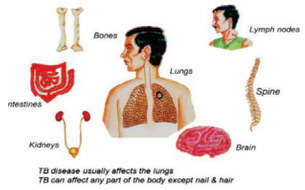
Can you share what you know about the disease?

What is Tuberculosis?

TB is an infectious disease caused by a bacteria.

There are two kinds of TB, Pulmonary TB (TB of the Lungs) and Extra pulmonary TB.

TB can occur in any part of the body, except the hair and nails.



TB spreads from one person to another mainly through the air while coughing.

The bacteria pass through the air from the person who has lung TB to another person.

Who are the people most vulnerable to the TB infection?

TB can affect anyone, but people who have lowered immunity are more prone to it. Elderly people and people with malnutrition are at risk of developing TB.

People with comorbidities such as HIV and Diabetes are also more likely to develop TB due to reduced immunity.

People who live in densely populated communities where there is no good ventilation.

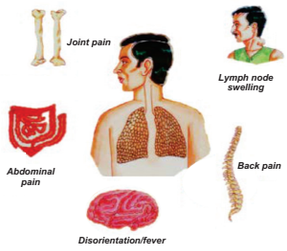
People working in environments such as mines and factories, where they are exposed to dust or hazardous particles are also prone to developing TB.

What are the symptoms of Lung TB?

- Cough for more than 2 weeks, usually persistent and producing sputum
- Fever, especially at night, with sweating for more than two weeks
- Loss of weight
- Coughing up blood

Other symptoms include
- Loss of appetite
- Chest pain
- Weakness or tiredness

What are the symptoms of Extrapulmonary TB (EPTB)?



Since EPTB affects different parts of the body, the symptoms are usually related to the parts of the body affected.

Persons with EPTB may also have persistent fever for more than two weeks, night sweats and significant weight loss.

How is Lung TB diagnosed?

To detect Lung TB, a sputum test is needed. Two sputum specimens are necessary.

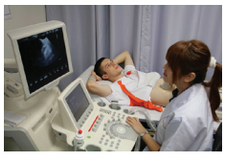
TB is diagnosed through /a simple sputum test.

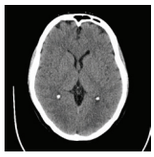
Test and treatment for TB at the Government facilities is Free of cost.

Private facilities offer test and treatment services at a cost.

How is EPTB diagnosed?

Different tests like scans and biopsies are used to diagnose EPTB. Your healthcare provider will recommend the test to you.





How is TB treated?

- TB is curable with right medicines of right dosage for right duration.
- The duration of treatment is **at least** 6 months.
- Medicines have to be taken daily as per doctors' advice.

- **The patient must complete the full course of treatment prescribed by the doctor.**
- Incomplete treatment increases risk of person getting the disease again.
- Side-effects can appear at any time during the treatment, but these can be managed.

What are potential barriers to treatment adherence and recovery?

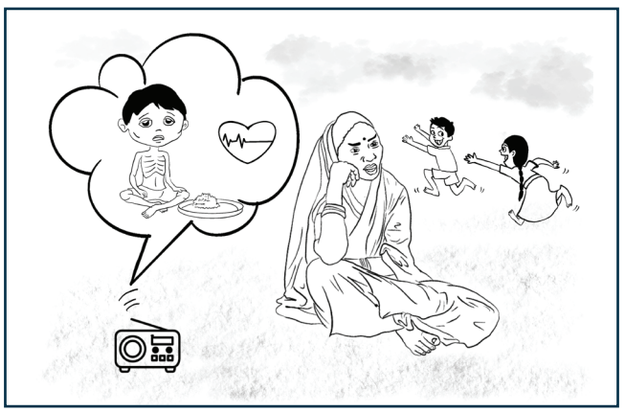
Tobacco and alcohol consumption interfere with nutrition and sleep and will affect recovery

