Evaluation of structure & process of Grama Arogya (GA), Karnataka

PRASANNA SCHOOL OF PUBLIC HEALTH,
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1. ABBREVIATIONS

Sl.No	Abbreviation	Expansion
1	ACS	Additional Chief Secretary
2	AIDS	Acquired Immunodeficiency Syndrome
3	ANM	Auxiliary Nurse and Midwife
4	ASHA	Accredited Social Health Activist
5	AWW	Anganawadi Worker
6	BP	Blood pressure
7	CDPO	Child Development Project Officer
8	CEO	Chief Executive Officer
9	CHC	Community Health Center
10	CHO	Community Health officer
11	DC	Deputy Commissioner
12	DD WCD	Directorate of women and child Development department
13	DHO	District Health Officer
14	DSO	District Surveillance Officer
15	EO	Executive Officer
16	FDA	First Division Clark
17	GA	Grama Arogya
18	GPAAA	Graama Panchayath Arogya Amrutha Abhiyana
19	GPs	Grama Panchayth

20	GPTF	Grama Panchayath Task Force
21	HWCs	Health and Wellness Centres
22	IEC	Information, Education & Communication
23	KHPT	Karnataka Health Promotion Trust
24	MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
25	MLHP	Mid-Level Health Provider
26	MRD	Medical Records Department
27	NCDs	Noncommunicable diseases
28	NGOs	Non-Governmental Organization
29	P2	Panchatantra 2
30	PDO	Panchayat Development Officer
31	PHC	Primary Health Centre
32	PHCO	Primary Health care officer
33	RDPR	Rural Development and Panchayat Raj Department
34	SDA	Second Division Clark
35	TB	Tuberculosis
36	THO	Taluk Health Officer
37	USAID	United States Agency for International Development
38	VRW	Village Rehabilitation Workers

2. EXECUTIVE SUMMARY

The Grama Arogya program is a pioneering convergence initiative in the country developed by the Karnataka government to encourage new synergy among GPs, communities, and rural health institutions. Adopting the design thinking approach, the program focuses on human-centric strategies to enhance public health services. It is also consistent with the flagship Ayushman Bharat program under the National Health Mission (NHM), which seeks to provide universal access to equitable, affordable, and quality healthcare while addressing social determinants of health. Notably, this low-cost approach emphasizes multi-department coordination and community participation. The process evaluation of the program was commissioned by the Rural Development and Panchayat Raj Department (RDPR) of the Government of Karnataka, to the Prasanna School of Public Health, MAHE, Manipal.

The objective of the evaluation study was to understand the structure and process of the GA program from a system perspective at Belagavi, Bengaluru, Mysuru, and Kalburgi, four revenue divisions of Karnataka, and to document best practices and way forward to sustain the GA program.

The evaluation work was developed using a Joint Construction Approach where PSPH, engaged the RDPR and the Karnataka Health Promotion Trust (KHPT) throughout the evaluation's design, development, and dissemination stages. This study employed a qualitative evaluation approach to collect relevant details regarding the GA program. The data collection was conducted in the four districts (Davangere, Koppala, Bagalkot, Mandya) across four revenue divisions of Karnataka state, with one district selected from each revenue division. Data collection involved in-depth interviews (IDIs) and focus group discussions (FGDs) with a total of 50 interviews, including 34 IDIs and 16 FGDs. The participants were the stakeholders associated with the GA program, such as implementers, service providers, beneficiaries, and representatives of the technical support agency

The major findings of the evaluation study are presented below.

The GA program was appreciated as a model for social innovation. The collaborative approach was highlighted, where Panchayats and health departments work together to strengthen community healthcare. Across the four revenue divisions, there is appreciation for the program's implementation in Karnataka and its positive impact on healthcare utilization. The effective convergence model creates a supportive environment for program implementation, which is a significant strength in ensuring smooth operation. However, it has also been suggested that there is room for improvement in the convergence between the departments.

The program capitalizes on the decision-making authority vested in Gram Panchayats. This empowers GPs to tailor public service development, including healthcare initiatives, to address the unique needs of their communities effectively. The concept of "ownership," referred by the stakeholders, reflects this sense of local control and accountability.

The program's positive aspects, such as the doorstep delivery of essential screening services and the focus on NCDs, were emphasized. This emphasis on accessibility and early detection resonated with the community. It was highlighted that the program addresses mental health concerns alongside NCDs and tuberculosis (TB) screenings. The GA program extends beyond disease screening by promoting broader health awareness within communities on child marriage, TB prevention, NCDs prevention, and menstrual hygiene.

Furthermore, state and district-level stakeholders participating in the study confirmed that the program effectively met its established objectives. While most stakeholders recognized the program's objectives, there were variations in recognizing the program by name. Some referred to the program's activities, such as NCD camps, rather than the formal name "Grama Arogya." Similarly, a few district-level stakeholders provided less detailed explanations of the program overall.

The program establishes task forces responsible for implementing the GA program. The stakeholders acknowledged the importance of Gram Panchayat Task Force (GPTF) meetings and the need to organize camp schedules selecting camp locations. These campsites are strategically chosen based on their potential to reach a significant portion of the population. However, concerns emerged regarding the variable camp targets assigned to different Panchayats. This inconsistency raises the question: Could a standardized approach to camp scheduling, informed by community needs assessments, ensure a more equitable distribution of program benefits and reach a wider population across all Panchayats?

While the program leverages the dedication of GPTF members, a critical gap was identified by some district-level stakeholders: the need for standardized training on program implementation. Equipping GPTF members with a comprehensive understanding of program protocols and best practices would empower them to maximize the program's impact at the ground level. The initiative to provide training for both GPTF members and health functionaries was spearheaded by the Karnataka Health Promotion Trust (KHPT). Their leadership in capacity building ensured that personnel at all levels were equipped with the necessary knowledge and skills to deliver the GA program effectively. The implementers consistently highlighted that the KHPT equipped GPs with essential screening kits at the program's inception. These kits contain the necessary supplies for conducting health camps.

The GA program utilizes a comprehensive communication strategy to ensure maximum community awareness about upcoming camps. This multifaceted approach leverages various channels, such as traditional (loud mic announcements) and interpersonal communication (service providers visit the communities). Health camp event dissemination was also done with the help of self-help groups (SHGs).

Several best practices were implemented at the field level, where panchayats were involved in increasing camp participation, particularly among females. This involved engaging SHGs to encourage community involvement, raise awareness, and promote participation. Targeting female work sites such as areca nut farms and encouraging female GP members to support health camps proved to be effective in increasing the number of participants in the screening camps. Providing information about the benefits of early screening and offering flexible health camp timings also proved to be beneficial. Announcing the details of the health camps

through loudspeakers (waste collection vehicle, dangura) in public areas, community meetings, and social gatherings ensured that the information reached a broad audience.

The health camps were conducted at various community hubs, including milk production societies, temples, ration stores, government libraries, and MNREGA work areas to ensure accessibility for a larger population segment. The visibility of health camps at these locations also raises awareness about the importance of regular health check-ups. Organize school events to educate young girls about health issues and the importance of regular health check-ups, fostering a culture of health awareness from a young age. Hold awareness events at schools, where female teachers, who can relate better to young girls, lead discussions on the dangers and illegality of child marriage. Organize events such as celebrating World TB Day to attract community members and create a platform for raising awareness.

There are several challenges, including a lack of knowledge and awareness among the people about the program and the allocation of funds for program implementation. The potential limitations of relying solely on GP revenue to support the GA program were noted. Since tax generation capacity varies across panchayats, a solely GP-funded model might lead to inconsistencies in program delivery. As an alternative, participants suggested increased government allocation for the program.

Camps organized with GP involvement offer additional benefits, potentially allowing participants access to a wider range of health facilities beyond just the basic screening services provided. The expertise of CHOs is utilized to recognize health issues other than the specified program components, and such cases are referred for further evaluation. However, in some areas, there were staffing gaps where CHOs were overburdened, managing two sub-centers.

Key recommendations

- **Establish a state-level multisectoral committee:** A state-level multisectoral committee should be established to coordinate efforts across various sectors for comprehensive public health initiatives. It will pool resources, ensure political support, and promote leadership and advocacy. The committee should include representatives from health, finance, education, and local governance. Clearly defining roles and responsibilities will enhance collaboration and oversight within departments
- **Set targets and indicators to foster accountability:** Setting clear targets and indicators is crucial for monitoring progress and ensuring accountability. Develop specific, measurable, achievable, relevant, and time-bound (SMART) targets for various components of the GA program. Regularly review and adjust strategies based on these indicators to measure impact and identify improvement areas.
- **Activities and campaigns to raise awareness among the public:** Public awareness is vital for community involvement and support for the GA program. Implement effective campaigns to educate on benefits and promote preventive health behaviours. Use diverse channels like community radio, social media, and local events for outreach. Engage community leaders and influencers to help disseminate information and encourage participation.

- **Camp planning and advance information:** Effective camp planning and advance information are crucial for ensuring community participation in health camps. Develop a detailed schedule and communicate it through multiple channels to inform the community. Choose accessible locations and allocate resources efficiently. Create and regularly update tailored plans to reach all potential beneficiaries, considering their specific needs and circumstances.
- **Expand program scope to include other diseases:** Expanding the program to include disease screenings for malaria, HIV, and others enhances its comprehensiveness and community benefits. This approach addresses diverse health needs and improves overall health outcomes. Integrate screening and testing for these diseases into health camps for a more holistic impact on community health.
- **Strengthen local-level convergence:** Local-level convergence ensures efficient collaboration among departments to support the GA program, enhancing resource sharing and coordination for better outcomes. Encourage cooperation between GP members and other departments and hold regular interdepartmental meetings to review progress, address challenges, and strategize effectively.
- **Improve communication between departments:** Effective communication is crucial for smoothly coordinating activities and addressing implementation gaps. Establish clear channels and protocols between departments, leveraging technology like shared databases and virtual meetings for information sharing. Regularly review communication processes to prevent misunderstandings and provide training to improve staff communication skills.
- **Budget Allocation for Consumables and Incentives:** Adequate budget allocation for consumables and incentives is crucial for sustained program operations, an incentive could enable the volunteer's motivation. Allocate funds for essential medical supplies and provide incentives to volunteers. Ensure appropriate consumables are procured to prevent service disruptions, identify compatible supplies, and maintain a list of reliable local vendors for quick procurement.
- **Designate a responsible contact person/volunteer in GP:** Having a dedicated person responsible for the GA program ensures accountability and smooth operations. It facilitates better coordination and communication between the community and external stakeholders. Designate a volunteer or staff member in each GP to oversee the implementation of the GA program. Clearly define the designated person's roles and responsibilities to avoid ambiguity.
- **Fill vacant positions for data entry operators:** Data entry operators are crucial for maintaining accurate records and ensuring data quality. Filling these positions ensures data is collected, entered, and analysed efficiently. Recruit and train data entry operators to fill existing vacancies. Provide ongoing support and training to ensure high standards of data management.
- **Capacity building through onsite training programs:** Continuous training and capacity building is crucial for equipping GP members with the skills needed for effective GA program implementation. Develop tailored training materials and conduct regular onsite sessions for practical learning. Regular training programs keep staff updated on

the latest practices, fostering improvement and innovation. Monitor and evaluate training to ensure its effectiveness and identify areas for enhancement.

- **Strengthen capacity for data management at the GP level:** Strong data management capabilities are essential for effectively monitoring and evaluating the GA program. Accurate data helps in making informed decisions and improving program outcomes. Enhance the capacity of GPs to collect and maintain the data effectively so that it eases the data analysis and utilization at the state level. Necessary training and resources for robust data management practices have to be supported by the state.
- **Develop and maintain a documentation repository:** Maintaining a documentation registry for the process of GA implementation ensures continuity and quality of care rendered, and helps in periodic monitoring and evaluation of the program. Developing a registry system to record and track diagnosed cases and referrals helps track outcomes and improve the quality of health services. Ensure that the registry is regularly updated and accessible to relevant healthcare providers.

This inaugural assessment report for the GA program underscores its significance and potential for long-term success. The program's ability to address social determinants of health through community outreach demonstrates a ground-breaking approach. Furthermore, point-of-care testing, by increasing accessibility and facilitating referrals, elevates the GA program to the realm of social innovation. With people at its core, this holistic and contextual approach offers a replicable model for improving healthcare delivery in underserved communities. By addressing initial challenges and leveraging innovative strategies like community radio and waste collection announcements, the GA program paves the way for a healthier future for all.

3. INTRODUCTION

The Panchayati Raj system is a form of local governance with a long history in South Asia, particularly in India. It has roots as one of the oldest such systems in the Indian subcontinent. The concept resonates with ideals of empowering local communities, echoing the dream of 'Gram Swaraj' (village self-rule) championed by Mahatma Gandhi. The 73rd Amendment to the Indian Constitution in 1992 further strengthened this system by granting Panchayats constitutional status and a role in planning and implementing programs for economic development and social justice (1).

As of 2024, Karnataka has a population of approximately 61.1 million. This represents a significant portion of India's total population. For reference, data from the 2011 census showed a gender breakdown of 30,966,657 males and 30,128,640 females (2). The 2011 census indicated that children under 15 accounted for roughly 29.7% of the population. Adults aged 60 and over comprised 5.5%, with the working population between 15 and 60 years old representing approximately 64.9% (3). The state of Karnataka is a pioneer in the decentralized administration system of the Panchayat Raj Institution. Karnataka Panchayat Raj Act 1993 introduced a 3 tier Panchayat system with elected bodies at all levels established to make our institution effective as units of local self-government (4). The Grama Panchayat (GP) represents the foundation of the Panchayati Raj system. Serving a cluster of villages, these bodies are directly elected by the local citizens. The GP is led by an Adhyaksha (President) and Upadyaksha (Vice President). The GP also has standing committees focused on production, social justice, and amenities (5).

Production Committee: This committee oversees matters related to agricultural production, animal husbandry, rural industries, and poverty alleviation programs.

Social Justice Committee: This committee promotes education, economic well-being, and social and cultural development for disadvantaged groups. It also focuses on protecting women, children, and vulnerable populations from exploitation.

Amenities Committee: This committee manages essential services within the GP's jurisdiction, including education, public health, and public works.

Staffing: Each GP is supported by a Panchayat Development Officer (PDO). The GP may appoint additional staff with approval from the Zilla Panchayat's Chief Executive Officer (ZP-CEO) (6).

Projections based on the Rural Health Statistics 2019-2022 suggest Karnataka's population may surpass 6.2 crore, representing approximately 5.05% of India's total. The state boasts a literacy rate of 75.4%, exceeding the national average of 72.99% as of March 2020. Karnataka has a well-established healthcare infrastructure with 9,188 sub-centers, 2,176 Primary Health Centres (PHCs), and 189 Community Health Centres (CHCs). It's noteworthy that Karnataka faces a significant gap in CHCs, with a current shortfall of about 43% compared to the

sanctioned number. While there's no shortfall in sub-centers and PHCs, the state currently has 2,071 medical doctors against the sanctioned 2,323 positions, reflecting a vacancy rate of about 11%. Similarly, there are 13,371 Auxiliary Nurse and Midwives (ANMs) compared to the sanctioned strength of 17,748, indicating a vacancy rate of approximately 25%. The state's overall IMR (Urban + Rural) stands at 23 infant deaths per 1,000 live births, with rural areas experiencing a slightly higher rate of 25 deaths per 1,000 live births (7) (8).

Grama Arogya (GA): Empowering Rural Healthcare

The Grama Arogya (GA), formerly known as Grama Panchayath Arogya Amrutha Abhiyaana (GPAAA), is a first-of-its-kind initiative launched by the Government of Karnataka. This program aims to strengthen the leadership of Grama Panchayats (GPs) in ensuring the health and well-being of rural communities. It has five components, “Gram Panchayat COVID Management Kit,” “TB Muktha Panchayat,” “Sahita Tele-counselling Careline,” “COVID Care Kit,” and “Awareness and IEC.” With a long-term goal of addressing NCDs, mental health issues, elimination of child marriages, and malnutrition. The program equips GPs with resources like the "Gram Panchayat COVID Management Kit" to effectively address health challenges. The "TB Muktha Panchayat" component actively works towards eliminating tuberculosis in rural areas. "Sahita Tele-counselling Careline" provides mental health support through a dedicated helpline. "COVID Care Kit" ensures essential supplies are readily available for COVID-19 management. "Awareness and IEC" campaigns educate communities on various health topics. GA goes beyond immediate needs, aiming to address chronic diseases (NCDs), mental health issues, child marriage, and malnutrition in the long run.

The program was initially rolled out in 2,816 GPs in 110 talukas across 13 districts (Bagalkot, Ballari, Belagavi, Chamarajanagara, Davanagere, Gadag, Kalburgi, Koppala, Mandya, Mysore, Raichur, Vijayapura, and Yadgiri). A dedicated Grama Panchayat Task Force (GPTF) was crucial in its implementation. Health and Wellness Centers (HWCs), Jan Arogya Samitis (JAS) with healthcare personnel like ASHAs, Mid-level Healthcare Providers (MLHPs), and ANMs, formed the backbone of service delivery. The GPTF will enable the screening for NCDs, identifying and referring suspected TB cases, establishing linkages to mental health services, promoting nutrition services, organizing campaigns against child marriage, mitigating stigma against certain diseases, and promoting the right information and awareness among the communities (9). On July 3rd, 2023, the program transitioned from a mission-mode initiative (Abhiyan) to a regular program (KPRA/development/285/2023), leading to its name change to Grama Arogya (GA). The Karnataka Health Promotion Trust (KHPT) provided technical support for capacity building of the GPTF and program monitoring (10).

The Rural Development and Panchayat Raj Department (RDPR) of the Government of Karnataka commissioned the Prasanna School of Public Health at Manipal Academy of Higher Education (MAHE) to evaluate the Grama Arogya program. A collaborative approach was adopted for district selection to ensure a representative sample. The research team, RDPR,

and the technical support agency worked together to reach a consensus on four districts. These districts were chosen based on two key criteria:

Geographical Representation: The four districts - Koppal, Davangere, Bagalkot, and Mandya - represent each of Karnataka's four administrative divisions.

Program Rollout: These districts were among the first to implement the Grama Arogya program.

3.1 Rationale for evaluation

Gram Panchayats (GPs) serve as the cornerstone of rural healthcare delivery in India. Recognizing this crucial role, the Government of Karnataka (GoK) launched the Grama Panchayath Arogya Amrutha Abhiyana (GPAAA), a pioneering initiative aimed at strengthening health and nutritional services within rural communities.

The initial rollout of GPAAA took place in September 2021, targeting 2,816 GPs across 14 districts. Given the program's promising impact, the GoK strategically expanded it state-wide in September 2022, encompassing all 5,957 GPs across 31 districts. This expansion ensures comprehensive coverage for Karnataka's rural population of approximately 37 million.

The Need for Process Evaluation:

Conducting a process evaluation of the GPAAA program is critical at this juncture. A thorough evaluation will shed light on the program's implementation strengths and weaknesses. We can leverage the program's successes and address existing challenges by identifying these areas. This information will be instrumental in informing future program planning and optimizing the delivery of vital healthcare services to Karnataka's rural communities.

4. Aim and Objectives

Aim

This project aims to understand the structure and processes involved in the implementation of the Grama Aarogya program in Karnataka.

Objectives

1. To understand the structure and process of GA program from a system perspective at Belagavi, Bengaluru, Mysuru, and Kalaburagi, four revenue divisions of Karnataka.

2. To document best practices and way forward to sustain GA.

5. METHODOLOGY

This study employed a qualitative evaluation approach to gather relevant details regarding the Grama Arogya program. The work was developed using a Joint Construction Approach, where PSPH, MAHE, and Manipal engaged the RDPR and the KHPT throughout the evaluation's design, development, and dissemination stage.

5.1 Setting

The state of Karnataka is the sixth largest state in India, spanning between 11° 30' and 18° 30' N latitude and 74° 15' and 78° 30' E longitude and divided into four revenue divisions for the ease of administration, i.e., Bengaluru, Belagavi, Mysuru, and Kalaburagi (11). The below map shows the four districts where the GA program was evaluated. One district from each revenue division was considered.

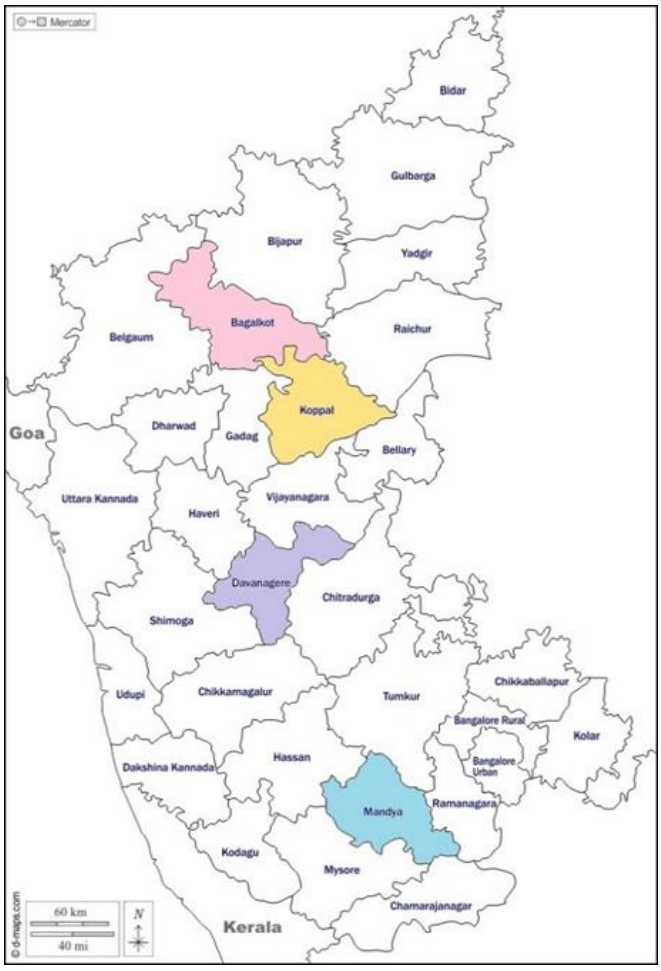

Figure 1: Four districts of Karnataka where the data collection was carried out.

5.2 Design

The study used a combination of in-depth interviews (IDI), focus group discussions (FGD), and stakeholder consultation. IDI "is a qualitative research technique used to conduct detailed interviews with a small number of participants." IDIs were used as it was easier to capture the information from the interviewees with minimal barriers to express (12). Focus groups are in-depth interviews employing relatively homogenous groups to provide information about topics specified by the researchers. FGDs provide a platform to express opinions and allow space for the participants to engage in a discussion between and with the moderator. Stakeholders are defined as "individuals, organizations or communities that have a direct interest in the process and outcomes of a project, research or policy endeavor" (13). Engaging stakeholders in the research cycle reduces the gap between evidence producers and consumers (14) (15).

5.3 Establishment of interpersonal relationships with participants:

The relationship with some of the participants was established *a-priori* (before the commencement of the data collection phase). The RDPR department issued a letter to the office bearers at the district level and informed them about the visit of the team to evaluate the GA program. The same was further shared with the implementing agency (KHPT), which had deployed district-level leads and taluk-level staff to provide technical support for the implementation of the program. The implementing agency had further appraised the prospective individuals regarding the interviews and facilitated the process. Thus, the participants were aware of the research team, their credentials, and the purpose of the visit.

5.4 Participant Selection

The participants were selected based on their designation, involvement in implementing the GA program, participation in the GA program as a beneficiary, and willingness to participate in the study. The research team from PSPH closely engaged with KHPT and the RDPR to identify all the potential stakeholders for the study.

5.5 Inclusion Criteria:

All the participants who voluntarily consented to participate in the study and were associated with the GA program. Interviews were transcribed for those individuals who consented to audio recording. They include the Additional Chief Secretary (ACS), Chief Executive Officer (CEO) of the Zilla Panchayat (ZP), the Executive Officer (EO) of the panchayat, the Public Development Officer (PDO), the Nodal Officer (a designated officer for the execution of the GA program at the district level), the president of the Panchayat, the District Health and Family Welfare Officer (DHO), the Community Health Officer (CHO), the ASHAs, the Anganwadi Workers (AWW), the Deputy Director of the Women and Child Development Department (DD-WCD), the members of the Grama Panchayat, and beneficiaries including the members of the vulnerable community Persons with Disabilities, Transgenders and KHPT zonal head and division head.

5.6 Exclusion Criteria: We excluded individuals who did not consent to participate in the study and those who were not available at the time of data collection.

5.7 The setting of the interview

Interviews were conducted in a location/setting comfortable to the interviewee or the members of the FGD. It included office rooms, discussion halls, and individual chambers. Since the interviews were conducted in government offices, bystanders were present. Field notes were taken by the interviewers and the note-takers. The same has been utilized to strengthen the report.

5.8 Tool Development and Data Collection

Developing and Refining the Interview Guide:

An iterative approach was employed to develop a comprehensive interview guide for the In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs). Trained researchers initially drafted the guide, incorporating valuable insights from the implementing agency (KHPT). Subsequently, the commissioning agency (RDPR) reviewed and provided further feedback on the content.

Ensuring Clarity and Consistency:

The interview guide was initially developed in English, the primary research language. It was then translated into Kannada, the local language, to ensure accessibility for participants. Stakeholder verification ensured consistency between the English and Kannada versions.

Pilot Testing and Refinement:

To pilot test the interview guide and assess its effectiveness, researchers conducted IDIs and FGDs in the Udupi district. Based on the pilot results, the researchers incorporated modifications to improve clarity and flow.

Data Collection Procedures:

The final interview guide was used to conduct IDIs and FGDs. All interviews were audio recorded using a designated audio recording device (SONY stereo IC Recorder, ICD-UX570F) to capture the discussions accurately. Importantly, audio recording also facilitated obtaining informed consent from participants. To accommodate participant preferences, interviews were conducted in both English and Kannada. Following each interview, researchers provided an opportunity for post-interview discussions, and any relevant points were documented in the field diary.

The following tools were developed:

1. IDI tool for the program implementers
2. IDI tool for the program beneficiaries

3. FGD tool for the program beneficiaries
4. IDI tool for the vulnerable group
5. FGD tool for Grama Panchayat members

5.9 Data management

Data Security and Retention:

All collected data will be stored securely for three years following the study's completion. The Principal Investigator (PI) will be responsible for ensuring data security in accordance with institutional policies and data protection regulations.

Data Usage and Access:

Data collected for this study will be used solely for academic and research purposes related to the Grama Arogya program evaluation. Access to the data will be granted only on a need-to-know basis and with the prior approval of the PI. The PI will ensure compliance with all relevant data protection regulations when considering data access requests.

5.10 Data analysis

The audio data was translated (orally) and transcribed using MS Word 2010 by the research team (RK, ADS, SN, and RN). RN was not a part of the team that conducted the interviews, and SN captured field notes. The transcribed files were not shared for member checking. The files were reviewed by NG for consistency in transcription, and corrections were incorporated. The files were then coded using ATLAS.ti, as the institution had access to the proprietary software (16,17).

5.11 Code development

To analyse the interview data effectively, a coding framework was developed using a combination of inductive and deductive approaches.

Inductive Codes: These codes emerged directly from the data itself. As researchers went through the interviews, they identified recurring themes and concepts, leading to the creation of new codes.

Deductive Codes: These codes were pre-determined based on existing knowledge and research questions related to the Grama Arogya program. To refine the deductive code list, an initial analysis of a representative sample (10% or five transcripts) was conducted. This analysis helped ensure the pre-determined codes were relevant to the actual data and allowed for additional codes to emerge organically during the coding process.

Ensuring Consistency and Interpretation

A codebook was developed to maintain consistency in applying the codes across all interviews. This codebook documented the meaning and application of each code, allowing

researchers to interpret the findings accurately and ensuring clarity for readers of the final report.

From Codes to Themes

Once the coding was complete, similar codes were grouped into categories based on their thematic connections. These categories were then further combined to form broader themes that captured the overall insights from the interviews. The themes could be pre-set (based on the initial research questions) or emerge organically during the analysis. We categorized the identified themes as major or minor based on the number of sub-categories they encompassed.

5.12 Thematic Analysis

Following the development of the coding framework and thematic identification, a thematic analysis was conducted to interpret the data and draw meaningful conclusions about the Grama Arogya program (17).

5.13 Study Reporting

The study is reported according to the Consolidate Criteria for Reporting Qualitative Studies (COREQ) (18).

5.14 Stakeholder consultation/workshop: To ensure a comprehensive evaluation of the Grama Arogya program, the Prasanna School of Public Health, Manipal Academy of Higher Education (PSPH-MAHE) organized a two-day stakeholder consultation workshop on February 15th and 16th, 2024. Key stakeholders from the Karnataka Health Promotion Trust (KHPT), the Grama Arogya team, and the PSPH-MAHE Evaluation team participated in these discussions.

The workshop fostered a collaborative environment for achieving a robust evaluation. The objectives focused on:

Program Understanding: Participants gained a deeper understanding of the Grama Arogya program and its goals.

Evaluation Tool Discussion: The developed evaluation tool was presented and discussed, ensuring its effectiveness for data collection.

Challenge Identification: Stakeholders identified potential obstacles and challenges that might arise during the evaluation process. Proactive mitigation strategies were explored to address these concerns.

Data Collection Planning: The workshop facilitated discussions on potential sites and dates for data collection, ensuring a well-defined data collection plan.

Tool Finalization: Data collection tools were finalized during the workshop, streamlining the data collection process.

5.15 Ethical Consideration

The study follows the principles envisaged in the Declaration of Helsinki (19). Since the study was commissioned by the RDPR, GOK, necessary approvals were obtained from them. The approvals were further submitted to the Institutional Ethics Committee of the Kasturba Medical College and Hospital Ethics Committee, and they received the clearance bearing no. 218/2023.

Informed Consent

A Participant Information Sheet (PIS) was provided to all the participants (Appendix-4A and 4B) in the local dialect, following which informed consent was obtained from all the participants who were willing to participate in the study voluntarily (Appendix-5A and 5B). Before obtaining the consent, the prospective participants were explained the aim, objectives, and potential risks of participating in the study.

Confidentiality and privacy

Throughout the data collection and analysis process, we prioritized participant confidentiality. We ensured it through:

De-identification: All interview recordings were anonymized during transcription. Names and any other direct identifiers were removed to protect participant privacy.

Secure Storage: All transcripts and related data were stored securely on password-protected systems in accordance with institutional data security protocols. Only authorized personnel involved in the research project had access to this data.

Limited Access: Following the completion of the technical report and dissemination activities, access to the data will be further restricted. Only the Principal Investigator (PI) will retain access for potential future research purposes, subject to additional ethical review and approval.

6. RESULTS

6.1 Respondents' characteristics

A total of 170 respondents were approached and invited to participate in the study. One hundred sixty-six individuals (97.6%) agreed to participate in the study and participated in the study. Four did not participate in the study due to elections and other official engagements. The details of the participants are attached in Annexure 11.

6.2 List of codes and their definitions

The qualitative data analysis employed a thematic approach, leveraging both inductive and deductive coding strategies.

Inductive Coding: This data-driven approach involved identifying recurring themes and concepts directly from the interview transcripts. Researchers coded the transcripts, assigning labels to capture the emerging issues raised by participants. This process yielded 59 inductive codes.

Deductive Coding: Building upon existing knowledge and research questions, the analysis also incorporated a set of 25 deductive codes derived from the interview guide and literature reviews related to the Grama Arogya program.

A detailed codebook was developed to ensure consistency in coding and interpretation. The same may be accessed in Annexure 12.

From Codes to Themes

Following the coding process, researchers grouped similar codes into broader categories to identify overarching themes. This analysis resulted in 30 categories, with 8 emerging from the deductive codes and 22 emerging from the inductive codes.

Identifying Key Themes

Finally, the identified categories were further analysed to form a smaller set of core themes that captured the most significant findings from the interviews. Seven major themes emerged from this process. Notably, six of these themes were pre-set based on the initial research questions, while one theme was a significant emergent theme not initially anticipated.

6.3 Themes and subthemes

On conducting a thematic analysis, the findings of the research are presented in the form of themes. Here are the core themes that emerged from the data:

Program Implementation: This section examines how effectively the program was rolled out and executed.

Convergence: Here, we explore how Grama Arogya collaborated with other initiatives to achieve its goals.

Decentralization: This theme analyzes the program's success in empowering Gram Panchayats.

Challenges and Enablers: We identify the key obstacles faced by the program and the factors that facilitated its progress.

Best Practices: This section highlights successful strategies employed during program implementation.

Sustainability: Here, we assess the program's long-term viability and potential for continued impact.

The themes and subthemes are summarised in Table 1. Each theme is enriched with 2-5 relevant quotes directly from participants, providing valuable insights from the field. The quotes are enlisted separately in Table 2 at the end of the results section and quote numbers are cited in the respective description.

	THEMES AND SUBTHEMES												
SUBTHEMES	THEMES												
	1	**PROGRAM IMPLEMENTATION**	**2**	**CONVERGENCE**	**3**	**DECENTRALISATION**	**4**	**CHALLENGES**	**5**	**ENABLERS**	**6**	**BEST PRACTICES**	**7**	**SUSTAINABILITY**
	1.1	Emergence of Grama Arogya Program	2.1	Coordination	3.1	Delegation	4.1	Program activities	5.1	Technical Support	6.1	Success stories of problem-solving	7.1	Suggestions on strategy
		• Program History		Coordination to procure Consumables	3.2	Ownership	4.2	Implementers (Stakeholders)	5.2	Beneficiary feedback	6.2	Success stories on disease screening	7.2	Technology adoption
		• Frugal Innovation-A low-cost new Initiative	2.2	Communication	3.3	Existing process	4.3	Implementation process			6.3	Mobilizing for camps	7.3	Human resources
	1.2	Program Understanding		• Communication at the stakeholders' level	3.4	Challenges	4.4	Community participation			6.4	Success stories of the fight against child marriage	7.4	Strengthening of GPTF
		• Program Objectives and Understanding by Implementers.		• Behavioral change communication			4.5	Consumables			6.5	Program as a Success Story	7.5	Budget allocation
		• Implementation process		• Information Communication									7.6	Capacity building

		• Program Monitoring		• Challenges in Communication								7.7	Rewarding Panchayats and Incentives
	1.3	Program Stakeholders and Capacity Building	2.3	Knowledge and Health Literacy								7.8	Technical support
		• Gram Panchayath Task Force structure and involvement		• Lack of knowledge about the GA program								7.9	Awareness and communication
		• Capacity Building		• Hesitancy due to low Health Literacy level								7.10	Monitoring and follow-up
	1.4	Program Activities, including finance and data management										7.11	Involving Vulnerable Community
		• Organization of health camps, Screening activities, Awareness programs, Child marriage											

		prevention, and Mental health, Referrals												
	1.5	Program Utilization and Anticipated Benefits												
		• Equity Access and gender differences												
		• Anticipated program benefits												

Table 1: Themes and subthemes

6.4 Description of themes and subthemes

The themes are derived as follows:

Program Implementation (E)	Convergence (PS)	Decentralisation (PS)	Challenges (PS)
Enablers (PS)	Best Practices (PS)	Sustainability (PS)	

*PS=Pre-set, E=Emerged

1. **PROGRAM IMPLEMENTATION**

The Grama Arogya program, a pioneering initiative by the Karnataka government, stands out for its focus on **convergence**. This means it brings together different resources and stakeholders to strengthen rural healthcare delivery by:

- **Equipping Gram Panchayats (GPs):**

One of the program's main pillars is empowering GPs, the backbone of rural healthcare in India. Grama Arogya equips GPs with the tools they need to serve their communities effectively. This includes providing them with:

Technical Tools: These tools, such as screening and testing kits, enable GPs to conduct basic health checks and identify potential health concerns within their communities.

