USAID FROM THE AMERICAN PEOPLE

Global Coalition of TB Advocates

KHPT engage, innovate, empower

Training Curriculum

# Strategy to End Stigma and Discrimination Associated with Tuberculosis

# TABLE OF CONTENTS

# BACKGROUND

Tuberculosis (TB) is a communicable disease, and one of the top 10 causes of death worldwide. Globally, an estimated 10 million people fell ill with TB in 2020, about 4 million of whom remained undiagnosed or unreported. This resulted in 1.5 million deaths. India carries over a fourth of this burden, averaging an incidence rate of 199 per 100,000 population in 2019. India's National Strategic Plan (NSP) for elimination of TB proposes bold strategies towards the elimination of TB in India by 2025, five years ahead of the global End-TB targets. However, there remain several challenges and barriers in the path towards TB elimination, with some preventing access to quality TB services and care.

Stigma and discrimination are recognized to be among the most common human rights-related barriers hindering the fight against the TB epidemic. In September 2018, Heads of State and Governments at the United Nations High-Level Meeting on TB, and in the resulting Political Declaration on the Fight to End TB, committed to promoting and supporting an end to TB stigma and all forms of discrimination. This commitment demonstrates recognition at the highest level that to end TB, we must end TB stigma.

WHO defines stigma as a mark of shame, disgrace or disapproval that results in an individual being rejected, discriminated against, and excluded from participating in various areas of society. Stigma harms the livelihoods and health of individuals who experience it, and severely hinders TB response. People who fear losing their jobs, loved ones, or being kicked out of school or their homes because of TB are less likely to seek testing and treatment, making an already challenging response even more difficult. The Global Coalition of TB Advocates (GCTA) fervently believes that efforts towards elimination of TB must involve social interventions along with medical and public health interventions. Therefore, GCTA, in collaboration with KHPT, has developed this training manual. It is in complement to the already existing Strategy to End Stigma and Discrimination Associated with TB, developed and published through a collaborative process led by the Central TB Division (CTD), Ministry of Health and Family Welfare, Government of India. This manual is an attempt to unpackage the strategy and develop training curricula on ending TB Stigma for community members, frontline health workers and district and state TB officers.

## Objectives of the Manual

1. Sensitize state(s)/district(s), TB affected individuals, and other stakeholders on stigma and discrimination, its impact on people affected by TB, and on the reasons it is critical to end stigma to eliminate TB

2. Provide an understanding of the drivers and facilitators of stigma associated with TB

3. Recommend ways to measure stigma related intervention outcomes and impacts at the state/district level

## Structure of the Manual

This manual has been designed as a complete package for a one-day training. As an alternative, individual modules addressing a particular thematic area or a combination of selected modules may also be used for specific contexts.

## How to Use this Manual

This manual is complementary to CTD, MoHFW, GoI's 'Strategy to End Stigma and Discrimination Assocaited with TB, the trainer can familiarise themselves with its contents. The facilitator(s) are required to read all the topics covered in these modules before the commencement of the training. This will provide them with a comprehensive understanding of the scope of each topic and its relevance, along with the sessions that they will be facilitating.

Prior to the training, facilitators should consider and discuss how they will use these modules to develop the knowledge and capacity of the participants. The sessions are meant to engage the participants in a participatory learning process based on adult learning principles. Facilitators are encouraged to:

- Identify participants' needs and what is important to them
- Provide real-life situations and emphasize the application of learning to real problems

- Conduct activities that require active participation by trainees
- Use a variety of training techniques
- Establish an atmosphere of respect and understanding of differences
- Provide opportunities for sharing information
- Discuss and analyze participants' experiences
- Engage participants as valued resources and encourage them to participate and share their experiences

Each session follows the below stated arrangement, although facilitators may choose to adapt them as per the requirements of the training:

### Time
Duration of the session

### Materials Required
Materials required during the training, including audio-visual equipment, stationery, handouts, reference materials, pre and post training assessment forms and feedback forms

### Objective
Desired learning objectives to be achieved by participants at the end of each session

### Methodology
Step-by-step participatory methods that will be employed to engage participants in the learning process

### Facilitator's Notes
Notes that provide the facilitator with useful information on the topic of discussion and tips for facilitating activities

## Tips for Trainers

Before each day's training, it is recommended that the trainers familiarize themselves with the topics to be covered that day by carefully reading the relevant materials. This will enhance their understanding of the concepts in each slide and their correlation to the accompanying text. Depending on the skills of the trainer and their background, they may wish to include examples or case studies to bring further depth and clarity to the topic being presented.

Most of the trainings require more than one trainer. In such cases, it should be ensured that the co-trainers have read all the training materials in this package and that they feel comfortable facilitating the selected topics from

the training manual. Trainers should meet before the training to agree on the agenda and to decide who is going to teach which topic. Some trainers feel more comfortable presenting certain topics than other trainers. For the benefit of the trainer and the trainees, this should be taken into consideration.

It is immportant to understand the profile of the participants attending the training in order to tailor the material to suit their requirements. For example, if it is a Hindi-speaking audience, then the training can be conducted in Hindi and the presentations can be translated in Hindi. If the participants are a mix of new and senior staff, then ensure that there is space for the senior staff to share their experience with the new staff.

## How to Facilitate

The facilitators should be familiar with participatory forms of learning.

- They should have the ability to ask exploratory open-ended questions and should make it a point to involve all the participants.
- The facilitators should be technically competent and be able to answer various intervention-related questions. The topics included may be adapted to suit local needs and priorities.
- While presenting, it is suggested that the facilitator take center stage and not hide behind a podium or a desk. The facilitator should face the participants when speaking and make eye contact with them. They should speak slowly, clearly and loudly. Use natural gestures and facial expressions, and avoid blocking the participants' view.
- Involve all participants in discussions. Ask direct questions to the quiet ones and rein in the talkative ones. Move around the room - approach participants to get their attention or response, and use their names.
- Repeat responses from participants when it is likely that not everyone heard. Respond encouragingly and positively to all answers - correct errors gently. Reinforce participants by thanking them for their comments and praising their good ideas. Respond adequately to questions - offer to seek answers if the answer is not known.
- Handle incorrect or off-the-subject comments tactfully.
- During group activities, explain clearly the purpose of the activity, what the participants should do, and the time limit.

