Ministry of Health and
Family Welfare
Government of India

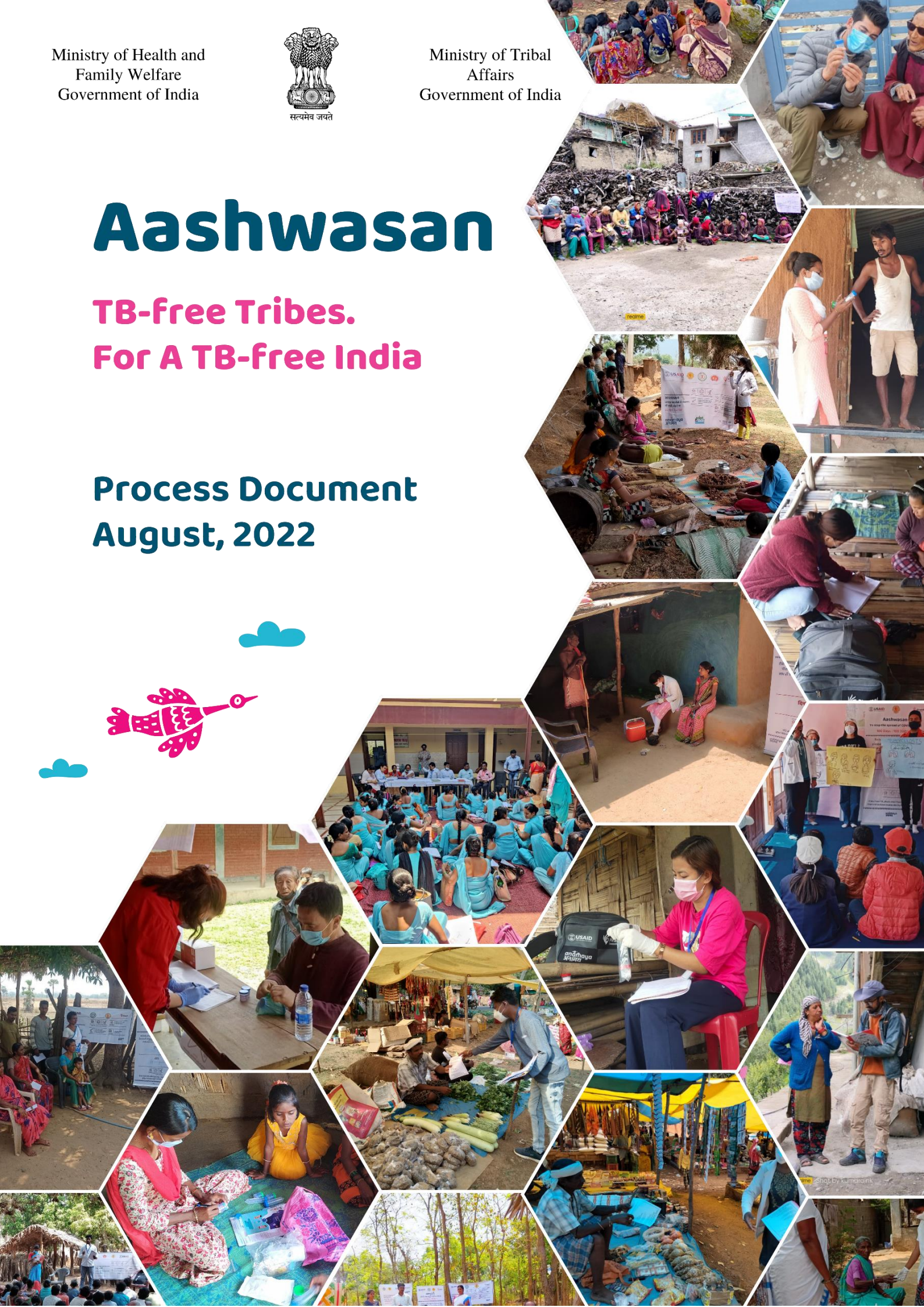
सत्यमेव जयते

Ministry of Tribal
Affairs
Government of India

Aashwasan

TB-free Tribes.
For A TB-free India

Process Document
August, 2022



Process Document for Active Case Finding (Tuberculosis) in remote, tribal districts of India

Based on learnings from the 100-day Aashwasan campaign carried out across all tribal districts of India as part of the Tribal TB Initiative

August 2022

USAID FROM THE AMERICAN PEOPLE

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME

anamaya अनामय

Piramal Swasthya

1. Background:

1.1 Tuberculosis (TB) in India:

TB remains a leading cause of morbidity and mortality in developing countries, including India. India has the highest Tuberculosis (TB) burden globally, with an estimated 2.59 million cases in 2020[1]. Each day, over 6775 cases are notified and close to 436,000 people annually die of TB in India[2]. Despite the sustained commitment to controlling the spread and impact of TB and having shown commendable progress in the fight against TB through the Revised National Tuberculosis Control Program (RNTCP), India still stands among the top five countries that account for more than half of the global missing cases. Recognising the urgency and intensity, in the year 2020, the Government of India set up an ambitious target of TB elimination by 2025. On the foundations of the past learnings, a further refined strategy was put in place and RNTCP was renamed as National TB Elimination Program (NTEP) was launched the same year.

1.2 TB among tribal populations in India:

TB is not just a medical disease but also a result of multifaceted socio-economic problems. The highest rates of TB are found in the poorest and socio-economically marginalised section of the community in any given geographic boundary. Fighting TB from among the vulnerable and marginalized sections of the citizens is the most crucial step to attaining India's ambitious target to eliminate TB.

In India, people from Scheduled Tribe (ST) communities are the population sub-group with the lowest rate of upward economic mobility with a significantly impoverished state of various health indicators. TB prevalence among STs is estimated to be 703 per 100,000 as against the national average of 256 per 100,000[3]. A quarter of the total self-reported TB cases[4] and 10.4% of all TB-notified patients are from tribal communities.[5] The National TB program has prioritized this sub-group of the population through Tribal Action Plan since 2005. However, the spread and impact of TB among tribal peoples continue to be a matter of grave concern that the nation is committed to solving. Inputs from different initiatives and available secondary literature indicated the need to probe deeper to strengthen the knowledge about TB among tribal peoples

1 World Health Organization. (2021). Global Tuberculosis Report 2021. ISBN: 978-92-4-003702-1

2 World Health Organization. TB Mortality, WHO India TB profile 2019. Available from: URL: https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22IN%22

3 Thomas, B. E., Adinarayanan, S., Manogaran, C., & Swaminathan, S. (2015). Pulmonary tuberculosis among tribals in India: A systematic review & meta-analysis. The Indian journal of medical research, 141(5), 614.

4 Mazumdar S, Satyanarayana S, Pai M. (2019). Self-reported tuberculosis in India: evidence from NFHS-4. BMJ global health, 4(3), e001371.

5 Central TB Division, Ministry of Health and Family Welfare, New Delhi. (2020, March). National Tuberculosis Elimination Program Annual Report 2020. Available from: https://tbcindia.gov.in/showfile.php?lid=3538

and to strengthen the existing efforts of detection and care to cater to the unique challenges faced by tribal populations living in remote, hard-to-reach districts.

1.3 Active Case Finding: An approach to reach the unreached

As outlined in the **Active Case Finding Guidance Document, 2017** Active Case Finding (ACF) or Intensive case finding activity (ICF) is basically a provider-initiated activity with the primary objective of detecting TB cases early by active case finding in targeted groups and initiating treatment promptly. It is done in a campaign mode and can target people who have sought health care with or without symptoms or signs of TB and also the people who have not sought care. Increased coverage can be achieved by focusing on clinically, socially and occupationally vulnerable populations. It must be remembered that 'Screening' is a dynamic process and the prioritization of vulnerable groups, choice of screening approach and screening interval should be regularly reassessed by the programme. Decisions on when and how to screen for TB, which vulnerable groups to prioritize and which screening tool to use depend on the vulnerable group, the capacity of the health system, and the availability of resources.

ACF remains to be one of the key approaches that can address the challenges of TB among tribal communities. This document outlines a suggestive Standard Operating Procedure for deploying ACF in remote, tribal districts based on the learnings from Aashwasan, a large-scale ACF campaign successfully implemented across 174 tribal districts of India in 2022. The campaign has been carried out as one of the early initiatives under the Tribal TB Initiative.

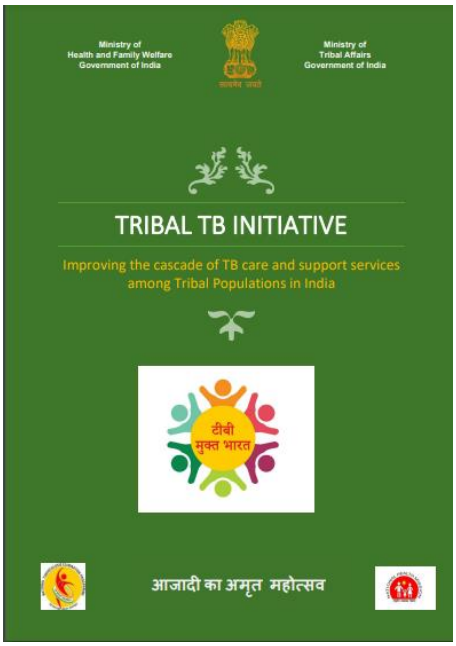
2. Tribal TB Initiative:

2.1 About Tribal TB Initiative:

Tribal peoples constitute 8.6% of the total population of India. Yet, they account for 10.4% of all notified TB cases in India. India's aim to eliminate TB by 2025 cannot be fulfilled without a focused effort to fight TB among tribal communities. A cross-cutting, comprehensive, and multi-stakeholder approach is the must-take path to address this challenge. Convergent actions by various Ministries, private and non-profit organizations, and civil societies can enhance the possibilities to realize India's vision for ending TB with a priority focus on TB hotspots of tribal areas.

Recognising the need to consolidate effort investment towards eliminating TB among tribal communities, the Ministry of Health and Family Welfare and the Ministry of Tribal Affairs collectively launched the Tribal TB Initiative on 26th March 2021.

Tribal TB Initiative brings together and leverages the expertise of stakeholders with diverse capabilities to tackle the multi-dimensional issues specific to TB among tribal communities. It accelerates the reduction of mortality and morbidity from TB among the tribal populations in India by improving the cascade of TB care and support services.



The Central TB Division, the National Health Mission, and the State Governments, have actively joined the effort to combat the spread and impact of TB among the tribal communities of India. Anamaya, the Tribal Health Collaborative has taken up this Initiative as one of its flagship projects. From among the partners of Anamaya, USAID is providing technical guidance and Piramal Swasthya is implementing the Initiative across the nation. A National Technical Support Unit (NTSU) for Tribal TB is established to provide technical and operational assistance to the TB elimination programme.