Supporting Health Camps: Grama Arogya facilitates organizing health camps within villages. Frontline workers (like ASHAs) and healthcare facility staff collaborate with GPs to deliver these services.

- **Enhancing Accessibility through Point-of-Care Testing**:

The program provides GPs with "health management kits" for point-of-care testing. This means health professionals can diagnose and potentially treat certain conditions immediately, eliminating the need to travel to distant facilities. For more complex cases, point-of-care testing also helps identify individuals who require referral to higher-level healthcare centers. The “program implementation” theme includes the below subthemes:

1.1. Emergence of Grama Arogya Program

1.2. Program Understanding

1.3. Program Stakeholders and Capacity Building

1.4. Program Activities, including finance and data management

1.5 Program Utilization and Anticipated Benefits

1.1 Emergence of Grama Arogya Program

1.1.1 Program History

Participants recounted how, during the COVID-19 pandemic, the Karnataka Health Promotion Trust (KHPT) and the Rural Development and Panchayat Raj Department (RDPR) collaborated on discussions to distribute essential healthcare devices to support communities. This collaboration also recognized the growing impact of co-morbidities like Non-Communicable Diseases (NCDs). As a result, a limited number of point-of-care devices were included in a health management kit.

Building on the successful multi-departmental coordination and the panchayat's response during the COVID-19 crisis, the concept of Grama Arogya was born. The program officially launched in 2021, with its initial phase implemented across 14 districts in Karnataka. Notably, the task force established to manage the COVID-19 response was expanded and transformed into the present-day Gram Panchayat Task Force (GPTF). This dedicated body now is responsible for implementing the Grama Arogya program at the grassroots level.

The Karnataka Health Promotion Trust (KHPT) provided technical assistance for the Grama Arogya program. With the crucial support of USAID, health management kits were procured and distributed to all participating Gram Panchayats (GPs) across the initial 14 districts. Recognizing the program's positive impact, the initiative was strategically expanded to encompass all 31 districts in Karnataka (Q1).

1.1.2 Frugal innovation, a low-cost new Initiative

Participants emphasized a key challenge: accessing healthcare often involved traveling to a hospital, a time-consuming and potentially expensive endeavor. Each required test added to the financial burden. The Grama Arogya program directly addresses these concerns. By providing screening services at the community level, the program eliminates the need for lengthy travel and ensures these services are free (Q2).

One interviewee appreciated the Grama Arogya program as a model for social innovation. They highlighted its collaborative approach, where Panchayats and health departments work together to strengthen community healthcare. Participants across the four revenue divisions expressed appreciation for the program's implementation in Karnataka and its positive impact on healthcare utilization (Q3).

1.2 Program Understanding

1.2.1 Program Objectives and Understanding by Implementers.

The study revealed a high level of awareness among some participants regarding the Grama Arogya program's objectives. Many participants specifically highlighted the program's positive aspects, such as doorstep delivery of essential screening services and a focus on NCDs. This emphasis on accessibility and early detection resonated with the community.

Furthermore, state and district-level stakeholders participating in the study confirmed that the program is effectively meeting its established objectives (Q4, Q5).

While most participants recognized the program's objectives, there were variations in recognising the program by name. Some referred to the program's activities, such as NCD camps, rather than the formal name "Grama Arogya." Similarly, a few district-level participants provided less detailed explanations of the program overall. However, these participants did demonstrate knowledge and experience with specific program activities relevant to their departmental roles (Q6, Q7).

Field-level implementers described how micro-plans are developed during initial meetings to ensure smooth program execution. These plans outline camp schedules, which are then communicated to villagers through loudspeaker announcements. Participants consistently mentioned the value of screening and awareness activities conducted at various campsites. Furthermore, feedback highlighted the positive collaboration between the health department, Anganwadi workers (community health workers), and GP staff in delivering program activities (Q8, Q9).

1.2.2 Implementation process

While participants acknowledged the importance of Gram Panchayat Task Force (GPTF) meetings and the need to organize camp schedules, concerns emerged regarding the variable camp targets assigned to different Panchayats. This inconsistency raises the question: Could a standardized approach to camp scheduling, informed by community needs assessments, ensure a more equitable distribution of program benefits and reach a wider population across all Panchayats? ((Q10, Q11, Q12)

1.2.3 Program Monitoring

Panchayat Development Officers (PDOs) are crucial at the ground level, overseeing program implementation. Participants described their involvement in organizing camps, visiting sites to ensure basic amenities like drinking water and chairs are available, and monitoring overall activity execution. While data entry may be delayed for various reasons, camp organization continues across numerous panchayats. Data entered at the panchayat level is further monitored at the taluk (sub-district) and district levels. However, interviewees highlighted a lack of dedicated meetings for Grama Arogya at the district level. Instead, program discussions are integrated into meetings focused on the 20-point program or other initiatives. Some district-level stakeholders expressed a need for regular reports from panchayats beyond just data entered the application. This suggests a potential gap between data collection and its utilization for program evaluation and improvement (Q13, Q14).

1.3 Program Stakeholders and Capacity Building

1.3.1 Gram Panchayath Task Force structure and involvement

Study participants acknowledged the active role of the Gram Panchayat Task Force (GPTF) team in coordinating field-level camps through dedicated meetings. However, a key inconsistency emerged regarding the frequency of these meetings. Some participants reported monthly meetings, while others indicated they occurred every two months. This discrepancy suggests a lack of standardized scheduling for these crucial coordination sessions (Q15, Q16).

Panchayat members play a critical role in organizing Grama Arogya camps. Participants highlighted their efforts, including making logistical arrangements for the camps, conducting regular campsite visits, and interacting with attendees. These interactions ensure that community members understand and actively participate in the program, maximizing the benefits available through the camps (Q17, Q18).

While the program leverages the dedication of Gram Panchayat Task Force (GPTF) members, a critical gap was identified by some district-level participants: the need for standardized training on program implementation. Equipping GPTF members with a comprehensive understanding of program protocols and best practices would empower them to maximize the program's impact at the ground level. This targeted training could ensure consistent program delivery across all Panchayats, optimize resource allocation, and ultimately reach a wider segment of the population in need (Q19).

1.3.2 GPTF roles and responsibilities

Participants indicated that most Panchayats effectively utilize loudspeaker announcements to inform communities about upcoming Grama Arogya camp schedules. This proactive approach ensures widespread awareness and encourages participation. Beyond communication, Panchayat members play a key role in microplanning these camps, ensuring logistical arrangements are in place for smooth execution. Furthermore, the report highlights that most Panchayats have taken responsibility for managing the health management kits provided by the program, demonstrating a high level of ownership and commitment to program success (Q20, Q21).

In many Panchayats, participants mentioned that the strips are not provided regularly; they are managed by the health department (Q22).

While field-level service providers are primarily focused on organizing camp activities and conducting awareness events, they recognize the value of collaboration. Participants emphasized that actively involving Gram Panchayat members strengthens program execution. This collaborative approach leverages the Panchayats' local knowledge and relationships within the community, ultimately contributing to the program's success (Q23, Q24).

1.3.3. Capacity Building

To ensure a smooth program implementation, the Karnataka Health Promotion Trust (KHPT), in collaboration with the Rural Development and Panchayat Raj Department (RDPR), undertook several training initiatives for elected representatives and officials at the Panchayat level. These training programs equipped Panchayats with the necessary knowledge and skills for effective program implementation. Furthermore, KHPT and RDPR co-developed a range of health education materials that were distributed along with the health management kits. These resources provided valuable information to community members, promoting awareness and utilization of program services. Through this study, we have captured the perceptions of different stakeholders on training activities as below.

Respondents at the state level described the capacity-building activities undertaken to support program implementation. These activities focused on two key groups:

Gram Panchayat Task Force (GPTF) Members: During the initial program rollout, all GPTF members received training on using the health management kits. This training likely included both verbal instruction and a video demonstration to ensure a clear understanding of the equipment's functionality.

Health Functionaries: Separate training sessions were also conducted for health functionaries involved in the program. The specific content of these trainings is not mentioned by participants, but it likely focused on broader program protocols and best practices.

KHPT's Role in Training Delivery: The initiative to provide training for both GPTF members and health functionaries was spearheaded by the Karnataka Health Promotion Trust (KHPT). Their leadership in capacity building ensured that personnel at all levels were equipped with the necessary knowledge and skills to deliver the GA program effectively (Q25).

Field participant responses regarding training revealed some inconsistencies. While some mentioned department-specific training on child marriage, others focused on their introduction to the Grama Arogya program by healthcare teams. There were also indications that some Panchayat members received training directly from the KHPT team, while others accessed training materials through online programs or television broadcasts (Q26).

The training materials were developed on diabetes, hypertension, TB, menstrual hygiene, anemia, and child marriage. Various health education aids were developed, such as charts, posters, and booklets. These materials were annexed and distributed along with the kit (Q27).

1.4 PROGRAM ACTIVITIES

Several activities are conducted in the program. After interviewing various stakeholders, several subthemes emerged that were relevant to the program activities, as below.

1.4.1 Organization of Health Camps
1.4.2 Screening activities
1.4.3 Awareness programs
1.4.4 Child Marriage Prevention
1.4.5 Mental health
1.4.6 Referrals
1.4.7 Finance Management - GP Revenue
1.4.8 Data management

1.4.1 Organization of Health Camps

The Grama Arogya program hinges on the successful collaboration between Gram Panchayats (GPs) and the health department. This partnership is crucial for organizing effective screening camps within communities. Camps organized with GP involvement offer additional benefits, potentially allowing participants access to a wider range of health facilities beyond just the basic screening services offered. Anganwadi workers, who play a vital role in community health outreach, actively participate in these camps. Their primary tasks involve informing residents about upcoming camps and maintaining a registration system alongside ASHA workers (community health volunteers). Some participants mentioned a standardized approach to camp scheduling, with designated days set aside each month. These camp dates are likely decided in advance during coordination meetings to ensure efficient planning and community awareness (Q28).

Participants consistently highlighted that the Karnataka Health Promotion Trust (KHPT) equipped Gram Panchayats (GPs) with essential screening kits at the program's inception. These kits contain the necessary supplies for conducting health camps. To ensure ongoing functionality, the GPs are responsible for replenishing specific test strips within the kits as they are used and depleted (Q29).

1.4.2 Screening activities

The Grama Arogya program prioritizes early detection of non-communicable diseases (NCDs) such as hypertension (high blood pressure) and diabetes. These conditions are screened in health camps alongside verbal tuberculosis (TB) and anemia screening.

Participants widely reported that the program extends its reach to laborers at MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act) worksites. These camps specifically focus on blood pressure and blood sugar testing. Individuals identified with potential health concerns are referred for further evaluation at Primary Health Care Centres. In severe conditions, referrals are directed to district hospitals for specialized care (Q30, Q31).

The program acknowledges that some community members, particularly the elderly, may face challenges attending Grama Arogya camps. To ensure inclusivity, participants highlighted instances where healthcare teams, accompanied by KHPT workers, conduct home visits for these individuals. These home visits allow essential health screenings to be conducted in a comfortable and familiar environment. Referrals to hospitals are made, if necessary, based on the screening results.

The program also recognizes that some residents may hesitate to participate in health camps for various reasons. In such cases, participants reported that healthcare workers provide counselling directly at home. This counselling addresses concerns, educates residents about the program's benefits, and ultimately motivates them to access essential preventive screening services (Q32).

1.4.3. Awareness programs

The Grama Arogya program extends beyond disease screening by promoting broader health awareness within communities. This is achieved through various initiatives:

Social Issue Awareness: Educational programs address critical social issues like child marriage and child labor. These programs likely aim to empower communities to identify and address these challenges.

Menstrual Hygiene Education: Adolescent girls receive dedicated educational programs on menstrual hygiene and sanitation in schools. Equipping young women with this knowledge promotes healthy practices and combats potential stigma.

Public Health Information Dissemination: The health department is crucial in distributing pamphlets to the public. These pamphlets raise awareness about various diseases, including tuberculosis (TB), leprosy, and AIDS. This information empowers individuals to take preventive measures and seek timely medical attention if needed (Q33, Q34).

1.4.4. Child marriage prevention

Participants reported a decline in the number of child marriage cases within the program's target communities. However, they also acknowledged the ongoing challenge of isolated incidents among migrant populations. This highlights the need for continued efforts to reach all community segments.

To combat child marriage, the program has implemented several awareness campaigns aimed at educating residents about the negative consequences of this practice. Furthermore, the program has broadened its approach by involving higher-level authorities in addressing concerns related to both child marriage and female foeticide. This collaborative approach strengthens efforts to protect children and promote gender equality (Q35).

1.4.5 Mental health

The Grama Arogya program recognizes mental health as an integral component of overall well-being. Participants highlighted that the program addresses mental health concerns alongside screenings for non-communicable diseases (NCDs) and tuberculosis (TB). However, a significant challenge identified is the stigma surrounding mental illness within the community. Many participants emphasized the need for increased awareness campaigns to educate residents about mental health conditions and encourage them to seek professional help when necessary.

The program demonstrates a preliminary effort to address this challenge by training Village Resource Workers (VRWs) to identify potential mental health cases during home visits. These identified individuals can then be referred to appropriate healthcare facilities for evaluation and support (Q36, Q37, Q38).

1.4.6 Referrals

The Grama Arogya program revolves around disease screening within communities. Participants described how health camps provide vital services such as blood pressure (BP) and blood sugar level checks. Individuals with readings outside the normal range are referred for further evaluation and treatment at nearby government hospitals. To ensure a smooth referral process, patients receive a referral slip to give at the hospital. Additionally, program staff maintain records of all referrals within a designated register (Q39).

1.4.7 Finance Management - GP Revenue

Study participants highlighted potential limitations associated with relying solely on Gram Panchayat (GP) revenue to support the Grama Arogya program. Since tax generation capacity varies across Panchayats, a solely GP-funded model might lead to inconsistencies in program delivery. As an alternative, participants suggested increased government allocation for the program. This approach could ensure a more dependable funding stream and potentially exceed the current limit of Rs. 50,000 allocated from GP revenue. Several participants further emphasized that the current allocation appears insufficient to cover program expenses, particularly those associated with organizing effective health camps (Q40, Q41).

1.4.8 Data management

Process of data management

Study participants described a two-pronged approach to data management within the Grama Arogya program:

Campsite Data Collection: ASHA or ANMs manually record essential data in a designated register at each camp location. This data includes details of all camp attendees.

Digital Data Entry: KHPT representatives utilize a program-specific mobile application called "Pragma" to capture data electronically.

Following the conclusion of each camp, an additional layer of data collection occurs at the Panchayat level. Here, Panchayat secretaries or designated data entry operators enter the camp data into a separate government application called "Panchatantra," maintained by the Department of Rural Development and Panchayat Raj (Q42).

As highlighted by many participants, meticulous preparations ensure the smooth running of Grama Arogya camps. On the day preceding each camp, staff conduct a thorough inventory check to verify the adequacy of test strips and other supplies within the health management kits. Additionally, record books are organized and readied alongside the kits to facilitate efficient data collection during the camp.

The program adheres to a multi-tiered data management system. KHPT representatives are responsible for maintaining detailed patient records, including medical history and any referrals generated during the camps. This data is uploaded electronically and stored at local, zonal, and state levels. At the state level, dedicated MRD (Medical Records Department) personnel oversee data management and ensure accuracy. Furthermore, monthly data updates are provided to relevant officials such as the CEO, DHO, THOs (Taluk Health Officers), and EOs (Executive Officers) (Q43, Q44).

Digital data entry

The Panchatantra application serves as the designated platform for Panchayat-level data entry within the Grama Arogya program. To ensure accurate data capture, program staff responsible for data entry received appropriate training (Q45).

Manual data entry

Participants described the program's use of multiple standardized data entry forms. These forms, categorized as Format 1, Format 2, and Format 3, serve distinct purposes:

Formats 1 and 2: Capture detailed patient information for individuals who receive health checkups during the camps.

Format 3: Functions as a daily camp activity summary, providing an overview of the camp's operations.

In addition to these data entry forms, Panchayats are also responsible for maintaining a dedicated kit register to track the health management kits provided by the program (Q46).

Recording and Reporting

Study participants indicated that Community Health Officers (CHOs) are responsible for maintaining various registers at Health Wellness Centers (HWCs). These registers serve as a vital repository of patient data. ASHA workers play a crucial role in maintaining

comprehensive patient records at the HWCs. In addition to general patient records, ASHA workers maintain separate registers specifically for individuals with chronic conditions like high blood pressure and diabetes mellitus. For patients diagnosed with both conditions, ASHA workers create a "line list" to ensure they receive focused monitoring and follow-up care. ASHA workers contribute to broader public health efforts by maintaining registers that track the incidence of cancer and cardiovascular diseases within the community.

Monthly Panchayat Meetings serve as a platform for communication and data sharing. During these meetings, HWC staff discuss newly identified health conditions among patients, an overview of supplies utilized from the health management kits, and a discussion of remaining stock levels (Q47, Q48).

1.5 Program Utilization

1.5.1 Equity Access and gender differences

The Grama Arogya program prioritizes ensuring equitable access to its services for all community members. This commitment is reflected in its outreach efforts, which target underserved populations such as those residing in tribal colonies and MGNREGA work areas and individuals with disabilities. The program also recognizes the specific needs of women and adolescent girls, ensuring their inclusion in program benefits. To address the unique needs of people with disabilities, some areas conduct separate camps with the support of Village Rehabilitation Workers (VRWs) from the Panchayats (Q49, Q50, Q51).

The program strives to offer equal access to its services for all genders. While initial participation among women may have been lower, efforts have been made to address this disparity. The program has implemented strategies like conducting camps in culturally appropriate settings like temples, marketplaces, and bus-stands. Awareness campaigns are integrated into women-focused gatherings like Tayendira Sabhe (a meeting for young mothers) and sanghas (community unions) to reach a wider female audience. A few interviewees mentioned instances where the health staff requested the women to wait until the male attendees left the camp and then attended to them. This is a common practice, and the women then discuss issues related to menstrual health (Q52, Q53, Q54, Q55).

1.5.2 Anticipated program benefits

Study participants highlighted the GA program's effectiveness in achieving several key health objectives:

Early Identification of Chronic Conditions: The program's screening efforts facilitate the early detection of lifestyle diseases, allowing for timely intervention and improved health outcomes.

Focus on High-Risk Pregnancies: The program identifies pregnant women at risk of complications such as gestational hypertension and diabetes. This enables closer monitoring by Anganwadi workers, potentially reducing pregnancy-related risks.

Reaching Underserved Populations: Interviewees emphasized the program's success in reaching lower socioeconomic groups. This increased access to healthcare services contributes to improved health awareness and empowers villagers to make informed health decisions (Q56, Q57).

The Grama Arogya program directly benefits community members by offering essential health screenings at their doorsteps. This approach, as highlighted by program beneficiaries themselves, offers several advantages:

Reduced Costs and Time Savings: Eliminating travel to distant primary healthcare facilities translates to significant cost and time savings for participants.

Improved Accessibility for Vulnerable Populations: Elderly individuals and people with disabilities can now access essential health screenings with greater ease, overcoming mobility challenges that might otherwise hinder their healthcare access.

Enhanced Privacy for Women: The program design allows women to confidentially discuss their health concerns with healthcare professionals after the main camp concludes, addressing potential privacy concerns (Q58).

2. CONVERGENCE

The success of health and development programs hinges on overcoming existing barriers and challenges. A key strategy lies in fostering integrated approaches that promote collaboration between various government departments. The success of health and development programs hinges on overcoming existing barriers and challenges

Convergence also necessitates the coordinated involvement of relevant departments at various levels – local (Panchayat), district, and state. For instance, successful program implementation involves collaboration between the RDPR, the Women and Child Development Departments, and the Department of Health and Family Welfare. Convergence is explained below in three subheadings:

2.1 Coordination
2.2Communication
2.3 Knowledge and Health Literacy

2.1 Coordination

A crucial factor contributing to the Grama Arogya program's success is the strong collaboration between various stakeholders at the field level. This includes the Panchayat, the health department, and the Women and Child Development department. This coordinated approach ensures that most participants are familiar with the program's stakeholders and the involved government departments. As study participants highlighted, this effective convergence model fosters a supportive environment for program implementation, acting as a significant strength in ensuring its smooth operation (Q59, Q60).

Study participants emphasized a positive working relationship between the technical support agency and individuals responsible for program execution at the grassroots level. Effective collaboration ensures the smooth functioning of the GA program (Q61).

However, a few participants also opined that the convergence between the departments could be even better. Additionally, it was pointed out that the WCD components in the program are not as pressing as other issues (Q62).

2.1.2 Coordination to procure consumables

Some members of the GP have stated that they have set aside a specific budget for healthcare purposes, using it to acquire necessary supplies for the camp. They were not informed about the allocation of funds from the 15th Finance Commission budget for the GA program. Nevertheless, the panchayat successfully secured funding for the program (Q63, Q64).

Study participants highlighted two key challenges related to program resources:

Limited Awareness of Allocations: Many participants were unaware that the 15th Finance Commission designated only Rs. 50,000 for the Grama Arogya program. This lack of awareness might hinder informed discussions about resource allocation.

Incompatibility of Supplies: Inconsistencies were identified between glucometers provided by the health department and those included in the program kits. This resulted in incompatibility between the glucometers and test strips, rendering some supplies unusable (Q65, Q66). At the taluk level, the instructions for buying the strips from funds of 15th finance were passed as per a few stakeholders (Q67, Q68).

2.2. Communication

Communication means disseminating information regarding the planning and implementation of the GA program among various stakeholders. This also involves the facilitation of awareness among the people in the community.

The communication is described under the below subheadings

- 2.2.1 Communication at the stakeholders' level
- 2.2.2 Behavioural change communication
- 2.2.3 Information Communication
- 2.2.4 Challenge Communication

2.2.1 Communication at the stakeholders' level

The Grama Arogya program effectively addressed initial hurdles to garner support at the Gram Panchayat level. While some PDOs were initially hesitant about organizing camps, persistent efforts were made. Through open communication, program representatives explained the program's activities, benefits, and alignment with RDPR mandates. This

collaborative approach fostered understanding and ultimately secured the support of Panchayat members.

The panchayats made loud mic announcements to communicate the venue and timings of the camp. It was noticed the prior information about the camp increased the number of participants (Q69).

2.2.2 Behavioural change communication

The interviewees mentioned that initially, people were not interested in getting screened at the camps. COVID-19 vaccination was also a reason for hesitancy, where people thought it was causing issues such as miscarriage.

To effectively address these concerns, the program leveraged the trusted voices of PDOs, ANMs, Panchayat members, Anganwadi workers, ASHA workers, and the KHPT team. These community leaders played a crucial role in:

Managing Misinformation: They provided accurate information about the program's benefits and ensured participants understood the safety measures implemented during camps.

Targeted Outreach: Female Panchayat members specifically motivated women within their wards to address potential gender-specific concerns.

Success Stories as Motivational Tools:

One interviewee suggested leveraging the positive experiences of past beneficiaries. Sharing success stories of individuals who received timely diagnoses or treatment through the program can inspire others to participate in future camps.

Schools as Partners in Community Education:

The program extended its reach beyond camps by integrating school health programs. These sessions focused on essential topics such as sanitation and hygiene, child marriage prevention, and menstrual and sexual health education. School teachers were empowered to act as influencers, fostering positive discussions about the program within their communities and encouraging participation in screening camps (Q70, Q71).

2.2.3 Information Communication

The Grama Arogya program utilizes a comprehensive communication strategy to ensure maximum community awareness about upcoming camps. This multifaceted approach leverages various channels:

Traditional Communication Methods: Panchayats employ time-tested methods like beating drums ("tam-tam") and using dangura to spread the message. Additionally, public announcements are made through loudspeakers mounted on garbage collection vehicles ("Swaccha Vahini").

Interpersonal Outreach: ASHAs, Anganwadi workers, and Panchayat members play a vital role in door-to-door communication, personally informing residents about the camp schedule.

Modern Communication Tools: The program recognizes the growing importance of technology and communication is carried out through WhatsApp and phone calls among the stakeholders and to the public.

Community Networks: Self-help groups, which often serve as strong social networks within communities, are utilized to further disseminate information about the program and encourage participation (Q72, Q73).

2.2.4 Challenges in communication

Study participants highlighted the importance of strengthening communication channels between district-level stakeholders and those at the Gram Panchayat (GP) level. Effective information sharing allows district-level representatives to maintain a comprehensive camp schedule for all Panchayats, fostering improved coordination and program implementation (Q74).

The program acknowledged challenges in communication due to language barriers within certain tribal communities, such as the Lambani tandas (settlements). To bridge this gap, health workers and Panchayat staff effectively collaborated with tribal community leaders. This collaborative approach facilitated successful awareness events within these communities, ensuring vital health information was communicated effectively (Q75).

2.3 Lack of knowledge about the GA program

The respondents discussed the various services offered to the health department and the community by the GP instead of focusing on the GA program (Q76).

While some Panchayat members and beneficiaries interviewed expressed a lack of familiarity with the specific name "Grama Arogya program," they did recognize the program's activities through their participation in Non-Communicable Disease (NCD) screening camps. This suggests potential areas for improvement in program communication and outreach strategies (Q77).

Some GP members mentioned that they were unsure about the budget allocated for the maintenance of the GA program. This highlights a potential need for improved transparency regarding program finances (Q78).

Low health literacy among people

Study participants highlighted several factors contributing to hesitancy among community members regarding health screenings offered through the Grama Arogya program:

Fear of Procedures: Some women expressed apprehension about minor medical procedures like finger pricks for point-of-care tests.

Limited Mobility and Social Norms: The ingrained custom for some women to remain at home, particularly in rural areas, might discourage them from attending camps unless they experience severe health concerns.

Lack of health awareness: Participants also pointed to a potential lack of health awareness, particularly in rural areas. Individuals who perceive themselves as healthy might neglect preventive screenings (Q79, Q80).

3. DECENTRALISATION

Decentralization refers to the strategic transfer of decision-making authority from a central governing body to local entities. In the context of healthcare, this approach empowers local communities by enabling them to participate in:

Health Planning: Decentralization allows for health planning that is responsive to the specific needs and priorities of the community. Local stakeholders can contribute their unique perspectives to program design and implementation.

Service Delivery: Increased decision-making power at the local level allows for the tailoring of service delivery to address the specific health challenges faced by the community.

Program Monitoring: Local involvement in program monitoring fosters a sense of ownership and accountability, potentially leading to improved program effectiveness.

The combined impact of these factors can contribute to achieving better development outcomes in the healthcare sector.

The following are the subthemes of Decentralization

3.1 Delegation
3.2 Ownership
3.3 Existing process
3.4 Challenges

3.1 Delegation

Interviewees mentioned directives issued by the CEO mandating local governments to organize Grama Arogya camps at least once a week within each Panchayat. They also mentioned that CHOs serve as the crucial local point of contact for implementing program activities, including screening procedures. They are also responsible for coordinating with PDOs to ensure a steady supply of necessary camp consumables. The program allows for flexibility in data entry. Panchayat staff members can record data in both the designated report book and the Panchatantra application. Some participants expressed the potential benefits of collaborating with active NGOs to reach vulnerable populations within the

community. NGOs may possess specialized outreach skills and experience in working with these groups (Q81).

3.2 Ownership

Study participants emphasized the critical role of local governments, particularly GPs, in fostering decentralized governance. These elected bodies operate at the grassroots level, maintaining proximity to the communities they serve. This proximity allows GPs to deeply understand local needs and priorities. The program leverages the decision-making authority vested in Gram Panchayats. This empowers GPs to tailor public service development, including healthcare initiatives, to effectively address the unique needs of their communities. The concept of "ownership" referred to by participants reflects this sense of local control and accountability. The program establishes task forces responsible for selecting camp locations. These sites are strategically chosen based on their potential to reach a significant portion of the population. Once locations are finalized, Gram Panchayats take the lead in organizing the camps, demonstrating their commitment to program implementation and community well-being (Q82).

While participants acknowledged the role of state-level officials in leading the Grama Arogya program rollout, they also highlighted the importance of ensuring strong implementation mechanisms at lower administrative levels, including districts, taluks, and Panchayats. This suggests a need for a collaborative approach that leverages the resources and expertise available at each level (Q83).

3.3 Existing process

The program adheres to principles of decentralized governance. Government directives outline the overall framework, while Gram Panchayats (GPs) take ownership at the local level. GPs develop micro-plans tailored to address the specific needs and context of their communities. GPs demonstrate financial accountability by allocating budgetary resources within their action plans to cover essential program supplies, such as test strips. GPs maintain a commitment to program effectiveness through regular meetings where progress is reviewed, and adjustments are made as needed. One participant expressed a concern that the program, while health-related, might place a significant burden on the Panchayats. However, it's important to remember that as local governments, Panchayats are directly accountable to the people they serve. This inherent accountability incentivizes them to prioritize program success, ultimately contributing to improved community health outcomes (Q84, Q85).

3.4 Challenges in decentralization

While acknowledging the program's decentralized structure, some participants expressed concerns regarding the distribution of financial resources. They felt that true decentralization should be accompanied by a more equitable allocation of funds for program implementation. The current system, where a significant portion of the budget is controlled by higher-level

Panchayats (Zilla and Taluka) with a smaller allocation reaching the Gram Panchayats at the local level, could potentially hinder program effectiveness at the grassroots (Q86).

A program implementer highlighted the ongoing challenges associated with achieving complete decentralization. Despite program efforts toward decentralization, strategic planning, and budgetary control often remain centralized at higher administrative levels. This limits the autonomy of Gram Panchayats in tailoring program implementation to meet local needs. The program's effectiveness hinges on the availability of essential consumables like test strips and lancets. However, discrepancies exist in procurement methods. Panchayats with robust tax revenue streams can utilize these funds for procurement, while those lacking enough resources may rely on coordination with the health department to obtain necessary supplies. This uneven approach can create disparities in program implementation across different regions (Q87).

4. CHALLENGES

Study participants highlighted several hurdles encountered during the rollout of the GA program. These challenges can be broadly categorized as follows:

Implementation Issues: Concerns were raised regarding the overall program execution process.

Availability of Consumables: Ensuring a steady supply of essential materials like test strips and lancets proved challenging for some regions.

Gram Panchayat Involvement: Enhancing Gram Panchayat engagement in program activities was identified as an area for improvement.

Resource Constraints: Limited financial resources at the local level were noted as a potential barrier to program effectiveness.

The following sections summarize the perspectives of various stakeholders regarding these challenges, providing a deeper understanding of the issues at hand. Challenges were related to the

4.1 Program activities
4.2 Implementers (Stakeholders):
4.3 Implementation process
4.4 Consumables

4.1 Program activities

While the core activities of the GA program might involve tasks like disease screening, health education, and data collection, these activities can become more complex when dealing with concurrently managing multiple programs.

Several participants highlighted the challenges associated with managing the workload demands of the Grama Arogya program. They expressed feeling overburdened due to the program's multifaceted nature, as it required organizing camps regularly, which required continuous planning. However, participants pointed out a critical constraint: a lack of additional human resources dedicated to the program. This necessitates relying on existing staff to shoulder the extra workload, potentially leading to strain and decreased efficiency (Q88, Q89).

4.2 Implementers (Stakeholders):

Study participants identified several factors contributing to lower attendance rates at health camps organized by the Grama Arogya program:

Scheduling Conflicts: The timing of the camps might conflict with the work schedules of some residents, particularly those heavily involved in agricultural activities. This can create a barrier to participation.

Limited Health Awareness: A potential lack of health literacy within the community could lead some individuals to underestimate the importance of preventive screenings offered through the program.

Perceptions of Local Governance: Negative attitudes or a lack of trust towards the Gram Panchayats might discourage some residents from engaging with program initiatives, including health camps.

These factors highlight the importance of developing targeted outreach strategies that consider work schedules, address knowledge gaps about preventative healthcare, and foster positive collaboration between the program and local communities (Q90).

The second major challenge interviewees identified was data management within the GA program. Here's a breakdown of the specific issues:

Workforce Strain and Data Entry Delays: Participants expressed concerns about the workload burden placed on data entry operators at the Gram Panchayat (GP) level. This can lead to delays in capturing and entering program data. Consequently, data availability at the district level is also delayed, hindering timely program monitoring and evaluation.

Technological Challenges with Panchatantra 2: The Panchatantra 2 (P2) application used for data entry reportedly experiences server issues, resulting in slow loading times and potential data processing delays.

Inconsistent Reporting Formats: The program's new reporting format has not been universally adopted across all talukas. This inconsistency, particularly evident in Phase 1 districts, creates further data collection and aggregation challenges.

These combined factors suggest solutions that address staffing limitations, ensure system stability within P2, and facilitate a smooth transition to the new reporting format across all program locations (Q91, Q92).

The program also faces challenges related to human resources and data management:

Limited Data Entry Capacity: Several Panchayats lack dedicated data entry operators, leading to potential delays in capturing and processing program data.

Vacant Community Health Officer (CHO) Positions: Vacancies in CHO positions at certain sub-centers create staffing gaps. While Public Health Care Officers (PHCOs) support these regions by assisting with camp activities, the ideal scenario would be to have a dedicated CHO for each sub-center.

CHO Workload and Data Verification: In some areas, CHOs are overburdened as they manage responsibilities for two sub-centers. Additionally, some Panchayat Development Officers (PDOs) feel compelled to spend extra time re-checking data entered the Panchatantra 2 (P2) application, potentially hindering their overall workflow.

Streamlining the Reporting System:

These challenges highlight the need for a streamlined reporting system that minimizes data entry burdens and fosters trust in the data collection process. Additionally, addressing staffing shortages through strategic recruitment and workload management could significantly improve program efficiency (Q93, Q94).

4.3 Implementation process

Study participants emphasized the critical role of GPs in the program's success. The strong involvement of the GP was identified as a key factor that contributed to effective program implementation. While some Panchayat officials provided valuable support, others lacked cooperation with GA program activities (Q95).

Some challenges highlighted by the participants are:

Resource Constraints: A significant hurdle identified by participants is the limited financial capacity of some Panchayats, particularly smaller ones. These Panchayats might struggle to procure essential program supplies (consumables) independently due to insufficient local revenue.

Shifting Levels of Cooperation: While initial resistance was encountered from some Panchayats regarding program involvement, these attitudes appear to have softened over time, leading to a more collaborative approach.

Interdepartmental Coordination: The compartmentalized structure of public administration can create challenges in fostering effective collaboration between different departments involved in the Grama Arogya program. This lack of seamless coordination might hinder the implementation of follow-up actions and the exchange of crucial feedback (Q96).

Some participants indicated a perception that the Grama Arogya program is solely the responsibility of the KHPT (Karnataka Health Promotion Trust) team. This perception leads to an expectation that the KHPT team should take full charge of organizing and conducting program activities, potentially reducing the level of ownership felt by the GPs (Q97).