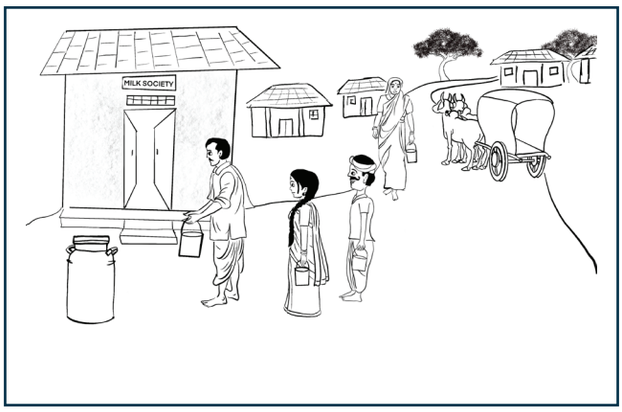
Stigma from the family and community can interfere with treatment adherence, and delay recovery

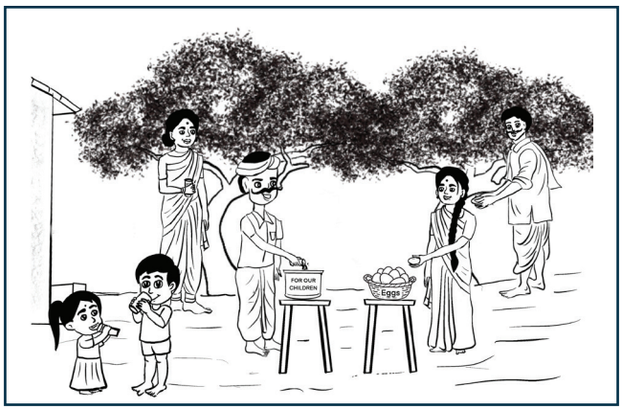
Lack of access to nutritious food can affect recovery. Nutritious food can help reduce the side effects of treatment. Side-effects can appear at any time during the treatment, but these can be managed.

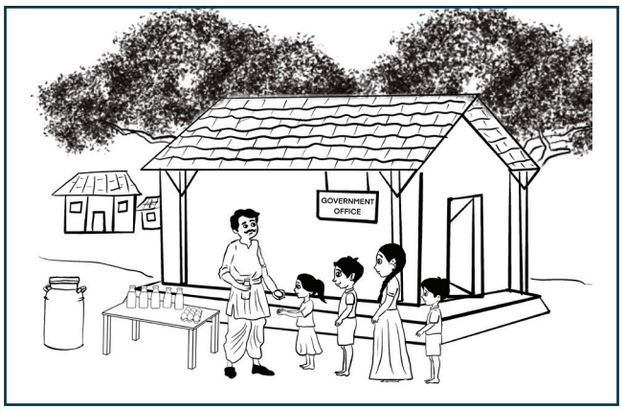
It is important to remember that TB is curable if the person is treated with right medicines, in right dosage, for the right duration

ANNEXURE D: FLIPCHART IMAGES ON COMMUNITY INVOLVEMENT









ANNEXURE E: COMMUNITY STRUCTURES: DEFINITION AND EXAMPLES

A community structure (CS) is a

- semiformal or formal/ organized and decentralized network of individuals,
- representing a certain group (men/ women/ transgenders/ youth from marginalized or vulnerable communities/ informal workers)
- in a defined geography
- having a shared agenda and a welfare mandate, with its own operational systems and leadership,
- members of which are not remunerated by the government

These include, but are not limited to:

- Self-help Groups
- Labour unions (both formal and informal workers' unions, such as sugar factory unions, cement factory unions, construction workers' unions, auto drivers' unions.
- Population-based groups such as Dalit groups, Tribal groups and caste-based community welfare groups
- Youth Associations such as National Cadet Corps, students' clubs at school and college level
- Faith-based organizations such as the Salvation Army, Mathas, Temple boards, etc.
- Panchayat sub-committees such as VSHNCs

The list above is indicative and the definition is intended to guide the trainer on defining a community structure. The trainer may add community structures according to the context of the region where the training is being conducted.