2.2 Objectives of Tribal TB Initiative:

The Tribal TB Initiative aspires to reduce the burden of morbidity and mortality from TB among tribal populations in India. The key objectives of this Initiative are:

1. Community empowerment and mobilization
2. Expand services to detect, treat and prevent TB
3. Strengthening the health system and capacity

2.3 Key Deliverables of Tribal TB Initiative:

Within the first four years of the Initiative's inception it aims to achieve:

A. Increased TB **case notification** (differentiated based on age and gender) among tribal populations.

B. Increase in **treatment success** rates among drug-susceptible TB (DS-TB) and drug-resistant TB (DR-TB) among tribal peoples (differentiated on age, gender, and geographic location).

C. **Decreased deaths** among tribal individuals infected with TB (differentiated on age, gender, and geographic location).

D. Increased **participation** of members of diverse tribal communities in TB prevention and care activities.

E. **Reduced TB vulnerability** among tribal populations in India.

3. Unique Challenges of Tribal Districts

Access, availability, and utilization of TB care services for tribal communities are hindered by several barriers including geographical difficulties, the poor state of social determinants of health, the high impact of malnutrition, and pervasive myths and stigmas around the disease. It is further weakened due to health system constraints such as inadequately equipped health centres, lack of trained human resources, cultural and communication gaps between the care providers and the community members, and inactive community engagement platforms resulting in insufficient community involvement.

Some of the key barriers that need to be considered and mapped while planning an ACF campaign in remote, tribal areas in India are:

a. Hard-to-reach area: Tribal and indigenous peoples across the globe choose to live close to and in solidarity with nature. They play a significant role in biodiversity conservation, although most often without much recognition. Understandably, a significant proportion of tribal communities in India also continue to live in hilly, forested, and remote rural areas. Unfortunately, this preference of a section of tribal communities poses a challenge to the health system that is historically designed in an urban-centric manner as it faces difficulty in ensuring access to healthcare services in locations which are rural and remote.

   The Aashwasan team has mapped and segregated the hard-to-reach areas into eight categories through a thorough situational analysis to develop micro plans. The micro plans include details of the route and resource mapping that can cater to the need of a specific location and help the field team execute the intensive outreach activities.

   The eight categories of hard-to-reach areas are:

- **Mining areas (eg. Stone/ coal. Copper mining areas):** Mining activities increase the risk of acute respiratory infection (ARI), tuberculosis, and many other health hazards among people living in and around mining areas. Additionally, there are higher amounts of fatal road traffic accidents in mining areas in India. [6]
- **Hilly terrain:** Tribal villages in hilly areas often are not connected by motorable roads. The houses are generally situated far away from each other. It slows down the commute speed resulting in a slower pace of service delivery including transportation of consumables and necessary medicines. It is difficult to carry out regular work for people who are not familiar with navigating in hilly terrain.
- **Landslide-prone areas:** Many hilly areas, especially the ones with heavy rainfall are landslide prone. Aside from natural causes, deforestation, and the construction of roads, trains, and dams in hilly areas are also increasing the frequency and intensity of landslides. It is difficult to carry out regular work for people who are not familiar with navigating in hilly and landslide-prone areas.
- **Areas with no road connectivity:** There are many villages spread across various tribal districts that are not connected to the rest of the block or the district with a proper motorable road. Often, walking long distances for hours is a must to reach the nearby paved or motorable road for most of these villages.
- **Forest-covered areas:** Road connectivity is often limited in forest-covered areas in the interest of saving wild lives. The movement time available to cover these areas are also comparatively lesser and stricter as one cannot commute after dark. It is difficult to carry out regular work for people who are not familiar with navigating in forest-covered areas even during the daytime.
- **Riverine areas (islands):** River islands like Majuli (Assam) are completely dependent on services that can travel across waterbodies.
- **Flood-prone areas:** Seasonal floods pose severe challenges to transport and communication services. With climate change, it is getting further difficult as untimely floods are also increasing.
- **Conflict-affected or conflict-prone areas:** Various tribal areas have been impacted by inter-community conflicts, political conflicts, and socio-political conflicts between tribal and non-tribal communities or even with the government. Often tribal peoples are also caught in the conflict between different rebellious or secessionist groups and the government.

b. Knowledge gap: There is a dearth of information on the prevalence of TB among the tribal population across India and the associated factors that influence TB prevalence.

[6] TAMNAR-PROJECT-REPORT-ICMR-NIRTH-1.pdf (mongabay.com)

Furthermore, little is known about the healthcare-seeking behaviour patterns among the tribal population and the factors that impede their utilization of health services.[7]

There is also not enough in-depth information available in an agile manner about the state of health facilities, equipment, and human resources in the context of TB diagnostic services and caregiving. This knowledge gap hinders the Govt. efforts from reaching desired results even after allocating resources and efforts.

c. Limited capacity of health facilities: Aashwasan team has conducted a brief situational analysis combining a secondary literature review and interaction with key stakeholders at the district and block levels at the onset of the project. The team has learned that:

- Information gaps at different stages of the health echo system
- The number of TB Units is lesser than the number of blocks in more than 50% of tribal districts
- There is a lack of TrueNat/CBNAAT testing facilities at district levels in most cases.
- Diabetes status is not known for a more significant share of TB patients in different states
- Mobile Units are very limited in operations. Only 1/3rd of districts have mobile units even though they can play a crucial role to improve access to care.
- NE states have a huge gap in the notification, due to having few testing facilities and difficult terrain
- Availability of chest X-ray facilities at the block levels is much lower among NE states.
- Routine ACF under the programme was not conducted since 2020 in many states as tackling the COVID-19 pandemic took precedence.
- Sub-optimal Sputum Collection and Transport mechanisms in place prior to Aashwasan in 104 out of 174 tribal districts where the campaign was deployed.

d. Limited capacity of health human resources (HR): The situational analysis has also found that:

- There is a lack of trained HR who can operate molecular diagnostic equipment.
- There is also an overall lack of dedicated TB staff (especially Lab Technicians). Often one-person function as a shared resource between different programme or have multiple responsibilities that make it difficult for her/ him to manage all the tasks optimally.
- Additionally, during the deployment of Aashwasan the team has also experienced barriers in terms of the existing staff's attitudinal readiness. For example, in many

[7] Burden of TB among the Tribal Population in India.pdf (nirt.res.in)

cases, the laboratory staff have not been happy with the increase in workload (number of tests) even though it was manageable within her/ his office hours. Often multi-directional interventions including requests from Aashwasan field staff and strict instructions from the block and district officials have been necessary for them to start warming up to the increased and yet manageable workload.

- At times, lab technicians come from distant places and hence they tend to leave early to avoid hassles they would face otherwise (some need to commute through forest-covered terrain or have limited transportation options) on their way back.
- The team has also encountered the issue of loss of hope in some cases. Many staff have internalised that the problem is too big to be solved.

e. Heavy impact of malnutrition: TB and malnutrition catch people in a vicious circle. Malnutrition can lead to secondary immunodeficiency that increases the host's susceptibility to infection. In patients with tuberculosis, it leads to a reduction in appetite, nutrient malabsorption, micronutrient malabsorption, and altered metabolism leading to wasting. Both protein-energy malnutrition and micronutrient deficiencies increase the risk of tuberculosis.[8] Tribal peoples are comparatively more vulnerable to food and nutrition uncertainty than their rural counterparts. [9] NFHS-4 shows a high prevalence of adult malnutrition among the members of tribal communities. Unless both the issues of TB and malnutrition are addressed simultaneously, TB-free India is to remain a dream. The Aashwasan team has come across way too many instances of severe malnutrition during their outreach activities. They have also failed to save a few lives as the patients were already in an advanced stage of TB with hardly any access to nutrition and no access to treatment. They also observed that the Direct Beneficiary Payment (DBT) provisioned by the Govt. does not always reach the beneficiary promptly.

f. Poor socio-economic status: Tribal communities of India have the lowest economic upward mobility among all the population subgroups including other marginalised groups.[10] Most of the patients identified through the Aashwasan campaign are from low-income backgrounds. They heavily depend on contractual and temporary jobs in the informal labour sectors. Heavy dependence on daily wages is one of the major reasons for them to often delay in seeking care, especially from health facilities away from their location that will need them to lose a day's wage should they decide or need to visit.

g. Fear and stigma about TB: While some people are aware of TB as a disease through various programmes or IEC initiatives, the knowledge about screening, diagnosis, and

[8] Krishna Bihari Gupta, Rajesh Gupta, et al. Tuberculosis and nutrition. 2009. Available at: Tuberculosis and nutrition - PMC (nih.gov)
[9] Subal Das, Kaushik Bose. Tribal malnutrition in India: An anthropometric and socio-demographic review. 2015. Available at: (PDF) Adult tribal malnutrition in India: An anthropometric and socio-demographic review (researchgate.net)
[10] Tribal Health Report, India – First Comprehensive Report on Tribal Health in India

treatment is still significantly low. Most information they receive is often not in the language that they are most familiar and comfortable with and it results in a gap in understanding even after being exposed to necessary information. This knowledge gap at the community level continues to boost various existing stigmas and fear associated with the disease. We often tend to trivialise the issue of stigma by using expressions such as 'belief, myths, misconception, and superstition'. But the intensity of fear associated with a disease is more when the knowledge about the same is limited and when a disease is considered to be a fatal one based on the community's knowledge, no matter what community it is. A culturally sensitive, contextualised, and community-rooted IEC mechanism in place of focusing on only standardisation of the IEC is useful in this context.

h. Inadequate community involvement: No public healthcare service or solution can meet the intended results unless people are actively involved in the process. People from tribal communities often have very limited participation due to a wide range of reasons including dysfunctional community engagement platforms, heavy dependency on informal and daily wage-based work, language barriers, prior experience of discrimination, lack of knowledge and information about available services and their needs, etc. Measures such as operationalisation of community engagement avenues such as Village Health and Sanitation Committee, Jan Arogya Samiti; encouraging interventions engaging with youth and young adults, and recruitment of HR who are from within the community and/ or understands the local context well, bringing healthcare solutions that provide service at the doorstep are crucial to improving community participation.

i. Lack of context-suitable solutions is comparatively higher in tribal regions

As the challenges are unique, the need for contextualisation of solutions and interventions is also higher in tribal areas. Contextualisation is not only required to ensure the cultural sensitivity of the interventions but also to make solutions more sustainable by targeting the root causes of TB in a particular region.