During the initial pilot phase of the Grama Arogya program, the Karnataka Health Promotion Trust (KHPT) shouldered the responsibility of providing essential program kits. However, as the government envisioned a broader program rollout, a budgetary allocation was made to support this expansion. This shift necessitated a change in logistics. While the government provided the necessary funding, procuring and distributing the program kits fell to the KHPT, leveraging their expertise to provide technical support in this crucial aspect (Q98).

Some additional challenges highlighted are:

Initial Hesitancy: The program's launch coincided with the COVID-19 pandemic, likely contributing to initial public fear and hesitation regarding participation in screening camps.

Strategic Outreach Needed: Even in non-pandemic times, some areas, particularly those with a high concentration of Mahatma Gandhi National Rural Employment Guarantee Act (MGNERGA) worksites, require strategic outreach strategies. Announcing camp dates well in advance might inadvertently lead to lower attendance.

Addressing Gender-Specific Concerns: Hesitancy among women, particularly those engaged in workplace activities, highlights the need for targeted outreach efforts that address their specific concerns and encourage participation in the program's health screenings (Q99).

4.4 Consumables

Challenges with Consumables and Medication Availability:

Irregular Procurement of NCD Screening Supplies: Study participants reported inconsistencies in procuring essential supplies like test strips and lancets needed for NCD screenings offered through the program. While the responsibility for purchasing these supplies falls on the Panchayats, there seems to be a lack of clear communication in some areas, leading to confusion among health staff.

Shortages of Essential Medications: Beyond NCD screening supplies, some participants mentioned a shortage of other crucial medications, such as tablets for managing hypertension and diabetes, at sub-centers within their communities (Q100).

Some members of the GPs interviewed expressed a lack of complete understanding regarding the specific budgetary allocations designated for the Grama Arogya program. This knowledge gap led them to suggest that the program's funds could be used for broader village maintenance activities, including sanitation efforts (Q101).

A participant mentioned that some health management kits lacked certain essential items. This could indicate inconsistencies in kit maintenance or potential stock management issues within certain Panchayats (Q102).

5. ENABLERS

To ensure the successful implementation and sustained outcomes of a health program like the GA program, several health determinants act as enablers. These determinants create an environment that supports health and well-being, facilitating the effectiveness and sustainability of the program. Here's a comprehensive breakdown of the key enablers:

5.1 Technical Support
5.2 Beneficiary feedback

5.1 Technical Support

Perceptions regarding the importance of KHPT's role in the GA program varied among participants. Many participants acknowledged the significant contributions of KHPT in providing technical support for the program. These contributions include:

Supervision and Training: KHPT supervises health camps, trains healthcare workers and Panchayat Raj Institution (PRI) staff at different government levels, and monitors program activities.

Panchayat Involvement: KHPT supports the development of action plans that encourage Panchayat participation in GPTF meetings.

Facilitating Communication: KHPT acts as a bridge, fostering communication between various stakeholders, including the three program departments and the community.

Interviewees who hold this view believe that KHPT's technical expertise and coordination efforts are crucial for effective program management. A smaller group of participants believed they could manage the program without KHPT support, considering it part of their job responsibility. These contrasting viewpoints highlight the potential need for further discussions to ensure a clear understanding of the roles and responsibilities of all GA program stakeholders (Q103).

Another program pillar was providing a health management kit containing certain medical equipment for the screening and point-of-care tests. Along with these kits, KHPT created and distributed various health awareness materials.

The KHPT team has one taluk coordinator representing each taluk and one district lead for each district. There is one divisional lead and M & E zonal lead for every four revenue divisions in the state. Then, at the state level, a project lead, a program implementation lead, a state M & E lead, and one staff for documentation and communication (Q104, Q105).

5.2 Beneficiary feedback

The program's effectiveness and convenience are evident from the positive feedback received by various participants regarding the healthcare services provided. Home visits by healthcare workers were particularly appreciated, especially by those who were unable to travel due to limited mobility or being bedridden. This service proved especially beneficial for the elderly and women, as screening camps were conveniently organized close to their homes. The repeated organization of these camps in the same areas ensured inclusivity, offering additional opportunities to participate for those who might have missed previous sessions (Q106).

Participants highlighted the program's increased accessibility due to doorstep screening services. This eliminated travel costs and burdens, simplifying access to non-communicable disease screening. Overall, the program was viewed as highly helpful, positively impacting community health (Q107).

6. BEST PRACTICES

The GA program is making a significant difference in healthcare delivery for rural and underserved communities. It achieves this by implementing a variety of successful strategies and practices tailored to local needs, leading to numerous success stories across different regions. Below are detailed accounts of best practices and success stories across various aspects of the program.

6.1 Success stories of problem-solving
6.2 Success stories on disease screening
6.3 Success stories on mobilization for camps
6.4 Success stories of the fight against child marriage
6.5 Program as a success story

6.1 Success stories of problem-solving:

Initially, female participation in health camps was lower than desired. This could be attributed to the COVID-19 pandemic and various socio-economic factors. To address this, the program implemented several targeted strategies. These strategies aimed to:

Increase awareness and accessibility: Leverage existing community networks and work environments to reach women more effectively.

Empower and motivate: Foster internal motivation mechanisms to encourage female attendance and engagement.

By focusing on accessibility and building on existing networks, the program aimed to create a more welcoming and supportive environment for women to participate in health camps.

6.1.1. Strategies to increase female participation in health camps are as below:

Leveraging Self-Help Groups (SHGs) for Engagement

- **Issue:** Participation of women was less during the initial days of the screening camps
- **Strategy**: The GA program involved local female SHGs in spreading awareness and encouraging participation.
- **Implementation**: SHGs were invited to the camps, where they received health education and screening services. These women then acted as ambassadors, encouraging their communities to attend (Q108).
- **Impact**: According to participants, this approach significantly increased female attendance as women felt more comfortable and motivated to participate when encouraged by their peers. One interviewee mentioned that seeing other women from their community participate made them feel safer and more compelled to join the camps.

6.1.2 Targeting Seasonal Work Sites

- **Issue:** Many women were absent from their homes due to seasonal employment in areca-nut peeling, which reduced their availability for health screenings.
- **Strategy:** Health camps were strategically organized at these work sites to reach women during their work hours.
- **Implementation:** The program coordinated with local employers to set up mobile health camps at or near the work sites, ensuring that women could access screenings without interrupting their workday.
- **Impact:** Women working in areca-nut peeling reported appreciating the convenience of bringing the health camp to their workplace. This not only increased participation but also, underscored the program's commitment to accommodate the unique circumstances of the community

Empowering female staff to motivate communities

- **Issue**: Women in the community were hesitant to participate in health camps due to lack of awareness and motivation.
- **Strategy**: Female staff members within local governance structures (female GP members) were empowered and motivated to advocate for the health camps.

- **Implementation**: Female staff received special training to encourage them to promote the camps actively within their communities. They were equipped with educational materials and tasked with organizing community meetings and discussions to raise awareness (Q109).
- **Impact**: This approach created a ripple effect, as motivated female staff inspired other women in the community to attend the health camps. One participant mentioned that seeing a trusted female community leader support the program increased her confidence in participating.

6.1.3 Strategies to increase community participation in the camps:

Convincing the Community for Health Screenings

- **Issue**: Reluctance among community members to participate in health screening camps.
- **Strategy**: Active efforts by the health department and panchayat staff to educate and persuade the community about the importance of health screenings.
- **Implementation**:
  Awareness Campaigns: Health department officials and panchayat staff organized awareness campaigns that included community meetings, educational sessions, and the distribution of informative materials about NCDs and the benefits of early screening. **Personal Engagement**: Staff engaged in door-to-door visits and personalized interactions to address specific concerns and encourage individuals to attend health camps (Q110). **Success Stories**: Sharing real-life success stories of individuals who had benefited from early diagnosis and treatment of NCDs helped build trust and motivate others to get screened.
- **Impact**:

Improved Awareness: Community members became more knowledgeable about the risks associated with NCDs and the benefits of early detection.

Increased Participation: There was a significant uptick in the number of individuals willing to participate in health screenings, leading to early diagnosis and management of health conditions.

6.1.4 Flexible Health Camp Timings

- **Issue**: Standard health camp timings were inconvenient for certain groups, such as MNREGA workers and dairy farmers, making it difficult for them to attend.
- **Strategy**: Adjusting the timing of health camps to align with the schedules of these specific groups to increase accessibility.
- **Implementation**:
  For MNREGA Workers: Health camps were scheduled from 7 am to 12 pm to cater to the work schedules of MNREGA workers, who typically start their day early (Q111). **For Dairy Farmers**: Camps were organized at milk collection centers from 6 am to 9 am to

coincide with the time dairy farmers deliver their milk, ensuring they could attend without disrupting their work.

- **Impact**:
  Convenient Access: The adjusted timings allowed workers to attend health camps without conflicting with their work commitments, leading to higher participation.
  Positive Reception: Both MNREGA workers and dairy farmers responded positively to the changes, appreciating the program's effort to accommodate their schedules.

6.1.5 Engagement of Gram Panchayat Members

- **Issue**: Lack of involvement from GP members in the health camp initiatives, leading to lower community engagement and support for the GA program.
- **Strategy**: Utilizing personalized postcards to communicate with GP members and highlight their roles and responsibilities in the GA program (Q112).
- **Implementation**:
  Postcard Campaign: The technical support team sent postcards to GP members detailing the number of individuals screened and those still needing screening in their respective areas.
  Call to Action: The postcards served as a visual reminder of the health camp's impact and the importance of their involvement, encouraging GP members to take a more active role.
- **Impact**:
  Increased Responsibility: The postcards prompted GP members to take more responsibility for ensuring the success of the health camps. Many became more engaged and proactive in promoting the program.
  Volunteer Involvement: Some GP members volunteered to take on additional responsibilities related to the GA program, leading to better organization and higher attendance at the health camps.

6.2 Success stories on strategies related to disease screening.

The Grama Arogya GA program has demonstrated a range of successful strategies and interventions aimed at improving public health outcomes through community-based health screenings and awareness activities. These efforts have led to the early detection of NCDs, the identification of other health conditions, and increasing health awareness among various population groups. Below is an overview of the key strategies and success stories reported by participants in the program.

6.2.1 Screening for Hypertension and Diabetes

- **Challenge**: High prevalence of undiagnosed hypertension and diabetes in the community.
- **Strategy**: Conducting widespread health screenings to detect these conditions early.
- **Implementation**:
  Community Screenings: The GA program set up screening camps in various community hubs, including milk production societies, temples, ration stores, government libraries,

and MNREGA work areas. This approach ensured accessibility for a larger segment of the population.

Comprehensive Testing: Participants underwent tests for hypertension and diabetes, allowing for the early identification of these common but serious conditions (Q113).

- **Impact**:

  Early Detection: Many individuals, including PDOs and panchayat staff, were diagnosed with hypertension and diabetes. This early detection facilitated timely medical intervention and management.

  Health Improvement: The early diagnosis and subsequent treatment have improved the quality of life for many participants, preventing complications associated with unmanaged hypertension and diabetes.

6.2.2. Referral and Follow-up for Suspected Conditions

- **Challenge**: Identifying and managing health conditions beyond common NCDs during screenings.
- **Strategy**: Utilizing the expertise of CHOs to identify potential health issues and refer cases for further evaluation.
- **Implementation**:

  Symptom Identification: CHOs at the screening camps assessed participants for signs and symptoms of various health issues beyond NCDs (Q114).

  Referral System: Suspected cases were referred to higher medical centers for further diagnosis and treatment, with a follow-up system in place to ensure continued care.
- **Impact**:

  Comprehensive Health Care: The ability to identify and refer suspected cases has led to diagnosing and treating various health conditions that might have otherwise gone unnoticed.

  Improved Outcomes: Early intervention for a wider range of health issues has contributed to better overall health outcomes for the community.

6.2.3. Targeted Screening Locations

- **Challenge**: Ensuring high community participation in health screenings.
- **Strategy**: Conducting health screenings at locations with high community footfall.
- **Implementation**:

  Strategic Locations: Screening camps were organized at places where people naturally gather, such as milk production societies, temples, ration stores, government libraries, and MNREGA work areas.

  Convenient Access: The strategic placement of screening camps made it easier for community members to access health services daily (Q115).
- **Impact**:

  Increased Participation: The convenient locations led to higher attendance and participation in the health screenings, reaching a broader segment of the community.

Awareness and Engagement: The visibility of health camps at these locations also raised awareness about the importance of regular health check-ups.

6.2.4. School-Based Health Initiatives

- **Challenge**: Addressing health issues among school-aged girls, particularly anaemia.
- **Strategy**: Conduct health awareness events and anaemia screenings in schools.
- **Implementation**:
  School Events: The GA program organized awareness events in high schools, focusing on health education and the importance of screenings.
  Anaemia Screenings: Specific screenings for anaemia were conducted for high-school girls to identify and address this common condition (Q116).
- **Impact**:
  Improved Health Knowledge: School events educated young girls about health issues and the importance of regular health check-ups, fostering a culture of health awareness from a young age.
  Anaemia Detection: The anaemia screenings helped identify cases of anaemia among schoolgirls, enabling early intervention and treatment.

6.2.5. Celebrating 'World TB Day'

- **Challenge**: Raising awareness about tuberculosis (TB) and encouraging community engagement in TB prevention and treatment.
- **Strategy**: Organizing evening events to commemorate 'World TB Day' and educate the community.
- **Implementation**:
  Evening Celebration: The GA program celebrated 'World TB Day' by organizing events in the evening, including lighting candles to symbolize the fight against TB.
  Community Involvement: These events were designed to attract community members and create a platform for raising awareness about TB prevention and treatment (Q117).
- **Impact**:
  Increased Awareness: The evening events attracted many community members and helped raise awareness about TB, its symptoms, and the importance of early diagnosis and treatment.
  Community Engagement: The symbolic act of lighting candles fostered a sense of solidarity and commitment to fighting TB within the community.

6.3 Success stories on mobilization for camps

Effective communication plays a crucial role in the success of community health initiatives, such as the health camps organized under the Grama Arogya (GA) program. Timely and accurate dissemination of information regarding the camp's venue and timings significantly

increased community participation and health screening rates. Participants highlighted the importance of using appropriate channels to inform the population about the health camps. Here's a detailed look at the communication strategies employed for mobilizing the people and their impacts.

Communication Strategies for Health Camps Challenge: Ensuring that the community is well-informed about the health camps, including the location and timing, to maximize participation.

- **Strategy**: Utilizing a variety of communication channels to inform and attract people to health camps.
- **Implementation**:
  Loud Announcements: Announcing the details of the health camps through loudspeakers in public areas ensured that the information reached a broad audience. These announcements were made through waste-collecting vehicles or beating the drums in the streets of the villages (Dangura).
  Involvement of ASHA and Anganwadi Workers: ASHA and Anganwadi workers played a critical role in disseminating information within the community. They conducted door-to-door visits, informed the people about the camps, and engaged with community members to provide details about the health camps.
  Multiple Communication Channels: A combination of direct and indirect communication methods, such as community meetings and social gatherings, was used to reinforce the message and ensure widespread awareness (Q118, Q119).
- **Impact**:
  Increased Awareness: The diverse communication methods ensured that a large segment of the population was aware of the health camps, leading to higher participation. **Enhanced Trust**: The involvement of trusted community figures like ASHA and Anganwadi workers helped build trust in the health camp initiative, encouraging more people to attend.
  Improved Health Outcomes: Greater participation in the health camps led to the early detection and management of health conditions, contributing to overall improved health outcomes in the community.

6.4 Success stories of the fight against child marriage

Child marriage is a pressing social issue that significantly impacts the health and well-being of young girls. The Grama Arogya (GA) program, along with community and government agencies, has been actively working to combat this issue through coordinated efforts and innovative strategies. Interviewees highlighted the effective measures taken to prevent child marriages and raise awareness about the legal and health implications of this practice. Below are detailed insights into the strategies employed and their impacts.

6.4.1 Preventive measures against child marriage

- **Challenge**: Preventing child marriages and protecting the rights and well-being of girls under 18.
- **Strategy**: Collaboration between various stakeholders, including Panchayat workers, police departments, healthcare workers, and the women and child welfare department, to identify and stop child marriages.
- **Implementation**:
  Coordination and intervention: In incidents where underage girls were being forced into marriage, immediate intervention by a coordinated team of Panchayat workers, police, and healthcare workers was crucial. This teamwork ensured that child marriages were prevented promptly and efficiently (Q120, Q121).
  Verification processes: During mass marriages, authorities cross-verified the ages of the couples with the women and child welfare department to ensure compliance with legal age requirements. This step was critical in preventing underage marriages.
- **Impact**:
  Immediate prevention: The prompt actions and coordinated efforts effectively stopped several child marriages, protecting the rights of the girls involved.
  Legal compliance: The verification process ensured marriages adhered to legal age requirements, reinforcing the importance of following the law.

6.4.2 Awareness and Education Initiatives

- **Challenge**: Raising awareness about the consequences of child marriage and educating the community about legal and health aspects.
- **Strategy**: Conduct school-based awareness events and community programs and engage female teachers to communicate effectively about the issue.
- **Implementation**:
  School Awareness Programs: Awareness events were held at schools, where female teachers, who could relate better to young girls, led discussions on the dangers and illegality of child marriage. These programs provided crucial education on girls' rights and the importance of delaying marriage (Q122).

  Street Plays and Public Events: Innovative methods, such as street plays and public awareness events, were organized to highlight the negative impacts of child marriage. Experts were invited to speak at these events, offering valuable insights and solutions.
  Community Announcements: Loud announcements were made in public spaces to inform the community about the legal implications and health risks associated with child marriage. These announcements ensured that the message reached a broad audience.

- **Impact**:
  Enhanced Awareness: School programs and public events increased awareness among students and community members about the consequences of child marriage, leading to more informed decisions.
  Community Engagement: The use of engaging and relatable methods, such as street

plays and loud announcements, effectively captured the community's attention and fostered greater participation in the fight against child marriage.

6.4.3 Innovative Approaches to Community Engagement

- **Challenge**: Ensuring community involvement and understanding of the importance of preventing child marriage.
- **Strategy**: Using innovative approaches such as street plays, expert talks, and public announcements to engage the community and disseminate information.
- **Implementation**:
  Street Plays: Performing street plays depicting child marriage's adverse effects. These plays were conducted in community gatherings, making the message accessible and relatable to everyone (Q123).
  Expert Talks and Workshops: Child rights, health, and law experts were invited to speak at community events and workshops. They provided comprehensive information on the risks and legalities of child marriage, fostering a deeper understanding of the issue.
  Loud Announcements: Information about the harmful effects of child marriage and details on how to report suspected cases were broadcasted through loud announcements in villages and towns. This method ensured that even those without access to formal education or media received the message.
- **Impact**:
  Broad Awareness: The diverse approaches ensured that a wide range of people, including those who might not attend formal educational programs, became aware of the issue and were motivated to act against it.

6.5 Program as a success story.

The GA program is a remarkable success story in community-based healthcare, largely due to local governments' proactive involvement and ownership, particularly the GPs. This initiative exemplifies a successful healthcare model and highlights local governance's potential to drive significant social change and improve public health outcomes. Here's an in-depth look at how the program has become a beacon of success through the active participation of local governments.

6.5.1 Local Government Ownership and Leadership

Capacity Building: The program focused on strengthening the capacities of GPs to manage and implement health initiatives effectively. Training sessions and workshops were conducted to equip local leaders with the necessary skills and knowledge. Local ownership led to more efficient and context-specific health interventions tailored to meet the unique needs of each community.

Policy Integration: Health initiatives were integrated into local governance policies, ensuring that health priorities were aligned with community needs and resources. By integrating health initiatives into local governance, the program ensured the sustainability and continued relevance of health interventions.

Leadership Roles: GPs were encouraged to take leadership roles in organizing health camps, awareness programs, and preventive health activities. This included planning, resource allocation, and mobilization of community participation. The active involvement of local governments empowered communities to take charge of their health outcomes, fostering a sense of responsibility and participation (Q124).

6.5.2 Expansion Beyond COVID-19 Activities

Post-Pandemic Transition: The GP task force, which had been instrumental in COVID-19 management, was guided to expand its focus to include other health priorities such as NCDs, maternal and child health, and preventive care. The transition from COVID-19 activities to broader health issues led to a more comprehensive approach to community health, addressing a wider range of health concerns.

Community Health Focus: GPs were involved in organizing health camps, conducting awareness campaigns, and collaborating with healthcare providers to deliver comprehensive health services. The experience and structures established during the pandemic were leveraged to strengthen local health systems and improve service delivery.

Resource Mobilization: Local governments mobilized resources and fostered partnerships with healthcare institutions to support diverse health initiatives beyond the pandemic. The expanded role of GPs in health initiatives increased community trust and engagement as people saw their local governments as committed to their overall well-being.

7. SUSTAINABILITY

Ensuring the long-term viability of the GA program requires a multifaceted approach that encompasses strategic planning, technological integration, human resources management, stakeholder engagement, and continuous capacity building. Feedback from various participants has highlighted key areas for improvement and provided a roadmap for the program's sustainability. Below are the detailed subthemes, each addressing a crucial aspect of sustaining and enhancing the GA program.

7.1 **Strategy** - A comprehensive strategy is essential to guide the program's long-term objectives and ensure consistent delivery of health services.

7.2 **Technology adoption**- Leveraging technology can enhance the efficiency and reach of health services

7.3 **Human resources**- Adequate and well-trained human resources are critical for the successful implementation of the GA program

7.4 **Stakeholders/strengthening GPTF**- Strengthening the GPTF and engaging stakeholders are vital for program sustainability.

7.5 **Budget allocation**- Adequate funding is crucial for sustaining health programs and ensuring the availability of essential resources.

7.6 **Capacity building**- Building the capacity of local health workers and community members is essential for the effective delivery of health services.

7.7 **Rewarding Panchayats and incentives**- Recognizing and rewarding the efforts of Panchayats can motivate them to maintain high standards in health service delivery.

7.8 **Technical support**- Providing technical support is crucial for the effective implementation and management of health programs.

7.9 **Awareness and communication**- Effective communication and awareness-raising are vital for increasing community participation and understanding of health programs.

7.10 **Monitoring and follow up**- Continuous monitoring and follow-up are essential to ensure the effectiveness of health programs and address any emerging issues.

7.11 **Involving vulnerable population** - Involving vulnerable populations is crucial for ensuring equitable access to health services and addressing health disparities.

7.1 Strategy

Participants have emphasized the need for more frequent and comprehensive screening camps to improve the reach and impact of the GA program. By increasing the number of camps and including regular testing for common ailments such as diabetes and hypertension, the program can provide timely diagnosis and treatment, thereby enhancing overall community health. Here are the suggestions and perspectives from participants:

- **Expansion of Screening Camps**: More frequent screening camps are necessary to cover a larger segment of the population and ensure comprehensive health monitoring (Q125).
- **Routine Health Checks**: regular screenings for diabetes, hypertension, and other common non-communicable diseases (NCDs) in the camp schedules.
- **Follow-Up Care**: Ensure individuals diagnosed with chronic conditions receive follow-up care and management advice to effectively control their conditions.
- **On-Site Medical Support and Treatment:** Some participants suggested that having doctors present at the screening camps could facilitate immediate diagnosis and treatment, improving health outcomes.
- **Diagnostic Equipment**: Some participants verbalized that they would equip camps with the necessary diagnostic tools and equipment to perform tests and provide accurate results.
- **Immediate Medication and Advice**: Many participants suggested providing immediate medical advice and prescribing medications for those diagnosed with conditions during the camp, ensuring they receive prompt treatment.

7.2 Technology Adoption

The participants have highlighted the potential of technology to streamline processes and improve the overall efficiency of health services. One key suggestion involves the

development of a digital dashboard to monitor various aspects of the program, including the types of screenings conducted, the number of individuals screened, and the performance of health workers. This technological innovation can greatly enhance the management and transparency of the program. A digital dashboard provides real-time access to data, allowing for immediate tracking of screening activities and health outcomes. It can generate detailed reports on various metrics, such as the number of screenings conducted, types of screenings, and demographic information of those screened (Q126).

Some participants have emphasized the need for advanced technology to improve the efficiency of health screenings, disease identification, monitoring, and follow-up. Integrating the right technological tools can significantly enhance the program's effectiveness by streamlining processes, improving accuracy, and ensuring timely interventions (Q127, Q128).

7.3 Human resources

Most participants highlighted the critical need for additional human resources to sustain and expand the program. The current workforce, including the KHPT staff, plays a crucial role in the program's success. To ensure the program's long-term viability and effectiveness, participants have suggested recruiting new staff or extending the tenure of existing KHPT staff.

Some participants suggested including volunteers from the local community to increase the workforce and ensure culturally appropriate care and recruitment of vacant positions at GA, such as data entry operators, administrative personnel, and field workers, to assist with various program activities (Q129, Q130).

7.4 Stakeholders/strengthening of GPTF

Most participants underscored the importance of involving GP members to ensure the program's success. Many have noted that while the GPTF was highly active during the COVID-19 pandemic, its involvement has diminished. Reactivating the GPTF and raising awareness among GP members about the program and the role of KHPT can significantly enhance the program's effectiveness and sustainability. It is important to raise awareness among GP members about the GA program and the role of KHPT in improving rural health, thereby garnering their support and involvement. Here’s a comprehensive plan for achieving these goals as expressed by the participants:

- **Scheduled Meetings**: Plan regular GPTF meetings to discuss the progress of the GA program, identify challenges, and develop solutions.
- **Capacity Building**: Provide training for GPTF members on health issues, program management, and community engagement.
- **Role Clarification**: Clarify the roles and responsibilities of GPTF members to ensure they understand their contributions to the program (Q131, Q132).
- **Recognition and Awards**: Implement recognition programs to reward active and effective GPTF members, motivating them to stay involved.

- **Incentives for Participation**: Offer incentives such as travel allowances or stipends for attending meetings and participating in program activities.

7.5 Budget allocation

Many participants highlighted the critical need for distinct budget allocations to ensure the program's sustainability and effectiveness. They emphasized that GPs with higher incomes must take responsibility for funding the program, while government support is essential for GPs with lower incomes. This approach would ensure equitable resource distribution and facilitate continuous health screening and other program activities. Here's an in-depth look at the financial recommendations and strategic measures for budget allocation for the GA program:

Establishing a Distinct Budget for the Grogram: to secure a specific budget dedicated to the GA program, ensuring financial resources are allocated exclusively for health-related activities and program sustainability.

Targeted Funding: Advocate for government grants and subsidies specifically for GPs with an income below 50 lakhs to support the GA program

Equitable Distribution: Ensure that funding is distributed equitably based on the specific needs and population size of each GP

Most of the participants expressed their opinion that a distinct budget should be assigned to this program. Certain gram panchayats with an income exceeding 50 lakhs are responsible for budgeting and providing funds, as the government will not contribute any money. However, for gram panchayats with an income below 50 lakhs, it would be beneficial if the government allocates a budget for gram Arogya, as it would facilitate conducting screening activities (Q133, Q134).

7.6 Capacity building

Participants have highlighted the importance of empowering GP members through targeted training and capacity-building initiatives. These steps are essential to ensure that GP members are well-equipped to implement and manage the program effectively, thereby bridging any gaps between planning and execution. Here's a comprehensive plan of suggestions for capacity building, training, and empowering GP members to enhance the effectiveness and sustainability of the GA program.

Key Focus Areas

7.6.1 Training and Capacity Building of GP Members
7.6.2 Pilot Study and Program Implementation
7.6.3 Onsite Training and Compulsory Attendance
7.6.4 Involvement of State Institute of Rural Development and RDPR
7.6.5 Utilization of Local Resources and Technical Support

7.6.1 Training and Capacity Building of GP Members

- **Select a Champion**: Identify one motivated GP member from each panchayat to serve as a health program champion. This person will be trained extensively and act as a liaison between the panchayat and the health department.
- **Comprehensive Training Programs**: Develop comprehensive training modules covering various aspects of the GA program, including disease prevention, health promotion, and community engagement.
- **Regular Capacity-Building Sessions**:
  Microplanning Activities: Conduct regular microplanning sessions where GP members can develop and refine strategies tailored to their specific community needs.
  Continuous Learning: Implement a continuous learning approach with refresher courses and updated training materials to inform GP members about new health policies and practices.

7.6.2 Pilot Study and Program Implementation

- **Pilot Study Implementation**:
  Conduct Pilot Studies: Implement pilot studies in selected GPs to test the effectiveness of training one member intensively. Monitor outcomes and gather feedback to identify best practices and areas for improvement (Q135).
  Evaluate and Scale: Evaluate the pilot study results, and if successful, scale the training program to other GPs with modifications as needed based on feedback and performance.
- **Full Responsibility for Implementation**:
  GP Autonomy: Assign full responsibility for the GA program's implementation to the GPs, ensuring that they are accountable for both planning and execution.
  Clear Guidelines and Support: Provide clear guidelines and continuous support to GPs to help them manage the program effectively.

7.6.3 Onsite Training and Compulsory Attendance

- **Onsite Training**:
  Practical Training Sessions: Organize practical, hands-on training sessions within the community to provide real-world experience and enhance learning.
  Local Context Training: Tailor the training content to address local health issues and community needs, making it more relevant and impactful.
- **Compulsory Training Attendance**:
  Mandatory Participation: Establish a policy that makes attendance at training sessions compulsory for all GP members involved in the GA program.
  Incentives for Compliance: Provide incentives such as certificates, recognition, or additional resources to GP members who complete the training and actively participate in the program.

7.6.4 Involvement of the State Institute of Rural Development (SIRD) and RDPR

- **Collaboration with SIRD and RDPR**:
    - **Partnerships for Training**: Partner with SIRD and RDPR to conduct structured training programs for GP members, leveraging their expertise in rural development and capacity building.
    - **Joint Training Programs**: Organize joint training programs that combine health-related training with broader rural development skills, enhancing the overall capability of GP members.
- **Resource Sharing and Support**:
    - **Shared Resources**: Utilize training resources and materials developed by SIRD and RDPR to ensure consistency and quality in training delivery.
    - **Technical Support**: Seek technical support from these institutions for program planning, implementation, and evaluation, ensuring continuous improvement (Q136).

7.6.5 Utilization of Local Resources and Technical Support

- **Technical Support and Rural Health Training**:
    - **Technical Assistance**: Provide ongoing technical support to GP members in areas such as data management, health information systems, and program evaluation.
    - **Rural Health Training**: Focus on training GP members in rural health issues, equipping them with the knowledge and skills to address the specific health needs of their communities.
- **Extended Training Programs**:
    - **Intensive Training**: Offer extended training programs that last up to ten days, allowing GP members to gain a comprehensive understanding of the program and its implementation.
    - **Group Training**: Conduct group training sessions to foster peer learning and collaboration among GP members (Q137).

7.7 Rewarding Panchayats and Incentives

One participant suggested the felicitation of the panchayat, which screens more individuals annually and shows extraordinary performances in conducting camps. This will motivate the other panchayats to work more vigorously. Some suggested that a particular day be kept to celebrate Grama Arogya Day to spread awareness (Q138).

Some participants also suggested that, as the existing health staff is overburdened, young adolescents, adult males or females, could be selected for the program-related activities and given some incentives. So, it also creates job opportunities for the village people (Q139, Q140).

7.8 Technical support

Most participants expressed that for the GA program to achieve sustained success and ongoing positive impact, the support of the KHPT is crucial. KHPT's continued involvement can provide stability, resources, and expertise necessary for the program's longevity and effectiveness (Q141, Q142).

7.9 Awareness and communication

Public awareness is the cornerstone of a thriving Grama Arogya (GA) program. To ensure its long-term success, engaging the community is paramount. Two approaches that were employed to engage the community were utilizing the community radio and utilizing the waste collection vehicles. Here's an in-depth look at how each method can be utilized effectively, along with their potential benefits:

Community Radio for Dissemination of Information

Community radio emerges as a powerful tool for amplifying public awareness about the Grama Arogya (GA) program, particularly in remote and underserved areas. It added the following strengths to the program:

- **Targeted Communication:** Unlike traditional media, community radio allows for messages tailored to specific demographics and localities. This ensures the program information reaches the intended audience, maximizing its impact within the community.
- **Ease of access:** Community radio thrives even in areas with limited internet connectivity or low literacy rates. This makes it a valuable tool for reaching those who might otherwise miss crucial information about the GA program and its services.
- **Effective Messenger:** Community radio excels at raising awareness and disseminating information. It can effectively communicate health messages and the program's schedule, empowering residents to participate and take charge of their well-being.

By harnessing the power of community radio, the GA program can bridge the information gap and ensure everyone can benefit from its services.

Announcing Camp Dates via Waste-Collecting Vehicles

One of the most popular suggestions from participants is a testament to resourceful innovation. Leveraging existing municipal resources, the program proposes utilizing waste-collecting vehicles to announce upcoming health camp dates. It added the following strength to the program:

- **Greater Reach:** Waste collection trucks traverse most neighbourhoods, ensuring program announcements reach a vast and diverse audience within the community.

- **Consistent Communication Channel:** These vehicles visit communities on a regular schedule, providing a reliable platform for consistent messaging about the health camps. This consistency is crucial for ensuring everyone can receive the information.
- **Cost-Effective Solution:** This method maximizes impact while minimizing costs. It leverages existing resources without requiring significant additional investment, making it a practical and sustainable approach.

This creative proposal demonstrates a commitment to maximizing community engagement with minimal burden on resources. By turning a familiar sight into a vehicle for health awareness, the program can significantly expand its reach and empower residents to take advantage of its services (Q143, Q144).

7.10 Monitoring and follow-up

Implementing a proper and regular review process for the GA program is crucial to ensure its effectiveness and sustainability. Monthly reviews allow for timely identification of issues, assessment of progress, and adaptation to meet the needs of vulnerable communities.

- **Schedule Regular Meetings**: Establish a schedule for monthly review meetings. Ensure these meetings are planned well in advance and communicated to all stakeholders, including community leaders, healthcare providers, and program staff.
- **Include Key Stakeholders**: Involve key stakeholders in the review process. This includes community leaders, healthcare professionals, program coordinators, and representatives from vulnerable communities (Q145).

7.11 Involving Vulnerable Community

Engaging vulnerable communities effectively in the Grama Arogya initiative requires strategic planning and inclusive communication. One key suggestion from participants is to inform community leaders in advance. This is a significant approach as it can greatly enhance participation and ensure the program meets the needs of the community (Q146).