ANNEXURE F: TB MUKT PANCHAYAT

The National Tuberculosis Elimination Programme (NTEP), Karnataka, has initiated the Kshaya Muktha Gram Panchayat (TB-Free Gram Panchayat) initiative as part of its ambitious Kshaya Muktha Karnataka (TB-Free Karnataka) campaign. By involving the members of Gram Panchayats, there will be a better understanding of the disease from the community perspective, an impetus for the early detection of cases and early initiation of treatment, community support to enable adherence by reducing stigma, and support to nutrition and treatment completion for better outcomes.

The NTEP program, the public health institutions at the local level, the field workers and the local representatives forge a collaborative activity to foster a bridge between the community and NTEP. This paves way for an integrated community-based activity. Hence engaging with Gram Panchayats, and thereafter with communities, helps bridge gaps between communities and the program, thereby converting the existing program to a robust patient centric elimination strategy which will help realize "Kshaya Muktha Karnataka."

The Kshaya Muktha Gram Panchayat involves the NTEP building the capacity of the GP members to promote community participation in TB related activities. GP members will be responsible for:

- Creating awareness on TB
- Helping reduce stigma and discrimination towards TB
- Identifying SHGs, TB champions and other community leaders and involve them in TB-related activities
- Ensuring regular contact with the community, TB patients cured and currently on treatment through identified responsible person
- Encouraging self-referral of people with symptoms to the nearest public health facility
- Supporting TB patients with social and livelihood schemes and ensuring treatment adherence among diagnosed TB patients
- Support community-led advocacy
- Supporting de-addiction activities for alcoholics and smokers among persons with TB
- Keeping a track of cross border migration among TB patients and migrants are provided with clinical and social support

ANNEXURE G: UNDERSTANDING ALLIED HEALTH STRUCTURES (HWC, JAS, VHSNC)

As part of the GPAAA, Health and Wellness Centres (HWC), Jan Arogya Samitis (JAS), and Village Health Sanitation and Nutrition Committees (VHSNC) can be leveraged to identify, treat, manage and prevent diseases like TB, COVID-19, diabetes or hypertension etc. Each of these supporting structures works at a different level, often under the ambit of different departments or programs and, with its own roles and vision, that have been given below.

I. HEALTH AND WELLNESS CENTRES

Health and Wellness Centres (HWCs) form the base pillar of the Ayushman Bharat program and have been formed by transforming existing Sub Health Centres (SHC) and Primary Health Centres (PHC). The delivery of Universal Comprehensive Primary Health Care through HWCs is envisioned to increase the responsiveness of the health system by bringing services closer to the communities and addressing needs of the most marginalized.

HWCs deliver Comprehensive Primary Health Care (CPHC) by bringing healthcare closer to the homes of people, covering both maternal and child health services along with non-communicable diseases, and include free essential drugs and diagnostic services. The level of complexity of care of services delivered at the PHC is higher than at the SHC level and this is indicated in the care pathways and standard treatment guidelines that are issued periodically. A PHC that is linked to a cluster of HWCs serves as the first point of referral for many disease conditions for the HWCs in its jurisdiction. Further, it is also strengthened as an HWC to deliver the expanded range of primary care services.

Vision	To deliver an expanded range of services to address the primary health care needs of the entire population in their area, expanding access, universality and equity close to the community
Department Or Level	NHM Division, Ministry of Health and Family Welfare
Composition	**SHC – HWC Team:** The HWC at the SHC level are equipped and staffed by an appropriately trained PHC team, comprising Multi-Purpose Workers (male and female) and ASHAs, and led by a Mid-Level Health Provider. Together they deliver an expanded range of services. In some states, SHCs were earlier upgraded to Additional PHCs. Such Additional PHCs have also been transformed to HWCs. **PHC/UPHC – HWC Team:** The Medical Officer at the PHC is responsible for ensuring that CPHC services are delivered through all HWCs in her/his area and through the PHC itself. The number and qualifications of staff at the PHC is as defined in the Indian Public Health Standards. States can choose to modify staffing at HWC and PHC, based on local needs.