For example, persons with presumptive TB in Jharkhand reported cough (90%) fever (22%) and weight loss (22%) in significantly larger proportions than in Sikkim (cough 58% fever 22%, Weight loss 5%). The duration of symptoms reported was also higher in Jharkhand than in Sikkim. The probable cause here is a higher impact of severe malnourishment in Jharkhand and hence the intervention to eliminate TB from Jharkhand would need to be slightly different from what needs to do in Sikkim.

4. The Aashwasan Campaign

4.1 About Aashwasan:

The Hindi word Aashwasan means assurance. The Aashwasan campaign is one of the early and major activities of the Tribal TB Initiative. It is a time-bound, intensive community outreach campaign aiming at jointly addressing the spread and impact of COVID-19 and TB among tribal populations in India. The campaign is carried out across 174 remote, tribal districts in India while focusing on the blocks with more than 25% of tribal populations. It is carried out by trained Community Mobilisers and Paramedical Staff recruited from among the local communities and the campaign is planned and deployed in partnership with the state and district health department.

4.2 Major Activities of Aashwasan:

- Identification of persons with presumptive TB in tribal blocks in these tribal districts
- Linking the identified patients to the public health system for diagnosis and initiation of treatment
- Increasing awareness of TB disease, symptoms, treatment, and prevention among the tribal communities.
- Improving awareness regarding COVID in all the tribal blocks of the tribal districts
- Improving COVID Appropriate Behavior in all the tribal blocks of the tribal districts
- Decreasing vaccine hesitancy in tribal populations
- Improving epidemic preparedness in tribal blocks by involving Community influencers

4.3 Expected Outcome of Aashwasan

- Intensive outreach activities (camp) in remote areas for screening COVID-19/Tuberculosis.
- Special active case finding camps in *Haat bazaar*/weekly markets for sputum collection for TB testing and initiation of diagnosis.
- Awareness programs for specific community groups such as faith leaders, traditional healers, tribal youth, and tribal leaders including community influencers within tribal communities for TB and COVID.
- Community-level activities to increase awareness of TB and prevent vaccine hesitancy including awareness of COVID-19 appropriate behaviour by working closely with community influencers such as PRI members, Tribal Healers etc.
- Complete coverage of all the tribal and hard-to-reach areas within a short span of time.

4.4 Core Approach of Aashwasan:

Community mobilisers and paramedics from local communities or who are familiar with the local terrain and context, are recruited and trained to deploy Aashwasan. The team is guided by micro-plans collectively developed by district-level officials and Tribal TB Initiative's district team. State and district officials and frontline workers are an integral part of the campaign and participate actively.

Figure 1 outlines the core approaches of Aashwasan:

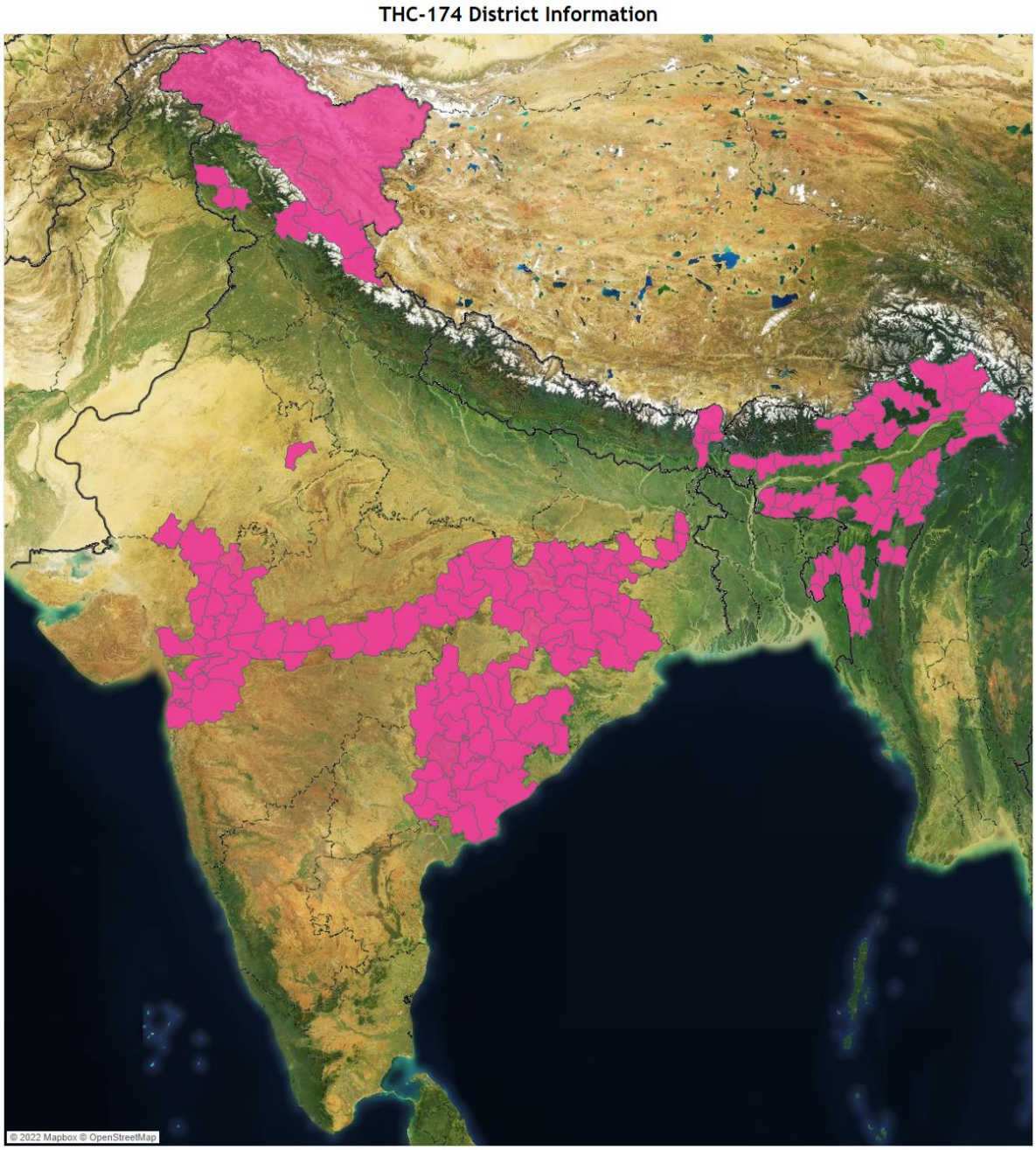
Aashwasan team members reach out to the remote areas of tribal districts and engage deeply with Panchayat members, Self-help groups, traditional healers and other community influencers. They conduct COVID and TB awareness sessions, encourage people to get vaccinated, screen people with presumptive TB, and motivate them to provide sputum samples and collect the same. They also carry the sputum samples to the nearest TB Unit to ensure timely diagnosis. Once a patient is diagnosed with TB, the Aashwasan team and government Front Line Workers (FLWs) connect with the patient and provide the necessary counselling. They also support them in the process of treatment initiation.

Aashwasan has significantly contributed to addressing COVID-19 vaccine hesitancy among tribal populations living in remote areas. It has also found new patients affected with tuberculosis and connected them with available free treatment facilities.

4.5 Geographical coverage of Aashwasan

The campaign has been implemented in 174 tribal districts as enlisted by the Ministry of Tribal Affairs across 21 states/UTs in a phased manner. In these districts, blocks where tribal peoples constitute more than 25% of the total population have been prioritised. The campaign has covered all rural and hard-to-reach areas in the identified blocks.

The following image outlines a snapshot of the geographic coverage of Aashwasan:



5. Implementation Process of Aashwasan:

5.1 Preparation Phase of Aashwasan:

5.1.A Convergence at National Level

Representatives of the National Tuberculosis Elimination Programme (NTEP) housed in the CTD, Ministry of Health and Family Welfare (MoHFW), representatives of the Ministry of Tribal Affairs, representatives from USAID and Piramal Swasthya have collectively organised a series of brainstorming sessions and meetings to develop the high-level strategy of the Tribal TB Initiative. ACF drive in remote tribal districts was prioritised as one of the early interventions under the Initiative.

5.1.B Situational Analysis

Upon finalization of the Tribal TB Initiative's high-level strategy, the NTSU for Tribal TB formed and appointed by the Initiative first embarks on developing a detailed blueprint of the ACF drive in consultation with the above-mentioned partners at the national level. The NTSU has conducted a thorough analysis of available secondary information (from reliable sources such as NFHS4, Nikshay portal, etc.) to gain a deeper understanding of the challenges in the optimization of the coverage of TB screening and care in tribal districts.

Following the same, a ground-level situational analysis has also been conducted across select districts. Tribal TB Initiative's State and District-level staff have interacted with members of state and district administration, visited the existing TB Units (TU) and interacted with the TU staff, and TB-specific consultants from WHO at the state and district levels, and have also interacted with community influencers through community visits to collate field-level information and insights necessary to inform to design the high-level implementation strategy of ACF across 174 tribal districts of India.

5.1.C Development of Implementation Strategy

The NTSU has analysed both the secondary and primary information, drawn and documented insights and arrived at the high-level implementation strategy of the ACF drive in consultation with the aforementioned partners at the national level. A district-wise 100-day-long campaign named Aashwasan is conceptualised through this process.

This strategy provides an overarching programmatic guideline to carry out the campaign at scale while ensuring that there is enough room for contextualisation of the implementation plan at the state, district, and block levels. This balanced approach has enabled Aashwasan to become a successful large-scale ACF campaign that has specifically focused on tribal and marginalised peoples from across remote, tribal districts in India.

5.1.D Aashwasan Campaign Strategy

The high-level strategy includes:

i. Plan of state and district-wise phasing of districts for implementation of the campaign across 174 tribal districts. (Annexure I outlines the phasing of state/ districts)

ii. The decision regarding the duration of the campaign: 100 days in each district

iii. Process flow to facilitate collaborative implementation

iv. Provision of additional human resources as temporary staff for the campaign (recruited by and housed in the implementation partner Piramal Swasthya) to work with state, district, and block-level human resources of the public health system to boost ongoing efforts.