## Key Things to Remember as a Facilitator

| | | |
|---|---|---|
| Be flexible. Scheduling may have to change depending on the needs of the participants |  | Read from the PowerPoint presentation – prepare and use the slides to elaborate on relevant points |
| Use different teaching methods to enhance participation and retain interest |  | Make the training a boring experience – intersperse the sessions with energizers/games |
| Ensure that teaching materials are ready and available before the beginning of the session |  | Speak more than the participants – let them brainstorm and discuss |
| Respect participants' local knowledge |  | Allow distractions like mobile phones and chatting among participants |
| Encourage participants to make presentations |  | Let any one person dominate the discussion |

# Session 1: Setting the Context

50 minutes

Post-it
Whiteboard
Flip chart

PPT for overview
Pre-training assessment forms
Laptop & LCD projector

By the end of this session, the participants will have introduced themselves to each other and the facilitator

## Methodology

1. Introductions (10 mins): Conduct a fun ice-breaker activity to get to know your group. This can be replaced with another game for introductions.
    a. Divide the participants into groups of 4 people each
    b. Each participant should state her/his name, organization and then, share what their "superpower" is. This can be a special skill, a curious fact about their lives, valuable knowledge they share, etc.
2. Expectations from the training (10 mins)
    a. Each participant is to be given a post-it note
    b. In one sentence, they should answer "What are your expectations from the training program today?"
    c. Ask the participants to stick their this post-it on a board. The facilitator can group the answers into major themes or simply read out the post-its
    d. The expectations that do not match the agenda of the training can be kept under a spot titled "Parking Lot". You can address this at a later time or state that it is outside the scope of this training
    e. Be sure to check the expectations board at the end of your training program to see if you have covered them all

3. From a PPT highlight objectives and overview of training (10 mins)

    a. Sensitize stakeholders on stigma and discrimination, its impact on people affected by TB, and on why it is critical to end stigma to eliminate TB

    b. Provide an understanding of the drivers and facilitators of stigma associated with TB

    c. Identify and prioritize context specific interventions to end stigma and discrimination in different settings and among specific target audiences

    d. Recommend ways to measure stigma-related intervention outcomes and impact at the national level

4. Ground rules (5 mins)

    a. Interact with participants to list down ground rules to be followed during the training so that there is maximum learning

    b. Note their suggestions on a flip chart and put it up on one side of the hall

5. Pre-Training Self-Assessment (15 minutes)

    a. Request participants to complete a pre-training self-assessment questionnaire

    b. Inform them that a similar post-training assessment will also be administered after the last session of this training

    c. Note that this is not an examination, but conducted to measure the learning and effectiveness of the training

# Session 2: Quick Overview of Facts on Tuberculosis

20 minutes

Chocolate, as rewards
Handout A
Laptop & LCD projector

Flip chart
Colour markers

By the end of this session, the participants will have a general overview of Tuberculosis, its transmission, diagnosis and treatment

## Methodology

1. Introductions (20 mins)

   a. Game to achieve a baseline understanding of TB within the participants, and to provide them with more information as needed. This is intended to be a quick revision of known TB facts

   b. The facilitator should prepare 8 to 10 questions on simple TB facts in advance. Ask the participants to provide answers to these questions, and give a reward to the participant with the greatest number of correct answers

      Sample Questions:

      - What is TB?
      - What is the difference between pulmonary and extra pulmonary TB?
      - What is a TB infection?
      - List some of the symptoms of TB.
      - How is TB treated?
      - What is drug resistant TB?
      - What type of support do persons with TB require?
      - How can TB be prevented?
      - List some of the psycho-social impacts of TB.

   c. Give Handout A to all participants

# Session 3: Stigma and its Impact on Persons Affected by TB

50 minutes

Survivor Stories
PPT: quotes of persons affected by TB, types of stigma, causes and consequences of stigma

Flip chart
Markers
Laptop & LCD projector

By the end of this session, the participants will be able to illustrate the causes, actions and consequences of stigma at all levels of society. They will also be able to identify relevant methods to address stigma and discrimination, along with the gender implications of TB stigma

## Methodology

1. Facilitator can narrate a case study to explain the stigma associated with persons with TB and the drivers of that stigma (5 mins)

    a. Survivor Story 1: Rameshwari, a 42-year-old female, was diagnosed with TB. When she started her treatment in August 2020, she lived in her marital home and her weight was 33 kgs. Her husband, upon learning of her TB diagnosis, accused her of bringing bad fortune to their house. He was terrified that he might get the infection and would die. He abandoned his wife, asking her for a divorce. By October 2020, when Rameshwari arrived at her parents' home, her weight was 28 kgs. Initially, she refused to continue her treatment and wanted to die. She was provided counselling to help her overcome her trauma. Her maternal family were also counselled and asked to support her in completing her treatment. She also attended Community Support Group meetings regularly, receiving peer support and counselling for treatment adherence. Furthermore, she was provided assistance in getting a decent job through her city's Chamber of Commerce and Industries, and received social entitlements from Women and Child Development schemes. With this support, she completed her treatment successfully.

    b. Survivor Story 2: Raki, a 32-year-old transgender person, was a popular leader within her community. Despite her health deteriorating, she did not get tested for TB or HIV. Her fear of stigma and discrimnation made her avoid tests that could confirm her sickness, resulting in delayed testing. This delayed detection of TB and HIV was the cause of her death.

c. Survivor Story 3: Chalapati, a 54-year-old transperson, was diagnosed with both TB and HIV. He was on second line ART. After his TB treatment resulted in side effects - there were ulcers in his mouth that were bleeding - the healthcare professionals kept him away from others in the hospital. He died.

Facilitator's Notes:

Stigma, lack of nutrition, below par living conditions, and difficulty accessing health services makes the transgender community more vulnerable to TB. Transpersons afflicted with TB usually have pulmonary TB. Due to severe TB stigma, and the resulting fear of getting thrown out of their family/village/community, they delay testing for TB. The TB stigma faced by transgender persons is so high that they do not even disclose past TB affliction. The layers of stigma of being transgender, HIV positive and TB afflicted makes them avoid government facilities. Even after detecting TB, they can discontinue treatment due to the stigma they face at healthcare facilities.

2. Move on to the PPT with quotes from various categories of people (5 mins)

a. From people with TB

» "I could not get a loaf of bread from the store near my house because they didn't want to sell it to me... I isolated myself... I could not bring myself to share my pain with my friends... I lost my job and was thrown out of my house..." - a man

» "At my workplace, people no longer wanted to share my lunchbox; they would avoid me... I induced self-stigma because I was feeling very guilty..." - a woman

» "My family members keep a distance... Everything is separated... I cook for myself, and wash my own dishes and clothes..." - an older woman

» "My grandchildren and children are innocent and should not get infected through me..." - an older man

» "I'm ashamed if I have to wear a mask in public..." - a young woman

» "I was not certain that I would pull through the long months of treatment..." - a man

» "I faced so many problems... I lost my job – they told me they didn't need me anymore and that I should rest at home...