Roles

SHC – HWC: Screening/identification, teleconsultation, medicine dispensation and follow up

PHC – HWC: Assessment, diagnosis, teleconsultation, treatment and referral

Services Offered:

- Screening, prevention, control and management of NCDs and chronic communicable disease like TB and leprosy
- Care in pregnancy and childbirth
- Neonatal and infant health care services
- Childhood and adolescent health care services
- Family planning, contraceptive services and other reproductive health care services
- Management of communicable diseases: National Health Programs
- Management of common communicable diseases and general out-patient care for acute simple illnesses and minor ailments
- Basic oral health care
- Care for common ophthalmic and ENT problems
- Elderly and palliative health care services
- Emergency Medical Services
- Screening and basic management of mental health ailments

II. JAN AROGYA SAMITI AT THE SUB HEALTH CENTRE LEVEL

Jan Arogya Samitis (JAS), meaning "people's health committees," are an institutional structure at HWC level, formed to formalise people's participation in planning, decision making and monitoring the quality of health services in their area. With the launch of Ayushman Bharat and the formation of Health and Wellness Centres (HWCs), Rogi Kalyan Samitis, which were a local level institutional mechanism at PHC level mandated to improve quality of services, were reformed as Jan Arogya Samitis. They are seen as a mechanism for democratizing health and promoting active public participation in healthcare.

Vision	To empower people to enable action for improvement in the availability and quality of facility infrastructure and services, and promote a culture of accountability amongst service providers in the public health system	
Department Or Level	NHM Division, Ministry of Health and Family Welfare (JAS is a facility-level structure)	
Composition	The JAS is composed of a mix of service providers/ system functionaries, elected representatives, persons who have received services and civil society representatives. Women should form at least 50% of the JAS and vulnerable communities should form one-third of the JAS members.	**Chairperson:** The Sarpanch of the Gram Panchayat falling under the Ayushman Bharat Health and Wellness Centre area **Co-Chair:** Block Medical Officer/Taluka Health Officer **Member Secretary:** Community Health Officer (CHO) of the HWC. **Members:** i. Ex-Officio a. Sarpanches of the other GPs of AB-HWC area b. President of VHSNCs: One per GP amongst those under AB-HWC area. This shall be on rotation (among VHSNCs under a GP) for 2 years to allow greater participation. c. ASHAs – ASHAs/Member Secretary of all VHSNCs in AB-HWC area d. All Multi-Purpose Health Workers (Male and Female) of AB-HWC ii. General 1. Women Self Help Groups - President of one SHG from each Gram Panchayat of the AB-HWC area – nominated by GP 2. School Health Ambassadors: One representative from among the Ayushman Bharat School Health & Wellness Ambassadors of the AB-HWC area (representative from the school with highest enrollment) 3. Peer Educator - One from AB-HWC area (Senior peer educator in the area) Special Invitees- Tuberculosis survivor, Youth representatives and "any male"who has undergone sterilization after one / two children"
Roles	• Serve as Institutional platform of SHC/PHC HWC for community participation • Support health promotion and action on social and environmental determinants of health • Provide mentorship to VHSNCs (SHC level) • Support and facilitate the conduct of Social Accountability exercise at HWC level • Act as a grievance redressal platform • Bring accountability for use of untied funds at SHC • Mobilize resources, both monetary and non-monetary for the improvement of quality of services and health promotion activities • Support Gram Panchayats in undertaking health planning	

III. VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES

The VHSNC is an institutional mechanism formed at the village level for the community to voice their health needs, be informed of health programmes and government initiatives and to participate in the planning and implementation of these programmes, leading to better outcomes. VHSNCs are expected to act as leadership platforms for improving awareness and access of the community to health services, to support the ASHA functionaries, develop village health plans specific to local needs, and serve as a mechanism to promote community action for health (particularly for social determinants of health).