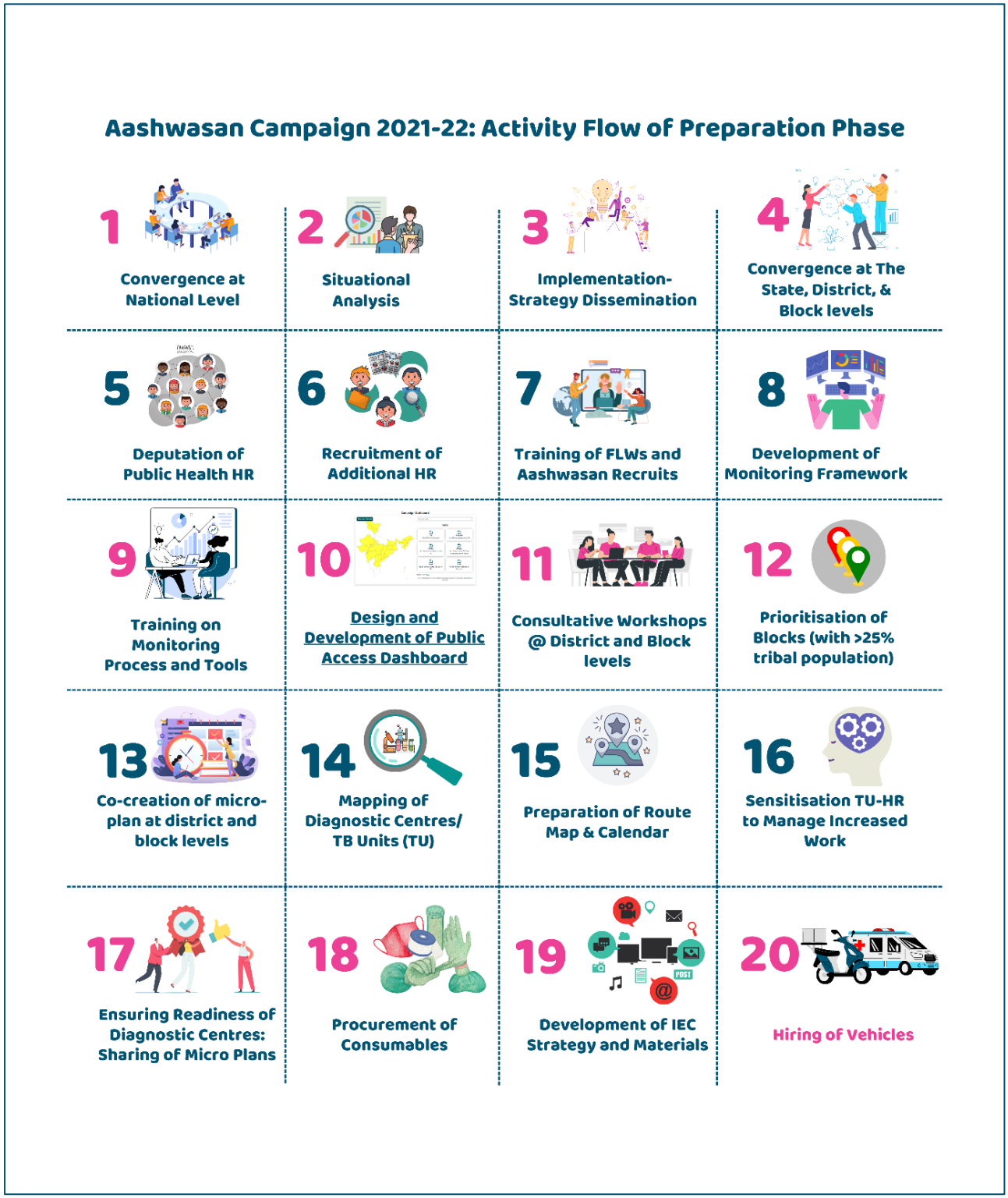
v. A clear flow of preparation-stage activities

vi. A clear activity flow of the campaign implementation at the village level with the necessary room for contextualisation/ micro-planning at the block and district levels.

vii. A transparent monitoring framework and mechanism along with supportive supervision to ensure quality, authenticity and scope of need-based (evidence-supported) course corrections.

viii. Strategic approach of Information Education and Communication (IEC)

Figure 2 outlines the flow of activities for the campaign-preparation phase at the national, state, district and block levels:



Note: Various organisations, partnering with the Government and/ or USAID or working with common impact interests, have been consulted at the state and district levels. The organisations offered their active support in the successful implementation of the Aashwasan campaign.

5.1.E Preparation of Budget

A central budget committee within Piramal Swasthya/ Anamaya, consisting of persons from operations, finance, administration, technical and HR functions is formed to prepare the overall budget necessary to deploy Aashwasan across 174 districts. The budget has been finalised within two working days to meet the tight deadlines and help expedite the process of procurement and production of supplies including the consumables and IEC materials.

The committee then collates state-wise requirements from the State Leads appointed under the Tribal TB Initiative. Then they prepare the final budget with capital expenditure calculated for each district and operational expenditure calculated for each block and district. The budget excludes the expenditures that are likely to be covered under the NTEP Programme Implementation Plan (PIP) in the respective districts e.g. ASHA incentive, Nikshay Poshan Yojana (NPY), etc. The final budget for the hiring of vehicles also varies due to differences in the market rates among the different states, terrain, distances, seasons, tourism period etc. In some districts, a significant share of the consumables has been provided by the state health department and that has also added some degree of variation among the state-level budgets.

The committee has worked out two models of operational expenditure. The model I has four-wheelers as the outreach vehicle and model II has two-wheelers as the outreach vehicle. In each district, 60% of the team is formed as per the four-wheeler model and 40% of the team is formed as per the two-wheeler-based model.

5.1.F The Budget Narrative

The categories of the budget include costs associated with human resources (recruitment, training, salaries, etc.), consumables, vehicle hiring, commute, launch events, production of localized IEC materials, etc.

The capital expenditure includes items needing one-time cost (at the district level) such as costs associated with recruitment and training of human resources, launch event at the district or state level, procurement of microphone and sound system for IEC, the printing of IEC materials, etc. To ensure safe and successful sample collection and transportation, the cost of specially designed kits (box, and bag) is also included in the capital expenditure.

Some of the capital expenditures are calculated as a central component as these are not fitting into the district-based and/ or block-based budget unit approach. For example, to ensure improved access to information disseminated through IEC materials, specific efforts have been invested to translate the content into tribal languages instead of sticking to the general approach of using Hindi and the State language. For each language, the translation cost of the campaign material is around INR 10,000.

The monthly operational expenditure primarily covers broad areas such as travel expenses, personnel costs, fringe benefits, and consumables. The travel expenses cover the commute carried out by the field staff to implement campaign activities and the commute carried out by

the district and state-level staff for periodic monitoring and supportive supervision as per the programme requirement.

The following table (Tables 1 and 2) outlines a brief version/ sample budget sheet:

Table 1

Particulars		Model-I (with four-wheeler) for one block	Model-II (with two-wheelers) for one block
Capital Expenditure (CAPEX) / One-time Cost	Recruitment	1,000	1,000
	Training	2,000	2,000
	Launch	2,500	2,500
	Miscellaneous	2,000	2,000
	IEC Print	5,000	2,000
	IEC Miking System	5,000	-
	Sample collection and transportation bag and box	1,000	1,000
Total		**19,500**	**10,500**

Table 2

Particulars		Model-I (with four-wheeler) for one block	Model-II (with two-wheelers) for one block
Opex/ Operational Cost (Monthly Recurring cost)			
Travel expenses	Van+POL (3000 Kms)	70,000	-
	Bike @ Rs 5/ km		15,000
	District Supervisor	8,000	8,000
	State Lead	5,000	5,000
Personnel Cost (Salaries)	Community Mobilizer	20,000	20,000
	Paramedics	20,000	20,000
	District Supervisor (one per 6 vans) *	30,000*	30,000*
	State MIS Officer**	40,000**	40,000 **
Fringe benefits	Mobile Data and Calling Charges	500	500
	Group Medical Insurance or ESI ~/ Group Accident insurance/ Group Life insurance	7200	7200
	Provident Fund	4800	4800

Consumables	PPE Kit (limited requirement) Gloves Mask Sanitiser Cling Wrap/ Parafilm Zip lock covers	2,000	2,000
Total		**137500$**	**92500$**

District level, **State level,* *$ Excluding District& State costs***

Staff are recruited for 4-6 months to ensure training, reporting and closure activities beyond the field visits, while vehicles are hired for 3.5 months.

5.1.G Communication and Dissemination of Implementation: Strategy

Official Communication from Union Ministries to State and District

Aashwasan has been conceptualised as a large-scale campaign under the joint leadership of the union ministry of health and the tribal affairs ministry. In a population-dense, geographically and culturally diverse nation like ours, a collaboration of national, state, and district-level government bodies are crucial for the success of any large-scale project. As health is a state subject, a set of formal letters explaining a programme or a campaign conceptualised at the national level, requesting the states' support mark a strong start.

Official communication regarding the Aashwasan campaign has been issued from both ministries to the concerned state departments with the request to actively participate and provide the necessary support for the campaign. Similar directives have been issued from the State TB Cells to the districts for streamlining the activities. There are official letters that have been released from the district to block and village levels. Many district-level officials have also sent formal letters to community influencers such as village heads and/ or PRI leaders to help Aashwasan gain support from and active participation of the community.

Annexures II, III, IV, V, VI and VII are sample official letters released to disseminate detailed information about the Aashwasan campaign and high-level implementation strategy.

In-person Meetings with The Key Stakeholders at the State and District Levels: Facilitated by Implementation Partner (Piramal Swasthya/ Anamaya)

State and district-level representatives of the Aashwasan team (housed in the implementing organisation Piramal Swasthya/ Anamaya) have visited respective government officials to discuss the campaign. During the early rounds of meetings, the Aashwasan team members inquired if they have received communication from the union ministries. In case the information is not received or missed, the NTSU has coordinated with the union ministries to re-share necessary communication.

To ensure communication reinforcement, the state and district-level Aashwasan teams have presented the campaign strategy overview and initiated dialogues around how different departments and the campaign team can work together to deploy Aashwasan successfully and contribute to the ambitious vision of making India TB-free.

All the state and district governments have actively engaged in strategy customisation, preparation of micro-plans, and village-level implementation of the Aashwasan campaign.

Formal Launch at the State/ District Level

A Formal launch event with local media coverage helps spread information about a campaign across the state and districts. This helps gain momentum that is crucial to gain peoples' support and motivating the field team to take on the challenging task of implementing an intensive health outreach campaign in remote, hard-to-reach areas.

The Aashwasan campaign has been formally launched at the district level in most districts with the active support of the office of the District Magistrate, District TB Units, National Health Mission (NHM) and other relevant departments. In some cases, the campaign was launched at the state level with the active participation of state ministries, State TB Cells, and representatives from various departments of district levels.