There was lot of gossip... Even my in-laws reacted meanly... I hated myself..." - a woman

b. From family and co-workers

- "Our biggest fear was how people would react to our daughter's illness... We avoided telling anyone... We did not want our family to get ostracized, but it's difficult to hide... We did it to protect her..." - a father
- "I had an effective team member with TB. He hesitated to seek leave. When he did, with great difficulty, I gave him 2 months... But other team members felt I should replace him as it's not OK for him to rejoin..." - a supervisor
- "My wife (who has TB) is the cause of additional expenditure." - a husband
- "I was so scared when my son was diagnosed with TB. I thought he would die" - a mother

c. From community members

- "I have seen how my neighbor, a young boy of 26 years, was kept away by his family, with everything separate..." - a neighbor
- "I know a family in my neighborhood whose lives were shattered due to TB. They had no money, and even the children were taken out of school. I definitely do not want this to happen to my family. I am completely staying away from the affected family, so that I do not get TB." - a neighbor

d. From healthcare providers

- "They don't share the (TB) disease status... they are not asking family members to seek a TB test..." - community care provider
- "Patients ask me if they'll ever be cured. They think that once they are affected, TB will never go away" - a doctor

e. TB & gender - Conduct a brief discussion on how gender impacts the risk of infection and disease, timely diagnosis, access to treatment, treatment adherence and the need for a gender-based approach to TB. *Please refer to point 6. Some guiding questions for TB and Gender*

3. Choose one of the following two activities

a. Let's grow a tree (20 mins)

- Divide the participants into groups of 6 members each and provide each group with chart paper and markers

- Instruct each group to draw a tree and list down the following as different parts of the tree - roots: causes of stigma, trunk and branches: actions of stigma, fruits and flowers: consequences of stigma
- Each group is given 2-3 minutes to present key points of their discussions and clearly identifying the causes, actions and consequences of stigma

b. Stigma balloons (30-40 mins)

- Ask participants to share different types of stigma experienced by persons with TB. The facilitator should list the stigma on the whiteboard or flip chart while correcting any misconceptions
- Divide the participants into groups of 5-6 members each and provide each group with chart paper and markers
- Assign one stigma to each group. Ask them to draw a circle in the center of their chart paper and then write or sketch a symbol of the stigma assigned to them inside the circle
- Ask the groups "Why does this happen?" and request them to draw or write the reasons in balloons. For every reason, keep asking "Why is it so?," adding further reasons in connecting balloons until they can think of no more reasons
- The facilitator will move from group to group and ask the participants "What does the diagram say about the root reasons of stigma - cultural & religious beliefs, fears, gender factors, myths, etc.?"
- Ask the participants to use a different colour pen to add the consequences to each balloon
- Next, ask the participants to target the root cause (the last of the balloon to the question "Why does this happen?" and list what can be done to prevent the stigma and what resources and support is needed. The points of each group discussion can be saved and utilized in Session 5: Strategic Interventions

4. Move on to the PPT with the definition of stigma and a list of different types of stigma

a. Take time to explain the different types of stigma. Use the facilitator's notes to expound further

b. Ask participants to describe their current thoughts and what they feel needs to change

**Stigma** is described as a phenomenon whereby an individual with an attribute that is deeply discredited by her/his society is rejected as a result of that attribute. It is a process by which the reaction of others spoils normal identity and which disqualifies the individual from full social acceptance. WHO defines stigma as a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society.

**Internalized or self-stigma** - TB-affected individuals may come to absorb or endorse negative stereotypes, and therefore behave or think according to false portrayals and negative messages.

**Anticipated or perceived stigma** - worry that one will be devalued after a TB diagnosis. This fear, often the result of observing others being stigmatized, is so great that it may delay people from seeking and returning for care, or impact adherence to the prescribed medicines. Whether or not stigma actually occurs, anticipated stigma may with interfere TB care.

**Enacted or experienced stigma** - reflects a range of stigmatizing behaviors, messages, and effects that are either directly experienced by persons with TB or by their families and/or that drive others – in particular members of the person's family, community, health care providers, and people at the person's workplace – to acts of discrimination, rejection, or isolation in different settings. Enacted and experienced stigma is two sides of the same coin, either seen from the perspective of the stigmatizer (enacted) or the stigmatized person (experienced).

**Secondary stigma** - refers to the idea that caregivers, friends or family members may expect negative attitudes or rejection because of their association with the disease and/or persons with TB. Furthermore, this may dictate their behaviors or beliefs, regardless of whether stigmatizing attitudes or reactions actually occur.

**Community or public stigma** - negative attitudes, beliefs and behaviors held by the wider community, neighbors or co-workers in particular, or the general public. Closely related to anticipated stigma.

**Structural stigma** - laws, policies, media and institutional architecture that may be stigmatizing or alternatively protective against stigma. This includes societal level conditions, cultural norms and institutional practices that constrain the opportunities, resources and wellbeing of stigmatized populations.

5. Summarize the drivers and facilitators of stigma, consequences of stigma, and the reasons to invest in stigma elimination (10 mins)

    a. Drivers and facilitators of stigma

        - **Fear of TB infection**: belief that TB will never be cured, that treatment is long and drawn out, and feeling that it eventually leads to death. A related fear is that TB leads to economic disaster. Some fears are based on or aggravated by myths, such as that TB is a hereditary disease, or a curse
        - **Belief that TB will not affect them**: as TB is believed to be a disease of the very poor, with the image of an "emaciated man with sunken eyes who is coughing blood", many believe that they or their family members will never get TB
        - **Prejudice about the person with TB:** believing that the disease afflicts those who do 'bad things'
        - **Belief that it is the societal norm**: doing what others, who stigmatize and discriminate against persons with TB, do

    b. Consequences of stigma

        - Low self-esteem
        - Social exclusion
        - Feeling of guilt
        - Isolation
        - Non-disclosure
        - Fewer economic opportunities
        - Reluctant to seek treatment and adhere to treatment
        - Self-stigma
        - Suicidal tendency
        - Negative attitude and behavior

    c. Three strategic reasons to invest in stigma elimination

        - Higher acceptance and utilization of NTEP services
        - Reduced catastrophic cost and better use of resource
        - Better realization of India's goal of TB elimination

6. Some guiding questions for TB and gender

    a. Does gender differences have any impact on how TB progresses?

    b. List different gender identities and how these affect TB?

# Session 4: Vision, Goal & Objectives of the End Stigma Strategy

90 minutes

Flip chart
PPT: vision & goal, flowchart of stigma-free TB response
Chart paper
Markers
Laptop & LCD projector

By the end of this session, the participants will understand the vision and goal of the end stigma strategy, and the principles behind them

## Methodology

1. Ask participants to respond out loud to "What is the need to have a vision and goal to end TB stigma?" Write the answers on the flip chart and circle those that are pertinent (15 mins)
    a. Supplement answers with
        - **Advocate for resource** investments to end stigma
        - **Adopt, build capacity**, and incorporate a cross-cutting strategy for ending stigma and discrimination in all TB interventions with active and informed engagement of persons with or affected by TB
        - Develop and execute a **communications strategy**
        - Design and support the r**oll out of community-led interventions** that mobilize societies to foster non-stigmatizing and non-discriminating behaviours towards persons affected by TB
2. Project the PPT of the vision and goal for the "End stigma associated with TB" strategy (45mins)
    a. Vision (PPT): addressing stigma and discrimination with a vision of a stigma-free TB response that enables India's goal of ending TB, reduces catastrophic costs, and builds higher acceptance and utilization of NTEP services
    b. Goal (PPT): to end stigma and discrimination faced by persons with or affected by TB, through all stages of the continuum of care
    c. Group activity: In groups of 5 members each, discuss (PPT): "In light of the vision and goal presentation, what should be the