Vision	To be central to local level community action and gradually support the process of decentralized health planning	
Department Or Level	Under the Gram Panchayat (as a Panchayati Raj Institution) at the revenue village level	
Composition	The VHSNC should have at least 15 members. States have the flexibility to decide the maximum number of members. The ANM, AWW and ASHA along with the Panchayat leadership are to ensure that every section is represented. Women must constitute 50% of total members and SC, ST & minority groups should be represented as per their population in the village. The VHSNC is composed of:	**Chairperson:** Female elected member of the Gram Panchayat (Panch), preferably from among the SC/ST communities, who is a resident of that village **Member Secretary and Convenor:** The ASHA will be the Member Secretary and Convenor of VHSNC. If there is more than one ASHA in the VHSNC village, then one of them is to be selected by consensus as Member Secretary and convener. **Elected GP members:** Those resident in the village are to be preferred. In areas where there are no elected panchayats, members of tribal councils, could be considered. Though more than one elected member of a Panchayat can be included in the VHSNC, their numbers should be limited to one third of the total number of members, and preference should be given to female GP members. **ASHAs:** All ASHAs of the village should be on the committee. In small villages there would be only one ASHA per VHSNC. **Frontline staff of government health related services:** The ANM of the health department, the Anganwadi worker of the ICDS, and the school teacher should be included as regular members only if they are residents of that particular village. Volunteers or village level workers of other government departments should also be considered if they are residents of the village. **Community based organizations:** Representatives of existing community-based organisations like Self Help Groups, Forest Management Committees, Youth Committees, etc. **Pre-existing committees:** Members from separate committees on School Education, Water and Sanitation or Nutrition. **Service users:** Pregnant women, lactating mothers, mothers with children of up to 3 years of age, and patients with chronic diseases who are using the public services. **Special invitees:** They are generally not residents of the village. This includes Medical Officer of the local PHC, Facilitator of the ASHA Programme, Supervisors in health and ICDS departments, Panchayat secretary and Block Development Officer, Zilla and block panchayat member.
Roles	• Monitoring and facilitating access to essential public services and correlating such access with health outcomes • Organizing local collective action for health promotion. • Facilitating service delivery and access to service providers in the village • Village health planning to assess gaps and organize local collective action to close these gaps, and/or identify healthcare priorities	

ANNEXURE H: POST TRAINING SURVEY

Name/Code.....

Date.....Place.....

Please answer the following honestly and to the best of your abilities by choosing the appropriate emotion:

	Yes	No	Can't Say
I know TB is a curable disease			
The most common symptom of TB is a persistent cough for more than two weeks			
There are many people in my area who are susceptible to developing TB because they already have other diseases such as HIV and diabetes			
Ending TB in my community is the responsibility of the health system			
My role in the fight to eliminate TB in my village/ area is clear to me			

Please select how you feel about each of these statements below:

	Yes	No	Can't Say
It was easy to follow what the facilitator was sharing			
I felt that I learnt a lot from my peers			
There was adequate opportunity for me to share my thoughts/experiences			

Please share any feedback or suggestions regarding the workshop below:

Please note: If the participants do not wish to use their names, the trainer may use an alternative suitable method for coding the forms. It is important that each form has a unique code that can be compared before and after the training.

ANNEXURE I: SELF-REFLECTION FORM FOR TRAINERS

Name: _____ Designation: _____

District/GP: _____ Date of training: _____

Please choose the appropriate answer to the following, honestly and to the best of your abilities:

1	I had enough time to prepare for the workshop	Yes	No	
2	I was able to read through the entire module once, before training	Yes	No	
3	I was able to understand and follow the module	With ease	With some difficulty	With great difficulty
4	I felt the module had too much text	Yes	No	
5	I felt the module did not have enough activities	Yes	No	
6	I felt the module wasn't very informative	Yes	No	
7	I liked the tone of the module	Yes	No	
8	I think the session timings could have be longer	Yes	No	
9	I felt it was easy to conduct the training	Yes	No	
10	I found I could keep the participants engaged	With ease	With some difficulty	With great difficulty
11	The participants were given sufficient opportunity to engage in discussions and ask questions	Yes	No	
12	I was able to elicit responses from all participants, irrespective of their gender or rank, equally	Yes	No	
13	I was able to respond to participant questions comfortably	Yes	No	
14	I was able to help participants achieve the objectives of the training	With ease	With some difficulty	With great difficulty
15	The participants understood the technical sessions of the module well	Yes	No	
16	I think the training was useful for the participants	Yes	No	
17	There was a gender balance within the group of participants	Yes	No	
18	Participant interaction offered me new insights and learning	Yes	No	

Notes:

CHECKLIST

Section 1: Panchayat checklist to assess preparedness to respond to TB

Instructions: One-time activity to be filled in as a baseline. A designated member of the GP will collect the information from all villages / HWC / ASHA as applicable and complete the form.

GP code:.....

Taluka: .....District:.....

Names of the Villages covered	Names of the HWCs	Name of the PHCs linked

Sl. No	Particulars	Observations
1	Have all GP members, other members of GPTF, Family Task Force, VHSNC, PDO been trained on TB?	Yes No
2	Have all SHGs, Youth & Mahila Mandals, NREGA Kayaka Bandhu Groups, GPLF, Cooperative members, NSS Volunteers GP Staff, and local leaders been trained on TB?	Yes No
3	Has TB Vulnerability assessment been done* (format to be in place)?	Yes No
4	Is there a Micro-plan in place with strategies, an activity plan and a time frame for implementing TB activities?	Yes No
5	Do we have a task force/committee to review GP activities?	Yes No
6	Do we have IEC materials on prevention, identification and treatment of TB displayed in public places?	Yes No
7	Do we have IEC materials on prevention, identification and treatment of TB (for distribution) and the contact details of the relevant staff?	Yes No
8	Do we have the Panchayat Health Management kit for screening for NCD and other health issues?	Yes No
9	Do we have a redressal and grievance mechanism in place to address cases of discrimination/other complaints related to TB services?	Yes No
10	Is information available on the current number of TB patients of all the villages in our GP area?	Yes No
11	Are TB Champions identified and do we have a list of them with GP	

Section 2: A checklist to assist the Panchayat in self-assessing their GP's progress in responding to TB