Below are a few glimpses from the Aashwasan launch at the state and district levels:

Below are a few glimpses from local media coverage of the launch at the district levels:


दैनिक भास्कर बड़वानी भास्कर 20-01-2022

आश्वासन अभियान की हुई शुरुआत
घर-घर जाकर करेंगे टीबी सर्वे

भास्कर संवाददाता | बड़वानी

100 दिन 100 जिलों में टीबी व कोविड के संक्रमण की कड़ी को तोड़ने के लिए बुधवार से आश्वासन अभियान की शुरुआत हुई। कलेक्टर शिवराजसिंह वर्मा ने बताया इसके तहत टीम लोगों के घर-घर जाकर टीबी का सर्वे करेगी। टीबी के प्रारंभिक लक्षण वाले लोगों की पहचान करने के लिए संचालित जनजागृति रथ को हरी झंडी दिखाकर रवाना किया।

कलेक्टर ने विश्वास व्यक्त किया कि समाजसेवी संस्था के सहयोग से हम भी बड़वानी जिले को टीबी मुक्त बनाने में सफल होंगे। इस वाहन के माध्यम से घर-घर होने वाले सर्वे को और प्रभावी तरीके से संचालित किया जा सकेगा। वहीं प्रारंभिक टीबी के लक्षण युक्त लोगों के खखार का कलेक्शन कर उसका परीक्षण समय पर करवाया जा सकेगा। इससे जिले को टीबी मुक्त बनाने के लक्ष्य को प्रोत्साहन मिलेगा। कलेक्टर ने वाहन के साथ जाने वाले दल के सदस्यों को भी प्रोत्साहित कि वे लोगों के मन में बैठी टीबी रोग के प्रति भ्रांतियों को दूर करते हुए उन्हें प्रोत्साहित करेंगे कि वे निःशुल्क इलाज व पोषण के लिए प्रतिमाह मिलने वाली 500 रूपए की राशि का उपयोग करते हुए अपने-आप को इस बीमारी से मुक्त करेंगे। वहीं आधुनिक चिकित्सा पद्धति में इसके सफल इलाज के लिए उपलब्ध सुविधाओं का भी लाभ उठाएंगे।


दैनिक भास्कर रांची आसपास 25-01-2022

डीसी ने पीरामल स्वास्थ्य के कोविड सह टीबी उन्मूलन जागरूकता रथ को किया रवाना
वैक्सिनेशन के प्रति लोगों को जागरूक करना अति महत्वपूर्ण

भास्कर न्यूज | खूंटी


ক'ভিড-যক্ষ্মা প্ৰতিৰোধৰ সজাগতা কাৰ্যসূচী
কোকৰাঝাৰৰ চাৰি জনজাতীয় খণ্ডত 'আশ্বাসন' অভিযানৰ আৰম্ভ


বাঙ্কাত আশ্বাসন অভিযানৰ শুভাৰম্ভ
ছটা ব্লকৰ বাবে তিনিখন সজাগতা বাহনৰ উদ্বোধন

5.1.H Human Resource for Aashwasan:

Prioritisation of Blocks

Once the high-level campaign strategy is discussed and deliberated with the state and district health departments, tribal welfare departments, and other key stakeholders, the Aashwasan team consult the district health department to finalise the list of priority blocks as a crucial step to depute, recruit, and train suitable human resources. The main criterion to prioritise a block is the percentage of the tribal population. Blocks having a minimum of 25% of tribal populations have been prioritised.

Formal Communication with FLWs by The District Health Department

The district health department has reached out to all the FLWs and formally advised them to prioritise the campaign activities such as household-level screening of people with TB symptoms, creating a line list of presumptive TB cases, working with the additional people recruited for Aashwasan in seeking the support of the community influencers and motivating the community members to go through the necessary screening and diagnostics processes, etc.

Additional HR for Aashwasan

At the district level, the campaign is led by a District Supervisor supported by a team of a Community Mobiliser and a Paramedical Staff per block. Furthermore, support of the staff from other verticals of Anamaya, the Tribal Health Collaborative is leveraged in the districts where they were present.

Brief information about the roles of the District Supervisor, Community Mobiliser, and Paramedical Staff is shared below:

- **District Supervisor:** Stationed at the district headquarters and is primarily responsible for driving the campaign in the district. Job responsibilities include
    - Supervision and support for operations of COVID and ACF activities in the district
    - Facilitating microplanning and training for the Health staff including ASHA, and AWW at the district and block level on the COVID, ACF Campaign
    - Regular field visits to ensure the expected quality of service for Meetings with the community, IEC, Specimen Collection and transport, and sharing of test reports.
    - Troubleshooting for sputum collection and transport as part of the ACF activities
    - Timely reporting of all activities
    - District administration liaison where required

- **Community mobiliser:** Job responsibilities include:
    - Develop weekly micro-plans and route plans for the Mobile Units, jointly with the district supervisor and NTEP staff
    - Coordinate with the health workers and plan community-level activities
    - Facilitate orientation of frontline health workers and provide handholding support during the campaign
    - Visit tribal villages/ habitations and conduct meetings with community influencers
    - Ensure all community-level activities are conducted as per SOPs, quality protocols and project guidelines
    - Conduct IEC activities related to TB and COVID-19 at villages and Haat/ Bazaars level or any other platform
    - Mobilize the community with the support of community influencers for sample collection and IEC activities on the day of the Mobile van visit
    - Daily reporting of all village-level meetings and IEC activities.

- **Paramedical worker:** Job responsibilities include:

    - Support/ orient FLWs on the technique of sample collection
    - Ensure the availability of Consumables, forms and & relevant registers in the mobile van
    - Ensure the quality of the sputum sample collected
    - Perform sample labelling, and fill collection forms as per the protocols
    - Proper packaging of samples for transport and handing over to the appropriate testing facility
    - Maintenance of Daily record of presumptive cases identified, and samples collected
    - Support IEC activities in the community
    - Follow up on the results of the samples delivered at the testing facility
    - Ensure the results are communicated back to the community
    - Safe & proper disposal of the used consumables

- **State MIS Personnel**:
    - Orient and support the field team on data collection and reporting mechanism
    - Collation of all the data coming from the block level

- Triangulate and maintain the data at the state level
- Responsible for on-time reports from the state/region
- If required, the support in digitizing the paper-based data coming from the field
- Support in the preparation of reports for various stakeholders

Recruitment of Additional HR for Aashwasan (by Piramal Swasthya/ Anamaya)

The intensity of the Aashwasan campaign has called for additional HR who have been recruited as temporary staff dedicated to the campaign. The recruitment process of additional staff has been taken care of by the implementation partner Piramal Swasthya/ Anamaya. Recruitment has happened state-wise separately.

A total of 2731 temporary staff have been recruited across all the districts. They have formed the block and district teams that have implemented Aashwasan. In each state, the recruitment process has been completed within 30 days from the rollout of the state-level preparation phase (before the launch of the campaign).

Additionally, about 300 permanent staff of Anamaya have been an active part of the campaign and have contributed in areas of project management, monitoring & evaluation processes, knowledge management, communications, etc.

More than 50 % of the total campaign staff are from tribal communities, 46 % of the staff are women, and about 8 % of the Aashwasan field staff are TB survivors.

Key Criteria for Recruitment:

Skillset and capability necessary for a particular role (District Supervisor, Community Mobiliser, and Paramedical Staff)

Familiarity with the local context: Candidates have been recruited either from one of the major communities living in the block/ district or familiar with the local context due to having lived there for a significant period.

Affirmative Action: Candidates who are women and/ or from tribal communities and/ or TB survivors are given priority when they matched the above two criteria

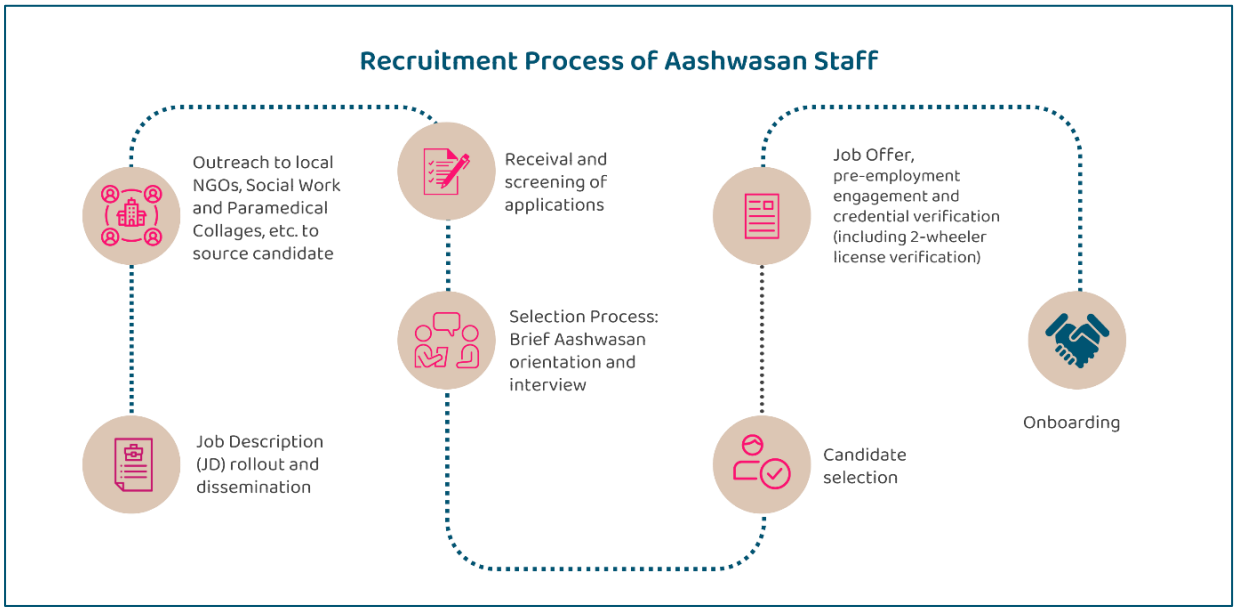
The emphasis on finding local resources is crucial as the campaign has focused on reaching the remotest part of the nation and one of the most marginalised population subgroups. The added focus on finding people from tribal communities is to strengthen the project's capability to become culturally sensitive and context-relevant. The lookout for women candidates enables

having a better understanding of the needs of women and enhances the reach among women from the community (Many studies suggest that TB symptoms among women are often neglected for a longer period. Aashwasan's field experience also confirms the same). The reason to find TB survivors as the staff is not only to motivate community members in seeking care but also to inspire the whole Aashwasan team through their lived experiences.