6.5 Quotes

Table 2: Quotes from the participants

Q. No	Quotes
Q1	*"We created a task force by giving a circular; in that task force, there were elected members and staff, including PDOs, secretary, and bill collector, water operator, along with the representatives from different departments wise representatives like Anganwadi workers, ASHA workers, village accountants, Police sub-inspectors, and if there was a bank, bank managers were the members of the task force."* ***(Female, 57 years, State-level officer)***
Q2	*"It's good, madam… because if they must be screened, they should go to the hospital, take the slip, and wait in queue for the check-ups. then the Doctor should write for the tests... Again, they must go and wait there for a test… that will be a time-consuming process. So, compared to that, the tests done at the camps are free of cost."* ***(Male, 61 years, GP Member)***
Q3	*"Even we felt it is a very good model, strengthening GP, which is also local government, a lot more can be achieved beyond COVID-related aspects. So, we started this program on a pilot basis in 14 districts. Later, we felt it became a success, and many benefited from it. People who have never gone for testing in their lifetimes got tested; even GPs appreciate this kind of effort."* ***(Male, 60 years, State-level Officer)***
Q4	*"I feel that there are three objectives. One is the involvement of the Grama Panchayath task force; the second is the screening of the population for the NCD; and the third is creating awareness about evil activities."* ***(Male, 43 years, ZP CEO)***
Q5	*"The Grama Arogya Program aims to provide door-to-door health facilities for all the villagers and improve the health and well-being of the people."* ***(Female, 39 years, CHO)***
Q6	*"In total, the goal is to raise awareness, and people should know about the available government health facilities. Everyone should be aware of it and learn about the program. This is the main objective, so they are raising awareness door to door."* ***(Male, 54 years, DHO)***
Q7	*"Grama Arogya program comes under the purview of the Department of Women and Child Development Services with a focus on their health."* ***(Male, 58 years, DD WCD)***
Q8	*"We conduct camps here, ma'am. We go and invite them to the camps, and they come and get checked and we check BP and sugar [Diabetes], and we talk to them about pregnancy-related problems, anemia, and shifting of malnourished*

	kids to higher centers; we advise against child marriage……." ***(Female, 56 years, PHCO)***
Q9	*"Monthly on 28th, we conduct health camps. There is an instruction for monthly five camps that must be conducted at panchayat, Anganwadi, and residential schools, and at high residential areas. Here we don't have residential schools so we conduct camps at Anganwadi and panchayats by using health kits. So, we will conduct camps where there is a crowd, for example, at a ration center."* ***(Female, 26 Years, CHO)***
Q10	*"Every second Tuesday of the month, CHOs are supposed to do the health camps. That time, we are involved in it."* ***(Female, 36 years, ASHA***
Q11	*"We conduct four camps in a month; we take suggestions from all members, in whose division camps to be conducted and when."* ***(Female, 36 years, GP Member)***
Q12	*"Monthly on 28 th, we conduct health camps. There is an instruction for monthly five camps have to be conducted at panchayat, Anganwadi, and residential schools, and at high residential areas."* ***(Female, 26 years, CHO)***
Q13	*"During Taluk panchayat meetings, they will ask about the number of camps conducted under the Grama Arogya program."* ***(Male, 40 years, PDO)***
Q14	*"If any problem from your KHPT, we will give direction to these…(to the district lead). We also give direction to the panchayat Development officer."* ***(Male, 38 years, Nodal Officer)***
Q15	*"Whatever sectors are here at the grama panchayath level, all people are involved in the task force. But the attitude towards work can be changed."* ***(Male, 41 years, Executive Officer)***
Q16	*"PDO, President, Members, Asha Workers, Health Departments, and Women and Children Departments participate in the meeting and make a micro plan for a health camp according to the area."* ***(Female, 39 years, CHO)***
Q17	*"In my area, if the camp date is fixed as tomorrow, I will visit the site. Generally, we will know who got tested in the camp. I will note the remaining who did not attend the camp, and later, I will ensure that they will be tested on further dates."* ***(Female, 35 years, GP Member)***
Q18	*"46 members were there including members from the health department, Sanjeevini Union members, gram panchayat members.. and Anganwadi workers, and ASHA workers... and it was done at panchayat level."* ***(Female, 36 years, PDO)***
Q19	*"GPTF involvement is good here. However, more involvement and training sessions are required. There is some hesitance from the elected body. Some GP members organize health camps, but the percentage is lower"* ***(Male, 46 years, Executive Officer)***
Q20	*"As a panchayat member, we will know about the people… and we inform people about the camps and motivate them to come to the camps."* ***(Female, 35 years, GP Member)***

Q21	*"Arrangements for camp, including a kit [Health management kit], will be provided."* ***(Male, 45 years, GP Member)***
Q22	*"No, madam, we are not procuring anything for the kit.. It will be managed by the health department."* ***(Male, 61 years, GP Member)***
Q23	*"We (PHCO) will do BP monitoring and sugar test (cross talk). ASHA workers will help gather people and do activities. KHPT staff help in doing height and weight."* ***(Female, 33 years, AWW)***
Q24	*"In our Clinician role, we will do screening, refer those suspected, and follow-up the cases. We provide health education on food, diet, exercise, medications, etc."* ***(Female, 26 years, CHO)***
Q25	*"Initially, we implemented it as a satellite-based training program held in 14 districts. Later, when all 31 districts were included, there was state-level cascade training. At the state level, three departments were clubbed, and a training program was conducted. We identified a master resource person in all three departments for every district, and training was given. Later, these masters trained the people at the district level. Representatives of all three departments at a taluk will be trained in that training."* ***(Male, 60 years, State-Level Officer)***
Q26	*"The KHPT team conducted a meeting and provided information and training. More information was provided through a TV program….. One resource person from their department provided training through TV. We called the President, ASHA workers, and other staff for training."* ***(Male, 47 years, ADS)***
Q27	*"Yes, there are five components in the program—mainly diabetes, hypertension, TB, menstrual hygiene, anemia, and child marriage. We made two manuals on these different aspects. One is charts, like posters, and the other is a booklet. GP individuals will not read if we provide heavy [big] documents, so charts were made. Visibility is good; they are big, like wall hangers, and have five charts. They had complete information, such as what the disease is about, its symptoms, complications, and where and how the treatment is. Every staff member conducting capacity-building activities had this kind of chart, and one was given to the GP. Then manuals with 100-120 pages in Kannada…… even charts were in Kannada…… Then all these materials, along with the kit, were annexed and distributed to GPs."* ***(Male, 60 years, State-Level Officer)***
Q28	*"There will be fixed dates to conduct the camp, which will be communicated to us, every Tuesday is fixed as a mandate for the camp. Healthcare professionals, like CHOs and representatives of KHPT, will be at some sites. They will support and coordinate to organize the medical checkups. In some areas, panchayats help gather and motivate the people for the camp. CHOs do NCD screening, which is a non-communicable disease screening they do every Tuesday. We do it in the health and wellness center, but it may be a different place. Before organizing camps, the place will be fixed during the panchayat meeting…… the plan will be fixed, and as per that, the panchayat will create awareness [announcements] and motivate people to attend the camp. In that camp, our health worker, who is called the Community Health Officer [CHO], will be there*

	checking for Hypertension for people who are above 30 years……" ***(Male, 54 years, DHO)***
Q29	*"A kit is provided to every Grama Panchayat to check blood pressure, blood tests, haemoglobin, and other health parameters by KHPT (Karnataka Health Promotion Trust), and we are also getting help from KHPT to the Grama Panchayat so we can conduct health camps. We informed Grama Panchayats about this, and with their help, we are conducting this program. Along with some consumables in the health kit, such as strips, we ordered Grama Panchayats to buy the strips using the 15th Finance Commission funds."* ***(Male, 55 years, Nodal Officer)***
Q30	*"This program is meant for screening non-communicable diseases, the most prevalent being hypertension and diabetes. Apart from that, the program also concentrates on creating awareness about social evils like child marriage and domestic violence against women, and it also aims to take the service of health delivery to the doorstep of the people."* ***(Male, 43 years, ZP-CEO)***
Q31	*"From the health department, we have to do four camps in a month. However, we are collaborating with the Grama Panchayath and organizing the four camps. While conducting the camps, coordinating with the Gram Panchayat helps us plan the camps and increases the success of the health camp as people reach more health facilities. Asha's workers inform people about the health camp."* ***(Female, 39 years, CHO)***
Q32	*"Even if some people refuse to come and get treated, we will visit their house. BP, sugar, TB, anything can be there; we motivate them to get tested and treated for these."* ***(Male, 45 years, GP member)***
Q33	*"I have mentioned BP, diabetes, malnutrition, anaemia, etc. Apart from that, we create awareness about adolescent problems, menstrual hygiene, and domestic violence against children and women. Health awareness has been created among the beneficiaries of the health camp."* ***(Female, 39 years, CHO)***
Q34	*"Mainly, we are raising awareness programs on various social issues like child marriage, child labour, children-related issues, and women-related issues. We organize the program and tell them to participate. Sometimes they (the Grama Arogya Team) organize the program, and our resource person goes there. During health camp, we find that anaemic children, anaemic pregnant women, or anaemic women are coming to health camp. Our staff mobilizes them to join the health camp, and then we follow up."* ***(Female, 55 years, WCD)***
Q35	*"We included DC, the CEO, in female foeticide prevention activities, and we also conducted training and awareness programs. Child marriage is more common among migrant people, and they are from Bellary and other northern districts; they will get married before migration."* ***(Male, 42 years, Nodal Officer)***

Q36	*"Weekly, two times, we will conduct screening tests for NCD, BP, sugar……. cleanliness in children, TB program-related, and mental health-related…… For physical health check-ups, they usually go, and mental health is also important, and our department addresses it."* ***(Female, 26 years, CHO***
Q37	*"We inform the VRW (Village Health Workers) to visit door-door to address mental health issues, they do home visits, and we do not have any cases here."* ***(Female, 36 years, PDO)***
Q38	*"I got data from the health department because whoever died of COVID-19, their children were given money. At that time, I observed that most of them had lost their fathers. We called all the mothers and talked to them. Some of them got depressed, but most of them did not talk about depression; they had a stigma about psychiatric problems. If anyone has any mental health problems, they have to see a counsellor. Raising awareness about mental health is very important."* ***(Female, 55 years, DD WCD)***
Q39	*"They will gather all the people, and we will record the details of the participants. We check BP and then sugar using a glucometer. If there is a follow-up case, we will look into the tablets; if there is a new case, we will refer them. This program aims to refer them to PHC; we are not supposed to prescribe medicines on the spot. There is a reference slip in the book, and we will also have our slip. We write the reference prescription and give it to patients."* ***(Female, 43 years, ASHA)***
Q40	*"As I mentioned, we do budgeting. However, not all the gram panchayats are financially stable and have not been strengthened in Karnataka. In this panchayat, we don't have any commercial buildings or other income sources."* ***(Male, 38 years, PDO)***
Q41	*"50 thousand is not enough sir, and we will use Grama Panchayat and Taluk Panchayat allocation funds."* ***(Male, 46 years, Executive Officer)***
Q42	*"There are two kinds of systems. One is that there is a record book at every GP. The details of when, where, and participants in the camp will be recorded; this is manually done. They are supposed to take this book [register] and enter details during every camp. Meanwhile, internally, we made a Pragma app [application], and our staff entered the camp details. The GP members are supposed to maintain the register provided. Later, the government introduced a reporting portal called Panchatantra; the GP individuals were supposed to provide all the details related to their GP development activities".* ***(Male, 60 Years, State-level Officer)***
Q43	*"Every week they fix the camp…if today is in a village and next week will be in another village. Before the day of the camp, the announcement will be made through our waste collection vehicle, which has a mike… we check the strips before the camp; if it is not there in adequate numbers, we will buy the strips and arrange the kits in advance. we arrange the books (record books)…. They have to maintain records of participants screened and treated. So we arrange*

	the books with the kit… every week, wherever they go, they carry the kit with the books". ***(Male, 44 years, GP President)***
Q44	*"In the program, we have criteria of entering the data on the same day or the next day or at least before Saturday and all…it is in our control… several camps done, places of camps, referral numbers, whether referral numbers are written correctly and all…we were doing a quality check of all the data in that app…****(Male, 55 years, Zonal Coordinator)***
Q45	*"There is a little difference while uploading in the Panchatantra-2.0 tool: training is done, and everyone uploads it. Everything is uploaded online, not offline. Initially, no one knew about it, but now everyone uploads it. Now, profile updation is done, and DCB has also done, now e-attendance is also there online."* ***(Male, 47 years, ADS)***
Q46	*"We have different formats for the program…. what we are doing publicity is format number 1. Format number 2 is about the details of the people who have undergone the check-up. In format 3, there is a summary of that day's program…. in that summary, we record how many people were with TB, diabetes, and other severe cases.. fourth one is the Arogya Kit book…. Whatever we issue will be entered in that book…."* ***(Male, 38 years, PDO)***
Q47	*"In the monthly meeting in this panchayath, the list of new cases of all these diseases, then the utilized items in the kit by KHPT, then the remaining stock, if anything is given again by them [KHPT], all these are discussed during that meeting. During this meeting, if GP asks for the new cases list, then we or ASHAs will give it"****(Female, 43 years, ASHA)***
Q48	*"I told ASHA's to maintain the record for follow-up cases of BP and sugar. If a person has both sugar and BP, line list them and maintain them in a separate register, and maintain the list of cancer and cardiovascular diseases…."* ***(Female, 26 years, CHO)***
Q49	*"Usually in the camps, female participants are more than men."* ***(Male, 60 years, Beneficiary)***
Q50	*"CHO is there. She gives awareness talks on teenage-related issues and menstrual hygiene. She also visits schools."* ***(Female, 32 years, Beneficiary)***
Q51	*"The Last camp was conducted on the 06th for physically challenged persons, and we did tests. Nearly 55 physically challenged persons participated in this program."* ***(Male, 40 years, PDO)***
Q52	*"Yes, members of sangha [societies], so many females go get tested in camps.. NRLM team is there, ma'am, in that there is =Sanjeevini okkuta=. In that MBK, LCRP is there, ma'am; they will manage everything. For example, getting loans to females in these groups, they tell about healthcare, camps, etc. They tell them that KHPT is organizing health camps, and all the females in their group should get checked in the camp."****(Female, 55 years, Beneficiary)***

Q53	*"Nowadays, everyone participates equally because, in every program, we create awareness about women's empowerment, so everyone participates equally."* ***(Male, 38 years, DD-WCD***
Q54	*"What I observed is that females are more interested in the program than males. , usually, backward-class people are quite natural; they will come to the health program."* ***(Female, 55 years, DD WCD)***
Q55	*"It is more the men who go, but here women are also getting screened. That is also a gender dimension to this; the elderly is getting screened, and everybody has an opportunity to be screened."* ***(Female, 57 years, State-level Officer)***
Q56	*"It will help in identifying lifestyle disorders. Imagine that this program is not there. They will not be tested, or they will not be screened."* ***(Male, 43 years, ZP CEO)***
Q57	*"At the village level PDO, the president, and bodies will be there, and they will conduct camp and house visits. In the past, house visits were not there. Health screening has been more effective in the last three to four years due to house visits. They are providing health care facilities to the doorstep, and even for long-term disease conditions, they will refer to the higher hospitals, which will help more in rural areas. Some people are financially unstable. It will also be more helpful for them."* ***(Male, 46 years, Executive Officer)***
Q58	*"We had to go outside to get tested for BP and sugar. Time was wasted traveling, and expenses to go there are saved. Camps will be helpful for old people who cannot go outside for testing."* ***(Male, 72 years, Beneficiary)***
Q59	*"Coordinating with Gram Panchayat helps us plan the camps and increases the success of the health camp as people reach more health facilities. Asha's workers inform people about the health camp. Anganwadi workers are involved in the health camp; they usually inform the people about the camp and maintain the register with Asha Workers."* ***(Female, 39 years, CHO)***
Q60	*"There is very good cooperation among all the departments… They all work together for the camps…"* ***(Female, 48 years, Beneficiary)***
Q61	*"We will do BP monitoring and sugar test (cross talk). ASHA workers will help in doing the activities. KHPT staff help in doing height and weight. We will share all the activities. We will take the responsibility of different works."* ***(Female, 44 years, ASHA)***
Q62	*"When it comes to convergence, all the departments need to work together; tasks are only possible then. One is at the state level, the second convergence at the implementation level, and the third at the monitoring and reporting system. At the state level, health and RDPR convergence are well established, not that great with WCD."* ***(Male, 55 years, State-level Officer)***
Q63	*"Panchayat will have anudana [grants]. Somehow, we can adjust, it is not a burden to us. If we want to manage, we have to keep the budget. If it falls short, we try to take money from other sections and give importance to health."* ***(Female, 35 years, GP Member)***

Q64	*"Yes, If we want to manage, we have to keep the budget. If it falls short, we try to take money from other sections and give importance to health."* ***(Female, 35 years, GP Member)***
Q65	*"Yes, Madam. The strips given by KHPT are exhausted, and the strips that we are using at PHC do not suit the device given by KHPT. So, we use the device also from the PHC* ***(Female, 36 years, ASHA)***
Q66	*"Consumables they are purchasing it, but as we observed, 100 percent of the support is not there. 50 to 60 percent of Grama Panchayat supports it."* ***(Male, 55 years, Nodal officer)***
Q67	*"Along with some consumables in the health kit, such as strips, we ordered Grama Panchayats to buy the strips using the 15th finance commission funds."* ***(Male, 55 years, Nodal Officer)***
Q68	*"In the letters, we mentioned purchasing the consumables. If there are no consumables, there won't be any camps… if the health department has the consumables, camps will happen; otherwise, it has to be purchased from the panchayat, letters are sent….. guidelines are there.. training is given…everything is done… from where money has to be used means from the 15th finance, or their fund or need to find local donors."****(Male, 55 years, Zonal Coordinator)***
Q69	*"We used to talk in common meetings.. that meeting was held on the third Wednesday of every month. During those meetings, no one supported us, including our administration body.. But in the second month, we explained to them clearly that this is the work that has to be carried out by us RDPR, which we will be supported by KHPT… we explained about the GPTF also.. after explaining everything, they started supporting."* ***(Female, 36 years, PDO)***
Q70	*"Anganwadi workers, sisters [Nurses], ASHA workers, and GP members will motivate them to visit their houses; else, we will ask that kind of people to come to a place, and then we try to do IEC activities. Sanitation and menstrual hygiene-related awareness events will be conducted in schools."* ***(Female, 45 years, PHCO)***
Q71	*"We can convince the people by showing our example. I did not know that I had sugar (Diabetes) until I got tested. If someone has tiredness, giddiness, etc, it is always better to go for screening BP and sugar."* ***(Female, 37 years, Beneficiary)***
Q72	*"Normally, we have to do camps weekly at any one village according to our schedule. At that time, we will inform the Panchayat through an ASHA worker and tam-tam [Loud announcement]."* ***(Female, 26 years, CHO)***
Q73	*"I already mentioned that we have a Sanjivini Women's Union. All our five village associations will have contact with them, and they will communicate through phone or WhatsApp. When they come to know that a camp is going on in a village, they also tell everyone to participate there or make good use of the program. Again, our ASHA keeps saying it during her door-to-door visits."* ***(Male, 44 years, GP President)***

Q74	*"If we get a calendar of events, we can coordinate with the other team members and plan for the camp. This type of coordination should be required and necessary."* ***(Male, 55 years, DHO)***
Q75	*"I called the community leader and said that I think they don't understand what we said, better you say your own language. We have done that also…. He started communicating in their own language."* ***(Male, 41 years, Executive Officer)***
Q76	*"We have worked towards GA. We have provided facilities for doctors from our Panchayath end. We have made a garden and road and provided masks. We have built Shishu Palana Kendra. Some five lakhs fund is there to build toilets."* ***(Male, 52 years, GP Member)***
Q77	*"No. I did not hear about the Grama Arogya Program. But I have attended health camps here, below that tree."* ***(Male, 36 years, Beneficiary)***
Q78	*" No, do not know about the budget allocated for it. If some budget does not come from a higher level, we use the tax collected here."* ***(Male, 38 years, GP Member)***
Q79	*"Whenever I was in a field, I visited a few camps, and people were too hesitant to get screened. That is the first thing they said: I am good; don't test me."* ***(Male, 43 years, ZP CEO)***
Q80	*"In the beginning, it was difficult to gather people at the camps. If any announcements are made that they were being lazy [neglect] and that all these can be checked in the hospital, why go to them and leave behind all our work? This was the attitude in the community. They did not like to take pricks [figure prick for blood test]; they were a little scared."* ***(Female, 35 years, GP Member)***
Q81	*"They bring 50-100 strips, organize one camp, and push one or two months.. like this is happening... after observing these things, we have made the CEO send circulars at the state, district level, and taluk level messages in WhatsApp. Along with this, every Monday, our staff will update the CEO and EO in their group. Weekly, one camp must be done under every panchayat; if last week's camp was done in some other panchayat, this week, it has to be done in this panchayat."* ***(Male, 55 years, Zonal Coordinator)***
Q82	*"There are no particular places where the availability of population is greater… we will conduct camps where houses are more and at schools and Anganwadis, gatherings [katte]……The main goal is that we have to cover the whole population."* ***(Male, 38 years, CHO)***
Q83	*"When it comes to ownership, state-level ownership is already present. What we need is ownership at the district level, taluka level, and the panchayath level. They also have that ownership, but it's tagged as a KHPT program."* ***(Male, 60 years, State-level Officer)***
Q84	*"One strength is focusing on panchayaths. Though it is a health-related program, instead of focusing on the health department, panchayath is the focus. This is because the panchayath is the local govt; they are accountable to the people. So this is the program's trump card, and nobody can deny it. The second*

	trump card is that wherever you go, people will buy this; it is convergence." ***(Male, 60 years, State-level Officer)***
Q85	*"This program is decentralized already…..circulars are issued….. They are reviewed in the meetings, asking to buy the strips and do the camps. Microplans are happening… they allocated money in their action plans, but it has not yet been released from the government….. In some places, it is released, and they are buying it…."* ***(Male, 55 years, Zonal Coordinator)***
Q86	*"At the field level, there are still…… For example, for screening, we need consumables; the departments say you procure them. Panchayath, from where should they procure? Other programs will have their grants, but this one does not yet. The circular for this is GP collects health cess and can utilize the same".* ***(Male, 60 years, State-level Officer)***
Q87	*"There is no money…. etc... there is no money for this program, and this is running only on the guidelines mentioned in the letter…..this program is initiated and implemented based on the circulars….there are no rules in this, unlike other programs, and there is no line head..in the budget... if it was like an order from the government the body could escape from it…. it is implemented through memos, letters and DO letters.. the places where people have understood the vision of this program, its usefulness for the people, it was easy for us to implement it.."* ***(Male, 55 years, Zonal Coordinator)***
Q88	*"We have some more programs also.. if we can do all three programs, we can do four programs, five programs also if it is unavoidable.. we will do everything, but what happens is.. when the number of programs increases, the quality of the program naturally reduces… like if I can run 50 meters and someone say me to run 100 meters it will be difficult for me. I can work for 4-8 hours effectively, and if someone says to work 10-12 hours.. there will be tiredness.. activeness reduced, there will not be any interest… and quality will be compromised…"* ***(Male, 54 years, DHO)***
Q89	*"The third is that we don't have any extra functionaries for this. The same functionaries, whoever is doing the work, this is an additional work. Making it happen is a task, it is not that anybody is unwilling to do the additional work but making it happen and panchayats also recognize this is important.. but dominant elites recognize the rural poor that is one part of it, for officials who are conditioned to do basic governance like street lights, drinking water sanitation, and so on and have their hands full with that.. traditionally health issues are dealt with by health department why should we get into it* ***(Female, 57 Years, State-level Officer)***
Q90	*"They don't go to work together, ma'am... they work in the different fields, they are going to farms for work. So they are not available to us, ma'am...Even I looked at their availability under the MNREGA scheme...I have not found them there also..."* ***(Female, 26 years, CHO)***

Q91	*"One thing is that each gram panchayat has one data entry operator. He was so burdened by his work that he was not able to devote that much time to this scheme, which is why we lag in the updating of data in P2. That is the reason I get information delayed by a month."* ***(Male, 43 years, ZP CEO)***
Q92	*"There is a sample module in Panchatantra. It is not working properly, server problems are there, and the capacity of it needs to be rechecked. For example, 10000 entries are made together. Not just software, the reporting system must be streamlined".* ***(Male, 60 years, State-level Officer)***
Q93	*"There is a communication barrier and a lack of staff. A change is required at the administration level. I am involved in creating awareness about health. Due to work pressure, managing all work at a time is difficult because we are handling 256 Grama Panchayats. One outsource department is also involved in this program, so a particular department for handling this program is there, which means it will be helpful"* ***(Male, 42 years, Nodal Officer)***
Q94	*"Some say they do not have a data entry operator; some do not prioritize these GA details for entry, which is why it is incomplete. In some areas, PDOs took time to approve even after entering data. So, at the state level, complete information couldn't be accessed."* ***(Male, 60 years, State-level Officer)***
Q95	*"Previously, there was one PDO, he supported everything, and there was another secretary also, madam…. we should remember him. If we organize any program, we just have to make a phone call. He used to come… now there is no one like them, madam.... but now, how I have to call many times, and they will come two or three hours after a call…. If there is any urgent work, I have to make adjustments from other places."* ***(Female, 26 years, CHO)***
Q96	*"We are not able to saturate it. That is one of the challenges, so instead of so many efforts, we are not able to activate 100% GPTF. There is a gap of some 30%, and another 20% of GPs are not contributing to the purchases of the consumables. So we should also take them into next, and then whoever is contributing now should do it regularly."* ***(Male, 43 years, ZP CEO)***
Q97	*"What we have observed is…… that it is not the state I am talking about; it is below the district level. Till we are in the field, we are tagged, saying it is your program or KHPT program. So, after the review…… Taluka-level EO does the review, and the district-level CEO does the review. They called our taluka coordinator and asked why it was not done. It is your responsibility, and this is why you are here. They used to blame your KHPT fellows for not working properly. Sometimes, we feel our [KHPT] presence is hampering the departments to consider this program as theirs."* ***(Male, 60 years, Zonal Coordinator)***
Q98	*"Later, we felt it became a success, and many benefited from it. People who have never gone for testing in their lifetimes got tested; even GPs appreciate this kind of effort. In mid-2022, oh no, 2021……the pilot phase lasted for 6-7 months, and the government appreciated and wanted to scale up for all 31 districts, but we were not ready. There was a funding requirement; kits needed to be purchased and distributed, so everything had a cost. The government*

	allocated 10.5 Cr,…… kits need to be provided for all GPs. The government entrusted =KHPT=, based on the previous experience implementing the project in 12 districts [06:27]. The government said you [KHPT] provide us with technical support to implement this program, and we will be responsible for GPs implementing this with your support". ***(Male, 60 Years, State-level Officer)***
Q99	*"Madam, usually they inform three days prior… but when we go for MGNERGA work if they inform in advance some people may abscond on that day and they may not turn up for the camp. So, nowadays they don't inform in advance. Just they come in the morning and do the camp…."* ***(Female, 51 years, Beneficiary)***
Q100	*"When we talk about testing non-communicable diseases, the shortage of strips and lancets is one of the major issues. It is impossible to do camp every month in every village, madam. The strips were given only until the end of August. There were no strips from September to November... It was difficult for us to follow up on the test then. We, the CHOs, adjusted among ourselves, and who had more strips we took from them and tested ...they gave 300 strips, madam... if I do one camp, 100 to 150 lancets, and strips will go…"* ***(Female, 26 years, CHO)***
Q101	*"Tourism is there, so we will collect parking charges and house tax; we will collect tax for building towers and their maintenance, and then we do not have any donors. In 15th, finance 50000 is there…..Yes, we can utilize it to maintain the cleanliness of the village."* ***(Male, 55 years, GP Member)***
Q102	*"When I was working in =Tadakallu=, they used to give me a kit, and it was kept in that panchayat. Whenever we organized a camp, they were giving that kit to us...when I was there no issues were with the kits.. I used to finish the camp with whatever was available in that kit. But after I joined here, this panchayat has not provided any kit to me..they say there is no kit in the panchayat. But the KHPT staff went and checked in the panchayat, there was a kit but they didn't find any glucometer or strips."* ***(Female, 26 years, CHO)***
Q103	*"They have given training to our secretary and the nodal officer. When KHPT gave the kit, they gave the training also... KHPT is very supportive, and they always stand with me.. "* ***(Female, 36 years, PDO)***
Q104	*"If KHPT is not there, the program won't continue. Because we are busy with our department work, they are busy with their department work. To be frank, the KHPT team effort is more than ours because they are the communicational bridge to people and all departments."****(Female, 28 years, PDO)***
Q105	*"Yes, Of course, Madam, we will handle it. We have our plan of action, and we have to do it because it's our duty to implement the government program or scheme according to the guidelines."* ***(Male, 40 years, PDO)***
Q106	*"Some will be bedridden; lifting them and taking them in auto, getting checked at the hospital is difficult. It is tested at the doorstep now; they even visit houses that cannot manage to come to the campsite."(****Female, 55 years, Beneficiary)***
Q107	*"Today, if a camp is here, we will go get checked. Then they will do camps in different areas and will come back to our area in 2-3 months of time. Then again, we can get checked; this is beneficial****."(Female, 32 years, Beneficiary)***

Q108	*"We addressed this issue first at the self-help group level. We called those females to get checked at the camps. Then they went and told others so that participation in camps increased."* ***(Female, 35 years, GP Member)***
Q109	*"Yes .. for me the challenging task was to get the females to camps, no one was coming for 3-4 months in the beginning. I started educating female members of the GP and asked them to educate the women of their wards, then females started coming slowly."* ***(Female, 36 years, PDO)***
Q110	*"Initially, the response of the people was like, they said, you have enough Panchayat works; first, you clean the drainage, construct the road, and light; instead of that, you come for tests. For them, we told them that we come with the health department to your doorstep, and if you have any health issues, you have to go to PHC, which we are trying to avoid. So, with the health facility available nearby, nobody resists it. The main problem is people will say, " I don't have any problem; we eat well and work well, so why are you coming for tests? Resistance in males was more here. We educated them and gave some examples of severe disease conditions, we identified high-resistance people, and we separately gave health education about health facilities and government schemes…. If one group is there, for them oner leader will be there, for the leader if we motivate, others also will participate in the camps. We gave motivation to people to attend the camps."* ***(Female,28 years, PDO)***
Q111	*"It is the scheme Mahatma Gandhi Rashtriya Udyoga Khathri Yojana, and we conduct camps for workers of this scheme. For them, we will conduct health checkups, and we must provide 100 days of work in a year. So, one day during work, we will go to the work site and conduct camps. The KHPT team, ASHA and Anganwadi workers, the health department team, and the Grama panchayat team will also be there."* ***(Female,28 years, PDO)***
Q112	*"If the health program is organized by the Gram Panchayat, participation will be more, people will communicate with each other.. awareness will be increased. If it is done under gram panchayat, people think that they can come and ask the panchayat if anything happens."* ***(Female, 38 years, PDO)***
Q113	*"Weekly, two times, we will conduct screening tests for NCD, BP, sugar……. cleanliness in children, TB program-related, and mental health-related…… For physical health check-ups, they usually go, and mental health is also important, and our department addresses it."****(Female, 26 years, CHO)***
Q114	*"In case of doubt, we will refer them to the PHC, and from there if it is not sorted, we will send them to the district level; at the district level, the NCD cell is there and depends upon the tests like biopsy and blood test and X-ray, they will take the patient history and do a follow up." (Male, 38 years, CHO)*
Q115	*"We conduct camps for NAREGA workers, milk dairy, and in the market on Tuesday. We conduct camps where more people are available; they come for the camps to get tests for BP and sugar. ."* ***(Female,28 years, PDO)***
Q116	*"We conduct camps in schools, especially in girl's high schools, we check the Hb level, and we conduct sessions with the coordination of the KHPT team about*

	hygiene, menstruation, child marriage, child labor, and other information. ." ***(Female,28 years, PDO)***
Q117	*"Again, we organized a program at the school... We did a program like World TB Day….. During the night around 7-8, we lit a candle and many people gathered there, it was a very nice program."* ***(Male, 44 years, GP President)***
Q118	*"Our vehicle is there….through SLRM vehicle, we make announcements, GP members inform them about the camp, and Anganwadi and ASHA workers will inform them. Sanjeevini, MBK, LCR, and other help groups will be informed and strictly make them attend the camps." (****Female, 28 years, PDO)***
Q119	*"Wherever we are planning the camps, we involve the Anganwadi workers, ASHA workers, and CHOs.. whoever comes there, we will inform them about the camps.. also inform them through swatch vahini… between 7 am -8 am and again at the same time during the evening.."****(Female, 36 years, PDO)***
Q120	*"A case of child marriage happened... Anganwadi and ASHA workers informed us that our village panchayat president informed the child line. The marriage had been canceled. ASHA workers, PHC doctors, and Anganwadi workers are more pressurized than us... If they don't stop the child marriage, a case will be filed against them, even on PHC medical officer… We get involved in that... We left that child at the childcare center [Makkala sahaya kendra] and stopped the marriage... In this way, we have done a small service to society."* ***(Male, 32 years GP Members)***
Q121	*"One year ago, a Muslim family was arranging a marriage for their daughter, who was not 18. Three months were there to turn 18. Later, we stopped the engagement and canceled the event, convincing them."* ***(Male, 45 years, GP member)***
Q122	*"Yes, madam…so maximum, we are concentrating on girls high school, anemia, malnutrition, and regarding child marriage, we conduct awareness camps and seminar programs*." ***(Female,28 years, PDO)***
Q123	*"Yes, we organized street plays, "Dangura" team came from the state, and they organized street plays at all schools. There are 16 schools, including an Urdu school...for the Urdu school, we informed the committee and created awareness."* ***(Female, 36 years, PDO****)*
Q124	*"Getting the local government to take up these issues is important... will yield a lot more, and it will, in the long run, if we sustain it, lead to…. people getting the right to health rather than the right to health care."* ***(Female, 57 years, State-level officer)***
Q125	*"For the government, this Grama Arogya program should continue..and it should be conducted more so that it will reach a larger number of people.. The camp should be conducted in more numbers and regularly."* ***(Female, 45 years, VRW)***
Q126	*"One would be the money that has to be spent, and number two, the dashboard in terms of what type of screening happened and for which group it has happened, and what is the performance of each individual and group. At the*

	policy level, we need to measure how much money is required, and that has to be provided." ***(Male, 31 years, CEO)***
Q127	*"The three strengths are: 1. Regular meetings of the GPTF; 2. Contributions by the Grama panchayath through the purchase of consumables; and 3. The appointment of volunteers by a few panchayats is another positive for the district. We would be happy to work on the technology that is required to increase our efficiency in screening and identification of diseases and also monitor follow-up actions."****(Male, 43 years, CEO)***
Q128	*"Of course, as you mentioned, changes are required everywhere. Even funding irregular, and there is a lack of adaptation to new technology. Officially some changes are required."* ***(Male, 58 years, DD WCD)***
Q129	*"It is already running well, to strengthen it, additionally human resources are required, and financial support like incentives should be given. Additional funds should be given to the Gram Panchayat, and it should be utilized properly. Then the program can be strengthened more."* ***(Male, 54 years, DHO)***
Q130	*"In terms of human resources, we have KHPT staff, but they were saying their contract will end in March, so it is better to continue them for the effective implementation of the program."* ***(Male, 51 years, Nodal Officer)***
Q131	*"In Grama Arogya, the main team, or heart, is GPTF. We have to activate it, and, anyway, other departments fall into the palace, and any CEO for dramatic issues directs all departments freely. That should not be a problem. It occurs more in the administrative mission. GPTF involves gram panchayat members, and activation of GPTF is important."* ***(Male, 43 years, CEO)***
Q132	*"Anganwadi workers are doing it as part of their job.. however, if panchayat members are actively involved in the program, it will be more successful…. Every program, whatever we organize, is incentive-based (laughing). So, we may invite the panchayat members by providing some incentives as well as arranging the food and refreshments… Otherwise, for common meetings without anything, they may not turn up."* ***(Male, 54 years. DHO)***
Q133	*"Yes. We will get more tax, and that can be utilized…for some gram panchayats whose income is more than 50 lakhs, they have to do the budgeting and give, and the government will not give any money…. for the Panchayats whose income is less than 50 lakhs if government allocate some budget for gram Arogya, it will useful in giving more treatment."* ***(Male, 43 years, CEO)***
Q134	*"As I mentioned earlier, an Arogya card is beneficial for major medical procedures or operations. It allows a family to access up to Rs. 5 lahks annually. It is better if we allow people to use it for minor illnesses so that major diseases can be prevented. Secondly, we are doing many health programs. To have a broader impact on society, there should be a separate budget for it."* ***(Male, 38 years, PDO)***
Q135	"*So, now the health and wellness centres already have ASHA workers and community health workers. We want to do a pilot now, and we are already discussing asking the panchayat to identify one member who will be the health*

	sector member of the panchayat and will be trained. We will do a similar pilot to train all GP members and any officials who want to get trained in this. So, we want to do both. There are two options. In Kerala, for example, every Panchayat ward member is responsible for all the things in their ward". ***(Female, 57 years, State-level Officer)***
Q136	*"There are a lot of preventive aspects and not just curative. Panchayath should start working on that. Related to these preventive aspects, panchayath members can be trained, and GPTF can develop a perspective on health and how they can increase their role in health. If such training is not provided, and we [KHPT] are not there, and the department is not bothering, then that proactive group will vanish. So, capacity-building is important. There is a unit called SIRD that conducts capacity-building in panchayaths. They can take some interest, and if RDPR allocates some money…… This is already in the planning; we requested many times, and RDPR allocated some money……"* ***(Male,60 years, State-level Officer)***
Q137	*"That means someone else is deciding what should be done, and GP is made to implement it. This is not the way to treat GP. This is why we trained them in micro-planning; the campsite must be decided by the panchayath, the number of participants to be screened, the required strips, and the pending individuals to be screened; all these must be taken care of by the panchayath. In which village should there be an awareness program on child marriage, and in which case should TB get nutrition supplements; the panchayath must decide all these. The intention is this plan should not be imposed from above. GP should understand the local context. Accordingly, they must plan. In that context, they can utilize the different existing forums for camps to decide on the better campsite…… This can avoid the disconnect between decision-making and implementation. We brought capacity-building and micro-planning into the program."* ***(Male, 60 years, State-level Officer)***
Q138	*"Every panchayath should have one member designated as a health member; it could be a person showing more interest in organizing camps or a person concerned about health. One more suggestion is to felicitate the panchayath, which screens more individuals yearly and recognizes them. This will motivate panchayats, and they will want to implement this program."* ***(Male, 60 years, State-level Officer)***
Q139	*"ASHA workers and Anganwadi workers also work, but their duties are different. ASHA is more about diseases or other health-related programs, and Anganwadi is more about preschool, SNP, and vaccination. But it will come to the village health of some young adolescents or adult males or females and give them some incentives they will keep following up; for anemia, diabetes, or hypertension, they should follow up whether they are following; it will employ the village people; they can happily say that in our village, no diabetes or hypertension is there."* ***(Female, 55 years, DD WCD).***

Q140	*"Pamphlets could be given… It can be celebrated as a specific day like we celebrate Gandhi Jayanthi or Independence Day…That is what some specific day can be dedicated to and celebrated."* ***(Female, 29 years, ASHA)***
Q141	*"When I joined, there was a KHPT team, and I was involved in this program with them. Initially, KHPT had volunteered, but their contract ended. Had they been there, it would have been easier for us to organize the camp."* ***(Female, 39 years, CHO)***
Q142	*"In my opinion, it is difficult if the KHPT collaboration is not there. Until our government staff or people get to know the aspects of this project, KHPT should continue to be in the program."* ***(Male, 51 years, Nodal Officer)***
Q143	*"Sir, community radio is one of the best ways to get information. I will disseminate the information, and people will get to know the information and how effective it will be based on the people's participation. If we want to increase participation, we need to promote health camps that also include other programs that have interesting factors and engagement with the community, which helps to find the problems of the people. For example, about domestic violence, they won't share unless they are very close to them or unless they come to know that this lady may help them out; otherwise, they won't come."* ***(Female, 55 years, DD WCD)***
Q144	*"While the participation by the people is low, we can observe that in some areas, there is participation. People have a feeling that it is the government's duty, and therefore, they are doing it and thus ignoring it. If people are made aware of their personal and environmental hygiene, it will be easier to implement the government program."* ***(Male, 58 years, DD WCD)***
Q145	*"Yes, I want the program to be reviewed every month, and that must include the follow-up part because we can give the numbers of participants and results of the health camp, but we also have to include the follow-up of the participants and what the percentage of improvement is because of this follow-up."* ***(Female, 55 years, DD WCD)***
Q146	"*In an area, we can find TG, but it is challenging to find MSM and Female sex workers. For that, we must inform their leaders, and they will help in the mobilization of these people."* ***(Female, 36 years, PDO)***

7. DISCUSSION

The COVID-19 pandemic has acted as a significant catalyst for social innovation, particularly in the healthcare sector. It highlighted critical healthcare delivery gaps, especially in emergencies, and underscored the need for innovative approaches that leverage multisectoral collaborations, community mobilization, and adaptation of pre-existing models to address these deficiencies. The Grama Arogya (GA) program in Karnataka is one such innovation that emerged during COVID-19, aiming to strengthen local healthcare delivery through a decentralized, community-based approach.