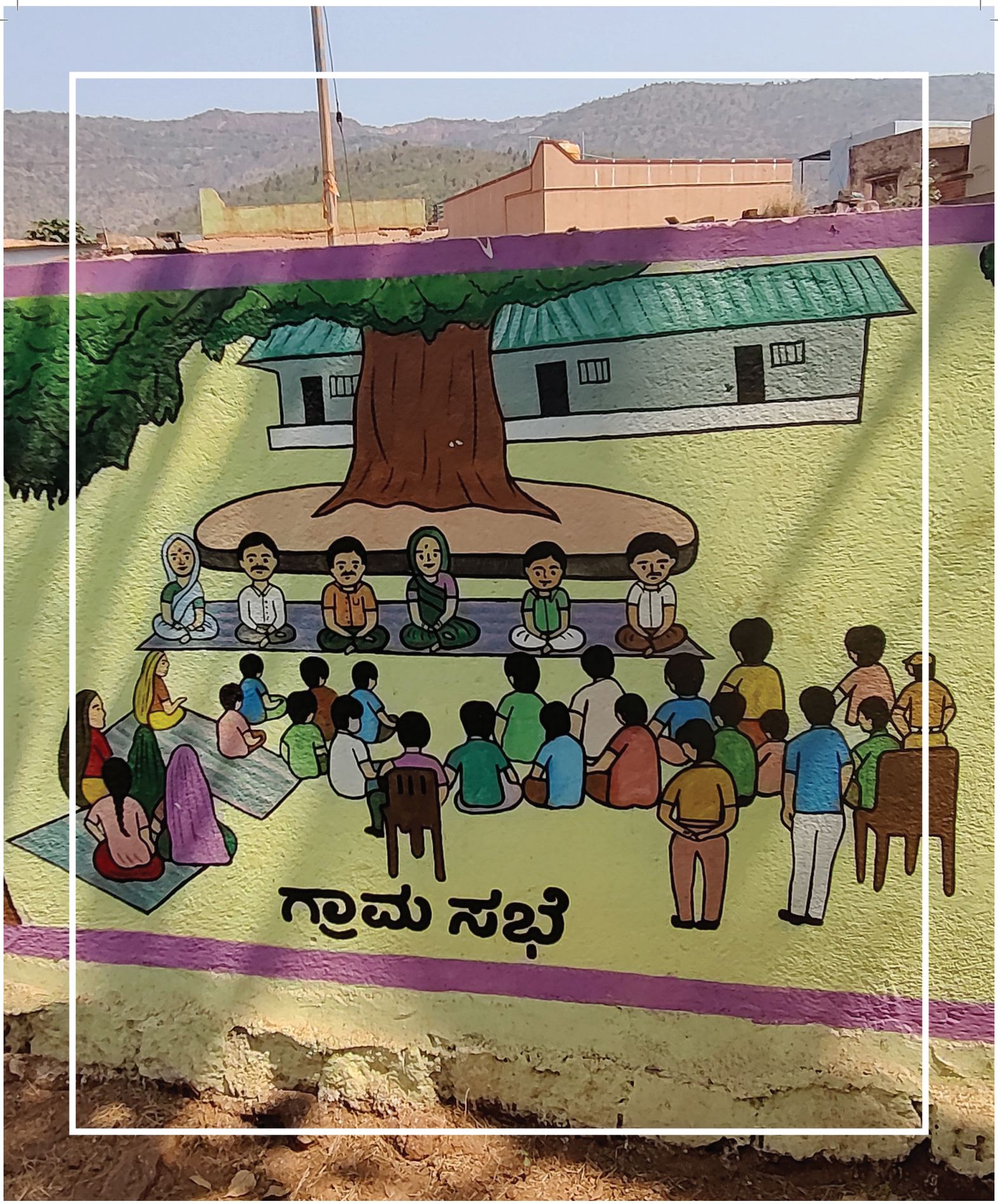
Instructions: To be completed on a quarterly basis. A designated GP member will gather information from all villages/HWC/ASHA as appropriate and complete the form.

Sl. No	Particulars	Observations
1	Have we conducted TB activities in our villages in this month (mass campaigns, health camps, door to door screening etc.,)?	Yes No
1a	Have we have conducted any special event on TB awareness (competitions at school/colleges & for youths/women, conducted street plays, any other mass program by using any local/traditional arts?	Yes No
2	Have we involved community stakeholders for TB activities (TB Champions, Community structure leaders and other groups such as Family Task Force, VHSNC, SHGs, Youth & Mahila Mandals, NREGA Kayaka Bandhu Groups, GPLF, Cooperative members, NSS Volunteers GP Staff, and local leaders as per the local context)?	Yes No
3	Have we provided any support to TB patients and family members like providing nutrition, transportation services to secondary and tertiary health facilities, and linkage to social security schemes?	Yes No
3a	Please narrate in 1 or 2 lines	
4	Has the task force/committee reviewed TB activities in this month?	Yes No
5	Have we addressed any grievance of discrimination/other complaints related to TB services?	Yes No

Section 3: Display board format

Instructions: The display board at the GP Office must be updated with the information below on a quarterly basis. A designated member of the GP will collect the information from all villages / HWC / ASHA as applicable and update the dashboard.

Sl. No	Particulars	Data
1	Number of TB awareness campaigns conducted in this month	
2	Number of health camps conducted where verbal screening for TB was done	
3	Number of presumptives referred for testing	
4	Number of people newly diagnosed with TB this month	
5	Cumulative number of people with TB in our GP	



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