Recruitment Process:

Job Descriptions (JD) of each role have been shared across all local media including digital, audiovisual and print media. Additionally, the recruitment team has reached out to local NGOs, social work colleges, paramedical colleges, and also local NTEP staff to attract suitable, quality candidate profiles for the roles of District Supervisors, MIS Coordinator (for select states/ districts) Community Mobilisers, and Paramedical Staff. Following this, thorough in-person rounds of interviews have been conducted. The interview process has also included a brief orientation about Aashwasan to help the candidates understand the asks of the roles better. Once selected, the candidates receive the offer and upon acceptance, the onboarding process is initiated that includes a background check and verification of credentials of the selected candidates. Along with necessary official documents, bike licenses have been reviewed especially for the members who were part of the teams using two-wheelers to implement Aashwasan activities.

Figure 3 showcases the key steps of the recruitment process for Aashwasan staff



Annexure VIII enlists the JDs for the roles of District Supervisor, Community Mobiliser, State MIS Coordinator, and Paramedical Staff

Training and Capacity Building of Aashwasan Recruits

The Aashwasan recruits have received intensive technical and operational training to get ready for deployment of the campaign. The training process has been conducted state-wise in collaboration with State TB Office, District TB Unit, representatives from the WHO TB team, et al present at the district level.

The key thematic areas covered in the training process are:

- Basics of Tuberculosis and COVID-19
- Campaign Activity Plan (Activity flow as laid out in the implementation strategy)
- Standard Operating Procedure (SoP) for the collection and transportation of sputum safely
- Key signs to recognise the quality of a sputum sample (crucial for appropriate test results/diagnostics)
- Principles and approaches necessary to engage with community influencers and other members of the community
- Orientation of reporting and monitoring mechanisms including the tools for daily and weekly reporting
- Process and guidelines to develop a micro plan at the block level involving government stakeholders, local NGOs and others working in the similar area
- Plan associated with the launch of the campaign in respective districts/ states

Refresher Training of The FLWs of Public Health System

Along with the official communication from district health departments, separate orientation sessions have been conducted to inform the FLWs about the Aashwasan campaign and based on the need refresher training has been organised as well.

Annexure IX shows the training material used for the orientation of the District Supervisor, community mobilizer and paramedical worker

5.1.I Design and Implementation of Monitoring Framework

A thorough monitoring framework and mechanism have been designed before the launch of the first phase of the campaign.

Lead, Monitoring & Evaluation of Tribal TB Initiative from NTSU has designed the M&E framework in partnership with the Lead, Research, Monitoring, Learning, and Evaluation (RMLE) of Anamaya and in consultation with CTD and USAID. The monitoring framework and process have been informed by the secondary research and situational analysis conducted at the preparatory stage along with the development of the high-level implementation strategy of the campaign.

Three key data collation tools have been designed to collect field-level information:

i. **Tool for Village Profile and Influencer-Meeting Details:** to capture socio-demographic information, typology of tribal communities living in the district, languages used, information on the terrain type, etc. and create a line list of the community influencers and FLWs who took part in the first round of meeting with the influencers

ii. **Awareness and Sample Collection Activity Records:** to capture information on the key outputs of the outreach activities such as the number of people reached through IEC sessions, the number of people screened, the number of samples collected, etc. A few qualitative questions such as if the FLW has prepared a draft line list prior to the Aashwasan team's visit as they were requested through the district health departments, details of activities carried out, etc. were also included in this tool.

iii. **Line list of people with presumptive TB:** to capture details about people with TB symptoms, if they have provided sputum samples or not, if they have been under TB treatment already or not, sharing of or refusal to share sputum samples, reason of refusal, test results for submitted sputum samples, etc.

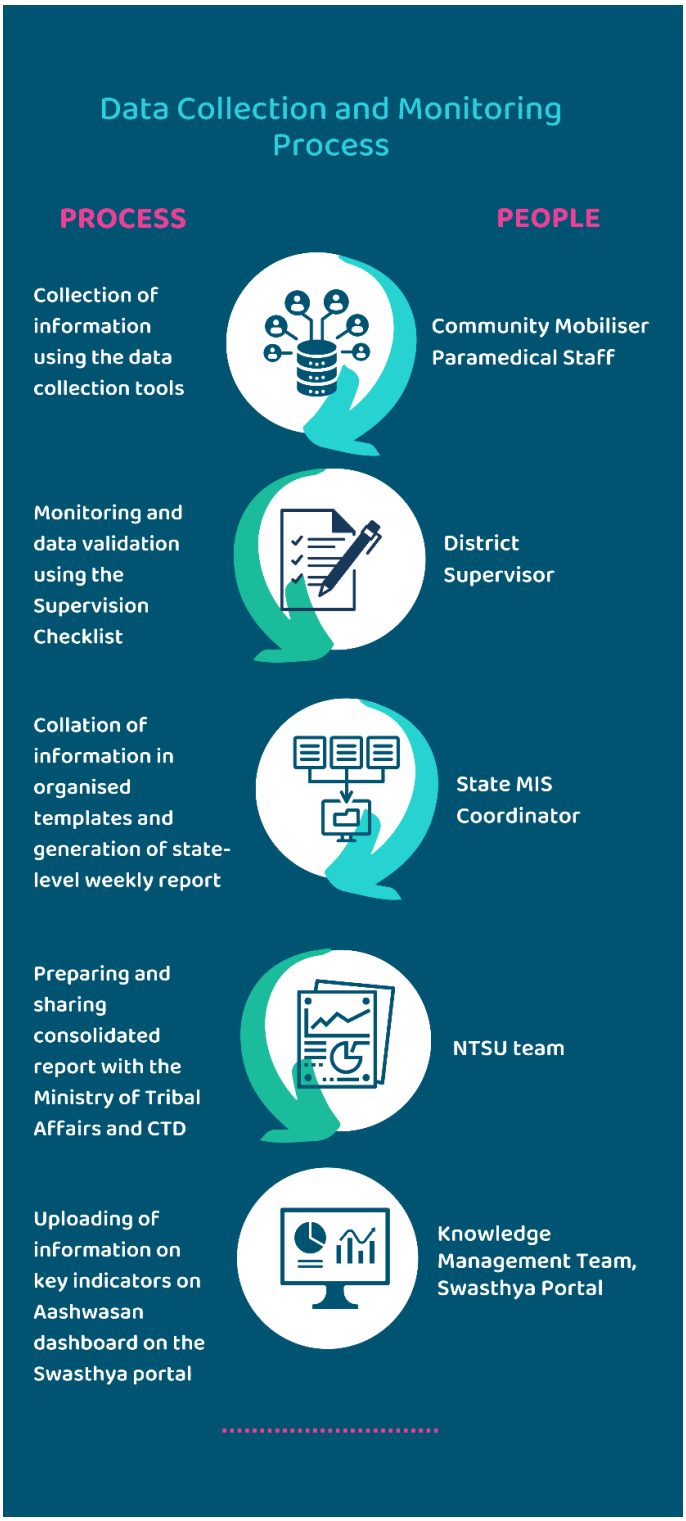
In addition to the above tools, a **Supervision Checklist** has been drafted for the District Supervisor to monitor and validate the data. They periodically visit different blocks to observe the activities and provide support and feedback to the block team using this checklist. Data collation templates have been created for the State MIS Coordinator to collate the data from the District Supervisors and for the NTSU, to collate the same from the states.

Annexure X.I enlists the monitoring tools/ data collection tools and annexure X.II outlines the supervision checklist used at various levels.

Data Collection and Monitoring Process:

The Community Mobilisers and Paramedical Staff collect and update information from the field using the three tools designed for field-level data collection. The data collected by them are reviewed and validated by the District Supervisors. District Supervisors collate and submit district-level reports to the State MIS Coordinator who further refines, organises, and cleans the data. Each State-MIS Coordinator generates state-level weekly reports and submits the same to the NTSU at the national level. They also share state-level reports with state health departments. The NTSU consolidates and analyses the data and submits reports to the Ministry of Tribal Affairs and CTD. The NTSU also circles back to the state team with observations necessary to mitigate gaps, if any. Additionally, to capture the qualitative elements of the campaign, a weekly update system for visual updates and a monthly collation of case studies and stories are also put in place. A centrally organised drive folder is created to collate the visuals and stories/ case studies to ensure content from one district is collated in a designated folder in a structured manner. This supplements the hard data and helps gain insights throughout the campaign.

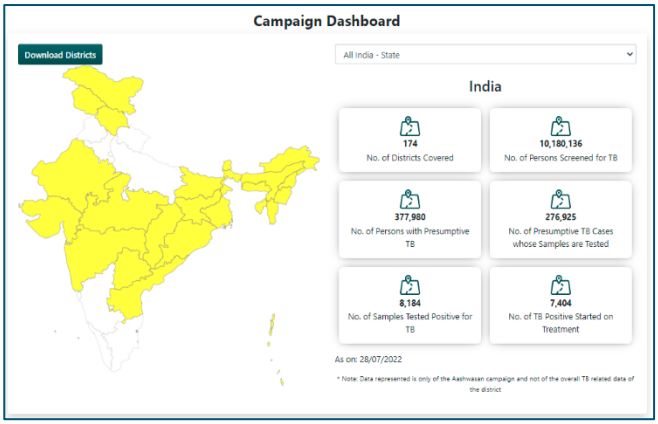
Figure 4 showcases the data collection and monitoring process

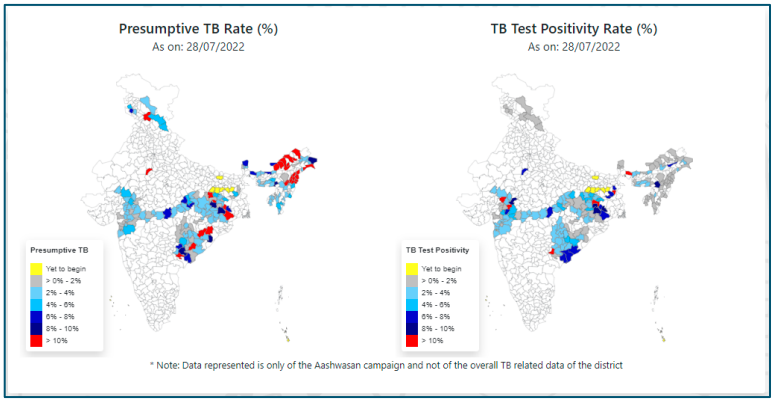


5.1.J Development of Public Access Dashboard:

A public access dashboard has been designed and developed upon the finalization of the monitoring framework. The dashboard is updated in a weekly manner and all progress of all the key outputs is accessible in the public domain. The dashboard is hosted on Swasthya (www.swasthya.tribal.gov.in), the tribal health and knowledge portal run by the Ministry of Tribal Affairs. The weekly dashboard and information collation process to create the same also enable the tribal affairs ministry, CTD, and the NTSU to collate insights and provide inputs to the campaign team if any.