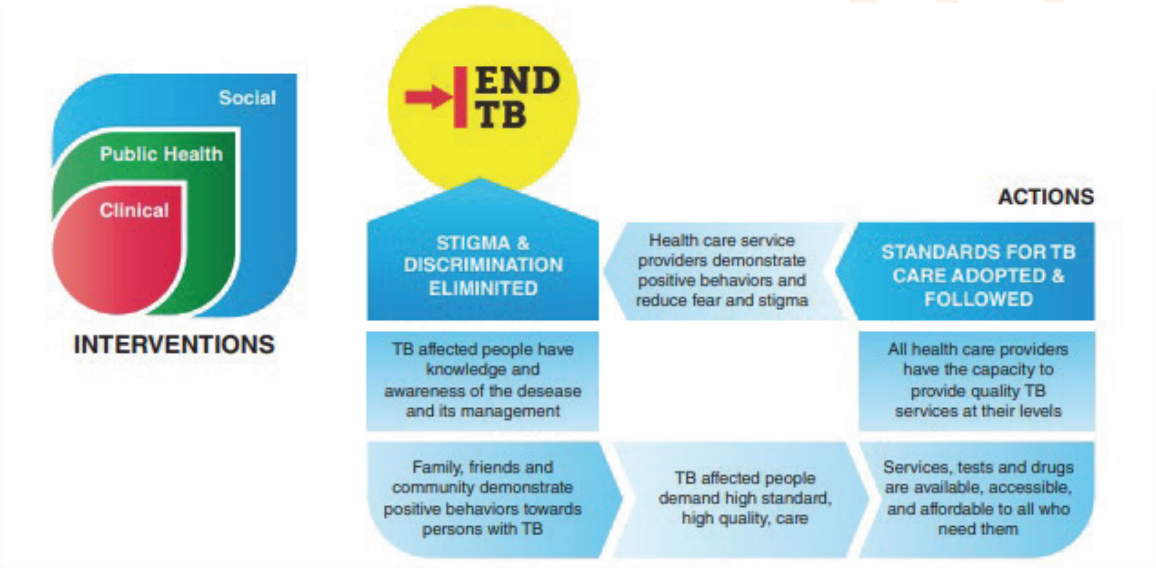
principles and interventions to prevent or remove stigma and discrimination associated with TB?"

Facilitator Notes:

Discussions on persons with TB's immediate needs, creating a sense of security, types of communication, social circle of the affected person, other influencers and their role

d. Presentation by each group on the topic, with the facilitator asking questions to clarify thinking and reach a conclusion (20mins)

e. Summarize with this chart on the PPT




A representation of a stigma-free TB response, and its contribution to the elimination of TB

# Session 5: Strategic Interventions

60 minutes

PPT: strategic interventions, categories of implementation, audience for intervention and strategic interventions summary

Handout B, C, D, E & F
Chart paper
Markers
Laptop & LCD projector

By the end of this session, the participants will be able to review and discuss recommendations for interventions aimed at influencing or benefiting different target audiences in different settings

## Methodology

1. Ask participants to take a moment to review what is being projected. It is clear that a vision and goal should have target audiences in order to draw out specific actions that they can accomplish (15mins)

2. Project over PPT and explain as needed: the strategy is aimed at influencing or benefiting different target audiences in different settings. The interventions are grouped under 3 buckets:

    a. Advocacy

    b. Communication

    c. Community engagement

3. Project over PPT that the above interventions may be implemented in 3 location categories:

    a. Community

    b. Workplace

    c. Health care facilities

4. Project over PPT that the target audience for the interventions are:

    a. Persons with Tuberculosis

    b. Inner circle of said persons

    c. Social circle of said persons

    d. Community members

e. Health care providers

f. Influencers

5. Brainstorm: Divide participants into 3 groups - advocacy, community engagement and communication. Provide them with Handout B, C, D, E & F and ask them to brainstorm the following (45mins)

   a. Under each category on Handout B, brainstorm the tasks/ activities that can be carried out in the region they are in

   b. They can refer to the handout with the definition of the category they are in

   c. Give the participants 20 minutes to brainstorm in each category

   d. At the end of 20 minutes, ask each group to appoint someone to present their insights to the larger group (20 mins)

6. The facilitator can note the key interventions that are being shared by the groups. After each presentation, summarize the strategic interventions listed in the Facilitator's Notes via PPT

   a. Projected on PPT as summary: strategic interventions at community, healthcare and workplace levels

   b. Close by asking participants of their thoughts and connections with their own presentations

7. Review the discussion points from Session 3

Facilitator's Notes:

1. Summary of Key Community Interventions

   a. Spread messages to normalize TB among all target audiences

   b. Encourage communities to promote understanding, empathy, and support to persons with TB and to members of their inner circle

   c. Disseminate messages that help prevent TB, reduce its spread, encourage early diagnosis, and treatment compliance and completion

   d. Improve awareness about the symptoms of TB. Inform people on where to seek health care in their vicinity, on what to expect from health care providers, and disseminate messages to reduce fear and stigma

   e. Where possible, use positive deviants from the target audience to spread messages that influence behavior change among others

of the same group. TB survivors can play an important role in influencing people, especially those with TB and members of their inner circle

f. Strategically engage influencers from political, business/industry, social, and health care arenas to influence communities and people affected by TB, using ways that are mutually beneficial to all concerned

g. Invest in 360-degree communication campaigns on stigma prevention and elimination, effectively and efficiently balancing the use of mass-media, mid-media, outreach (inter-personal communication), and digital media; the campaigns focus on offering solutions to problems faced by persons affected by TB

h. Create treatment support groups locally, to ensure that issues concerning persons with TB and their inner circle are heard and addressed; these support groups include and are preferably facilitated by empowered TB affected persons, or survivors

2. Summary of Key Workplace Interventions

a. In workplaces where NTEP services are not available, carry out advocacy with workplace managers to provide TB services under the program, including screening, testing, treatment, and post diagnosis care and support

b. Advocate for a workplace policy against stigma and discrimination, with specific recommendations and actions that comprise of legal measures against discriminatory practices by employers or co-workers, including during the hiring process

c. Sensitize employers about the impact of TB and TB stigma on workers' productivity and their unique position to support their employees who are affected by TB through early identification, and initiation and completion of treatment

d. Encourage TB survivors and their networks to share their perspectives and advocate for a TB stigma free work environment

e. Improve TB awareness among business owners/proprietors and management personnel

f. Spread messages that normalize TB through amplification of personal TB-related experiences of political leaders, celebrities, and other business leaders

g. Disseminate messages that prevent TB, its transmission from one person to another, and help contacts of persons with TB to reach out for screening, testing and treatment

h. Disseminate messages that promote understanding, empathy, and support towards co-workers with TB and their families

i. Disseminate messages through positive deviants from among co-workers, influencing changes in behavioral norms, or through empowered TB survivors

j. Establish treatment support groups, preferably facilitated by TB survivors, to encourage the sharing of experiences and addressing issues pertaining to people with TB