The GA program's evaluation, conducted across the Belagavi, Bengaluru, Mysuru, and Kalburgi revenue divisions, provided an in-depth analysis of its structure and processes from a system perspective. This evaluation offered critical insights into the program's implementation, focusing on aspects such as decentralization, convergence of efforts, and the challenges and enablers that affect its success. The study documented best practices, revealing the program's potential for sustainability and highlighting areas for improvement.

One of the core strategies of the GA program is to empower local governments, specifically the Gram Panchayats (GPs), to manage and control public health issues. The program envisions microplanning of screening camps to be driven by the GPs, thereby enhancing local ownership and accountability. The Gram Panchayat Task Forces (GPTFs) have become pivotal platforms for community participation in planning, organizing, and monitoring healthcare activities. However, the evaluation indicated a need for increased authority and responsibility to be vested in GPs to ensure effective local governance. The recommendation is to delegate more authority to Panchayats, allowing them to exercise greater control over health initiatives rather than reducing their power, which could undermine their effectiveness (20). The findings are in coherence with the report from a World Bank working paper, which highlighted that enhanced fiscal capacity and broader decision-making authority are deemed essential for improving governance.

Regular meetings and monitoring by the GPTFs are crucial for the program's success. As per our observations, there is a need for increased involvement of the elected GP members in the monitoring and implementation of the health services, which was also evident in other program evaluation reports (21). While the GA program has increased awareness about health services and schemes, the evaluation suggests that there is still a need for further strengthening in the planning and implementation process to achieve better outcomes. The variation in program utilization across different districts highlights the importance of local governance and active community involvement in ensuring the program's success.

The GA program's reach and impact varies across different districts, with some areas demonstrating high levels of engagement as evidenced by effective interdepartmental coordination, sound budgetary management, and the implementation of regular screening health camp activities.

Factors contributing to successful implementation include good coordination between stakeholders, technical support, awareness among the beneficiaries, and active involvement from GPs. These elements are crucial enablers that facilitate effective healthcare delivery and ensure that the program reaches its intended beneficiaries. To strengthen these aspects, our evaluation recommends fostering collaboration between GP members and other departments and conducting regular interdepartmental meetings to address challenges and track progress. Furthermore, effective communication is crucial for smooth operations, to improve the coordination between the departments, establish clear communication channels and protocols (22).

We identified there were many vacant positions (particularly for data entry operators) at the GP level which impedes the implementation of the GA program. Accurate and timely data entry is critical for program monitoring. The evaluation underscores the need to recruit and train data entry operators and ensure continuous training to maintain data quality. Addressing staffing issues is vital for the proper functioning and success of the GA program. The findings corroborate with that of another program that entails maintenance of ambulance services within Karnataka, where impetus was laid on capacity building and retention of human resources (23).

Effective leadership and communication are essential for keeping staff informed and engaged. The tenure of staff representing a technical support agency (KHPT) was coming to an end. Therefore, the GPs must take over and sustain the program.
A designated point of contact is needed to guarantee accountability and efficient operations of GA program. It is therefore recommended to assign or designate a staff member at each GP, clearly outlining their job duties, including planning and organizing the camps, managing consumables, and maintaining records. In one evaluation report, it was mentioned that GPs should be encouraged to involve more stakeholders and create locally relevant strategies in the implementation of sanitation-related activities (24).

There is a need for efficient coordination between departments and community leaders to support various activities of the GA program. Lack of coordination among stakeholders, leading to reduced involvement, improper camp planning, and community mobilization thereby hindering the program's success. These challenges highlight the need for improved communication between and within departments and enhanced stakeholder engagement to ensure the program's objectives are met. Strengthening management practices and community engagement can significantly increase the program's efficiency and effectiveness. A similar observation was made during the evaluation of the National Rural Health Mission in 2013-14 (25).

Effective reporting involves documenting program activities, analyzing data, and communicating results to stakeholders. Regular reporting aids in tracking the progress of the program activities and to identify areas for improvement. The evaluation highlights the need to develop and maintain an electronic registry for recording diagnosed and referred cases,

which is regularly updated and accessible to healthcare providers at different levels in the healthcare delivery system**.** The data management issue is raised in other programs as well. Enhancing data analysis capabilities is crucial, as existing staff often lack training in public health and health statistics (26).

Budgeting is a critical aspect of the GA program, involving the planning and management of financial resources. The evaluation identified funding and resource allocation challenges, particularly in smaller GPs. There was no adequate budget to purchase consumables in some of the GPs. Therefore, it is imperative to allocate a sufficient budget to ensure the availability of essential supplies and equipment such as blood sugar monitoring devices and strips, BP apparatus, weighing scale, etc. The program may revisit financial allocations by allocating a separate budget to the program. A similar suggestion was provided in one of the government's evaluation reports of the Aids and Appliances program, where it was recommended to revise the total financial allocations and increase budgetary provisions to make a successful demand-driven program (27).

The structured approach provides a clear roadmap for addressing the challenges identified in the evaluation and building on the program's strengths. Despite several challenges, the GA program has made significant strides in focusing on vulnerable and underserved populations in rural areas. By targeting these groups, the program addresses critical healthcare disparities and ensures that essential health services are accessible to those who need them most.

8.STRENGTHS AND LIMITATIONS

8.1 STRENGTHS

The evaluation study on the Grama Arogya (GA) program in Karnataka represents a significant and pioneering effort, enhancing the credibility and impact of this process evaluation. The study's approach and methodologies underscore its thoroughness and effectiveness. Here's an in-depth look at the key aspects and strengths of the evaluation study:

Key Strengths of the Evaluation Study

1. Joint Construction Model

- **Collaborative Approach:** The study was carried out using a joint construction model, which involves collaboration among multiple stakeholders, including the Rural Development and Panchayat Raj (RDPR), Government of Karnataka (GoK). This collaborative effort ensures that various perspectives are considered, making the evaluation more comprehensive and inclusive.
- **Enhanced Credibility:** By involving governmental and non-governmental stakeholders, the study gains credibility and legitimacy, which is crucial for accepting and implementing its recommendations.

2. Robust Feedback Mechanism Before Field Testing

- **Iterative Development:** The evaluation tools and questionnaires were developed in consultation with the technical assistance team and RDPR. This iterative process ensured that the tools were well-suited to the context and objectives of the study.

- **Field Testing:** The tools were tested in the field, and feedback was gathered to refine them further. This collaborative development ensured that the tools were relevant and effective for the intended purpose. This step ensured that the instruments were practical and effective for data collection in the real-world setting of Karnataka's rural areas.

3. Comprehensive and Rigorous Research Methodology

- **Qualitative Research Focus:** The study employed robust qualitative research methodologies, including in-depth interviews (IDI) and focus group discussions (FGD). This approach allows for a deep understanding of the program's impact from the perspective of various stakeholders.
- **Comprehensive Data Collection:** The research team conducted fifty qualitative interviews (IDI/FGD) in the selected districts. This method provides rich, detailed data and allows for an in-depth understanding of the program's impact on the community.
- **Local Language Interviews:** Conducting interviews in the local language ensured that participants could express their views and experiences freely and accurately, yielding more authentic and meaningful data.

- **Localized Data Collection:** The research team visited remote areas in selected districts to conduct interviews in the local language. By visiting remote areas and conducting interviews in the local language, the research team ensured that the evaluation was inclusive and sensitive to the cultural context of the participants. This approach ensures that the voices of the community members are heard and accurately represented in the evaluation.

- **Quality Assurance:** Collected data was translated and transcribed, with repeated quality checks performed to maintain high data integrity and reliability. This process ensures that the findings are based on accurate and high-quality data.

4. Advanced Data Analysis Techniques

- **Multi-layered Coding:** A three-layered coding system was used to analyze the qualitative data. This technique helps systematically identify and categorize themes and patterns within the data, providing a detailed and nuanced understanding of the findings.
- **Use of Proprietary Software:** The analysis was conducted using proprietary software (Atlas.ti), which supports advanced qualitative data analysis and ensures a rigorous approach to coding and interpretation.

5. Expert Involvement

- **Diverse Expertise:** The evaluation team comprised professionals with varied research expertise. The inclusion of experts from different departments and disciplines brought a broad range of knowledge and perspectives, enriching the evaluation process.
- **Holistic Insights:** The diverse backgrounds of the team members contribute to a more thorough and well-rounded analysis, leading to insights that are actionable and relevant to various stakeholders.
- **Comprehensive Analysis:** This multidisciplinary approach enabled a thorough and holistic evaluation of the GA program, considering different aspects such as healthcare delivery, community engagement, and program management.
- **Expert Input:** The expertise of the team members ensures that the evaluation is conducted with a high level of professionalism and adherence to best practices in research and evaluation.

8.2 Limitations of the Grama Arogya (GA) Evaluation Study

The evaluation study of the Grama Arogya program in Karnataka, while thorough and methodologically robust, has certain limitations that could affect the generalizability and applicability of its findings. Below are the key limitations identified:

1. Narrow Geographical Scope

- The study was conducted in only four selected districts within Karnataka, which may not represent the diverse contexts and conditions across the entire state.

Impact:

- **Limited Representativeness:** The findings and conclusions drawn from these districts may not be fully applicable to other regions in Karnataka that might have different demographic, socio-economic, and health conditions.
- **Adaptability Issues:** Policies or interventions recommended based on the study might not be suitable for areas with different local contexts, potentially limiting the effectiveness of scaling the GA program state-wide.

Recommendation:

- To enhance representativeness, future evaluations should include a more diverse sample of districts that reflect the state's various geographical, socio-economic, and cultural landscapes.

2. **Purposive Selection of Panchayats**

Description:

- The study involved a purposive selection of panchayats within the selected districts. This method focuses on selecting panchayats that are deemed significant or typical for the study rather than using random sampling.

Impact:

- **Potential Bias:** The findings may reflect the specific conditions and characteristics of the selected panchayats rather than providing a comprehensive view of all panchayats in the region. This could lead to biased conclusions that are not fully generalizable.
- **Specificity of Findings:** The results might be heavily influenced by the unique features of the chosen panchayats, thus limiting the applicability of the findings to other panchayats that were not included in the study.

Recommendation:

- Future evaluations should consider using random sampling techniques to select a more representative sample of panchayats. This approach would help in achieving more generalizable findings that can be applied across different contexts within the state.

3. **Need for a Comprehensive Multi-Method Approach**

Description:

- The current study primarily used qualitative methods, which, while providing in-depth insights, may not capture the full scope of the program's impact or the quantitative aspects of program performance.

Impact:

- **Data Limitations:** The reliance on qualitative methods alone may miss out on important quantitative data that could provide a broader understanding of the program's effectiveness and areas for improvement.
- **Holistic Understanding:** A comprehensive evaluation that includes both qualitative and quantitative methods is necessary to gain a complete picture of the GA program's impact and effectiveness.

Recommendation:

- Future evaluations should adopt a multi-method approach that combines qualitative and quantitative data collection and analysis. This approach would provide a more holistic view of the program's impact and facilitate a deeper understanding of its successes and challenges.

9. RECOMMENDATIONS

The recommendations for the Grama Arogya (GA) program encompass a comprehensive approach that addresses key areas across policy, program, and process levels. These recommendations are critical for ensuring the successful implementation and sustainability of the program. Below is the detailed elaboration and rationale for each of the recommendations:

Policy Level Recommendations

1. Establish a state-level multisectoral committee

Rationale:

- A multisectoral committee ensures a coordinated approach across various departments and sectors, essential for addressing the multifaceted aspects of public health.
- It helps pool resources, ensure political commitment, and promote effective leadership and advocacy for the GA program.

Action Points:

- Form a committee with representatives from health, finance, education, and local governance sectors.
- Define the roles and responsibilities of the committee to facilitate coordination and oversight within the respective departments, thereby fostering collaboration among the higher-level cadres.

2. Set targets and indicators to foster accountability

Rationale:

- Setting clear targets and indicators is crucial for monitoring progress and ensuring accountability.
- It helps measure the program's impact and identify areas for improvement.

Action Points:

- Develop specific, measurable, achievable, relevant, and time-bound (SMART) targets for various components of the GA program.
- Regularly review progress against these indicators and adjust strategies as needed.

3. Activities and campaigns to raise awareness among the public

Rationale:

- Public awareness is key to ensuring community participation and support for the GA program.
- Effective campaigns can educate the community about the program's benefits and encourage preventive health behaviors.

Action Points:

- Design and implement awareness campaigns using multiple channels such as community radio, social media, and local events.
- Involve community leaders and influencers to spread the message and encourage participation.

Program Level Recommendations

1. Activities: Camp planning and advance information

Rationale:

- Advance planning and communication help ensure community members are aware of upcoming health camps and can participate effectively.
- This approach allows for better resource allocation and logistical planning.

Action Points:

- Create a detailed schedule for health camps well in advance and communicate it to the community through various channels.
- Ensure that camp locations are strategically chosen to maximize accessibility for all community members.

2. Microplanning to reach all the beneficiaries

Rationale:

- Microplanning helps identify and reach all potential beneficiaries, ensuring that no one is left out.
- It facilitates targeted interventions and efficient use of resources.

Action Points:

- List all potential beneficiaries and develop tailored plans to reach them, considering their specific needs and circumstances.

- Regularly update beneficiary lists to reflect changes in the community.

3. Expand program scope to include other diseases

Rationale:

- Broadening the scope to include screening for diseases like malaria, HIV, etc., makes the program more comprehensive and beneficial to the community.
- It addresses multiple health needs and improves overall community health outcomes.

Action Points:

- Integrate screening and testing for other prevalent diseases into the health camps.

4. Strengthen local-level convergence

Rationale:

- Convergence at the local level ensures that various departments work together efficiently to support the GA program.
- It enhances resource sharing and coordination, leading to better program outcomes.

Action Points:

- Foster collaboration between GP members and other departments to support the GA program.
- Hold regular interdepartmental meetings to discuss progress, challenges, and strategies.

5. Improve communication between departments

Rationale:

- Effective communication is essential for the smooth operation and coordination of activities.
- It helps identify and address gaps in the implementation process.

Action Points:

- Establish clear communication channels and protocols between different departments.
- Use technology such as shared databases and regular virtual meetings to facilitate information sharing.

6. Address gaps in communication processes

Rationale:

- Identifying and addressing gaps in communication can prevent misunderstandings and delays.
- It ensures all stakeholders are informed and aligned with the program's objectives.

Action Points:

- Conduct regular reviews of communication processes and identify areas for improvement.
- Implement training and capacity-building initiatives to enhance communication skills among staff.

7. Budget Allocation for Consumables and Incentives

Rationale:

- Adequate budget allocation is necessary to purchase essential consumables and incentivize volunteers, ensuring sustained program operations.
- It enhances the quality of services and motivates volunteers to remain committed.

Action Points:

- Allocate a dedicated budget for consumables like medical supplies and equipment.
- Provide financial or non-financial incentives to volunteers to recognize their contributions and encourage ongoing participation.

Process Level Recommendations

1. Ensure procurement of appropriate consumables

Rationale:

- Ensuring that the right consumables are procured and readily available is essential for the effective delivery of health services.
- It prevents disruptions in service delivery due to shortages or unsuitable supplies.

Action Points:

- Identify and procure consumables compatible with the devices used in health camps.
- Maintain a list of local vendors to facilitate quick and reliable procurement.

2. Designate a responsible contact person/volunteer in GP

Rationale:

- Having a dedicated person responsible for the GA program ensures accountability and smooth operations.
- It facilitates better coordination and communication between the community and external stakeholders.

Action Points:

- Appoint a volunteer or staff member in each GP to oversee the implementation of the GA program.
- Clearly define the designated person's roles and responsibilities to avoid ambiguity.

3. Fill vacant positions for data entry operators

Rationale:

- Data entry operators are crucial for maintaining accurate records and ensuring data quality.
- Filling these positions ensures data is collected, entered, and analyzed efficiently.

Action Points:

- Recruit and train data entry operators to fill existing vacancies.
- Provide ongoing support and training to ensure high standards of data management.

4. Capacity building through onsite training programs

Rationale:

- Continuous training and capacity building are essential for equipping GP members with the skills and knowledge necessary to implement the GA program effectively.
- Onsite training ensures that learning is practical and directly applicable to the local context.

Action Points:

- Develop training materials and modules tailored to the needs of GP members.
- Organize regular onsite training sessions to ensure continuous skill development.

5. Regular and continuous training programs

Rationale:

- Regular training programs help keep the staff updated with the latest practices and technologies.
- Continuous learning fosters a culture of improvement and innovation.

Action Points:

- Schedule regular training programs at various levels to ensure all staff members are well-trained.
- Monitor and evaluate training effectiveness to identify areas for improvement.

6. Strengthen state capacity for data management

Rationale:

- Strong data management capabilities are essential for effectively monitoring and evaluating the GA program.
- Accurate data helps in making informed decisions and improving program outcomes.

Action Points:

- Enhance the capacity of state health departments to collect, analyze, and use data effectively.
- Provide training and resources necessary for robust data management practices.

7. Develop and maintain a registry for diagnosed and referred cases

Rationale:

- Maintaining a registry for diagnosed and referred cases ensures continuity of care and better management of patients.
- It helps track outcomes and improve the quality of health services.

Action Points:

- Develop a registry system to record and track diagnosed cases and referrals.
- Ensure the registry is regularly updated and accessible to relevant healthcare providers.

This assessment report offers valuable recommendations addressing critical aspects of policy, program design, and implementation processes. These recommendations hold the potential to significantly strengthen the GA program, ensuring its long-term sustainability and impact. By focusing on strategic planning, effective communication strategies, and robust capacity-

building initiatives, the proposed recommendations pave the way for a more efficient and impactful delivery of quality healthcare services to the community. We believe that implementing these suggestions will not only enhance the effectiveness of the GA program but also act as a catalyst for improving the overall health and well-being of the population. Working together, we can leverage these insights to create a robust framework for success and ensure the GA program thrives in serving the community.

10. CONCLUSION

This inaugural assessment report for the GA program underscores its significance and potential for long-term success. The program's ability to address social determinants of health through community outreach demonstrates a ground-breaking approach. Furthermore, point-of-care testing, by increasing accessibility and facilitating referrals, elevates the GA program to the realm of social innovation. With people at its core, this holistic and contextual approach offers a replicable model for improving healthcare delivery in underserved communities. By addressing initial challenges and leveraging innovative strategies like community radio and waste collection announcements, the GA program paves the way for a healthier future for all.

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Annexures

Annexure I: Permission letter from the ACS

ಕರ್ನಾಟಕ ಸರ್ಕಾರ
ಪಂಚಾಯತ್ ರಾಜ್ ಆಯುಕ್ತಾಲಯ
ಕಾಳಿದಾಸ ರಸ್ತೆ, ಗಾಂಧಿನಗರ ಬೆಂಗಳೂರು – 560 009.

ಸಂಖ್ಯೆ:ಕಪಂರಾಆ/ಅಭಿವೃದ್ಧಿ/ಮಾಹೆ/165/2024 ದಿನಾಂಕ: 20.02.2024
Comp. No.:1335637

ಇವರಿಗೆ,

ಮುಖ್ಯ ಕಾರ್ಯನಿರ್ವಾಹಕ ಅಧಿಕಾರಿಗಳು
ಜಿಲ್ಲಾ ಪಂಚಾಯಿತಿ ದಾವಣಗೆರೆ, ಕೊಪ್ಪಳ,
ಬಾಗಲಕೋಟೆ ಮತ್ತು ಮಂಡ್ಯ

ಮಾನ್ಯರೆ,

ವಿಷಯ: ರಾಜ್ಯದ 04 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನದ ಕುರಿತಾಗಿ ಅಧ್ಯಯನ ನಡೆಸಲು Manipal Academy of Higher Education ತಂಡಕ್ಕೆ ಬೆಂಬಲ ನೀಡುವ ಬಗ್ಗೆ

ಉಲ್ಲೇಖ: Prasanna School of Public Health- Manipal Academy of Higher Education ನ ಇಮೇಲ್, ದಿನಾಂಕ: 17 ಫೆಬ್ರುವರಿ 2024

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ಗ್ರಾಮೀಣಾಬಿವೃದ್ಧಿ ಮತ್ತು ಪಂಚಾಯತ್ ರಾಜ್ ಇಲಾಖೆಯು ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ ಹಾಗೂ ಮಹಿಳಾ ಮತ್ತು ಮಕ್ಕಳ ಅಭಿವೃದ್ಧಿ ಇಲಾಖೆಗಳ ಸಹಭಾಗಿತ್ವದಲ್ಲಿ ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವನ್ನು ರಾಜ್ಯದ 31 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಅನುಷ್ಠನಗೊಲಿಸಲಾಗುತ್ತಿದೆ. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವನ್ನು 14 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಪ್ರಾಯೋಗಿಕವಾಗಿ ಅನುಷ್ಠಾನಗೊಳಿಸಿದ ಅನುಭವ ಇರುವ ಕೆ.ಹೆಚ್.ಪಿ.ಟಿ.ಯ ತಂಡವು ಈ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನಕ್ಕೆ ತಾಂತ್ರಿಕ ಬೆಂಬಲ ನೀಡುತ್ತಿದೆ.

ಗ್ರಾಮೀಣ ಜನರಲ್ಲಿ ಮೂಲಭೂತ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ತಪಾಸಣೆ ಮತ್ತು ಜಾಗೃತಿಯನ್ನು ಮೂಡಿಸುವಲ್ಲಿ ಹಾಗೂ ಮೂಲಭೂತ ಆರೋಗ್ಯ ಸೇವೆಗಳನ್ನು ಒದಗಿಸುವ ಗುರಿಯನ್ನು ಹೊಂದಿರುವ ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಅಧ್ಯಯನವನ್ನು ನಡೆಸಲು Prasanna School of Public Health- Manipal Academy of Higher Education ತಂಡಕ್ಕೆ ನೀಡಲಾಗಿದೆ. ಈ ಅಧ್ಯಯನವನ್ನು ರಾಜ್ಯದ 04 ಜಿಲ್ಲೆಗಳ ಆಯ್ದ ಗ್ರಾಮ ಪಂಚಾಯಿತಿಗಳಲ್ಲಿ ಯೋಜನೆಯನ್ನು ರೂಪಿಸಿದೆ.

ಈ ಅಧ್ಯಯನಕ್ಕೆ ಗುರುತಿಸಲಾದ 04 ಜಿಲ್ಲೆಗಳಿಂದ ಅಗತ್ಯವಿರುವ ಭಾಗಿದಾರರ ಪಟ್ಟಿಯನ್ನು ತಮ್ಮ ಮಾಹಿತಿಗಾಗಿ ಮತ್ತು ಸೂಕ್ತ ಕ್ರಮಕ್ಕಾಗಿ ಈ ಪತ್ರದೊಂದಿಗೆ ಲಗತ್ತಿಸಲಾಗಿದೆ. ಮೇಲೆ ತಿಳಿಸಿರುವಂತೆ ಈ ನಾಲ್ಕು ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಗುಂಪು ಚರ್ಚೆ ನಡೆಸಲು ಹಾಗೂ ಅಧಿಕಾರಿಗಳೊಂದಿಗೆ ವೈಯಕ್ತಿಕ ಸಂದರ್ಶನ ನಡೆಸಲು ಸಂಬಂಧಿಸಿದಂತೆ 04 ಜಿಲ್ಲೆಗಳ ಜಿಲ್ಲಾ ಪಂಚಾಯಿತಿ ಮುಖ್ಯ ಕಾರ್ಯನಿರ್ವಾಹಕ ಅಧಿಕಾರಿಗಳಿಂದ Prasanna School of Public Health- Manipal Academy of Higher Education ತಂಡಕ್ಕೆ ಪೂರ್ಣ ಬೆಂಬಲ ಮತ್ತು ಸಹಕಾರ ನೀಡುವುದು. ಹಾಗೂ ಅಧ್ಯಯನ ತಂಡಕ್ಕೆ ಆಯಾ ಜಿಲ್ಲೆಗಳಲ್ಲಿ ವಸತಿ ಮತ್ತು ಸ್ಥಳೀಯ ಪ್ರಯಾಣ ವ್ಯವಸ್ಥೆಯನ್ನು ಮಾಡಲು ಈ ಮೂಲಕ ತಿಳಿಸಿದೆ.

ಅಡಕ: ಉಲ್ಲೇಖಿತ ಪತ್ರ

ತಮ್ಮ ವಿಶ್ವಾಸಿ,

ಆಯುಕ್ತರು

ಕರ್ನಾಟಕ ಪಂಚಾಯತ್ ರಾಜ್ ಆಯುಕ್ತಾಲಯ

ಬೆಂಗಳೂರು

ಪ್ರತಿಯನ್ನು ಅಗತ್ಯ ಕ್ರಮಕ್ಕಾಗಿ:

1. ಸಂಬಂಧಿಸಿದ ತಾಲ್ಲೂಕು ಪಂಚಾಯಿತಿ ಕಾರ್ಯನಿರ್ವಾಹಕ ಅಧಿಕಾರಿಗಳು (ಸಂಬಂಧಿಸಿದ ಜಿಲ್ಲಾ ಪಂಚಾಯಿತಿ ಮುಖ್ಯ ಕಾರ್ಯನಿರ್ವಾಹಕ ಅಧಿಕಾರಿಗಳ ಮುಖಾಂತರ)

ಪ್ರತಿಯನ್ನು ಮಾಹಿತಿಗಾಗಿ:

1. ಸರ್ಕಾರದ ಅಪರ ಮುಖ್ಯ ಕಾರ್ಯದರ್ಶಿಗಳು(ಪಂ.ರಾಜ್), ಗ್ರಾಮೀಣಾಭಿವೃದ್ಧಿ ಮತ್ತು ಪಂಚಾಯತ್ ರಾಜ್ ಇಲಾಖೆ ಇವರ ಆಪ್ತ ಕಾರ್ಯದರ್ಶಿರವರಿಗೆ ಮಾಹಿತಿಗಾಗಿ.
2. Prof. and Head Department of Global Health Governance Prasanna school of public health, Manipal Academy of Higher Education, Manipal.
3. ಮುಖ್ಯ ಕಾರ್ಯನಿರ್ವಾಹಕ ಅಧಿಕಾರಿ, KHPT, ಬೆಂಗಳೂರು.
4. ಕಛೇರಿ ರಕ್ಷಾ ಕಡತಕ್ಕೆ.

Annexure II: Letter of Support

Government of Karnataka
Panchayat Raj Commissionerate
Kalidasa Road, Gandhinagar, Bangalore – 560 009.

NO:KPRC/DEV/GPAAA/MAHE/204(part-1)/2023 DATE:06.06.2023
C.NO: 1091113

Letter of Support

To,

Professor and Director
Prasanna School of Public Health
Manipal Academy of Higher Education
Manipal – 576104

Sir,

Sub: Letter of support to conduct the evaluation of Gram Panchayath Arogya Amrutha Abhiyana (GPAAA) project in Karnataka

****

Rural Development and Panchayat Raj (RDPR) Department, Government of Karnataka is happy to support this project and ensure the smooth functioning of the project activities. In this regard, RDPR will provide local facilitation to conduct the evaluation. Please note that this project is non-financial in nature.

At the end of the project, the project report should be submitted to the RDPR department. Necessary Institutional ethics clearance should be taken before the initiation of the project work.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

Commissioner
Karnataka Panchayat Raj Commissionerate
Bangalore

Annexure III: IEC Approval

KASTURBA HOSPITAL
MANIPAL
(An associate Hospital of MAHE, Manipal)

Kasturba Medical College and Kasturba Hospital
Institutional Ethics Committee
(Registration No. ECR/146/Inst/KA/2013/RR-19)
(DHR Registration No. EC/NEW/INST/2022/KA/0042)

Communication of the decision of the Institutional Ethics Committee

Tuesday 20th February 2024 **IEC1 : 218/2023**

Project title	:	Evaluation of structure and process of Grama Arogya (GA), Karnataka.
Principal Investigator	:	Dr. Sanjay Pattanshetty
Co Investigators	:	Dr. Chythra R Rao, Dr. Ashwini Kumar, Dr. Rakshitha K, Dr. Anupama D S, Dr. Teddy Andrews J
Name & Address of Institution	:	Department of Global Health Governance, Prasanna School of Public Health, Manipal, Department of Community Medicine, KMC, Manipal, Department of Global Health Governance, Prasanna School of Public Health, Manipal, Department of Social and Health Innovation, Prasanna School of Public Health, Manipal.
Status of review	:	New
Date of review	:	13.06.2023
Amendment	:	Modified on 20.02.2024
Decision of the IEC	:	Approved with modifications till 30.04.2024 with the change in study title and increase in the number of FGDs as suggested by KHPT.
IEC Approval Date	:	20 OCT 2023 20 OCT 2023

Additional Recommendations:

- CTRI Registration

Members present in the meeting

Dr. Ravindranath Rao (Chairperson & Social Scientist)
Mr. Rajaram Rao(Lay Person)
Dr. Mahadev Rao (Scientific Member)
Dr. Krishna Prasad P R (Clinician)
Dr. Sneha Deepak Mallya (Clinician)
Dr. Varalakshmi Chandra Sekaran (Clinician)
Dr. Vijetha Shenoy Belle (Clinician)
Dr. Sangita G Kamath (Basic Medical Scientist)
Dr. Vinu Thomas George (Scientific Member)
Dr. Saadi Abdul Vahab (Scientific Member)
Ms. Anupama (Legal Expert)
Dr. Binil (Scientific Member)
Dr. Arul Amuthan L(Basic Medical Scientist)
Dr. Sreenivasa Acharya (Social Scientist)
Dr. Rajeshkrishna Bhandary P
(Member Secretary)

Standing Instructions

- The PI and all members of the project shall ensure compliance to current regulatory provisions (NDCT Rules 2019 and ICH-GCP), Ethical Guidelines for Biomedical Research on Human Participants by ICMR, and the SOP of IEC including timely submission of Interim Annual Report and Final Closure Report
- Participant Information Sheet and a copy of signed Informed Consent shall be given to every research participant (for all prospective studies)
- Inform IEC in case of any proposed amendments (change in protocol / procedure, site / Investigator etc.)
- Inform IEC immediately in case of any Adverse Events and Serious Adverse Events.
- Members of IEC have the right to monitor any project with prior intimation.
- **If CTRI/ HMSC/ CDSCO registration:** Ensure registration and clearance from the respective authorities before the enrollment of the first participant The IEC to be notified about the same within 7 days of successful registration/ clearance.