The following images share a glimpse of the dashboard:



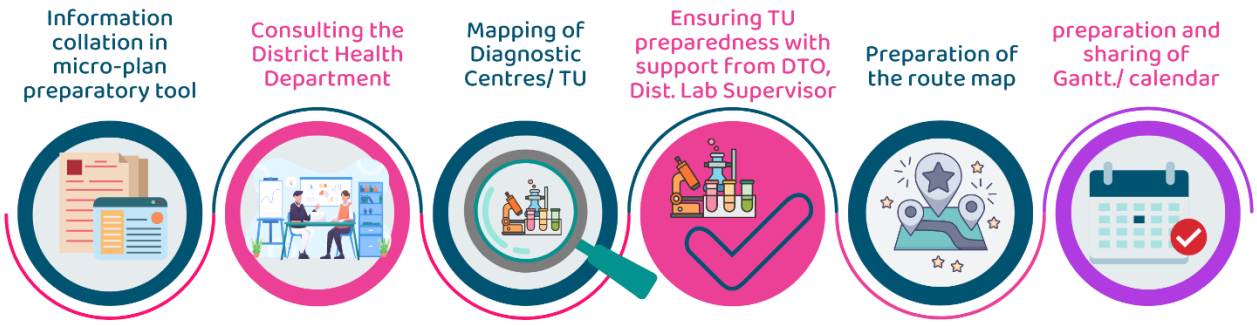


5.1.K Co-creation of Micro-plans at the District and Block: Levels

At the district and the block levels, the District Supervisor, Community Mobilisers, and Paramedical Staff have developed a detailed micro-plan for the campaign implementation in consultation with the district and state health departments, especially the DTO and the STS and with support from the State Lead of Tribal TB Initiative and with the guidance of Tribal TB Initiative' state team and the NTSU.

The block and district teams have first collated the key information necessary to develop the micro-plan for carrying out the campaign activities. Following the information collation, the team then consult with the DTO and STS to seek their input. The TUs/ Diagnostic Centres/ Laboratories have been mapped to the villages that are to be covered. The preparedness of the TUs, in terms of availability of functional equipment, skilled staff, etc. has also been checked. Some of the gaps identified by the team are mitigated with the help of the DTO and STS. The TUs that are not fit to cater to the need of Aashwasan have been excluded from the list of TUs that are to support the campaign. Post this, a detailed route map and calendar of village-wise activities have been prepared and shared with all the key stakeholders including the TU staff, DTO, STS, and other representatives of the District Health Department at the district and block levels. The micro-plans have also been submitted to the state team of the Tribal TB Initiative. They monitor the process and help remove implementation barriers if any.

Figure 5 outlines the process followed to develop the micro-plan at the block and district levels.



Annexure XI enlists the tool used by the Community Mobilisers and Paramedical Staff to collate information necessary to prepare the micro-plan.

5.1.L Procurement of Consumables

Timely availability and proper utilization of consumables such as sample collection cops, PPE Kits, cartridges, etc. are crucial for the implementation of any intensive campaign. Hence Aashwasan has put in place a thorough procurement process. The process has helped maintained an agile supply chain throughout the duration of the campaign. A long list of necessary items has been prepared with clear mention of which partner is responsible for the availability of which product/ consumable.

Annexure XII is the list of consumables that have been procured for Aashwasan with specific mention of stakeholders responsible for the availability of specific sections of the consumables.

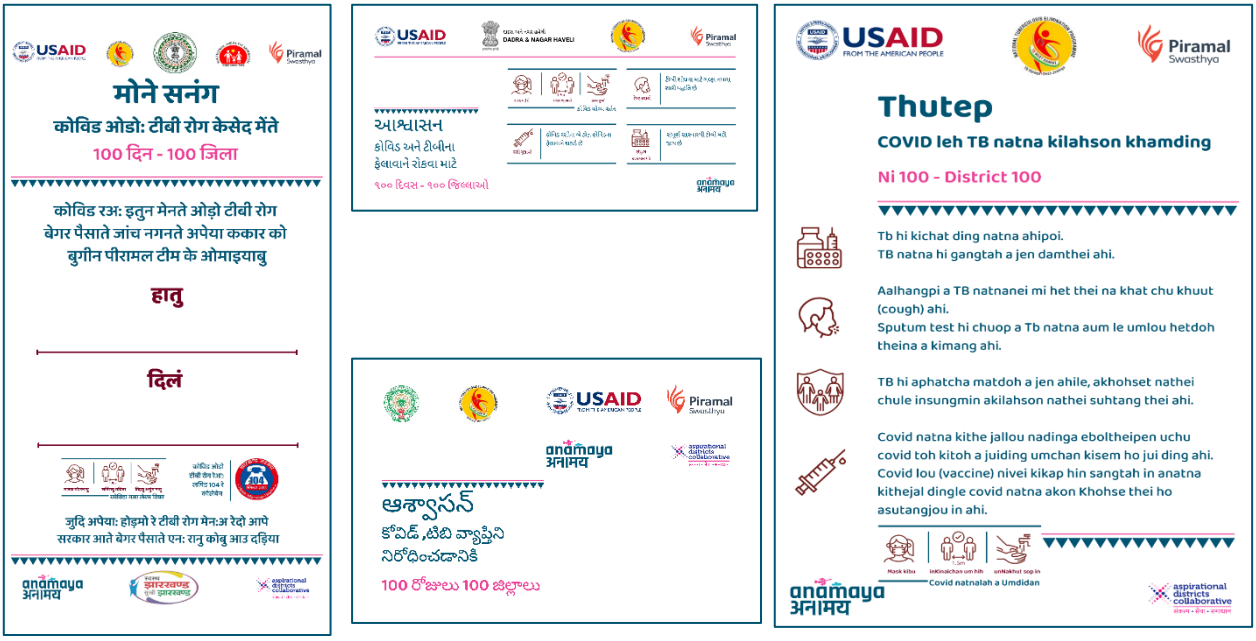
5.1.M Information Education and Communication

For the successful implementation of a campaign, it is important to create a suite of communication materials that inform the intent of the campaign to communities through a set of concise messages aimed at behaviour change. The messages are crafted so that they are easy to remember, have high audio and/ or visual and/ or audio-visual appeal, offer a distinct call-to-action and reinforce positive behaviour change.

i. Understand Community-Level Communication Landscape
ii. Review Existing IEC Materials
iii. Design & finalise Key Messages
iv. Align IEC Materials to Micro-planning Activities
v. Review At-Source IEC Production Infrastructure
vi. Translate & Design IEC Materials
vii. Produce & Deploy IEC Materials
viii. Feedback on Efficacy of IEC Materials

Aashwasan campaign IEC material includes products that have been used as printed materials and various audio and/ or audio-visual products such as recorded jingles, video guidelines on 'how to provide sputum samples for TB diagnosis, etc.

Some of the samples of printed IEC materials used in the Aashwasan campaign are shared here:



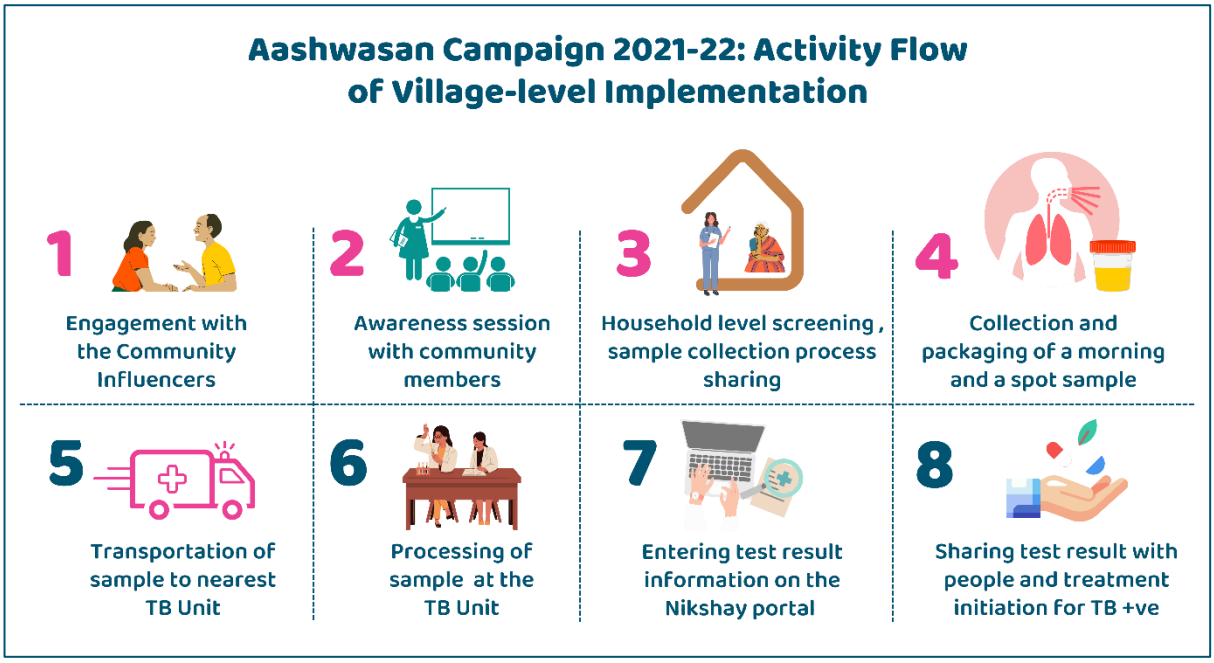
5.1.N Hiring of Vehicles

Suitable vehicle hiring vendors are searched and screened in each state and finalised after a thorough price comparison. Due to the nature of the campaign and the need to regularly commute through difficult terrain, in many locations, it has been difficult to get suitable vendors at a reasonable price and a significant amount of operational negotiation has been put in place to make each location vehicle-ready.