3. Summary of Key Health Care Facility Interventions

a. The rights-based policy against stigma and discrimination issued by the Government of India includes recommendations for health care service providers

b. Standards for stigma-free TB care are included in the Standards for TB Care in India

c. Include stigma prevention and elimination, and addressing social issues, in medical education and training programs for health care providers

d. Awareness of patient rights among health care providers is improved, and stigma is included as a topic in medical conferences

e. Build capacity of health care providers on use of soft skills, including suitable tone of voice, counseling techniques and avoidance of stigmatizing language and euphemisms.

f. Encourage health care providers to openly discuss TB with persons with TB and their inner circle

g. Improve mechanisms to protect health care staff from infection and provide them with timely post-infection support when needed, thus reducing fear among them

h. Provide communication aids to health care providers, supporting dialogue with persons affected by TB

i. Encourage communities of health care providers and associations of health care facilities to:

» Promote adoption of non-stigmatizing and non-discriminatory language and tone while dealing with people affected by TB

» Engage in conversations on stigma with persons affected by TB to help them deal with, or avoid, stigma and discrimination in various settings

# Session 6: Monitoring and Evaluation of the End TB Stigma Strategy

90 minutes

Handout G, H, I & J
PPT: Objectives of strategy, theory of change to end TB stigma
Flip chart
Markers
Post-training assessment forms
Laptop & LCD projector

By the end of this session, the participants will understand the need for monitoring and evaluating efforts to end TB stigma. They will be presented with the guidelines and indicators applied to measure input and responses to implementation. The participants will also come up with a list of qualitative and quantitative local indicators to end TB stigma at the block/village/district/state level

## Methodology

1. Ask the participants: What is monitoring and evaluation (M&E) and what is the need for it (10 mins)

Faclitator's Notes:

Monitoring and evaluation are both tools that help determine when plans are not working and when circumstances have changed. Monitoring is the periodic assessment of programmed activities to determine whether they are proceeding as planned. Evaluation involves the assessment of the programs towards the achievement of results, milestones, and impact of the outcomes based on the use of performance indicators.

2. Ask the participants how we will perform M&E in this strategy and draw out a few responses from the participants. Capture these responses on the flipchart (10 mins)
    a. Choose 3 participants and give them a handout each (30 mins)
    b. Ask the first participant to read *Handout G: High-level National Indicators* aloud
        » Draw out the participants' understanding of these indicators

- » Facilitator takes time to go into some detail of this indicator

c. Ask the second participant to read *Handout H: National and Sub-National Indicators* aloud

- » Draw out the participants' understanding of these indicators
- » Facilitator takes time to go into some detail of this indicator

d. Ask the third participant to read *Handout I: Other Output Indicators Reported by States and Union Territories, and Reported at the National Level* aloud

- » Draw out the participants' understanding of these indicators
- » Facilitator takes time to go into some detail of this indicator

3. Facilitator explains each section and ties it to the objectives of the strategy (PPT, 15 mins)

   a. Advocate for resource investments to end stigma and discrimination associated with TB

   b. Adopt, build capacity, and implement a cross-cutting and integrated stigma prevention and reduction strategy in all TB care activities, with active participation of TB affected people

   c. Develop and execute a communications strategy using multiple media and formats, addressing various dimensions of TB-related stigma and discrimination

   d. Design and support the roll out of community-led interventions that mobilize societies to foster non-stigmatizing and non-discriminating behaviors towards persons with or affected by TB

4. Draw out any questions, comments, confusion among the participants. Take time to discuss and clarify (20 mins)
5. Give Handout J to all participants
6. Post training assessment (15 mins)

## Handout A: All About Tuberculosis

### 1. What is TB? How does it spread?

- TB is an infectious disease caused by a germ called “Mycobacterium Tuberculosis”
- TB mostly affects the lungs, causing pulmonary TB, but can also affect other organs including bones and joints, kidneys, brain, genitals, urinary tract, spine, lymphatic system, intestines, etc
- When TB affects any organ other than the lungs, it is called extra-pulmonary TB.
- TB spreads through the air. When someone with pulmonary TB coughs, spits or sneezes, droplets of mucous carrying TB germs may be expelled into the air. Anyone who inhales these droplets could develop an active TB infection
- TB can affect people of any age group or economic strata
- Since TB is an airborne disease, anyone who inhales the bacteria can get infected with TB
- When someone inhales the TB bacteria, it can settle in their lungs and cause pulmonary TB. However, it could also spread to other organs via the blood stream and lymph system, and cause an infection in whichever part of the body it settles in
- Many of us have already inhaled the TB bacteria and carry it within our bodies, often without our knowledge. All of us who inhale the TB bacteria do not become ill with the disease. In most people, the normal immune system of the body is able to keep the bacteria well under control. In about 10% of the people who harbour the bacteria, the germs multiply and cause TB disease
- A person with TB infection usually develops TB disease when his or her immunity is lowered
- Poor nutrition, diabetes and HIV are some of the risk factors for TB, as they all lower a person’s immunity
- Smoking is also a risk factor as it weakens the lungs
- Anyone in close contact with someone who has pulmonary TB is at a greater risk of developing TB

### 2. Diagnosing TB

- The symptoms of pulmonary or lung TB may include

- Persistent cough
- Cough of any duration in people who are living with HIV (PLHIV)
- Blood in the phlegm (haemoptysis)
- Fever
- Chest pain
- Loss of appetite
- Loss of weight
- Breathlessness
- In children, specific symptoms such as falling off growth curve, reduced playfulness

### Latent TB Infection (LTBI) and TB disease

» If someone has had a persistent cough, it is important to consult a doctor and get tested for TB

» Pulmonary TB is diagnosed by testing the sputum sample by microscope, any rapid molecular tests such as Cartridge Based Nucleic Acid Amplification Test (CBNAAT) or by sputum culture

» In the case of extra-pulmonary TB, the person will develop symptoms that are specific to the affected area. For example, in a case of intestinal TB, the person may experience diarrhoea or in the case of TB of a particular joint, the person may experience pain and swelling in that area. Besides this, fever, loss of appetite and weight loss is also possible

» Extra-pulmonary TB is ideally diagnosed by examining the affected organ or site. This is done through a biopsy, in which a small bit of tissue or fluid from the affected part is removed through a surgical procedure and examined under a microscope. Alternatively, the sample can be tested by CBNAAT. When a biopsy is not feasible, for instance in the case of the spine, the diagnosis is made with a combination of X-rays, CT or MRI scans and symptoms. A genotypic test would be the preferred test over microscopy, especially in PLHIV and children

» Serological tests (blood tests) are very often inaccurate and have been banned by WHO for the diagnosis of TB. In other words, a blood test will not tell someone if they have latent TB infection or TB disease