KMC & KHIEC APPROVED MANIPAL

Dr. Muralidhar M Kulkarni
MEMBER SECRETARY – KMC & KH IEC

(SOP: The chairperson endorses the comments before communicating to the investigators. The Member Secretary signs on behalf of the Chairperson on the IEC certificate)

IEC Secretariat, Room No. 22, Ground Floor, Faculty Room Complex, Kasturba Medical College Premises,
Kasturba Medical College, Manipal - 576104, Karnataka, India. Phone : +91 - 0820 - 2933522,Fax : +91 - 0820 - 2571927. Email : iec.kmc@manipal.edu

MR-798

Annexure IVa: Informed consent form- Kannada

ಮಾಹಿತಿಯುಕ್ತ ಒಪ್ಪಿಗೆ ಪತ್ರ

ಅಧ್ಯಯನದ ಹೆಸರು: ಕರ್ನಾಟಕದಲ್ಲಿ ಗ್ರಾಮ ಆರೋಗ್ಯ (GA)ದ ರಚನೆ ಮತ್ತು ಪ್ರಕ್ರಿಯೆಯ ಕುರಿತ ಮೌಲ್ಯಮಾಪನ

ನಾನು ಈ ಮೇಲೆ ಸೂಚಿಸಿದ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗಿದಾರರ ಮಾಹಿತಿ ಪತ್ರವನ್ನು ಓದಿಕೊಂಡಿದ್ದೇನೆ. ಮತ್ತು ಅದರ ಮಾಹಿತಿಗಳನ್ನು ನನಗೆ ವಿವರಿಸಲಾಗಿದೆ. ನನಗೆ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ಅವಕಾಶ ನೀಡಲಾಗಿದ್ದು ಮತ್ತು ಅವುಗಳಿಗೆ ಸಮಾಧಾನಕರವಾದ ಉತ್ತರಗಳು ಲಭಿಸಿವೆ ಎಂದು ದೃಢೀಕರಿಸುತ್ತೇನೆ.

ಈ ಅಧ್ಯಯನದಲ್ಲಿ ನನ್ನ ಭಾಗವಹಿಸುವಿಸುಕೆಯು ಐಚ್ಛಿಕವಾಗಿದ್ದು, ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಯಾವುದೇ ಕಾರಣ ನೀಡದೆ ಅಧ್ಯಯನದಿಂದ ಹಿಂದೆ ಸರಿಯುವ ಹಕ್ಕು ನನಗಿದೆ ಮತ್ತು ಅದರಿಂದ ನನ್ನ ವೈದ್ಯಕೀಯ ಆರೈಕೆ ಅಥವಾ ಕಾನೂನು ಬದ್ಧ ಹಕ್ಕುಗಳಿಗೆ ತೊಂದರೆಯಾಗುವುದಿಲ್ಲ ಎಂಬುದನ್ನು ತಿಳಿಸಿದ್ದೇನೆ.

ನಾನು ಈ ಮೇಲಿನ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಸಮ್ಮತಿಸಿದ್ದೇನೆ. ವಿಷಯ ಮಾಹಿತಿ ಪತ್ರ ಹಾಗೂ ಸಹಿ ಮತ್ತು ದಿನಾಂಕ ಇರುವ ಈ ಮಾಹಿತಿಯುಕ್ತ ಒಪ್ಪಿಗೆ ಪತ್ರದ ಪ್ರತಿ ನನಗೆ ಲಭಿಸಿದೆ ಎಂದು ದೃಢೀಕರಿಸುತ್ತೇನೆ.

☐ ಸಂಶೋಧಕರು ನನ್ನ ಮಾಹಿತಿಯ ಗೌಪ್ಯತೆಯನ್ನು ಕಾಪಾಡುತ್ತಾರೆ ಎಂದು ಅರ್ಥಮಾಡಿಕೊಂಡು ನನ್ನ ಸಂದರ್ಶನದ ಆಡಿಯೋ ರೆಕಾರ್ಡಿಂಗ್‌ಗೆ ನಾನು ಸಮ್ಮತಿಸುತ್ತೇನೆ

ಅಧ್ಯಯನ ಭಾಗಿಯ ಹೆಸರು:

ಅಧ್ಯಯನ ಭಾಗಿಯ ವಯಸ್ಸು:

ಅಧ್ಯಯನ ಭಾಗಿಯ ವಿಳಾಸ:

ಉದ್ಯೋಗ:

ಭಾಗಿಯ ವಾರ್ಷಿಕ ಆದಾಯ:

ನಾಮಿನಿಯ ಹೆಸರು ಮತ್ತು ವಿಳಾಸ ಮತ್ತು ಭಾಗಿದಾರರೊಡನೆ ಅವರ ಸಂಬಂಧ:

ಅಧ್ಯಯನ ಭಾಗಿದಾರರ ಸಹಿ: ದಿನಾಂಕ:

_____ _____

ಸಾಕ್ಷಿದಾರರ ಹೆಸರು ಮತ್ತು ಸಹಿ ದಿನಾಂಕ:

_____ _____

ಒಪ್ಪಿಗೆ ಪತ್ರವನ್ನು ವಿವರಿಸಿದವರ ದಿನಾಂಕ:

ಹೆಸರು ಮತ್ತು ಸಹಿ

_____ _____

Annexure IVb: Informed consent form- English

INFORMED CONSENT FORM

Project title: Evaluation of structure & process of Grama Panchayath Arogya Amrutha Abhiyana (GPAAA), Karnataka

I confirm I have read the Participant Information Sheet for the above study and its contents were explained and I have had the opportunity to ask questions and received satisfactory answers.

I understand that my participation in the study is voluntary and that I have the right to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I agree to take part in the above study. I confirm that I have received a copy of the Participant Information Sheet along with this signed and dated informed consent form.

I consent for the audio recording of my interview understanding that the PI will ensure my confidentiality ☐

Name of the Research Participant:

Age of the Research Participant:

Address of the Research Participant:

Occupation:

Annual Income of the Participant:
(Indicate so if not ready to disclose)

Name & address of the nominee(s) and his relation to the Participant:

_____

_____ _____
Signature of the research subject Date

_____ _____
Name & Signature of the Witness Date

_____ _____
Name & Signature of the person explaining the consent Date

Annexure Va: Participant information sheet- English

PARTICIPANT INFORMATION SHEET

Title of the project: Evaluation of structure & process of Grama Panchayath Arogya Amrutha Abhiyana (GPAAA), Karnataka

IEC number: Click or tap here to enter text.

Sponsor name: NA

Principal Investigator: Prof. Dr. Sanjay Pattanshetty

Designation: Professor and Head of the Department of Global Health Governance

Mobile number: +919964381100

Hospital: KMC, Manipal

Language: English

Please read this form carefully. If you don't understand the language or any information in this document, please discuss it with study investigator. Your participation in this study is voluntary, and you can enquire about all details before giving your written consent to participate in this study.

1. Introduction to the research study: You are invited to participate in this study because you have been implementing or beneficiary of Grama Panchayath Arogya Amrutha Abhiyana (GPAAA), Karnataka

2. **Purpose of the study:** To understand the structure and process of Grama Panchayath Arogya Amrutha Abhiyana (GPAAA) from a system perspective at Belagavi, Bengaluru, Mysuru, Kalburgi, four revenue divisions of Karnataka.

3. Who can take part: Both male and female stakeholders from health and Rural Development and Panchayath Raj (RDPR) departments at the district, taluk, GP, and village levels will be included in the study. At the district level, the Chief Executive Officers (CEOs), District Health and Family Welfare Officers (DHOs), and Zilla Panchayat members will be included. Members of GPs and Panchayath Development Officers (PDOs) will be included at the GP level. At the village level, we include Accredited Social Health Activists/ facilitators (ASHAs), and individuals from community structures such as Self-help Groups (SHGs), Village Health Sanitation and Nutrition Committees (VHSNCs), Mahatma Gandhi National Rural Employment Guarantee Act group (MNREGA).

4. Information about the study (as a whole): For this process evaluation of GPAAA we will be conducting in-depth interviews and Focus group Discussions (FGD) for 30 participants (6-7 Key stakeholders per district) and the study period is for 6 months. Informed consent will be obtained, and the interviews will be audio recorded. The interviews will be conducted for 30-40 minutes.

5. What will happen to you (the individual participant) during the study:

After getting informed consent to take part in the study, the participants will be interviewed with an in-depth questionnaire containing different domains of GPAAA. Audio will be recorded and used for further qualitative analysis. The participants are free to take part in the study or reject their participation.

Participants will be contacted over the phone, if they are willing to take part, additional 1-2 Focus Group Discussions (FGD) will be conducted with ASHAs, ANMs, and beneficiaries (general population) in each selected district. Researchers will visit each participant only once and each interview will last for 30-40 minutes.

6. Your (the individual participant) role/responsibility in the study:

- Provide accurate information whenever asked. • Follow the investigator's instructions. • If you want to discontinue the study inform the instructor/researcher.

7. What are the risks?

The study has minimal risks as it involves only interviewing. It may cause discomfort to the participants as they must spend a minimum of half an hour time for the interview.

8. What are the potential benefits of participating in the study: You may not get any direct benefit from participating in this study. The information you provide in the interview will help identify strengths, weaknesses, opportunities, and challenges in the implementation process of GPAAA, and, can inform future planning of the program. It also documents the best practices and way forward to sustain GPAAA.

9. What are the alternative treatments available: NA as there is no medical treatment is involved in the study.

10. Cost of participating in the study: No cost is incurred on respondents to participate in this study.

11. Compensation for injury: If a medical problem arises during this research study as a direct result of the study procedure (e.g. questionnaire) the study doctor will be responsible for making sure that proper care is provided to you.

12. Confidentiality of information: Information from the study records including your name, address, and study results will be kept confidential and will be reviewed only by authorized personnel from the sponsor or their representative, Ethics Committee, or regulatory bodies. The data will not be made available to another individual unless you specifically give permission in writing. Information and results from this study may be presented at meetings or published in journals without including your name and personal identification. No reference will be made in oral or written reports which could link you to the study. The audio recording will be transcribed using codes to prevent identification, and raw data will be stored for three years.

13. New information about the study: Any new information available during the study will be informed to you if it has relevance to your decision regarding continuing in the study. Results of your participation will be disclosed to you if you indicate your desire for it.

14. Voluntary participation: Your participation in this study is voluntary; you may decline to participate at any time, and you need not give any reason for the same, and such withdrawal shall be without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study prior to its completion, you will receive the usual standard of care for your disease, and your nonparticipation will not have any adverse effects on your subsequent medical treatment or relationship with the treating physician. If you withdraw from the study before data collection is completed, your data collected until you indicated withdrawal will be used in the study report. The sponsor or the investigator may stop the research or your participation in it at any time for some or other reason without your permission.

15. Whom to contact in case of any questions:

If you experience adverse effects because of participating in this study, you may contact the Principal Investigator, Dr. Sanjay Pattanshetty, as detailed above.

If you have any questions about the informed consent process or your rights as a participant, you may contact the Member Secretary of the Kasturba Medical College and Kasturba Hospital - Institutional Ethics Committee at Room 22, Ground floor, KMC Faculty Rooms, adjacent to KMC Administrative Block, Kasturba Medical College, Manipal - 576104. Phone: 0820 29 33522. Timings: 9:00 AM to 5:00 PM.

If you have any questions about this form or any study related issue, you may also contact the following person.

Name: Dr Ashma Dorothy Montero

Address: Assistant professor, Dept of data science, Prasanna school of public health, MAHE, Manipal

Telephone No: 8660591151 (Including a mobile number available after office hours)

Annexure Vb: Participant information sheet- Kannada

ಅಧ್ಯಯನದ ಬಗ್ಗೆ ಮಾಹಿತಿ ಪತ್ರ

ಅಧ್ಯಯನದ ಹೆಸರು: ಕರ್ನಾಟಕದಲ್ಲಿ ಗ್ರಾಮ ಪಂಚಾಯತ್ ಆರೋಗ್ಯ ಅಮೃತ ಅಭಿಯಾನ(GPAAA)ದ ರಚನೆ ಮತ್ತು ಪ್ರಕ್ರಿಯೆಯ ಕುರಿತ ಮೌಲ್ಯಮಾಪನ

ಅಧ್ಯಯನದ ಸಂಖ್ಯೆ:
ಪ್ರಾಯೋಜಕರ ಹೆಸರು:
ಭಾಷೆ: ಕನ್ನಡ

ಮುಖ್ಯ ಸಂಶೋಧಕರು: ಡಾ. ಸಂಜಯ್ ಪಟ್ಟಣಶೆಟ್ಟಿ
ಹುದ್ದೆ: ಪ್ರಾಧ್ಯಾಪಕರು ಮತ್ತು ಮುಖ್ಯಸ್ಥರು, ಗ್ಲೋಬಲ್ ಹೆಲ್ತ್ ಗವರ್ನೆನ್ಸ್ ವಿಭಾಗ, ಪ್ರಸನ್ನ ಸ್ಕೂಲ್ ಆಫ್ ಪಬ್ಲಿಕ್ ಹೆಲ್ತ್
ಆಸ್ಪತ್ರೆ: ಕೆಎಮ್‌ಸಿ, ಮಣಿಪಾಲ
ದೂರವಾಣಿ ಸಂಖ್ಯೆ: +919964381100

ದಯವಿಟ್ಟು ಈ ಮಾಹಿತಿ ಪತ್ರವನ್ನು ಸರಿಯಾಗಿ ಓದಿಕೊಳ್ಳಿ. ಒಂದುವೇಳೆ ಯಾವುದೇ ಮಾಹಿತಿ, ಭಾಷೆ ಅರ್ಥವಾಗದೆ ಇದ್ದಲ್ಲಿ, ಅಧ್ಯಯನ ನಡೆಸುತ್ತಿರುವ ವೈದ್ಯರ/ಸಂಶೋಧಕರ ಬಳಿ ಚರ್ಚಿಸಿ. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನೀವು ಲಿಖಿತ ಒಪ್ಪಿಗೆ ಕೊಡುವ ಮೊದಲು ಎಲ್ಲಾ ವಿಚಾರಗಳನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ತಿಳಿದು ಕೊಳ್ಳಿ.

1. ಅಧ್ಯಯನದ ಪ್ರಸ್ತಾವನೆ:
ನಿಮ್ಮನ್ನು ಈ ಅಧ್ಯಯನ / ಸಂಶೋಧನೆ / ಪ್ರಯೋಗದಲ್ಲಿ ಭಾಗವಹಿಸುವಂತೆ ಕೇಳಿ ಕೊಳ್ಳಲಾಗಿದೆ. ಕಾರಣ ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮ್ಮನ್ನು ಆಹ್ವಾನಿಸಲಾಗಿದೆ ಏಕೆಂದರೆ ನೀವು ಕರ್ನಾಟಕದಲ್ಲಿ ಗ್ರಾಮ ಪಂಚಾಯತ್ ಆರೋಗ್ಯ ಅಮೃತ ಅಭಿಯಾನ (GPAAA) ವನ್ನು ಅನುಷ್ಠಾನಗೊಳಿಸುತ್ತಿರುವಿರಿ ಅಥವಾ ಫಲಾನುಭವಿಯಾಗಿದ್ದೀರಿ.

2. ಅಧ್ಯಯನದ ಉದ್ದೇಶ:
ಕರ್ನಾಟಕದ ನಾಲ್ಕು ಕಂದಾಯ ವಿಭಾಗಗಳಾದ ಬೆಳಗಾವಿ, ಬೆಂಗಳೂರು, ಮೈಸೂರು, ಕಲ್ಬುರ್ಗಿಯಲ್ಲಿ ಗ್ರಾಮ ಪಂಚಾಯತ್ ಆರೋಗ್ಯ ಅಮೃತ ಅಭಿಯಾನದ (ಜಿಪಿಎಎಎ) ರಚನೆ ಮತ್ತು ಪ್ರಕ್ರಿಯೆಯನ್ನು ವ್ಯವಸ್ಥೆಯ ದೃಷ್ಟಿಕೋನದಿಂದ ಅರ್ಥಮಾಡಿಕೊಳ್ಳುವುದು.

3. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಯಾರು ಭಾಗವಹಿಸಬಹುದು:
ಜಿಲ್ಲೆ, ತಾಲೂಕು, ಗ್ರಾಮ ಪಂಚಾಯತ್ ಮತ್ತು ಗ್ರಾಮ ಮಟ್ಟದಲ್ಲಿ ಆರೋಗ್ಯ ಮತ್ತು ಗ್ರಾಮೀಣಾಭಿವೃದ್ಧಿ ಮತ್ತು ಪಂಚಾಯತ್ ರಾಜ್ (RDPR) ಇಲಾಖೆಗಳ ಪುರುಷ ಮತ್ತು ಮಹಿಳಾ ಪಾಲುದಾರರನ್ನು ಅಧ್ಯಯನದಲ್ಲಿ ಸೇರಿಸಲಾಗುತ್ತದೆ. ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ ಮುಖ್ಯ ಕಾರ್ಯನಿರ್ವಹಣಾಧಿಕಾರಿಗಳು (ಸಿಇಒಗಳು), ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿಗಳು (ಡಿಎಚ್ಒಗಳು), ಮತ್ತು ಜಿಲ್ಲಾ ಪಂಚಾಯಿತಿ ಸದಸ್ಯರನ್ನು ಸೇರಿಸಲಾಗುವುದು. ಗ್ರಾಮ ಪಂಚಾಯತ್‌ಗಳ ಸದಸ್ಯರು ಮತ್ತು ಪಂಚಾಯತ್ ಅಭಿವೃದ್ಧಿ ಅಧಿಕಾರಿ(PDOs)ಗಳನ್ನು ಗ್ರಾಮ ಪಂಚಾಯತ್ ಮಟ್ಟದಲ್ಲಿ ಸೇರಿಸಲಾಗುವುದು. ಗ್ರಾಮ ಮಟ್ಟದಲ್ಲಿ, ಮಾನ್ಯತೆ ಪಡೆದ ಸಾಮಾಜಿಕ ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತರು/ಫೆಸಿಲಿಟೇಟರ್ಸ್ (ಂಖಖೂಂಗಳು), ಮತ್ತು ಸ್ವ–ಸಹಾಯ ಗುಂಪು (ಖಉಊಗಳು), ಗ್ರಾಮ ಆರೋಗ್ಯ ನೈರ್ಮಲ್ಯ ಮತ್ತು ಪೋಷಣೆ ಸಮಿತಿಗಳು (VHSNC ಗಳು), ಮಹಾತ್ಮ ಗಾಂಧಿ ರಾಷ್ಟ್ರೀಯ ಗ್ರಾಮೀಣ ಉದ್ಯೋಗ ಖಾತರಿ ಕಾಯಿದೆ (MNREGA)ಗುಂಪಿನಂತಹ ಸಮುದಾಯ ರಚನೆಗಳಲ್ಲಿನ ವ್ಯಕ್ತಿಗಳನ್ನು ಸೇರಿಸುತ್ತೇವೆ.

4. ಅಧ್ಯಯನದ ಬಗ್ಗೆ ಮಾಹಿತಿ (ಸಂಪೂರ್ಣ):
GPAAA ದ ಈ ಪ್ರಕ್ರಿಯೆಯ ಮೌಲ್ಯಮಾಪನಕ್ಕಾಗಿ ಭಾಗವಹಿಸುವ ೩೦ ಜನರಿಗೆ (ಪ್ರತಿ ಜಿಲ್ಲೆಗೆ ೬–೭ ಪ್ರಮುಖ ಪಾಲುದಾರರು) ನಾವು ಆಳವಾದ ಸಂದರ್ಶನಗಳು ಮತ್ತು ಕೇಂದ್ರೀಕೃತ ಗುಂಪು ಚರ್ಚೆಗಳನ್ನು (FGD) ನಡೆಸುತ್ತೇವೆ ಮತ್ತು ಅಧ್ಯಯನದ ಅವಧಿಯು ೬ ತಿಂಗಳುಗಳವರೆಗೆ ಇರುತ್ತದೆ. ಮಾಹಿತಿಯುಕ್ತ ಒಪ್ಪಿಗೆಯನ್ನು ಪಡೆಯಲಾಗುತ್ತದೆ ಮತ್ತು ಸಂದರ್ಶನಗಳನ್ನು ಆಡಿಯೊ ರೆಕಾರ್ಡ್ ಮಾಡಲಾಗುತ್ತದೆ. ಸಂದರ್ಶನಗಳನ್ನು ೩೦–೪೦ ನಿಮಿಷಗಳ ಕಾಲ ನಡೆಸಲಾಗುತ್ತದೆ

5. ಅಧ್ಯಯನದ ಸಂದರ್ಭದಲ್ಲಿ ನಿಮಗೆ (ಒಬ್ಬ ಭಾಗಿದಾರನಿಗೆ) ಏನಾಗುವುದು?:

ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಲು ತಿಳುವಳಿಕೆಯುಳ್ಳ ಒಪ್ಪಿಗೆಯನ್ನು ಪಡೆದ ನಂತರ, ಭಾಗವಹಿಸಿದವರನ್ನು GPAAA ಯ ವಿವಿಧ ವಿಭಾಗಗಳನ್ನು ಒಳಗೊಂಡಿರುವ ಆಳವಾದ ಪ್ರಶ್ನಾವಳಿಯೊಂದಿಗೆ ಸಂದರ್ಶನ ಮಾಡಲಾಗುತ್ತದೆ. ಆಡಿಯೊವನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲಾಗುತ್ತದೆ ಮತ್ತು ಹೆಚ್ಚಿನ ಗುಣಾತ್ಮಕ ವಿಶ್ಲೇಷಣೆಗಾಗಿ ಬಳಸಲಾಗುತ್ತದೆ. ಭಾಗವಹಿಸುವವರು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಅಥವಾ ಅವರ ಭಾಗವಹಿಸುವಿಕೆಯನ್ನು ತಿರಸ್ಕರಿಸಲು ಸ್ವತಂತ್ರರು. ಭಾಗವಹಿಸುವವರನ್ನು ಫೋನ್ ಮೂಲಕ ಸಂಪರ್ಕಿಸಲಾಗುತ್ತದೆ, ಅವರು ಭಾಗವಹಿಸಲು ಸಿದ್ಧರಿದ್ದರೆ, ಆಯ್ಕೆಯಾದ ಪ್ರತಿ ಜಿಲ್ಲೆಯಲ್ಲಿ ಆಶಾಗಳು, ಎಎನ್ಎಂಗಳು ಮತ್ತು ಫಲಾನುಭವಿಗಳೊಂದಿಗೆ (ಸಾಮಾನ್ಯ ಜನಸಂಖ್ಯೆ) ಹೆಚ್ಚುವರಿ ೧–೨ ಕೇಂದ್ರೀಕೃತ ಗುಂಪು ಚರ್ಚೆಗಳನ್ನು (ಎಫ್‌ಜಿಡಿ) ನಡೆಸಲಾಗುತ್ತದೆ. ಸಂಶೋಧಕರು ಪ್ರತಿ ಭಾಗವಹಿಸುವವರನ್ನು ಒಮ್ಮೆ ಮಾತ್ರ ಭೇಟಿ ಮಾಡುತ್ತಾರೆ ಮತ್ತು ಪ್ರತಿ ಸಂದರ್ಶನವು ೩೦–೪೦ ನಿಮಿಷಗಳವರೆಗೆ ಇರುತ್ತದೆ.

6. ನಿಮ್ಮ (ಒಬ್ಬ ಭಾಗಿದಾರನಿಗೆ) ಜವಾಬ್ದಾರಿ/ಪಾತ್ರ:

- ಕೇಳಿದಾಗ ನಿಖರ ಮಾಹಿತಿಯನ್ನು ನೀಡಬೇಕು.
- ಅಧ್ಯಯನದ ಅವಧಿಯಲ್ಲಿ ಯಾವುದೇ ತೊಂದರೆ/ ಸಮಸ್ಯೆ / ಅಡ್ಡಪರಿಣಾಮ ಅನುಭವಕ್ಕೆ ಬಂದಲ್ಲಿ ಕೂಡಲೇ ಸಂಶೊಧಕರಿಗೆ / ಅಧ್ಯಯನಕಾರ ವೈದ್ಯರಿಗೆ ತಿಳಿಸುವುದು
- ಸಂಶೋಧಕರ ಸೂಚನೆಗಳನ್ನು ಪಾಲಿಸುವುದು.
- ಒಂದು ವೇಳೆ ಅಧ್ಯಯನದಲ್ಲಿ ಮುಂದುವರಿಯದಿರಲು ಇಚ್ಛಿಸಿದಲ್ಲಿ ವೈದ್ಯರಿಗೆ ತಿಳಿಸುವುದು.

7. ಅಪಾಯಗಳಾವುವು?:

- ಅಧ್ಯಯನವು ಕನಿಷ್ಠ ಅಪಾಯಗಳನ್ನು ಹೊಂದಿದೆ ಏಕೆಂದರೆ ಇದು ಸಂದರ್ಶನವನ್ನು ಮಾತ್ರ ಒಳಗೊಂಡಿರುತ್ತದೆ. ಸಂದರ್ಶನಕ್ಕಾಗಿ ಕನಿಷ್ಠ ಅರ್ಧ ಘಂಟೆಯ ಸಮಯವನ್ನು ವ್ಯಯಿಸಬೇಕಾಗಿರುವುದರಿಂದ ಭಾಗವಹಿಸುವವರಿಗೆ ಇದು ಸ್ವಲ್ಪ ಅನಾನುಕೂಲತೆಯನ್ನು ಉಂಟುಮಾಡಬಹುದು.

8. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳುವುದರಿಂದ ಆಗಬಹುದಾದ ಸಂಭಾವ್ಯ ಪ್ರಯೋಜನಗಳು:

ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದರಿಂದ ನೀವು ಯಾವುದೇ ನೇರ ಪ್ರಯೋಜನವನ್ನು ಪಡೆಯದಿರಬಹುದು.

ಸಂದರ್ಶನದಲ್ಲಿ ನೀವು ಒದಗಿಸುವ ಮಾಹಿತಿಯು GPAAA ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆಯಲ್ಲಿ ಸಾಮರ್ಥ್ಯ, ದೌರ್ಬಲ್ಯ, ಅವಕಾಶಗಳು ಮತ್ತು ಸವಾಲುಗಳನ್ನು ಗುರುತಿಸಲು ಸಹಾಯ ಮಾಡುತ್ತದೆ ಮತ್ತು ಕಾರ್ಯಕ್ರಮವನ್ನು ಭವಿಷ್ಯದಲ್ಲಿ ಉತ್ತಮವಾಗಿ ಯೋಜಿಸಲು ಸಹಾಯ ಮಾಡಬಹುದು. ಇದು GPAAA ಅನ್ನು ಉಳಿಸಿಕೊಳ್ಳಲು ಉತ್ತಮ ಅಭ್ಯಾಸಗಳು ಮತ್ತು ಮುಂದಿನ ಮಾರ್ಗವನ್ನು ಸಹ ದಾಖಲಿಸುತ್ತದೆ

9. ಯಾವ ಯಾವ ಪರ್ಯಾಯ ಚಿಕಿತ್ಸೆಗಳು ಲಭ್ಯ ಇವೆ?

ಸಂಶೋಧನೆಯು ಯಾವುದೇ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಯು ಅಧ್ಯಯನದಲ್ಲಿ ಒಳಗೊಂಡಿಲ್ಲದ ಕಾರಣ ಇದು ಅನ್ವಯಿಸುವುದಿಲ್ಲ.

10. ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗಿಯಾಗುವುದರಿಂದ ತಗಲುವ ವೆಚ್ಚ :

ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಯಾವುದೇ ವೆಚ್ಚವನ್ನು ತೆರಬೇಕಾಗಿಲ್ಲ

11. ಹಾನಿ / ತೊಂದರೆಗೆ ಪರಿಹಾರ

ಅಧ್ಯಯನದ ಪ್ರಕ್ರಿಯೆಯ ನೇರ ಪರಿಣಾಮವಾಗಿ ಈ ಸಂಶೋಧನಾ ಅಧ್ಯಯನದ ಸಮಯದಲ್ಲಿ ವೈದ್ಯಕೀಯ ಸಮಸ್ಯೆಯು ಉದ್ಭವಿಸಿದರೆ (ಉದಾ. ಪ್ರಶ್ನಾವಳಿ) ನಿಮಗೆ ಸರಿಯಾದ ಕಾಳಜಿಯನ್ನು ಒದಗಿಸಲಾಗಿದೆಯೆ ಎಂದು ಖಚಿತಪಡಿಸಿಕೊಳ್ಳಲು ಅಧ್ಯಯನ ವೈದ್ಯರು ಜವಾಬ್ದಾರರಾಗಿರುತ್ತಾರೆ.

12. ಮಾಹಿತಿಯ ಗೌಪ್ಯತೆ:

ಅಧ್ಯಯನ ದಾಖಲೆಯಲ್ಲಿ ಇರುವ ನಿಮ್ಮ ಹೆಸರು ವಿಳಾಸ, ವೈದ್ಯಕೀಯ ದಾಖಲೆ, ಪರೀಕ್ಷಾ ಫಲಿತಾಂಶ ಅಧ್ಯಯನ ಫಲಿತಾಂಶ ಮುಂತಾದ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿ ಇಡಲಾಗುತ್ತದೆ. ಮತ್ತು ಅದನ್ನು ಅಧ್ಯಯನಕ್ಕೆ ಸಂಬಧಿಸಿದ ಅಧಿಕೃತ ವ್ಯಕ್ತಿಗಳಾದ ಪ್ರಾಯೋಜಕರು ಅಥವಾ ಅವರ ಪ್ರತಿನಿಧಿ, ನೈತಿಕ ಸಮಿತಿ ಅಥವಾ ನಿಯಂತ್ರಣ ಸಂಸ್ಥೆಯಿಂದ ಮಾತ್ರ ಪರಿಶೀಲಿಸಲಾಗುವುದು, ನಿಮ್ಮ ಲಿಖಿತ ಅನುಮತಿ ಇಲ್ಲದೆ ಮಾಹಿತಿಯನ್ನು ಅನ್ಯವ್ಯಕ್ತಿಗಳಿಗೆ ಲಭ್ಯವಾಗಲು ಬಿಡುವುದಿಲ್ಲ. ಈ

ಅಧ್ಯಯನದ ಮಾಹಿತಿ ಮತ್ತು ಫಲಿತಾಂಶವನ್ನು ವೈಜ್ಞಾನಿಕ ಕೂಟ /ಸಭೆ ಅಥವಾ ಪ್ರಬಂಧಗಳಲ್ಲಿ ನಿಮ್ಮ ಹೆಸರು ಮತ್ತು ವೈಯಕ್ತಿಕ ಗುರುತು ಇಲ್ಲದೆ ಪ್ರಕಟಿಸಲಾಗುವುದು. ಮೌಖಿಕ ಅಥವಾ ಲಿಖಿತವರದಿಯಲ್ಲಿ ಈ ಅಧ್ಯಯನಕ್ಕೆ ಸಂಬಧಿಸಿದಂತೆ ನಿಮ್ಮ ಉಲ್ಲೇಖ ಇರುವುದಿಲ್ಲ.

13. ಅಧ್ಯಯನದ ಬಗ್ಗೆ ಹೊಸ ಮಾಹಿತಿ:
ಅಧ್ಯಯನದ ಸಮಯದಲ್ಲಿ ಯಾವುದೇ ಹೊಸ ಮಾಹಿತಿಗಳು ಲಭ್ಯವಾದಲ್ಲಿ ಅದು ನಿಮಗೆ ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಮುಂದುವರಿಯಲು ಸಹಕಾರಿಯಾದಲ್ಲಿ ಅದನ್ನು ನಿಮಗೆ ತಿಳಿಸಲಾಗುವುದು ನಿಮ್ಮ ಭಾಗವಸುವಿಕೆಯಿಂದಾದ ಫಲಿತಾಂಶವನ್ನು ನೀವು ಇಚ್ಛಿಸಿದಲ್ಲಿ ನಿಮಗೆ ತಿಳಿಸಲಾಗುವುದು.

14. ಐಚ್ಛಿಕ ಭಾಗವಹಿಸುವಿಕೆ:
ಈ ಅಧ್ಯಯನದಲ್ಲಿ ನಿಮ್ಮ ಭಾಗವಹಿಸುವಿಕೆಯು ಐಚ್ಛಿಕವಾಗಿದ್ದು ನೀವು ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಸಮ್ಮತಿಸಿದರೂ ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ನಿಮ್ಮ ಅನುಮತಿಯನ್ನು ಹಿಂತೆಗೆದುಕೊಳ್ಳಬಹುದು. ಹಾಗೂ ಇದಕ್ಕೆ ಯಾವುದೇ ಕಾರಣ ನೀಡ ಬೇಕಾಗಿಲ್ಲ. ಇದಕ್ಕಾಗಿ ನಿಮಗೆ ಯಾವುದೇ ದಂಡವಿರುವುದಿಲ್ಲ ಮತ್ತು ನಿಮಗೆ ಸಿಗಬೇಕಾಗುವ ಉಪಯೋಗ/ಲಾಭಕ್ಕೆ ಯಾವುದೇ ನಷ್ಟವಿಲ್ಲ. ನೀವು ಅಧ್ಯಯನ ಪೂರ್ಣಗೊಳ್ಳುವ ಮೊದಲು ಅಧ್ಯಯನದಿಂದ ಹೊರಬಂದರೆ ನೀವು ನಿಮ್ಮ ಕಾಯಿಲೆಗೆ ಬೇಕಾಗುವ ಸಾಮನ್ಯಾವಾದ ಚಿಕಿತ್ಸೆಯನ್ನು ಪಡೆಯುತ್ತೀರಿ ಮತ್ತು ನಿಮ್ಮ ಭಾಗವಹಿಸುವಿಕೆಯು ನಿಮ್ಮ ಮುಂದಿನ ಚಿಕಿತ್ಸೆಯ ಮೇಲೆ ಯಾವ ಅಡ್ಡ ಪರಿಣಾಮವನ್ನು ಬೀರುವುದಿಲ್ಲ ಅಥವಾ ನಿಮಗೆ ಚಿಕಿತ್ಸೆ ನೀಡುವ ವೈದ್ಯರೊಂದಿಗಿನ ಸಂಬಂಧಕ್ಕೆ ಯಾವುದೆ ತೊಂದರೆ ಯಾಗುವುದಿಲ್ಲ.

ಅಧ್ಯಯನ ಪೂರ್ಣಗೊಳ್ಳುವ ಮೊದಲು ನೀವು ಅಧ್ಯಯನದಿಂದ ಹಿಂದೆ ಸರಿದರೆ ನೀವು ಅಧ್ಯಯನದಿಂದ ಹಿಂದೆ ಸರಿಯುವ ಮೊದಲು ಸಂಗ್ರಹಿಸಿದ ಅಧ್ಯಯನದ ಮಾಹಿತಿಯನ್ನು ಅಧ್ಯಯನ ವರದಿಯಲ್ಲಿ ಉಪಯೋಗಿಸಲಾಗುವುದು.