» The Mantoux test is a skin test. It checks to see if the immune system of the body recognizes TB, which is a sign that someone may have TB in the system. However, the Mantoux test cannot be used to determine active TB disease but only the presence of the bacteria in the system. A Mantoux test cannot definitively tell if someone has TB disease or not, particularly in the case of adults. However, in children, the Mantoux test is often used to diagnose TB disease

- Screening is sometimes done prior to referring an individual for diagnosis. Screening means assessing whether someone is vulnerable to the disease and needs to be referred for diagnosis. Symptom screening, for example, means assessing whether a person has any of the TB symptoms and is often used as a tool for finding missed people with TB

## 3. Treating TB

- TB is a curable disease
- The course of TB treatment is 6 months for drug-sensitive TB and 24 months or 2 years for drug-resistant TB
- TB is treated with a combination of drugs (HREZ-Isoniazid, Rifampicin, Ethambutol and Pyrazinamide). These drugs are given daily and sometimes as fixed dosed combinations (FDC)
- Every person diagnosed with TB is assigned a treatment supporter (follow national TB guidelines in country) who will be responsible for ensuring that medicines are taken as required, updating the treatment cards, reminders to go for reviews on time, follow-up if there are any side effects and ensuring that the entire course of treatment is completed
- Nikshay is the Treatment Supporter Scheme under NTEP in India. A staff/Treatment Supporter can be any personnel from Medical Officer to MPWs and community volunteers who will be working with the program, including personnel from partner organizations and JEET, and informants.
- It is very important to complete the full course of treatment. It is likely that someone with TB will feel better in a few weeks after starting treatment but that does not mean they are cured. Anti-TB medicines are strong antibiotics and it is essential to complete the course of medicines to ensure that one does not have a recurrence of TB and that the body does not become resistant to the anti-TB drugs (and cause a more serious complication, i.e drug-resistant TB)
- TB can easily be treated on an outpatient basis. Only severe cases and complicated TB treatment require hospitalisation
- TB treatment is available free of cost at all government centres. However, costs in the private sector vary tremendously
- For most people TB treatment is safe and does not cause side effects. However, some people may develop side effects and they should be evaluated by the doctor and offered testing to see if one of the TB medicines is the cause of the problem
- Some side effects with TB treatment include vomiting, nausea, problems with the liver, and problems with the nerves in the hands or feet. Early identification of these side effects is important to make sure they do not cause permanent damage. People on TB treatment experiencing side effects should talk to their doctors right away

| Possible Adverse Drug Reactions (ADR) that need monitoring | | | |
|---|---|---|---|
| | **Adverse Drug Reaction** | **Early Signs and Symptoms** | **Usual Offending Agents** |
| 1 | Gastro Intenstinal Symptoms | Nausea, vomiting, gastritis, diarrhoea | Most drugs, especially Etionamide/PAS/ Pyrazinamide/ Ethambutol |
| 2 | Giddiness | Giddiness, oversleeping, poor concentration | Amino glycosides, Ethionamide, Quinolones and/or Pyrazinamide |
| 3 | Ocular Toxicity | Blurring of vision, disturbance in color vision | Ethambutol |
| 4 | Renal Toxicity | Less than normal urination, total stoppage of urination, puffiness of face, swelling of feet | Kanamycin |
| 5 | Arthralgia | Joint pains | Pyrazinamide, Quinolones |
| 6 | Cutaneous (skin) Reactions | Itching, localised rash, generalized erythematous rash associated with fever and/or mucous membrane involvement | Any of the drugs may give rise to this |
| 7 | Hepatitis | Loss of appetite, nausea/ vomiting, abdominal discomfort, dark coloured urine, jaundice | Ethionamide, Pyrazinamide |
| 8 | Peripheral Neuropathy | Pain and/or tingling sensations, especially in feet and hands | Cycloserine, Ethionamide |
| 9 | Seizures | Convulsions, fits | Quinolones, Cycloserine |
| 10 | Psychiatric disturbances | Depression, excessive chatting, unusual violent tendencies, suicidal tendencies | Cycloserine, Quinolones, Ethionamide |
| 11 | Vestibulo-Auditory disturbances | Ringing in the ear, deafness, unsteady gait, tendency to lose balance and fall | Aminoglycoside |
| 12 | Hypothyroidism | Lethargy/tiredness, slowing of activities, puffiness of face, swelling of the thyroid (neck swelling) | PAS Ethionamide |

## 4. Drug-resistance

- Drug resistance means that the TB medicines are not able to kill the TB bacteria in a person. The bacteria have become resistant to specific drugs, which are therefore no longer effective
- When someone with TB develops resistance to two of the most important drugs used in the treatment, Isoniazid and Rifampicin, the person is said to have MDR-TB
- Drug-resistant forms of TB spread through the air just like other forms of TB
- In some cases, people get MDR-TB by inhaling MDR-TB infected droplets
- The symptoms of MDR-TB are the same as those of "ordinary TB" – a persistent cough, chest pain, fever, loss of appetite and weight loss
- Those who come into frequent contact with someone who already has MDR-TB or a person with TB whose treatment has been interrupted are at a higher risk of developing MDR-TB
- MDR TB is diagnosed by CBNAAT, LPA, MGIT and conventional culture methods. However, it takes anywhere from three to twelve weeks to get results from culture tests
- In 2012 and 2014, two new drugs: Bedaquiline and Delamanid , were conditionally approved by the FDA (Food and Drug Administration) and EMA (European Medicines Agency) for treating MDR-TB, and WHO has issued guidelines for their usage
- XDR-TB is an advanced stage of MDR-TB in which the bacteria, in addition to being resistant to isoniazid and rifampicin, are also resistant to two of the most potent drugs used to treat MDR-TB i.e, flouroquinolones and the injectables. Since someone with XDR-TB is resistant to most of the core drugs used to treat TB, treatment options are limited, highly expensive and have many side effects
- Everyone has a right to the best possible treatment free of charge and people also have a right to know about the side effects before starting on treatment (people-centered, rights-based TB response)

## 5. TB and co-infections

- People living with HIV are up to 20 times more likely to fall ill with TB. TB is the most common opportunistic infection for people living with HIV. This means that those with HIV are considered vulnerable to TB on account of their lowered immunity
- This co-infection also contributes to increased mortality, with over a quarter of the deaths among PLHIV resulting from TB

» The programme mandates that PLHIV should be regularly tested for TB and all people diagnosed with TB should be tested for HIV

» People with diabetes have an increased risk of active TB or TB disease (2-3 times higher than people without diabetes). It is essential that anyone diagnosed with TB is tested for diabetes regularly and vice-versa

» There is some preliminary evidence to show that diabetes worsens TB treatment outcomes – increased deaths and relapse rates

» For the affected individual, managing two infections can be difficult, and support from families and communities is essential

## 6. Support required

» Like other long drawn-out illnesses, TB affects an individual in multiple ways. Apart from the physical symptoms, TB also influences the earning capacity of an individual and patients are often not able to support their family