ಪ್ರಾಯೋಜಕರು ಅಥವಾ ಅಧ್ಯಯನಕಾರರು ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಅವರ ಅಧ್ಯಯನವನ್ನು ಅಥವಾ ನಿಮ್ಮ ಭಾಗವಹಿಸುವಿಕೆಯನ್ನು ಒಂದಲ್ಲ ಒಂದು ಕಾರಣಕ್ಕಾಗಿ ನಿಮ್ಮ ಅನುಮತಿ ಇಲ್ಲದೆಯೇ ನಿಲ್ಲಿಸಬಹುದು.

15. ಒಂದು ವೇಳೆ ಪ್ರಶ್ನೆಗಳೇನಾದರೂ ಇದ್ದಲ್ಲಿ ಯಾರನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು:
ಈ ಅಧ್ಯಯನದಲ್ಲಿ ನೀವು ಭಾಗವಹಿಸುತ್ತಿರುವಾಗ ಅದರ ಪರಿಣಾಮವಾಗಿ ಯಾವುದೇ ಅಡ್ಡ ಪರಿಣಾಮಗಳನ್ನು ಅನುಭವಿಸಿದಲ್ಲಿ ನೀವು ಮುಖ್ಯ ಅಧ್ಯಯನಕಾರರಾದ ಡಾ. ಸಂಜಯ್ ಪಟ್ಟಣಶೆಟ್ಟಿ ಮೇಲೆ ವಿವರ ನೀಡಿದವರನ್ನು ಸಂಪರ್ಕಿಸಹುದು.

ಅಧ್ಯಯನದ ಭಾಗಿದಾರರಾಗಿ ಮಾಹಿತಿ ಸಮ್ಮತಿ ಪತ್ರದ ಪ್ರಕ್ರಿಯೆ ಬಗ್ಗೆ ಅಥವಾ ಭಾಗಿದಾರರಾಗಿ ನಿಮ್ಮ ಹಕ್ಕುಗಳ ಬಗ್ಗೆ ನಿಮಗೆ ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳಿದ್ದಲ್ಲಿ ಸದಸ್ಯ ಕಾರ್ಯದರ್ಶಿ, ಕಸ್ತೂರ್ಬಾ ಮೇಡಿಕಲ್ ಕಾಲೇಜು ಮತ್ತು ಕಸ್ತೂರ್ಬಾ ಆಸ್ಪತ್ರೆ – ನೈತಿಕ ಸಮಿತಿ ಸಂಸ್ಥೆ, ಕೊಠಡಿ ನಂ. 22, ನೆಲಮಹಡಿ, ಕೆಎಮ್‌ಸಿ ಪ್ರಾಧ್ಯಾಪಕರ ಕೊಠಡಿಗಳು, ಕೆಎಮ್‌ಸಿ ಆಡಳಿತ ಕಛೇರಿ ಪಕ್ಕ, ಕಸ್ತೂರ್ಬಾ ಮೆಡಿಕಲ್ ಕಾಲೇಜು, ಮಣಿಪಾಲ – 576 104, ಇವರನ್ನು ಸಂದರ್ಶಿಸಬಹುದು. ಫೋನ್ : 0820 29 33522. ಸಮಯ: ಬೆಳಿಗ್ಗೆ 9:00ರಿಂದ ಸಾಯಂಕಾಲ 5:00.

ಈ ಮಾಹಿತಿ ಪತ್ರದ ಬಗ್ಗೆ ಅಥವಾ ಅಧ್ಯಯನಕ್ಕೆ ಸಂಬಧಿಸಿದಂತೆ ಯಾವುದೇ ವಿವಾದಾಂಶಗಳಿದ್ದರೆ ಈ ಕೆಳಗಿನವರನ್ನು ಕೂಡಾ ಸಂಪರ್ಕಿಸಬಹುದು.

ಹೆಸರು: ಡಾ ಅಶ್ಮಾ ಡೊರೊಥಿ ಮೊಂಟೆರೊ
ವಿಳಾಸ: ಸಹಾಯಕ ಪ್ರಾಧ್ಯಾಪಕರು, ದತ್ತಾಂಶ ವಿಜ್ಞಾನ ವಿಭಾಗ, ಪ್ರಸನ್ನ ಸ್ಕೂಲ್ ಆಫ್ ಪಬ್ಲಿಕ್ ಹೆಲ್ತ್, ಮಾಹೆ, ಮಣಿಪಾಲ

ದೂರವಾಣಿ ಸಂಖ್ಯೆ : 8660591151 (ಕಚೇರಿ ವೇಳೆಯ ನಂತರವೂ ಸಂಪರ್ಕಿಸುವ ಮೊಬೈಲ್ ನಂಬರ್ ಸಹಿತ)

Annexure – VI: Demographic Information Sheet

Title: Evaluation of structure and process of Grama Arogya (GA), Karnataka

Demographic Information Sheet

[To be filled for each participant and filed with translated Data]

ID No. _____ Date: _ _/_ _/_ _

Category: KII/FGD Time of interview: _ _: _ _

PI _____ Place of interview: _____

Name	
Age (in years)	
Gender	
Qualification	
Designation	
Organization/Department	
No. of years of experience	
Address	
Contact No.	

Annexure VIIa: Tool for Implementers (IDI) -English

Title: Evaluation of structure and process of Grama Arogya (GA), Karnataka

In-depth interview guide- Tool for implementers

Preamble: Namaskar, I am _____ (name) from _____ (organization). I will be moderating the discussion today. I must thank you all for coming to the focus group discussion today. Gram Arogya (GA) is being implemented in your district. Here, we have gathered to understand the Grama Arogya program's activities, strengths, issues, and implementation process. As a implementer, kindly share your experience and views on this program. I must share that there is no right or wrong answer. Please feel free to express your views and solutions. You may respond to each other also. Whatever we discuss today is going to be very important and we do not want to miss any of your views. The information that you share here will be kept confidential. I would like to introduce _____ (Name), the note-taker. We are audio recording this FGD/IDI with your permission (please record the consent). With your permission, let us start with our discussion:

1. As an implementer of GA, could you briefly describe the program? What is your role in the implementation of GA?
   (Probe on goals, objectives, activities, tasks, and responsibilities)

2. Do you think that GA program is meeting the set objectives? If yes, please explain.
   (Probe on various actors involved, convergence, decentralization, successful partnership incidences, areas that require improvement)

3. What is your opinion about the level of coordination among the different stakeholders?
4. Could you please elaborate on successful strategies, and approaches you have observed?
5. What are the main challenges or barriers you have encountered during the implementation of GA?
   (Probe on technology utilization and issues if any, equity, gender differences, vulnerable group, caste. Provide specific examples if any and how it influences the program)

6. What strategies have been effective in engaging and involving the community in GA? Are there any community-driven activities?

7. Have you identified any gaps in the provision of these program services?
   (Probe on nature of the gap and measures taken or recommended to address them)

8. Have you received any feedback from the beneficiaries?
   (Probe on experience or concerns raised by beneficiaries)

9. As per your experience, what improvements or modifications would you suggest to enhance the impact of this program?
   (Probe on changes in the structure (GPTF), implementation process, policies, and resource allocation)

Annexure - VIIb: Tool for Implementers (IDI) - Kannada

ದೀರ್ಘ ಸಂದರ್ಶನ ಮಾರ್ಗದರ್ಶಿ– ಕಾರ್ಯಕ್ರಮ ಅನುಷ್ಠಾನಕಾರರಿಗೆ ಪ್ರಶ್ನೆಗಳು

ಮುನ್ನುಡಿ: ನಮಸ್ಕಾರ ನಾನು_____, ಸಂಸ್ಥೆಯ ಹೆಸರು_____. ನಾನು ಇಂದು ಚರ್ಚೆಯನ್ನು ಮಾಡರೇಟ್ ಮಾಡುತ್ತೇನೆ. ಇಂದು ನೀವು ಈ ಸಂದರ್ಶನಕ್ಕೆ ಬಂದಿದ್ದಕ್ಕಾಗಿ ಧನ್ಯವಾದಗಳು. ನಿಮ್ಮ ಭಾಗವಹಿಸಿದ್ದಕ್ಕಾಗಿ ನಾವು ನಿಮಗೆ ಕೃತಜ್ಞತೆ ಸಲ್ಲಿಸುತ್ತೇವೆ. ಇಂದು ನಾವು ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆ, ಸಾಧಕ ಭಾದಕಗಳು, ಮತ್ತು ಚಟುವಟಿಕೆಗಳ ಕುರಿತು ಚರ್ಚಿಸಲು ಬಯಸುತ್ತೇವೆ. ಇದರಲ್ಲಿ ಸರಿ ಅಥವಾ ತಪ್ಪು ಉತ್ತರವಿಲ್ಲ, ದಯವಿಟ್ಟು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯ ಮತ್ತು ಪರಿಹಾರಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ, ಇಂದು ನಾವು ಇಲ್ಲಿ ಚರ್ಚಿಸುವ ವಿಷಯಗಳು ಬಹಳ ಮುಖ್ಯವಾಗಿರುತ್ತವೆ ಮತ್ತು ನಾವು ನಿಮ್ಮ ಯಾವುದೇ ಅಭಿಪ್ರಾಯಗಳನ್ನು ಕಳೆದುಕೊಳ್ಳಲು ಬಯಸುವುದಿಲ್ಲ, ನೀವು ಇಲ್ಲಿ ಹಂಚಿಕೊಂಡ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ. ನಾನು ಟಿಪ್ಪಣಿ ತೆಗೆದುಕೊಳ್ಳುವವರನ್ನು ಪರಿಚಯಿಸಲು ಬಯಸುತ್ತೇನೆ., ಇವರ ಹೆಸರು_____, ನಿಮ್ಮ ಅನುಮತಿಯ ಮೇರೆಗೆ ನಾವು ಈ ಸಂದರ್ಶನವನ್ನು ಆಡಿಯೋ ರೆಕಾರ್ಡ್ ಮಾಡುತ್ತಿದ್ದೇವೆ (ದಯವಿಟ್ಟು ಅನುಮತಿ ನೀಡಿರುವುದನ್ನು ರೆಕಾರ್ಡ್‌ಮಾಡುವುದು). ನಿಮ್ಮ ಅನುಮತಿಯೊಂದಿಗೆ ಈಗ ಚರ್ಚೆಯನ್ನು ಪ್ರಾರಂಭಿಸೋಣ:

೧. ಗ್ರಾಮ ಆರೋಗ್ಯ (GA) ಕಾರ್ಯಕ್ರಮ ಅನುಷ್ಠಾನಕಾರರಾಗಿ, ನೀವು ಈ ಕಾರ್ಯಕ್ರಮವನ್ನು ಸಂಕ್ಷಿಪ್ತವಾಗಿ ವಿವರಿಸಬಹುದೇ? ಇದರ ಅನುಷ್ಠಾನದಲ್ಲಿ ನಿಮ್ಮ ಪಾತ್ರವೇನು?
(ಗುರಿಗಳು, ಉದ್ದೇಶಗಳು, ಚಟುವಟಿಕೆಗಳು, ಕಾರ್ಯಗಳು ಮತ್ತು ಜವಾಬ್ದಾರಿಗಳ ಬಗ್ಗೆ ಕೇಳುವುದು)

೨. ಈ ಕಾರ್ಯಕ್ರಮವು ನಿಗದಿತ ಉದ್ದೇಶಗಳನ್ನು ಪೂರೈಸುತ್ತಿದೆ ಎಂದು ನೀವು ಭಾವಿಸುತ್ತೀರಾ? ಒಂದು ವೇಳೆ ಹೌದು ಎಂದಾದರೆ ದಯವಿಟ್ಟು ವಿವರಿಸಿ.
(ತೊಡಗಿಸಿಕೊಂಡಿರುವ ವಿವಿಧ ಪಾಲುದಾರರು, ಯಶಸ್ವಿ ಪಾಲುದಾರಿಕೆಯ ಘಟನೆಗಳು, ಸುಧಾರಣೆಯ ಅಗತ್ಯವಿರುವ ಕ್ಷೇತ್ರಗಳ ಬಗ್ಗೆ ಕೇಳುವುದು)

೩. ವಿವಿಧ ಪಾಲುದಾರರ ನಡುವಿನ ಸಮನ್ವಯದ ಮಟ್ಟವನ್ನು ಕುರಿತು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು?

೪. ನೀವು ಗಮನಿಸಿದ ಯಶಸ್ವಿ ಕಾರ್ಯತಂತ್ರಗಳು ಮತ್ತು ವಿಧಾನಗಳ ಬಗ್ಗೆ ದಯವಿಟ್ಟು ವಿವರಿಸಬಹುದೇ?

೫. ಗ್ರಾಮ ಆರೋಗ್ಯ ಅನುಷ್ಠಾನದ ಸಮಯದಲ್ಲಿ ನೀವು ಎದುರಿಸಿದ ಮುಖ್ಯ ಸವಾಲುಗಳು ಅಥವಾ ಅಡೆತಡೆಗಳು ಯಾವುವು?
(ಯಾವುದಾದರೂ ನಿರ್ದಿಷ್ಟ ಉದಾಹರಣೆಗಳಿವೇ ಎಂದು ಕೇಳಿ ಮತ್ತು ಅದು ಕಾರ್ಯಕ್ರಮದ ಮೇಲೆ ಹೇಗೆ ಪರಿಣಾಮ ಬೀರುತ್ತದೆ ಎಂದು ಕೇಳಿ)

೬. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಸಮುದಾಯವು ತನ್ನನ್ನು ತಾನು ತೊಡಗಿಸಿಕೊಳ್ಳುವಲ್ಲಿ ಮತ್ತು ಒಳಗೊಳ್ಳುವಲ್ಲಿ ಯಾವ ತಂತ್ರಗಳು ಪರಿಣಾಮಕಾರಿಯಾಗಿವೆ? ಯಾವುದೇ ಸಮುದಾಯ-ಚಾಲಿತ ಚಟುವಟಿಕೆಗಳಿವೆಯೇ?

೭. ಈ ಕಾರ್ಯಕ್ರಮದ ಮೂಲಕ ಸೇವೆಗಳನ್ನು ಒದಗಿಸುವಲ್ಲಿ ನೀವು ಯಾವುದಾದರೂ ಅಂತರವನ್ನು ಗುರುತಿಸಿದ್ದೀರಾ?
(ಅಂತರದ ಸ್ವರೂಪ ಮತ್ತು ತೆಗೆದುಕೊಂಡ ಕ್ರಮಗಳ ಮೇಲೆ ತನಿಖೆ ಅಥವಾ ಅವುಗಳನ್ನು ಪರಿಹರಿಸಲು ಶಿಫಾರಸು ಮಾಡಲಾಗಿದೆ)

೮. ನೀವು ಫಲಾನುಭವಿಗಳಿಂದ ಯಾವುದೇ ಪ್ರತಿಕ್ರಿಯೆಯನ್ನು ಸ್ವೀಕರಿಸಿದ್ದೀರಾ?

(ಫಲಾನುಭವಿಗಳಿಂದ ಅನುಭವ ಅಥವಾ ಕಳವಳಗಳ ಮೇಲೆ ತನಿಖೆ)

೯. ನಿಮ್ಮ ಅನುಭವದ ಪ್ರಕಾರ, ಈ ಕಾರ್ಯಕ್ರಮದ ಪ್ರಭಾವವನ್ನು ಹೆಚ್ಚಿಸಲು ನೀವು ಯಾವ ಸುಧಾರಣೆಗಳು ಅಥವಾ ಮಾರ್ಪಾಡುಗಳನ್ನು ಸೂಚಿಸುತ್ತೀರಿ?

(ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆ, ನೀತಿಗಳು ಮತ್ತು ಸಂಪನ್ಮೂಲ ಹಂಚಿಕೆಯಲ್ಲಿನ ಬದಲಾವಣೆಗಳ ಕುರಿತು ತನಿಖೆ)

೧೦. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವನ್ನು ಕಾರ್ಯಗತಗೊಳಿಸಲು ಯಾವ ಹೆಚ್ಚುವರಿ ಬೆಂಬಲ ಅಥವಾ ತರಬೇತಿ ಪ್ರಯೋಜನಕಾರಿ ಎಂದು ನೀವು ನಂಬುತ್ತೀರಾ?

(ತಂಡಕ್ಕೆ ಅಗತ್ಯವಿರುವ ಸಂಪನ್ಮೂಲಗಳ ಕುರಿತು ತನಿಖೆ)

೧೧. ನಿಮ್ಮ ಅಭಿಪ್ರಾಯದಲ್ಲಿ, ಗ್ರಾಮ ಆರೋಗ್ಯದಲ್ಲಿರುವ ಕಾರ್ಯತಂತ್ರಗಳು ಬದಲಾಗುತ್ತಿರುವ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆ ಅಥವಾ ಜನರ ಅಗತ್ಯಗಳಿಗೆ ಹೇಗೆ ಹೊಂದಿಕೊಳ್ಳುತ್ತವೆ?

(ಪ್ರಸ್ತುತ ಪರಿಸ್ಥಿತಿ ಅಥವಾ ಭವಿಷ್ಯದ ಸವಾಲುಗಳನ್ನು ಸೇರಿಸಲು ಪ್ರೋಗ್ರಾಂನಲ್ಲಿ ನವೀಕರಿಸಬೇಕಾದ ಅಥವಾ ಪರಿಷ್ಕರಿಸಬೇಕಾದ ಅಂಶಗಳ ಕುರಿತು ತನಿಖೆ ಮಾಡಿ)

೧೨. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ಯಾವುದೇ ಹೆಚ್ಚುವರಿ ಶಿಫಾರಸುಗಳು, ಒಳನೋಟಗಳು ಅಥವಾ ಟೀಕೆ(ಕಾಮೆಂಟ್)ಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ.

12. ಕಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ GAಗೆ ತಾಂತ್ರಿಕ ಬೆಂಬಲವನ್ನು ನೀವು ಹೇಗೆ ನೀಡುತ್ತೀರಿ?

[Probe : ತಾಂತ್ರಿಕ ಬೆಂಬಲವಿಲ್ಲದೆ ಸುಸ್ಥಿರತೆ (Sustainability)]

Annexure VIIIa: Tool for service providers (FGD) - English

Title: Evaluation of structure and process of Grama Arogya (GA), Karnataka

FGD- Tool for Service Providers (Healthcare workers-ASHA/ANMs)

After a brief introduction of participants and the purpose of the study, the following FGD/IDI pointers can be used to facilitate the discussion:

Preamble: Namaskar, I am _____ (name) from _____ (organization). I will be moderating the discussion today. I must thank you all for coming to the focus group discussion today. Gram Arogya (GA) is being implemented in your district. Here, we have gathered to understand the Grama Arogya program's activities, strengths, issues, and implementation process. As a service provider, kindly share your experience and views on this program. I must share that there is no right or wrong answer. Please feel free to express your views and solutions. You may respond to each other also. Whatever we discuss today is going to be very important and we do not want to miss any of your views. The information that you share here will be kept confidential. I would like to introduce _____ (Name), the note-taker. We are audio recording this FGD/IDI with your permission (please record the consent). With your permission, let us start with our discussion:

1. As an implementer, what is your understanding of GA? What is your role in the implementation of GA? What does ASHA or any volunteer in this program do daily in the village?

(Probe on intention of program, activities, responsibilities, and tasks they are involved in, microplanning of health camps, provision of communication materials for awareness events, training & utilization of health management kit)

2. What is the strength of GA implementation? What is good about the program? As an enabler, how is it supporting health outcomes?

(Probe on various actors involved, successful partnership incidences, areas that require improvement)

3. What is your opinion about the level of coordination among the different stakeholders?

(Probe: Stakeholders involved and suggestion on involvement of any other department)

4. What are the main challenges or barriers you have encountered while implementing GA? What are the solutions you found?

(Probe the problems they face in the community, community mobilization, specific examples, if any, and how it impacts the program, identified solutions)

5. What strategies have effectively engaged and involved the community in GA? Are there any community-driven activities?

(Probe on involvement of Self-help-group or any such community involvement)

6. What can you do so people continue/adhere to the treatment? How is the referral procedure and follow-up done? What are the issues you face?

(Probe on the medicines related to TB and other NCDs, problems, and solutions they identified)

7. Please explain your responsibilities in data feeding and management?

(Probe: Record maintenance and reporting)

Annexure VIIIb: Tool for service providers (FGD) - Kannada

ಕೇಂದ್ರೀಕೃತ ಗುಂಪು ಚರ್ಚೆ/ದೀರ್ಘ ಸಂದರ್ಶನ ಮಾರ್ಗದರ್ಶಿ–ಸೇವೆಯನ್ನು ಒದಗಿಸುವವರಿಗೆ ಪ್ರಶ್ನೆಗಳು (ASHA/ANM/CHO)

ಮುನ್ನುಡಿ: ನಮಸ್ಕಾರ ನಾನು_____, ಸಂಸ್ಥೆಯ ಹೆಸರು_____ ನಾನು ಇಂದು ಚರ್ಚೆಯನ್ನು ಮಾಡರೇಟ್ ಮಾಡುತ್ತೇನೆ. ಇಂದು ನೀವು ಈ ಸಂದರ್ಶನ/ ಗುಂಪು ಚರ್ಚೆಗೆ ಬಂದಿದ್ದಕ್ಕಾಗಿ ಧನ್ಯವಾದಗಳು. ನೀವು ಭಾಗವಹಿಸಿದ್ದಕ್ಕಾಗಿ ನಾವು ನಿಮಗೆ ಕೃತಜ್ಞತೆ ಸಲ್ಲಿಸುತ್ತೇವೆ. ಇಂದು ನಾವು ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆ, ಸಾಧಕ ಭಾದಕಗಳು, ಮತ್ತು ಚಟುವಟಿಕೆಗಳ ಕುರಿತು ಮಾತನಾಡಲು ಬಯಸುತ್ತೇವೆ. ಇದರಲ್ಲಿ ಸರಿ ಅಥವಾ ತಪ್ಪು ಉತ್ತರವಿಲ್ಲ, ದಯವಿಟ್ಟು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯ ಮತ್ತು ಪರಿಹಾರಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ, ಇಂದು ನಾವು ಇಲ್ಲಿ ಚರ್ಚಿಸುವ ವಿಷಯಗಳು ಬಹಳ ಮುಖ್ಯವಾಗಿರುತ್ತವೆ ಮತ್ತು ನಾವು ನಿಮ್ಮ ಯಾವುದೇ ಅಭಿಪ್ರಾಯಗಳನ್ನು ಕಳೆದುಕೊಳ್ಳಲು ಬಯಸುವುದಿಲ್ಲ, ನೀವು ಇಲ್ಲಿ ಹಂಚಿಕೊಂಡ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ. ನಾನು ಟಪ್ಪಣಿ ತೆಗೆದುಕೊಳ್ಳುವವರನ್ನು ಪರಿಚಯಿಸಲು ಬಯಸುತ್ತೇನೆ., ಇವರ ಹೆಸರು_____, ನಿಮ್ಮ ಅನುಮತಿಯ ಮೇರೆಗೆ ನಾವು ಈ ಸಂದರ್ಶನವನ್ನು ಆಡಿಯೋ ರೆಕಾರ್ಡ್ ಮಾಡುತ್ತಿದ್ದೇವೆ (ದಯವಿಟ್ಟು ಅನುಮತಿ ನೀಡಿರುವುದನ್ನು ರೆಕಾರ್ಡ್‌ಮಾಡುವುದು). ನಿಮ್ಮ ಅನುಮತಿಯೊಂದಿಗೆ ಈಗ ಚರ್ಚೆಯನ್ನು ಪ್ರಾರಂಭಿಸೋಣ:

೧. ಗ್ರಾಮ ಆರೋಗ್ಯ(GA) ಕಾರ್ಯಕ್ರಮ ಎಂದರೇನು? ಇದರ ಕುರಿತು ನಿಮ್ಮ ತಿಳುವಳಿಕೆ ಏನು? ಈ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನದಲ್ಲಿ ನಿಮ್ಮ ಪಾತ್ರವೇನು? ಆಶಾ ಅಥವಾ ಈ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಯಾವುದೇ ಸ್ವಯಂಸೇವಕರು ಗ್ರಾಮದಲ್ಲಿ ಪ್ರತಿದಿನ ಏನು ಮಾಡುತ್ತಾರೆ?

(ಕಾರ್ಯಕ್ರಮದ ಉದ್ದೇಶ, ಚಟುವಟಿಕೆಗಳು, ಜವಾಬ್ದಾರಿಗಳು ಮತ್ತು ಅವರು ತೊಡಗಿಸಿಕೊಂಡಿರುವ ಕಾರ್ಯಗಳು, ಆರೋಗ್ಯ ಶಿಬಿರಗಳ ಸೂಕ್ಷ್ಮ ಯೋಜನೆ, ಜಾಗೃತಿ ಕಾರ್ಯಕ್ರಮಗಳಿಗೆ ಸಂವಹನ ಸಾಮಗ್ರಿಗಳನ್ನು ಒದಗಿಸುವುದು, ಆರೋಗ್ಯ ನಿರ್ವಹಣಾ ಕಿಟ್‌ನ ತರಬೇತಿ ಮತ್ತು ಬಳಕೆ ಕುರಿತು ಕೇಳುವುದು)

೨. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮ ಅನುಷ್ಠಾನದ ಶಕ್ತಿ ಏನು? ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಯಾವ ಅಂಶಗಳು ಸರಿಯಾಗಿವೆ ಅಥವಾ ಒಳ್ಳೆಯದಾಗಿವೆ? ಇದು ಆರೋಗ್ಯದ ಫಲಿತಾಂಶಗಳನ್ನು ಹೇಗೆ ಸಕ್ರಿಯವಾಗಿ ಬೆಂಬಲಿಸುತ್ತದೆ?

(ಒಳಗೊಂಡಿರುವ ವಿವಿಧ ಪಾಲುದಾರರ ಕುರಿತು ಕೇಳುವುದು, ಯಶಸ್ವಿ ಪಾಲುದಾರಿಕೆಯ ಘಟನೆಗಳು, ಸುಧಾರಣೆಯ ಅಗತ್ಯವಿರುವ ಕ್ಷೇತ್ರಗಳು)

೩. ವಿವಿಧ ಪಾಲುದಾರರ ನಡುವಿನ ಸಮನ್ವಯದ ಮಟ್ಟವನ್ನು ಕುರಿತು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು?

(ಭಾಗಿಯಾಗಿರುವ ಮಧ್ಯಸ್ಥಗಾರರು ಮತ್ತು ಯಾವುದೇ ಇತರ ಇಲಾಖೆಯ ಒಳಗೊಳ್ಳುವಿಕೆಯ ಬಗ್ಗೆ ಸಲಹೆಗಳನ್ನು ಕೇಳುವುದು)

೪. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಗತಗೊಳಿಸುವಾಗ ನೀವು ಎದುರಿಸಿದ ಮುಖ್ಯ ಸವಾಲುಗಳು ಅಥವಾ ಅಡೆತಡೆಗಳು ಯಾವುವು? ನೀವು ಕಂಡುಕೊಂಡ ಪರಿಹಾರಗಳು ಯಾವುವು?

(ಸಮುದಾಯದಲ್ಲಿ ಅವರು ಎದುರಿಸುತ್ತಿರುವ ಸಮಸ್ಯೆಗಳು, ಸಮುದಾಯ ಸಜ್ಜುಗೊಳಿಸುವಿಕೆ, ನಿರ್ದಿಷ್ಟ ಉದಾಹರಣೆಗಳು, ಯಾವುದಾದರೂ ಇದ್ದರೆ ಮತ್ತು ಅದು ಕಾರ್ಯಕ್ರಮದ ಮೇಲೆ ಹೇಗೆ ಪರಿಣಾಮ ಬೀರುತ್ತದೆ, ಗುರುತಿಸಲಾದ ಪರಿಹಾರಗಳ ಬಗ್ಗೆ ಕೇಳಿ)

೫. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಸಮುದಾಯ ತನ್ನನ್ನು ತಾನು ತೊಡಗಿಸಿಕೊಳ್ಳುವಲ್ಲಿ ಮತ್ತು ಒಳಗೊಳ್ಳುವಲ್ಲಿ ಯಾವ ತಂತ್ರಗಳು ಪರಿಣಾಮಕಾರಿಯಾಗಿವೆ? ಯಾವುದೇ ಸಮುದಾಯ–ಚಾಲಿತ ಚಟುವಟಿಕೆಗಳಿವೆಯೇ?

(ಸ್ವ–ಸಹಾಯ ಗುಂಪು ಅಥವಾ ಅಂತಹ ಯಾವುದೇ ಸಮುದಾಯದ ಒಳಗೊಳ್ಳುವಿಕೆಯ ಬಗ್ಗೆ ವಿವರವಾಗಿ ಕೇಳುವುದು)

೬. ಜನರು ಚಿಕಿತ್ಸೆಯನ್ನು ಮುಂದುವರಿಸಲು/ಪೂರ್ತಿಗೊಳಿಸಲು ನೀವು ಏನು ಮಾಡಬಹುದು? ರೆಫರಲ್ ಕಾರ್ಯವಿಧಾನ ಮತ್ತು ಅನುಸರಣೆ ಹೇಗೆ ಮಾಡಲಾಗುತ್ತದೆ? ನೀವು ಎದುರಿಸುತ್ತಿರುವ ಸಮಸ್ಯೆಗಳೇನು?

(ಟಿಬಿ ಮತ್ತು ಇತರ ಎನ್‌ಸಿಡಿಗಳಿಗೆ/ಅಸಂಕ್ರಾಮಿಕ ರೋಗಗಳಿಗೆ ಸಂಬಂಧಿಸಿದ ಔಷಧಿಗಳು, ಸಮಸ್ಯೆಗಳು ಮತ್ತು ಅವರು ಗುರುತಿಸಿದ ಪರಿಹಾರಗಳ ಕುರಿತು ತನಿಖೆ ಮಾಡಿ)

೭. ಡೇಟಾ ಫೀಡಿಂಗ್ ಮತ್ತು ನಿರ್ವಹಣೆಯಲ್ಲಿ ನಿಮ್ಮ ಜವಾಬ್ದಾರಿಗಳನ್ನು ದಯವಿಟ್ಟು ವಿವರಿಸಿ?

(ತನಿಖೆ: ಮಾಹಿತಿ/ದಾಖಲೆ ನಿರ್ವಹಣೆ ಮತ್ತು ವರದಿ)

೮. ಗ್ರಾಮ ಆರೋಗ್ಯ ಅನುಷ್ಠಾನಕ್ಕೆ ಮೊದಲು, ಸ್ಕ್ರೀನಿಂಗ್/ತಪಾಸಣೆ ಚಟುವಟಿಕೆಗಳನ್ನು ಹೇಗೆ ನಡೆಸಲಾಗುತ್ತಿತ್ತು?

೯. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ಯಾವುದೇ ಹೆಚ್ಚುವರಿ ಶಿಫಾರಸುಗಳು, ಒಳನೋಟಗಳು ಅಥವಾ ಕಾಮೆಂಟ್‌ಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ.

(ಅಗತ್ಯವಿರುವ ಬೆಂಬಲ ವ್ಯವಸ್ಥೆ ಅಗತ್ಯ, ಕಾರ್ಯ ಬದಲಾವಣೆಯ ಕುರಿತು ಕೇಳಿ)

Annexure IXa: Tool for GP members (FGD) - English

Title: Evaluation of structure and process of Grama Arogya (GA), Karnataka

FGD tool for GP members

Preamble: Namaskar, I am _____ (name) from _____ (organization). I will be moderating the discussion today. I must thank you all for coming to the focus group discussion today. Gram Arogya (GA) is being implemented in your district. Here, we have gathered to understand the Grama Arogya program's activities, strengths, issues, and implementation process. As a GP member, kindly share your experience and views on this program. I must share that there is no right or wrong answer. Please feel free to express your views and solutions. You may respond to each other also. Whatever we discuss today is going to be very important and we do not want to miss any of your views. The information that you share here will be kept confidential. I would like to introduce _____ (Name), the note-taker. We are audio recording this FGD/IDI with your permission (please record the consent). With your permission, let us start with our discussion:

1. Could you please briefly describe the GA program? What is your role in the implementation of GA?
   (Probe on intention of the program, activities, responsibilities, and tasks they are involved in, microplanning of the health camps, facilitation of logistics (kits) for the camp)

2. What is your opinion about the level of coordination among the different stakeholders?
   (Probe: Stakeholders involved, suggestion on involvement of any other departments)

3. Could you please elaborate on successful strategies, and approaches you have observed?

4. What are the main challenges or barriers you have encountered during the implementation of GA?
   (Probe on community mobilization, gender differences, vulnerable group, caste. Provide specific examples on issues if any)

5. What strategies have been effective in engaging and involving the community in GA? Are there any community-driven activities?

6. Have you received any feedback from the beneficiaries?
   (Probe on experience or concerns raised by beneficiaries)

7. As per your experience, what improvements or modifications would you suggest to enhance the influence of this program?
   (Probe on changes in the implementation process, budget allocation)

8. What additional support or training do you believe would be beneficial in implementing the GA?
   (Probe on required resources for the team)

Annexure IXb: Tool for GP members (FGD) - Kannada

ಕೇಂದ್ರೀಕೃತ ಗುಂಪು ಚರ್ಚೆ/ದೀರ್ಘ ಸಂದರ್ಶನ ಮಾರ್ಗದರ್ಶಿ– ಗ್ರಾಮಪಂಚಾಯತಿ ಸದಸ್ಯರಿಗೆ ಪ್ರಶ್ನೆಗಳು

ನಿಮ್ಮ ಜಿಲ್ಲೆಯಲ್ಲಿ ಗ್ರಾಮ ಆರೋಗ್ಯ (ಜಿಎ) ಜಾರಿಗೊಳಿಸಲಾಗುತ್ತಿದೆ. ಸಮುದಾಯದವರ ಆರೋಗ್ಯವನ್ನು ವಿಚಿತಪಡಿಸಿಕೊಳ್ಳಲು ಇದು ಒಂದು ಉಪಕ್ರಮವಾಗಿದೆ. ಗ್ರಾಮಪಂಚಾಯತಿ ಸದಸ್ಯರಾಗಿ ಈ ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ನಿಮ್ಮ ಅನುಭವ ಮತ್ತು ಅಭಿಪ್ರಾಯಗಳನ್ನು ದಯವಿಟ್ಟು ಹಂಚಿಕೊಳ್ಳಿ.

ಮುನ್ನುಡಿ: ನಮಸ್ಕಾರ ನಾನು_____, ಸಂಸ್ಥೆಯ ಹೆಸರು_____ ನಾನು ಇಂದು ಚರ್ಚೆಯನ್ನು ಮಾಡರೇಟ್ ಮಾಡುತ್ತೇನೆ. ಇಂದು ನೀವು ಈ ಸಂದರ್ಶನ/ ಗುಂಪು ಚರ್ಚೆಗೆ ಬಂದಿದ್ದಕ್ಕಾಗಿ ಧನ್ಯವಾದಗಳು. ನೀವು ಭಾಗವಹಿಸಿದ್ದಕ್ಕಾಗಿ ನಾವು ನಿಮಗೆ ಕೃತಜ್ಞತೆ ಸಲ್ಲಿಸುತ್ತೇವೆ. ಇಂದು ನಾವು ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆ, ಸಾಧಕ ಭಾದಕಗಳು, ಮತ್ತು ಚಟುವಟಿಕೆಗಳ ಕುರಿತು ಮಾತನಾಡಲು ಬಯಸುತ್ತೇವೆ. ಇದರಲ್ಲಿ ಸರಿ ಅಥವಾ ತಪ್ಪು ಉತ್ತರವಿಲ್ಲ, ದಯವಿಟ್ಟು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯ ಮತ್ತು ಪರಿಹಾರಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ, ಇಂದು ನಾವು ಇಲ್ಲಿ ಚರ್ಚಿಸುವ ವಿಷಯಗಳು ಬಹಳ ಮುಖ್ಯವಾಗಿರುತ್ತವೆ ಮತ್ತು ನಾವು ನಿಮ್ಮ ಯಾವುದೇ ಅಭಿಪ್ರಾಯಗಳನ್ನು ಕಳೆದುಕೊಳ್ಳಲು ಬಯಸುವುದಿಲ್ಲ. ನೀವು ಇಲ್ಲಿ ಹಂಚಿಕೊಂಡ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ. ನಾನು ಟಪ್ಪಣಿ ತೆಗೆದುಕೊಳ್ಳುವವರನ್ನು ಪರಿಚಯಿಸಲು ಬಯಸುತ್ತೇನೆ., ಇವರ ಹೆಸರು_____, ನಿಮ್ಮ ಅನುಮತಿಯ ಮೇರೆಗೆ ನಾವು ಈ ಸಂದರ್ಶನವನ್ನು ಆಡಿಯೋ ರೆಕಾರ್ಡ್ ಮಾಡುತ್ತಿದ್ದೇವೆ (ದಯವಿಟ್ಟು ಅನುಮತಿ ನೀಡಿರುವುದನ್ನು ರೆಕಾರ್ಡ್‌ಮಾಡುವುದು). ನಿಮ್ಮ ಅನುಮತಿಯೊಂದಿಗೆ ಈಗ ಚರ್ಚೆಯನ್ನು ಪ್ರಾರಂಭಿಸೋಣ:

೧. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಬಗ್ಗೆ ಸಂಕ್ಷಿಪ್ತವಾಗಿ ವಿವರಿಸಬಹುದೇ? ಈ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನದಲ್ಲಿ ನಿಮ್ಮ ಪಾತ್ರವೇನು?
(ಕಾರ್ಯಕ್ರಮದ ಉದ್ದೇಶ, ಚಟುವಟಿಕೆಗಳು, ಜವಾಬ್ದಾರಿಗಳು ಮತ್ತು ಅವರು ತೊಡಗಿಸಿಕೊಂಡಿರುವ ಕಾರ್ಯಗಳು, ಆರೋಗ್ಯ ಶಿಬಿರಗಳ ಸೂಕ್ಷ್ಮ ಯೋಜನೆ, ಶಿಬಿರಕ್ಕಾಗಿ ಲಾಜಿಸ್ಟಿಕ್ಸ್ (ಕಿಟ್‌ಗಳು) ಸುಗಮಗೊಳಿಸುವಿಕೆಯ ಕುರಿತು ಕೇಳುವುದು)

೨. ವಿವಿಧ ಪಾಲುದಾರರ ನಡುವಿನ ಸಮನ್ವಯದ ಮಟ್ಟವನ್ನು ಕುರಿತು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು?
(ಭಾಗಿಯಾಗಿರುವ ಪಾಲುದಾರರು, ಯಾವುದೇ ಇತರ ಇಲಾಖೆಗಳ ಒಳಗೊಳ್ಳುವಿಕೆಯ ಬಗ್ಗೆ ಸಲಹೆ)

೩. ನೀವು ಗಮನಿಸಿದ ಯಶಸ್ವಿ ಕಾರ್ಯತಂತ್ರಗಳು ಮತ್ತು ವಿಧಾನಗಳ ಬಗ್ಗೆ ದಯವಿಟ್ಟು ವಿವರಿಸಬಹುದೇ?
(ಉದಾಹರಣೆಗಳನ್ನು, ಸನ್ನಿವೇಶಗಳನ್ನು ಕೇಳುವುದು)

೪. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನದ ಸಮಯದಲ್ಲಿ ನೀವು ಎದುರಿಸಿದ ಮುಖ್ಯ ಸವಾಲುಗಳು ಅಥವಾ ಅಡೆತಡೆಗಳು ಯಾವುವು?

(ಸಮುದಾಯ ಸಜ್ಜುಗೊಳಿಸುವಿಕೆ, ಲಿಂಗ ವ್ಯತ್ಯಾಸಗಳು, ದುರ್ಬಲ ಗುಂಪು, ಜಾತಿಗಳ ಕುರಿತು ಕೇಳುವುದು. ಸಮಸ್ಯೆಗಳ ಬಗ್ಗೆ ಏನಾದರೂ ನಿರ್ದಿಷ್ಟ ಉದಾಹರಣೆಗಳನ್ನು ಒದಗಿಸಿ)

೫. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಸಮುದಾಯವು ತನ್ನನ್ನು ತಾನು ತೊಡಗಿಸಿಕೊಳ್ಳುವಲ್ಲಿ ಮತ್ತು ಒಳಗೊಳ್ಳುವಲ್ಲಿ ಯಾವ ತಂತ್ರಗಳು ಪರಿಣಾಮಕಾರಿಯಾಗಿವೆ? ಯಾವುದೇ ಸಮುದಾಯ-ಚಾಲಿತ ಚಟುವಟಿಕೆಗಳಿವೆಯೇ?

೬. ನೀವು ಫಲಾನುಭವಿಗಳಿಂದ ಯಾವುದೇ ಪ್ರತಿಕ್ರಿಯೆಯನ್ನು ಸ್ವೀಕರಿಸಿದ್ದೀರಾ/ತೆಗೆದುಕೊಳ್ಳುತ್ತೀರಾ?
(ಫಲಾನುಭವಿಗಳಿಂದ ಅನುಭವ ಅಥವಾ ಕಳವಳಗಳ ಕುರಿತು ಕೇಳುವುದು)

೭. ನಿಮ್ಮ ಅನುಭವದ ಪ್ರಕಾರ, ಈ ಕಾರ್ಯಕ್ರಮದ ಪ್ರಭಾವವನ್ನು ಹೆಚ್ಚಿಸಲು ನೀವು ಯಾವ ಸುಧಾರಣೆಗಳು ಅಥವಾ ಮಾರ್ಪಾಡುಗಳನ್ನು ಸೂಚಿಸುತ್ತೀರಿ?
(ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆ, ಬಜೆಟ್ ಹಂಚಿಕೆಯಲ್ಲಿನ ಬದಲಾವಣೆಗಳ ಕುರಿತು ತನಿಖೆ)

೮. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವನ್ನು ಕಾರ್ಯಗತಗೊಳಿಸಲು ಯಾವ ಹೆಚ್ಚುವರಿ ಬೆಂಬಲ ಅಥವಾ ತರಬೇತಿಯು ಪ್ರಯೋಜನಕಾರಿ ಎಂದು ನೀವು ನಂಬುತ್ತೀರಿ?
(ತಂಡಕ್ಕೆ ಅಗತ್ಯವಿರುವ ಸಂಪನ್ಮೂಲಗಳ ಕುರಿತು ವಿವರಣೆ)

೯. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ಯಾವುದೇ ಹೆಚ್ಚುವರಿ ಶಿಫಾರಸುಗಳು, ಒಳನೋಟಗಳು ಅಥವಾ ಕಾಮೆಂಟ್‌ಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ.

Annexure Xa: Tool for Beneficiaries (FGD) - English

Title: Evaluation of structure and process of Grama Arogya (GA), Karnataka

FGD Tool for Beneficiaries

After a brief introduction of participants and the purpose of the study, the following FGD/IDI pointers can be used to facilitate the discussion:

Preamble: Namaskar, I am _____ (name) from _____ (organization). I will be moderating the discussion today. I must thank you all for coming to the focus group discussion today. Gram Arogya (GA) is being implemented in your district. Here, we have gathered to understand the Grama Arogya program's activities, strengths, issues, and implementation process. As a beneficiary, kindly share your experience and views on this program. I must share that there is no right or wrong answer. Please feel free to express your views and solutions. You may respond to each other also. Whatever we discuss today is going to be very important and we do not want to miss any of your views. The information that you share here will be kept confidential. I would like to introduce _____ (Name), the note-taker. We are audio recording this FGD/IDI with your permission (please record the consent). With your permission, let us start with our discussion:

1. What are the common health diseases/issues among people in your area?

(Probe on NCDs, infectious diseases, undernutrition, mental health)

2. Who are the healthcare providers in your area? Are you aware of this program GA? what is your perception/understanding?

(Probe on public, private practitioners, intention of program, activities in the community)

3. What are the advantages of the program? How it helps you in early diagnosis and treatment? How did it enable you to get proper care in less time?

(Probe on frequency of screening camps, awareness events on NCDs and communicable diseases, referrals, treatment, and follow-up)

4. What is your opinion about the GA program? Who are the people in your area involved?

(Probe on various actors involved, successful partnership incidences, areas that require improvement, volunteers/social organizations getting involved SHG, NGOs, youth groups, etc.)

5. What is your opinion about the level of coordination among the different stakeholders?(Panchayat staff and healthcare workers)

(Probe: Stakeholders involved and suggestion on involvement of any other department)

6. Do you have any difficulties/barriers/challenges in utilizing the program? If yes, please elaborate.

(Probe: Getting tested for common diseases, treatment, follow-ups, specifically probe on gender perspective)

7. Please share any additional recommendations, insights, or comments about the GA program. How this program can be improved?

Annexure Xb: Tool for Beneficiaries (FGD) - Kannada

ಕೇಂದ್ರೀಕೃತ ಗುಂಪು ಚರ್ಚೆ ಮಾರ್ಗದರ್ಶಿ–ಫಲಾನುಭವಿಗಳಿಗೆ ಪ್ರಶ್ನೆಗಳು

ನಿಮ್ಮ ಜಿಲ್ಲೆಯಲ್ಲಿ ಗ್ರಾಮ ಆರೋಗ್ಯ (ಜಿಎ) ಕಾರ್ಯಕ್ರಮ ಜಾರಿಗೊಳಿಸಲಾಗಿದೆ. ಸಮುದಾಯದವರ ಆರೋಗ್ಯವನ್ನು ಸಧೃಡಗೊಳಿಸಲು ಇದು ಒಂದು ಉಪಕ್ರಮವಾಗಿದೆ. ಒಬ್ಬ ಫಲಾನುಭವಿಯಾಗಿ, ಈ ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ನಿಮ್ಮ ಅನುಭವ ಮತ್ತು ಅಭಿಪ್ರಾಯಗಳನ್ನು ದಯವಿಟ್ಟು ಹಂಚಿಕೊಳ್ಳಿ.

ಮುನ್ನುಡಿ: ನಮಸ್ಕಾರ ನಾನು_____, ಸಂಸ್ಥೆಯ ಹೆಸರು_____ ನಾನು ಇಂದು ಚರ್ಚೆಯನ್ನು ಮಾಡರೇಟ್ ಮಾಡುತ್ತೇನೆ. ಇಂದು ನೀವು ಈ ಸಂದರ್ಶನ/ ಗುಂಪು ಚರ್ಚೆಗೆ ಬಂದಿದ್ದಕ್ಕಾಗಿ ಧನ್ಯವಾದಗಳು. ನೀವು ಭಾಗವಹಿಸಿದ್ದಕ್ಕಾಗಿ ನಾವು ನಿಮಗೆ ಕೃತಜ್ಞತೆ ಸಲ್ಲಿಸುತ್ತೇವೆ. ಇಂದು ನಾವು ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆ, ಸಾಧಕ ಭಾದಕಗಳು, ಮತ್ತು ಚಟುವಟಿಕೆಗಳ ಕುರಿತು ಮಾತನಾಡಲು ಬಯಸುತ್ತೇವೆ. ಇದರಲ್ಲಿ ಸರಿ ಅಥವಾ ತಪ್ಪು ಉತ್ತರವಿಲ್ಲ, ದಯವಿಟ್ಟು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯ ಮತ್ತು ಪರಿಹಾರಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ. ಇಂದು ನಾವು ಇಲ್ಲಿ ಚರ್ಚಿಸುವ ವಿಷಯಗಳು ಬಹಳ ಮುಖ್ಯವಾಗಿರುತ್ತವೆ ಮತ್ತು ನಾವು ನಿಮ್ಮ ಯಾವುದೇ ಅಭಿಪ್ರಾಯಗಳನ್ನು ಕಳೆದುಕೊಳ್ಳಲು ಬಯಸುವುದಿಲ್ಲ, ನೀವು ಇಲ್ಲಿ ಹಂಚಿಕೊಂಡ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ. ನಾನು ಟಪ್ಪಣಿ ತೆಗೆದುಕೊಳ್ಳುವವರನ್ನು ಪರಿಚಯಿಸಲು ಬಯಸುತ್ತೇನೆ., ಇವರ ಹೆಸರು_____, ನಿಮ್ಮ ಅನುಮತಿಯ ಮೇರೆಗೆ ನಾವು ಈ ಸಂದರ್ಶನವನ್ನು ಆಡಿಯೋ ರೆಕಾರ್ಡ್ ಮಾಡುತ್ತಿದ್ದೇವೆ (ದಯವಿಟ್ಟು ಅನುಮತಿ ನೀಡಿರುವುದನ್ನು ರೆಕಾರ್ಡ್‌ಮಾಡುವುದು). ನಿಮ್ಮ ಅನುಮತಿಯೊಂದಿಗೆ ಈಗ ಚರ್ಚೆಯನ್ನು ಪ್ರಾರಂಭಿಸೋಣವೇ:

೧. ನಿಮ್ಮ ಪ್ರದೇಶದ ಜನರಲ್ಲಿ ಸಾಮಾನ್ಯವಾದ ಕಾಯಿಲೆಗಳು/ಆರೋಗ್ಯ ಸಮಸ್ಯೆಗಳು ಯಾವುವು?
(ಎನ್‌ಸಿಡಿಗಳು, ಸಾಂಕ್ರಾಮಿಕ ರೋಗಗಳು, ಅಪೌಷ್ಟಿಕತೆ, ಮಾನಸಿಕ ಆರೋಗ್ಯ ಸಮಸ್ಯೆಗಳ ಕುರಿತು ಕೇಳುವುದು)
೨. ನಿಮ್ಮ ಪ್ರದೇಶದಲ್ಲಿ ಆರೋಗ್ಯ ಸೇವೆ ಒದಗಿಸುವವರು ಯಾರು? ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಬಗ್ಗೆ ನಿಮಗೆ ತಿಳಿದಿದೆಯೇ? ಇದರ ಕುರಿತು ನಿಮ್ಮ ಗ್ರಹಿಕೆ/ತಿಳುವಳಿಕೆ ಏನು?
(ಸಾರ್ವಜನಿಕ ಹಾಗೂ ಖಾಸಗಿ ವೈದ್ಯರ ಪಾತ್ರ, ಕಾರ್ಯಕ್ರಮದ ಉದ್ದೇಶ, ಸಮುದಾಯದಲ್ಲಿನ ಚಟುವಟಿಕೆಗಳು)

೩. ಈ ಕಾರ್ಯಕ್ರಮದಿಂದ ಆಗುವ ಅನುಕೂಲಗಳು ಯಾವುವು? ಆರಂಭಿಕ ರೋಗನಿರ್ಣಯ ಮತ್ತು ಚಿಕಿತ್ಸೆಯಲ್ಲಿ ಇದು ನಿಮಗೆ ಹೇಗೆ ಸಹಾಯ ಮಾಡುತ್ತದೆ? ಕಡಿಮೆ ಸಮಯದಲ್ಲಿ ಸರಿಯಾದ ಆರೈಕೆಯನ್ನು ಪಡೆಯಲು ಈ ಕಾರ್ಯಕ್ರಮದಿಂದ ನಿಮಗೆ ಹೇಗೆ ಸಾಧ್ಯವಾಯಿತು?
(ತಪಾಸಣಾ ಶಿಬಿರಗಳ ಆವರ್ತನ, ಎನ್‌ಸಿಡಿಗಳು(ಅಸಾಂಕ್ರಾಮಿಕ ರೋಗಗಳು) ಮತ್ತು ಸಾಂಕ್ರಾಮಿಕ ರೋಗಗಳ ಕುರಿತು ಜಾಗೃತಿ ಕಾರ್ಯಕ್ರಮಗಳು, ಉಲ್ಲೇಖಿಗಳು, ಚಿಕಿತ್ಸೆ ಮತ್ತು ಅನುಸರಣೆಯ ಕುರಿತು ತನಿಖೆ)

೪. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಬಗ್ಗೆ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು? ನಿಮ್ಮ ಪ್ರದೇಶದಲ್ಲಿ ಭಾಗಿಯಾಗಿರುವ ಜನರು ಯಾರು?

(ಸಮುದಾಯ ಸಜ್ಜುಗೊಳಿಸುವಿಕೆ, ಲಿಂಗ ವ್ಯತ್ಯಾಸಗಳು, ದುರ್ಬಲ ಗುಂಪು, ಜಾತಿಗಳ ಕುರಿತು ಕೇಳುವುದು. ಸಮಸ್ಯೆಗಳ ಬಗ್ಗೆ ಏನಾದರೂ ನಿರ್ದಿಷ್ಟ ಉದಾಹರಣೆಗಳನ್ನು ಒದಗಿಸಿ)

೫. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಸಮುದಾಯವು ತನ್ನನ್ನು ತಾನು ತೊಡಗಿಸಿಕೊಳ್ಳುವಲ್ಲಿ ಮತ್ತು ಒಳಗೊಳ್ಳುವಲ್ಲಿ ಯಾವ ತಂತ್ರಗಳು ಪರಿಣಾಮಕಾರಿಯಾಗಿವೆ? ಯಾವುದೇ ಸಮುದಾಯ-ಚಾಲಿತ ಚಟುವಟಿಕೆಗಳಿವೆಯೇ?

೬. ನೀವು ಫಲಾನುಭವಿಗಳಿಂದ ಯಾವುದೇ ಪ್ರತಿಕ್ರಿಯೆಯನ್ನು ಸ್ವೀಕರಿಸಿದ್ದೀರಾ/ತೆಗೆದುಕೊಳ್ಳುತ್ತೀರಾ?
(ಫಲಾನುಭವಿಗಳಿಂದ ಅನುಭವ ಅಥವಾ ಕಳವಳಗಳ ಕುರಿತು ಕೇಳುವುದು)

೭. ನಿಮ್ಮ ಅನುಭವದ ಪ್ರಕಾರ, ಈ ಕಾರ್ಯಕ್ರಮದ ಪ್ರಭಾವವನ್ನು ಹೆಚ್ಚಿಸಲು ನೀವು ಯಾವ ಸುಧಾರಣೆಗಳು ಅಥವಾ ಮಾರ್ಪಾಡುಗಳನ್ನು ಸೂಚಿಸುತ್ತೀರಿ?
(ಅನುಷ್ಠಾನ ಪ್ರಕ್ರಿಯೆ, ಬಜೆಟ್ ಹಂಚಿಕೆಯಲ್ಲಿನ ಬದಲಾವಣೆಗಳ ಕುರಿತು ತನಿಖೆ)

೮. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವನ್ನು ಕಾರ್ಯಗತಗೊಳಿಸಲು ಯಾವ ಹೆಚ್ಚುವರಿ ಬೆಂಬಲ ಅಥವಾ ತರಬೇತಿಯು ಪ್ರಯೋಜನಕಾರಿ ಎಂದು ನೀವು ನಂಬುತ್ತೀರಿ?
(ತಂಡಕ್ಕೆ ಅಗತ್ಯವಿರುವ ಸಂಪನ್ಮೂಲಗಳ ಕುರಿತು ವಿವರಣೆ)

೯. ಗ್ರಾಮ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ಯಾವುದೇ ಹೆಚ್ಚುವರಿ ಶಿಫಾರಸುಗಳು, ಒಳನೋಟಗಳು ಅಥವಾ ಕಾಮೆಂಟ್‌ಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಿ.

Annexure: XI

Description of the particiapnts

SL.No	Unique ID	Age	Gender	Designation	District	Bystander Influence	Duration of the interview
1	IDI_DVG_1	38	M	PDO	Davangere	Yes	36:18
2	IDI_DVG_2	45	F	VRW	Davangere	Yes	22:49
3	IDI_DVG_3	39	F	CHO	Davangere	Yes	24.58
4	IDI_DVG_4	38	M	District-level Officer	Davangere	No	57:24
5	IDI_DVG_5	44	M	GP President	Davangere	Yes	38:32
6	IDI_DVG_6	55	F	District-level Officer	Davangere	No	32:16
7	IDI_DVG_7	54	M	District-level Officer	Davangere	No	24:07
8	IDI_DVG_8	43	M	District-level Officer	Davangere	No	31:13
9	IDI_DVG_9	51	M	District-level Officer	Davangere	No	15:28
10	IDI_DVG_10	36	F	PDO	Davangere	Yes	34:51
11	IDI_DVG_11	38	M	CHO	Davangere	No	57:14
12	IDI_KOP_12	41	M	District-level Officer	Koppala	No	36:05
13	IDI_KOP_13	38	M	District-level Officer	Koppala	No	19:02
14	IDI_KOP_14	28	F	PDO	Koppala	Yes	42:96
15	IDI_KOP_15	26	F	CHO	Koppala	Yes	30:19
16	IDI_KOP_16	49	M	District-level Officer	Koppala	No	26:24
17	IDI_KOP_17	23	F	Vulnerable Group	Koppala	Yes	48:48
18	IDI_BGK_18	55	M	District-level Officer	Bagalkote	No	19:09
19	IDI_BGK_19	38	M	District-level Officer	Bagalkote	No	17:15
20	ID_BGK_20	44	M	PDO	Bagalkote	Yes	27:44
21	IDI_BGK_21	26	F	CHO	Bagalkote	Yes	22:24
22	IDI_BGK_22	47	M	District-level Officer	Bagalkote	No	32:11
23	IDI_BGK_23	39	M	Mobile shop keeper	Bagalkote	Yes	18:41
24	IDI_MND_24	42	M	District-level Officer	Mandya	No	23:28
25	IDI_MND_25	31	M	District-level Officer	Mandya	No	22:34
26	IDI_MND_26	46	M	District-level Officer	Mandya	Yes	20:12

27	IDI_MND_27	40	M	PDO	Mandya	No	17:04
28	IDI_MND_28	26	F	CHO	Mandya	Yes	21:43
29	IDI_MND_29	55	M	District-level Officer	Mandya	No	11:39
30	IDI_MND_30	58	M	District-level Officer	Mandya	No	17:33
31	IDI_MND_31	36	TG	Social worker	Mandya	Yes	19:53
32	IDI_MND_32	55	M	State-level Officer	Bangalore	No	01:17:00
33	IDI_MND_33	57	F	State-level Officer	Bangalore	No	31:14
34	IDI_MND_34	60	M	State-level Officer	Bangalore	No	49:21

Focus Group Discussions (FGDs)

SL.No	Unique ID	Age	Gender	Designation	District	Bystander Influence	Interview Time	No of Participants
1	FGD_DVG_1	72	M	Farmer	Davangere	No	36:55	Beneficiaries, 9 Males
2		33	M	Kooli				
3		37	M	Farmer				
4		33	M	Kooli				
5		25	M	Kooli				
6		45	M	Farmer				
7		70	M	-				
8		73	M	Farmer				
9		63	M	Farmer				
10	FGD_DVG_2	35	F	Housewife	Davangere	Yes	29:52	Beneficiaries 9 Females
11		55	F	Housewife				
12		55	F	Housewife				
13		32	F	Housewife				
14		30	F	Housewife				
15		28	F	Housewife				
16		35	F	Housewife				
17		60	F	Housewife				
18		35	F	Housewife				
19	FGD_DVG_3	35	F	GP Member	Davangere	No	41:59	GP Members 4 Females, 3 Males
20		39	M	GP Member				
21		35	F	GP Member				
22		35	F	GP Member				
23		45	M	GP Member				
24		42	M	GP Member				
25		36	F	GP Member				
26	FGD_DVG_4	36	F	ASHA	Davangere	Yes	45:56	Service providers, 10 Females
27		37	F	ASHA				
28		29	F	ASHA				
29		32	F	AWW				

30		39	F	AWW				
31		44	F	AWW				
32		55	F	AWW				
33		33	F	PHCO				
34		45	F	PHCO				
35		56	F	PHCO				
36	FGD_KOP_1	76	M	Farmer	Koppala	Yes	40:39	Beneficiaries, 9 Males
37		30	M	Farmer				
38		58	M	Farmer				
39		60	M	Farmer				
40		58	M	Farmer				
41		75	M	Farmer				
42		59	M	Farmer				
43		48	M	Kooli				
44		65	M	Farmer				
45	FGD_KOP_2	56	F	Farmer	Koppala	Yes	23:38	Beneficiaries, 9 Female
46		65	F	Housewife				
47		52	F	Housewife				
48		55	F	Farmer				
49		85	F	Farmer				
50		30	F	Housewife				
51		53	F	Housewife				
52		65	F	Farmer				
53		56	F	Farmer				
54	FGD_KOP_3	52	M	GP Member	Koppala	Yes	28:45	GP members 6 Males, 4 Females
55		32	M	GP Member				
56		38	M	GP Member				
57		32	F	GP Member				
58		40	F	GP Member				
59		38	F	GP Member				
60		45	M	GP Member				
61		35	M	GP Member				
62		45	M	GP Member				
63		25	F	GP Member				
64	FGD_KOP_4	43	F	ASHA	Koppala	No	50:26	Service providers, 9 females
65		29	F	AWW				
66		29	F	PHCO				
67		43	F	ASHA				
68		49	F	PHCO				
69		53	F	ASHA				
70		31	F	AWW				
71		43	F	AWW				
72		49	F	AWW				
73	FGD_BGK_1	43	M	Sheep raring	Bagalkote	Yes	22:48	Beneficiaries, 4 Male
74		36	M	VRW				
75		48	M	Kooli				
76		65	M	Kooli				
77	FGD_BGK_2	40	F	MNREGA worker	Bagalkote	No	36:06	Female beneficiaries, 9
78		35	F	Caretaker				
79		19	F	Caretaker				
80		28	F	Caretaker				
81		35	F	NRLM				
82		24	F	Caretaker				
83		34	F	NRLM				
84		21	F	NRLM				

85		24	F	NRLM				
86	FGD_BGK_3	35	F	GP Members	Bagalkote	Yes	57:02	GP members, 5 Males, 4 females
87		35	F	GP Members				
88		40	F	GP Members				
89		32	M	GP Members				
90		43	M	GP Members				
91		40	M	GP Members				
92		40	M	GP Members				
93		52	M	GP Members				
94		43	F	GP Members				
95	FGD_BGK_4	56	F	AWW	Bagalkote	Yes	36:06	Service Providers, 10 females
96		41	F	ASHA				
97		38	F	ASHA				
98		32	F	ASHA				
99		39	F	ASHA				
100		37	F	ASHA				
101		46	F	ASHA				
102		35	F	AWW				
103		43	F	AWW				
104		37	F	AWW				
105	FGD_MND_1	77	M	Farmer	Mandya	No	26:02	Beneficiaries, Male 8
106		61	M	Farmer				
107		65	M	Farmer				
108		60	M	Farmer				
109		73	M	Farmer				
110		54	M	Farmer				
111		63	M	Farmer				
112		60	M	Farmer				
113	FGD_MND_2	51	F	Housewife	Mandya	Yes	30:17	Beneficiaries, 8 Female
114		40	F	Kooli				
115		37	F	Housewife				
116		37	F	Housewife				
117		32	F	DEO				
118		48	F	Housewife				
119		40	F	LCRP				
120		40	F	Housewife				
121	FGD_MND_3	38	F	GP Members	Mandya	No	35:43	GP members,4 Males, 1 female
122		50	M	GP Members				
123		49	M	GP Members				
124		61	M	GP Members				
125		42	M	GP Members				
126	FGD_MND_4	44	F	ASHA	Mandya	Yes	52:42	Service Providers, 7 Females
127		36	F	ASHA				
128		40	F	AWW				
129		33	F	AWW				
130		33	F	ASHA				
131		37	F	ASHA				
132		39	F	ASHA				

Annexure : XII

List of codes-Code book

Sl No	Type of Code (I/D)	Code Name	Code Description
1	D	**Activity**	Activities conducted under the project Grama Arogya.
2	D	**Program Objective**	Understanding the objective of the program.
3	D	**Individuals/departments involved (stakeholders)**	Various Stakeholders are involved in the implementation of the GA program.
4	D	**Roles and responsibilities**	Various roles and responsibilities handled by different stakeholders
5	D	**Vulnerable Population_participation**	Engagement of representatives of the vulnerable community.
7	D	**Technical Support Agency**	A not-for-profit agency that was supporting the government in implementing the program.
8	D	**Stakeholder_Cooperation**	Describes how various actors from different sectors work to implement a program.
9	D	**Sustainability_Strategy**	Description about how a program can be institutionalized or how administrative processes can be made easier.
10	D	**Convergence_Examples**	Describes how convergence was achieved by engaging various stakeholders for the benefit of the population.
11	D	**Challenges_GAimplementation**	The challenges faced by various stakeholders in implementing GA.
12	D	**Challenges_TechnologyAdoption**	The challenges faced by individuals for adopting technology (portals, software).
13	D	**Equity_Access**	Describes the access to and utilization of services offered through GA.
14	D	**Beneficiary Feedback**	Feedback from the beneficiaries after attending the program.
15	D	**Low HL levels_Hesitancy**	Lack of knowledge and awareness of health and the program respectively.
16	D	**Disease_Screening Suggestion**	Suggestions to strengthen the screening process.
17	D	**Consumables_Supply Chain**	Describes the supply chain process involved in procuring and utilizing the consumables for the GA program.
18	D	**Suggestion_Strengthning Program**	Suggestions provided by individuals to strengthen the program.
19	D	**Anticipated_BenefitGA**	The benefit of the program to the population.
20	D	**GPTF_Strengthing**	Suggestions to strengthen the GPTF.
21	D	**GPTF_involvement**	Describes the involvement of the GPTF in the GA program.
22	D	**TB Screening**	Describes the procedure involved in TB screening.
23	D	**Anemia Screening**	Describes the procedure involved in Anemia screening.
24	D	**Screening_Diseases**	Describes the diseases screened in the GA program.
25	D	**Challenges_Screening**	Describes the challenges encountered while screening

26	I	**Information_Communication**	Describes how the information is communicated within and between the stakeholders.
27	I	**Data_Management**	Strategies and challenges of data management
28	I	**Suggestions_Capacity Building**	Suggestions for capacity building of staff at various levels.
29	I	**Mental Health_Requirement**	Requirement for addressing mental health related issues.
30	I	**Diseases_community**	Various diseases in the community
31	I	**Healthcare_preference**	Preference expressed by the beneficiary to seek health services.
32	I	**Good_Health Literacy**	Adequate health literacy levels as evident from their participation in camps.
33	I	**Stakeholder_SHG_participation**	Stakeholders being a part of the Self-help groups participate in the GA program.
34	I	**Healthcare_Requirement**	Healthcare requirements that may be added to the program.
35	I	**GPTF_Planning_GA**	Describes how GPTF will contribute to the planning of the Graama Arogya.
36	I	**GPTF Role_Stopping Child Marriage**	Role of GPTF members in stopping child marriage.
37	I	**Behavioural Change Communication**	The behavioral change that is observed when individual or group of individuals change their practice. It also includes the need for behavioral change.
38	I	**Menstural Hygiene_Awareness**	Initiatives taken through the GA program to inform women and adolescent girls regarding the menstrual hygiene.
39	I	**Patient Referral Issue**	Challenges in forward and backward referral once the Patient is referred from/to a different health facility.
40	I	**GP_WASH Activities**	Role of Grama Panchayat in water, Sanitation and hygiene programs.
41	I	**Program Understanding_Implementers**	Degree to which the GA program is understood by the implementers.
42	I	**Multiple Programs_Management**	Describes the issue of staff who manage multiple programs leading to burnout and poor outcomes.
43	I	**Program_monitoring**	Describes the approach in which the program is reviewed by the officials.
44	I	**Child Marriage_Migration**	Issue of child marriage observed in communities who have migrated from a different district.
45	I	**Program History**	History of the GA program.
46	I	**COVID-19 Response**	Response activities by the RDPR towards the management of COVID-19.
47	I	**Tech enabled health delivery**	Utilization of technology for delivering healthcare.
48	I	**Exploring Funding mechanisms_GA**	The need for development and exploring funding mechanism for the GA program as it is on the verge of institutionalization.
49	I	**Plans_GA Scale up**	Plans and the vision to scale up the existing program.
50	I	**Lack of Knowledge_GA**	Lack of awareness about the program.

51	I	**Efforts_Capacity Building**	The efforts made by various stakeholders to enhance the capacity of the individuals in the GA program.
52	I	**Decentralization_existing process**	Current administrative structure with defined hierarchies.
53	I	**Challenges_decentralization**	Challenges arising out of the current decentralization structures.
54	I	**Challenges_Communication**	General commutation challenges to access healthcare services
55	I	**Program Implementation Process**	Camp Frequency, participants, camp site
56	I	**Gender_differences**	Gender differences in camp participation
57	I	**Attitude**	The attitude of the community towards the GA program
58	I	**BCC_Stakeholders**	Behavioural change communication among stakeholders
59	I	**Camps_GA**	Screening of diseases in the camps
60	I	**Challenge_HR**	Challenges faced during implementing program due to lack of human resource
61	I	**Challenges_ mobilization**	Challenges during Community Mobilization
62	I	**Challenges_consumables**	Challenges faced due to lack of consumables (Strips, lancets, etc)
63	I	**Challenges_GP involvement**	Lack of GP involvement in the GA program
64	I	**Community involvement**	Community involvement in the GA program
65	I	**Coordination_repercussion**	The unintended consequences during implementation of the GA program
66	I	**Delegation**	Assigning tasks of the program from higher authority to lower authority
67	I	**Digital Data Entry**	Details on data uploaded to the Panchatantra-2 application
68	I	**GP revenue**	GP income and its sources
69	I	**GPTF structure**	Grama Panchayat task Force members and their responsibility
70	I	**Lack of information**	Lack of information about the GA program
71	I	**Low-cost initiative**	GA program is a low-cost initiative
72	I	**Manual Data Entry**	Documentation of screening activity
73	I	**New initiative**	GA as a new social innovation
74	I	**Ownership**	Program implementers take responsibility for implementing the program
75	I	**Recording**	Maintaining data entry of the patients at the camp
76	I	**Referral**	Referring patients from camps to higher health care settings for management
77	I	**School awareness requirement**	Requirement of school awareness program
78	I	**Special camps for disabled**	Camps organized for specially-abled people
79	I	**Stigma**	Taboo/negative perception towards health camps
80	I	**Success stories_Mobilization**	Strategies used for successful mobilization
81	I	**Success stories_screening**	Detection of disease in the camps through screening

82	I	**Success story_problem solving**	Problem-solving strategies used for the challenges faced during implementation of the program
83	I	**Success story_prorgam**	Successful implementation of the GA program
84	I	**Suggestions_Data Maintaining**	Suggestions for handling data of camp participants

Annexure XIII: Photos of data collection

Davangere

Koppala

Bagalkot

Mandya