» People affected by TB face a certain amount of stigma and risk being isolated or ostracised. Everyone should have access to diagnostics and treatment for free

» Psycho-social support

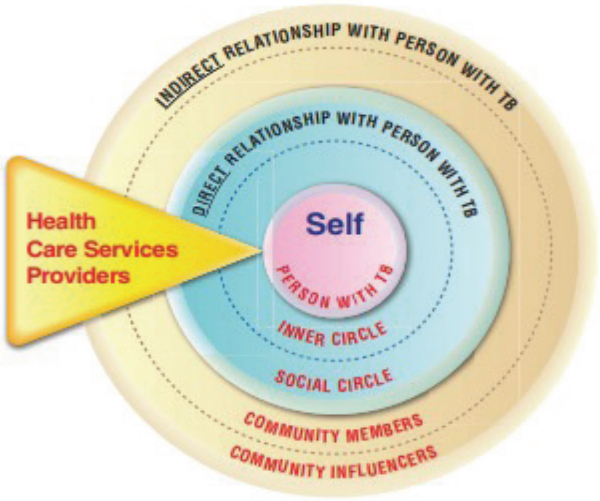
- Counselling: Peer-counselling from TB survivors and/or people affected by TB can be very effective in providing support. Channels for open communication that allow information sharing, peer support, undertaking collective activities and problem-sharing should be established. This can be through meetings, app-based groups, phone calls or other preferred means. Peer counsellors need to keep in mind that issues that fall beyond their scope should be referred to professional counsellors and experts (for example: potential mental health issues, suicidal ideation, serious unaddressed medical complications, etc.)
- Social support: During the course of the treatment, persons affected by TB need the support of family, friends, well-wishers and community members. A good support system can help prevent the patient from spiralling into depression and giving up the treatment. To avoid catastrophic costs, adequate financial support is essential for people who are diagnosed and on treatment for TB

» Access to nutritious food is also important during TB treatment

Handout B

| Location | Strategic Interventions | | |
|---|---|---|---|
| | Advocacy | Communications | Community Engagement |
| In the community | | | |
| At the workplace | | | |
| At the healthcare facility | | | |

Handout C

| Target Audience | Impact Desired |
| --- | --- |
|  | » Diagnosis<br>» Treatment<br>» Post-treatment |

## Handout D: Advocacy

### 1. Advocacy Basics

- Advocacy denotes activities designed to place the TB response high on the political and development agenda, foster political will, increase financial and other resources on a sustainable basis, and hold authorities accountable to ensure that pledges are fulfilled, and results are achieved
- Advocacy often focuses on influencing policy-makers, funding agencies and international decision making bodies through a variety of channels: conferences, summits and symposia, celebrity spokespeople, meetings between various levels of government and civil society organizations, news coverage, official memoranda of understanding, parliamentary debates and other political events, partnership meetings, patients' organizations, press conferences, private physicians, radio and television talk shows, service providers
- While several definitions for advocacy exist, this definition fits our need and is in keeping with existing UN advocacy definitions. Advocacy denotes activities designed to place the TB response high on the political and development agenda, foster political will, increase financial and other resources on a sustainable basis, and hold authorities accountable to ensure that pledges are fulfilled, and results are achieved
- Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions
- Advocacy is a process of change- a series of activities linked to a defined goal – and not just a one-off event
- Advocacy consists of more than one strategy or activity. It entails the implementation of various strategies and activities over time, with creativity and persistence
- Advocacy victories often are preceded by numerous failures. It is important not to give up, but to learn from our mistakes and to continually strengthen an organization in terms of its social power and technical capacity
- Advocacy combines various complementary initiatives in order to achieve an objective. Advocacy influences policy-makers, funders and decision-makers; variety of channels

## 2. Types of Advocacy

- Reactive: Reactive advocacy is based on responding to events after they have happened
- Proactive: A proactive approach focuses on eliminating problems before they have a chance to appear

## 3. Forms of Advocacy

- Policy Advocacy: Informs politicians, etc. how an issue will affect the country; requests specific actions to improve laws and policies
- Program Advocacy: Targets opinion leaders at the national/community level to take action
- Media Advocacy: Validates the relevance of a subject; puts issues on the public agenda, prompts the media to cover TB-related topics

## 4. Possible Advocacy Tools

- Information: Gathering, managing and disseminating information lays the basis for determining the direction of an advocacy campaign. Research is one way of gathering information
- Research: Conducting research and policy analysis uses the information from various sources and develops it into policy options which become the key content of an advocacy campaign
- Media: Various media are used to communicate the campaign's message(s) to the different stakeholders
- Social Mobilization: Mobilizing the broadest possible support from a range of stakeholders, including the public at large, is essential to building the influence of the campaign
- Influencing: Convincing the decision-makers who have the power to make the desired change involves a set of special knowledge and skills.
- Litigation: Sometimes, using the court system to challenge a policy or law can reinforce an advocacy campaign
- Networks, Alliances and Coalitions: Sharing of information and resources, and strength in commonality of purpose are key to the success of advocacy work.
- In relation to TB, it could for example be: (a) a coalition of civil society organisations (CSOs) holding a press conference or jointly signing an open letter; (b) a meeting with a country's President; (c) a drama about rights performed for key decision-makers by actors living with TB
- Advocacy can be written, spoken, sung or acted. It can also vary in the time it takes – from a few minutes to several years. We can do advocacy on our own or with others. It is possible to advocate for other people or for our own selves

## Handout E: Communication

### 1. Communication Basics

» Communicating effectively is the most important of all life skills

» Communication is simply the act of transferring information from one place to another, whether this be:

- Vocally/verbally (using voice)
- Written (using printed or digital media such as books, magazines, websites or emails)
- Visually (using logos, maps, charts or graphs)
- Non-verbally (using body language, gestures and the tone and pitch of voice)

» How well this information can be transmitted and received is a measure of how good our communication skills are

» Communication is the process of imparting or interchanging of thoughts, opinions, or information by speech, writing, or signs

» Principals of Effective Communication for Health

- Accessible – Map your stakeholders and tailor your communication channels to fit them
- Actionable - Messages should encourage decision-makers to take the recommended steps
- Credible - The action-makers should perceive your information to be credible. Use data points from reliable resources only
- Relevant – Communicate to help audiences to see the health information, advice or guidance as applicable to them, their families, or others they care about
- Timely – Communicate the right information at the right time
- Understandable – Communicate without jargon

### 2. Possible Methods

» Spread the message “Anyone can get TB” through amplification of personal TB related experiences of political leaders, celebrities, and community leaders at appropriate levels (local, state, national, others)

» Disseminate messages that encourage community influencers to reassure persons with TB and their inner circle that they will be supported in overcoming barriers to access quality TB care services

» Use all mediums of communication

## Handout F: Community Engagement

### 1. Community Engagement Basics

- The term “community” is widely interpreted in many ways. For our understanding, is is used to refer to a group of people, defined by some common characteristics
- The phrase “affected community” is specifically used to refer to those who have been directly affected by a disease. This could include, for example, someone living with TB as well as their family
- Inadequately served populations refer to people who are vulnerable, underserved or at-risk of TB infection and illness. This could include people living with HIV, people who use drugs, people who have increased exposure to TB due to where they live or work, people who have limited access to quality TB services, and people at increased risk of TB because of biological or behavioral factors that compromise their immune function
- Community engagement is defined as the process of working collaboratively with and through communities to address issues affecting their well-being
- Empowering communities is key to a robust and sustained community engagement programme – communities need the right information in order to participate in the TB response.

### 2. The involvement of communities can:

- Ensure engagement with policymakers and implementers to ensure justice, rights and dignity of persons with TB for effective service delivery
- Supplement and complement government initiatives to enforce persons with TB friendly law, policy and programs
- Help reduce stigma and discrimination and ensure social security of persons with TB, survivors and their families
- Increase the social acceptance of those affected by these diseases
- Break down the barriers/silence around issues of people living with TB
- Bring the perspective of affected populations and people living with disease to the programmes

## Handout G: High-level National Indicators

A. Resources invested to end stigma and discrimination associated with TB

B. Adoption and implementation of a stigma prevention and reduction strategy in TB care activities, with active participation of TB affected people

C. States and partners supported for the development of local strategies and operational guidelines for advocacy, communications, and community engagement, to end TB associated stigma and discrimination

## Handout H: National and Sub-National Indicators

A. Advocacy actions undertaken to improve resource allocation and effort to end TB associated stigma and discrimination; segregated by level of action

B. Communication messages and posts that are aimed at preventing, ending, and mitigating TB associated stigma and discrimination; segregated by route of messaging – mass media, social media, print, out-of-home (posters, hoardings), and other

C. Community engagement activities that solely or inclusively address TB associated stigma and discrimination; segregated by type of activity, and level

## Handout I: Other Output Indicators Reported by States and Union Territories, and Monitored at the National Level

A. TB affected persons recruited, and sensitized or trained, to support the NTEP's efforts to end stigma and eliminate TB; disaggregated by gender, and level or recruitment and sensitization/training

B. Sensitization/training modules developed for capacity building in stigma mitigation; disaggregated by target audience, and level

C. Research activities concerning stigma and discrimination associated with TB, and addressing where in the continuum of care to focus, and on how to act; segregated by type of stakeholder conducting the research, and level

## Handout J: Stigma Free Language Guide

### 1. Ground Realities Highlight Challenges for Accessing Care

» The GCTA conducted trainings across the globe with 250 affected community members. With every training we heard communities listing stigma as one of the top barriers. There are several levels at which stigma needs to be addressed, along with multistakeholder involvement and several creative interventions led by the affected community. One of these is the use of language that is non-stigmatizing and non-discriminatory. Words matter!

### 2. Terms not to use → Use instead

» TB contact → contact person

*(The term does not have strong negative connotations, but it is not person-centered)*

» defaulter → loss to follow-up

*(Historically, the word default(er) unnecessarily and unfairly places the blame on the person receiving the treatment)*

» he/his, she/her → they/them

*(Gender-sensitive language does not presume a binary opposition such as male/female)*

» suspect → person with presumed TB

*(A person who presents with symptoms or signs suggestive of TB. The term suspect is generally used in a criminal law context to indicate a person who is suspected of committing an offense. The term person with presumed TB removes that negative association)*

» TB control → TB prevention and care

*(This term's use is no longer recommended by the WHO because it is not people-centred and ignores the contribution of communities and people affected by TB)*

### 3. These terms have use when discussing certain aspects of TB care. Use carefully

» presumed/presumptive

*Places emphasis on the disease and not the person. Can be rephrased to focus on the person*

- burden

  *It should be stressed that it is the disease and not the people affected by the disease that burden a country, a region or the world*

- case finding/case detection

  *Identification of newly developed TB in an active systematic way or through an inactive identification of new TB by virtue of action taken by the person experiencing symptoms*

- adherent/nonadherent

  *This term unfairly assigns singular responsibility for treatment completion on the person*

- risk groups

  *When discussing an individual or group, it is best to say key and vulnerable populations*

- sputum or smear negative/positive

  *The preferred term is bacteriologically positive/negative*

- patient/TB patient

  *Person on treatment, person receiving health care and, in some countries, client are preferable terms and phrases*

## Pre and Post Assessment Questionnaire

1. TB affects only the lungs.
   a. True b. False

2. TB is the most common opportunistic infection for people living with HIV.
   a. True b. False

3. Stigma is caused by lack of education on TB and its modes of transmission.
   a. True b. False

4. The vision for the 'End stigma associated with TB' strategy is
   a. addressing stigma and discrimination
   b. ending TB
   c. a stigma-free TB response
   d. utilization of NTEP services

5. The following are avenues to engage with audiences that can impact decisions for change:
   a. Communication
   b. Bank loans
   c. Signing files
   d. Advocacy

6. Reactive advocacy is the only kind of advocacy that works.
   a. True b. False

7. Stakeholders can refer to both individuals and institutions.
   a. True b. False

8. One indicator of the program achieving results is
   a. resources allocated to end stigma
   b. more PowerPoint presentations
   c. food distribution

9. Inner circle of those affected with TB are
   a. a close-knit club
   b. people who are emotionally, financially or otherwise invested in persons with TB
   c. public and private providers of healthcare

10. The final outcome of the theory of change to end TB stigma is
    a. to ensure education for all suffering due to TB
    b. to ensure toilets for all suffering due to TB
    c. to ensure zero deaths, disease and suffering due to TB

Answers to Pre and Post Assessment Questionnaire

1. False
2. True
3. True
4. All of the choices mentioned
5. Communication and Advocacy
6. False
7. True
8. Resources allocated to end stigma
9. People who are emotionally, financially or otherwise invested in persons with TB
10. to ensure zero deaths, disease and suffering due to TB

Feedback Form

| Sessions | Excellent | Good | Fair | Poor | Remarks |
|---|---|---|---|---|---|
| Session 1 | | | | | |
| Session 2 | | | | | |
| Session 3 | | | | | |
| Session 4 | | | | | |
| Session 5 | | | | | |
| Session 6 | | | | | |

1. What did you learn during today's sessions that you anticipate using in your work?

2. Was there anything you did not like during today's sessions? Please provide specific examples.

3. Please provide any other comments or suggestions.

Thank you!

Evaluation Form

| | Strongly Disgree | Disagree | Agree | Strongly Agree |
|---|---|---|---|---|
| This course has provided me with new insights and knowledge about various issues related to ending TB stigma | | | | |
| I feel better informed to address TB stigma | | | | |
| I believe this course is very useful in my work environment | | | | |
| I have learned new information and skills that I feel I will be able to pass onto others | | | | |

Do you have any comments on:

Trainers?

Training Methods?

Venue, accommodation, food? (where applicable)

What information was missing from this training that you think is important?

Do you have any other suggestions or remarks?