5.2 Implementation Phase of Aashwasan:

The Aashwasan outreach team first connects with the ASHA worker and other community influencers including the Sarpanch, PRI members, SHG leaders, tribal healers, faith leaders, school teachers, the traditional village head, et al and introduces the campaign to them. They share how TB spreads and how it can be cured by early screening, diagnosis, and completion of the treatment regime. After the community influencers are updated with Aashwasan's services and implementation steps, the team requests their support in mobilizing the larger community from the village. With the community influencer's support, the Aashwasan outreach team then conducts a more detailed awareness and screening session with a larger group of community members from across the village. Following this, the team visits each household, especially the ones which are part of the ASHA worker's pre-developed line listing as part of the contact tracing process. They encourage people with presumptive TB to participate in the campaign and give them sample collection cups. The team visits the same village the next day and collects the sputum sample that the person has stored in the cup in the morning following their instruction from the day before. They also take another spot sample and package both the samples securely and safely. During the household visits, the team often comes across individuals and or families who are hesitant to share their sputum samples due to the fear stigma associated with TB. They

Figure 6 outlines the activity flow of village level implementation of Aashwasan



spend time to help them be free of those fear. The community influencers also support the team to help people combat their fear and provide the samples.

Once all the samples are collected, the team then travel back to the nearest TU that is mapped to the village for the duration of the campaign and submits the samples there. In most cases, the Aashwasan team has submitted the samples within 24 hours of collection and only in a few

cases where the distance between the TU and the village is significantly high, they have taken up to 48 hours. Once the sample is tested at the TU, the information is updated on the Nikshay portal. For the people who have tested negative, the team shares the test result through the ASHA worker, and visits and provides counselling when necessary to ensure that they start their treatment.

5.3 Role of Partners and Stakeholders:

Different partners and stakeholders played various crucial roles at different phases and levels. Initially, the Central TB Division, the Ministry of Health and Family and Welfare, the Ministry of Tribal Affairs, USAID, the NTSU for Tribal TB housed in Piramal Swasthya, and members of Anamaya converged to arrive at the overarching strategy for Aashwasan.

Once the implementation strategy outline was in place, the Ministries issued formal letters to states and districts to communicate the strategy and request the state's participation in the campaign. Simultaneously, Piramal Swasthya's field team reached out to all the key ministries and administrative bodies at the state and district levels to discuss the strategy. They engaged with the state and district-level bodies to get their insights and initiate the process of developing a detailed operational plan suitable to the need and context of the communities and the public health system.

A thorough mapping was conducted in prioritised blocks by Piramal Swasthya with the support of the district administration teams including the officials from the State and District TB Cell. This was followed by communication with and refresher training of FLWs by the state and district administration, and recruitment of Additional HR for Aashwasan by Piramal Swasthya/ Anamaya team. Representatives from Piramal Swasthya/ Anamaya, State and District TB Officers, other officials, and World Health Organisation (WHO) representatives collectively oriented and trained the FLWs and the recruits to make them Aashwasan-ready. Collectively, they also played a crucial role in providing supportive supervision and monitoring support to the implementation team.

The key partners in this initiative are:

- **Ministry of Health and Family Welfare, Ministry of Tribal Affairs**
- **State Governments**
- **District Administrations**
- **USAID**
- **Piramal Swasthya Management and Research Institute**
- **Anamaya, the Tribal Health Collaborative**
- **WHO, India**

Table 3 enlists some of the key roles carried out by the key partners and stakeholders:

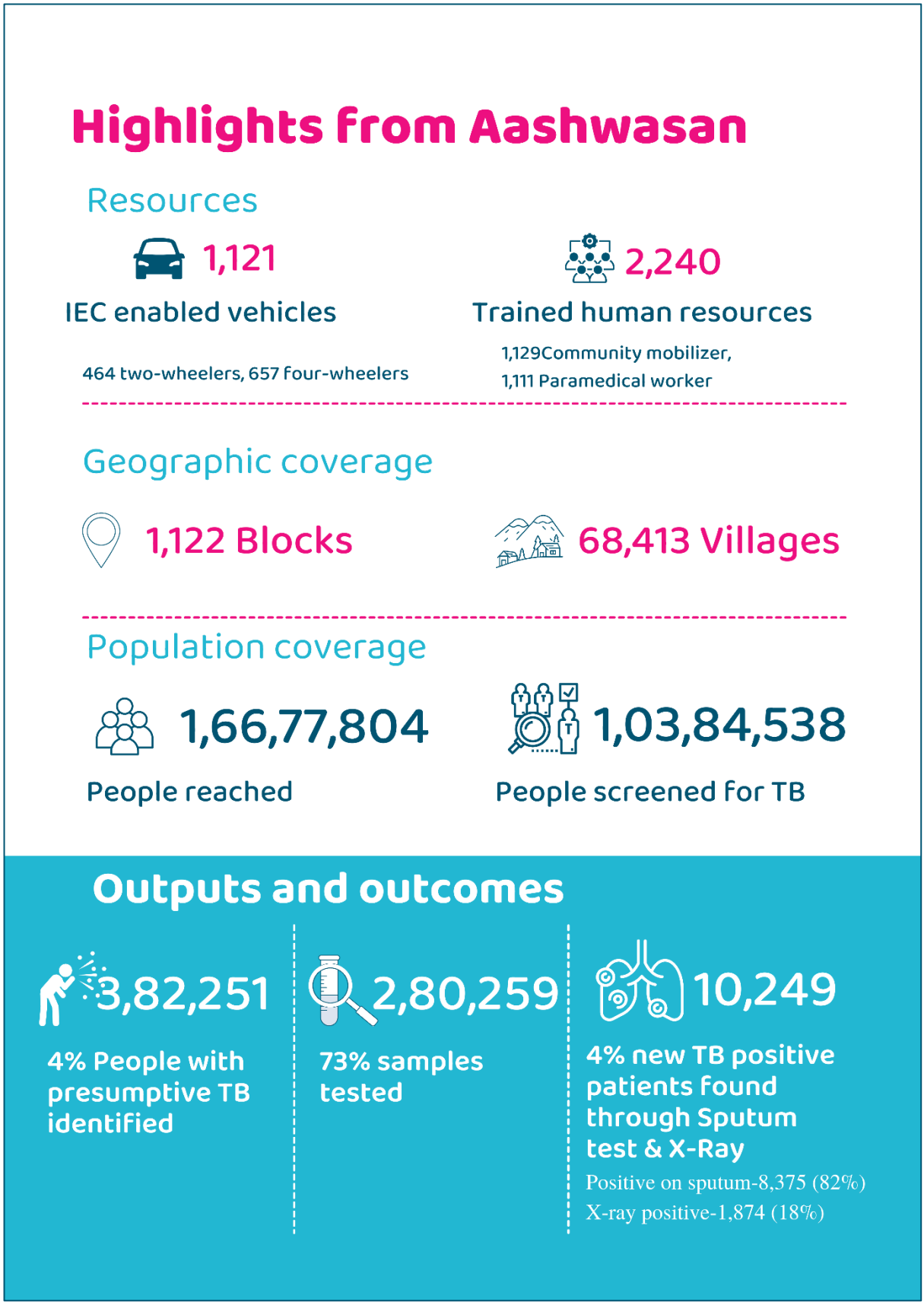
Sn.	Responsibility/ Activity	Position	Department/ Organisation
1	Political and administrative commitment, Joint action plan to make people in Tribal districts and geography, TB-free.	Government	MoH&FW and MOTA
2	Technical support and funding for the Aashwasan campaign	Developmental partner	USAID/India
3	Architecture and the main driving force of the campaign	Implementing partner	PSMRI
4	Technical inputs on activities and coordination support at the national and state level	Technical partner	WHO/India
5	Coordination at the National/ Central Level	NTSU	Piramal Swasthya (Anamaya)
6	Coordination at the state and district levels	State Lead, Tribal TB Initiative	Piramal Swasthya (Anamaya)
7	Deputation of FLWs (ASHAs, ANMs, et al.)	Chief Medical & Health Officer (CMHO)/Civil Surgeon (CS)	State Health Departments
8	Recruitment District supervisor (DS), Community Mobiliser (CM) and Paramedical workers (PM)	Operation team led by the State Lead, Tribal TB Initiative	Piramal Swasthya (Anamaya)
9	Development and/ or curation of training resources and tools	NTSU, State TB Teams Strategic Communication team	Piramal Swasthya (Anamaya)
10	Development/ curation of IEC materials	NTSU Strategic Communication team	Piramal Swasthya (Anamaya)
11	Training of human resources (campaign protocols, data collation tools, usage of IEC resources, engagement with community influencers such as PRI members, healers, overall roles and responsibilities, etc.)	District TB Officer (DTO)	District Health Department
		State Lead, Tribal TB Initiative Training Officer, Tribal TB Initiative	Piramal Swasthya (Anamaya)
12	Development of ACF Micro plans: Prioritisation of villages, preparing route maps and calendar, mapping of diagnostic centres against the villages	DTO Senior Treatment Supervisor (STS) Senior TB Laboratory Supervisor	District Health Department

		District Supervisor (DS), Tribal TB Initiative	Piramal Swasthya (Anamaya)
13	Preparation of Diagnostic Centres (sensitisation, calendar of activities, ensuring an adequate supply of consumables for testing, enabling the Centre to cater to an increased number of testing)	DTO Senior Treatment Supervisor (STS) Senior TB Laboratory Supervisor	District Health Department
		District Supervisor, Tribal TB Initiative	Piramal Swasthya (Anamaya)
14	Orientation of ASHAs, ANMs, ASHA supervisors, and other staff on the ACF process, their roles and responsibilities, activity-calendar	DTO	
		District Supervisor, Tribal TB Initiative	Piramal Swasthya (Anamaya)
15	Procurement of consumables for sputum collection and Leverage consumables for Sputum collection from the government	DTO	District Health Department
		District Supervisor, Tribal TB Initiative	Piramal Swasthya (Anamaya)
16	The hiring of mobile units (Vehicles) for the ACF	Operations team, Tribal TB Initiative	Piramal Swasthya (Anamaya)
17	Engagement session (IEC strategy-enabled) with PRI and Community influencers, Tribal Healers by ASHA, and community mobilizer (for raising awareness in the community and enlisting their support for a house-to-house survey and sample collection) IEC materials to include Community radio, banners, 4 tools (Village level, HH level, Sample collection form, Participatory guide with community influencers)	Paramedic Community Mobiliser	Piramal Swasthya (Anamaya)
		ASHA ANM	District Health Department
18	House-to-house survey for symptomatic cases by the ASHAs to prepare a line listing of persons with presumptive TB.	ASHA	District Health Department
		Paramedic Community Mobiliser (in support role)	Piramal Swasthya (Anamaya)
		Community influencers: PRI members, healers, SHG members, et al. (support role)	Community-based-organisations,

			independent members
19	IEC engagement with community members, primarily at the household levels	Paramedic Community Mobiliser	Piramal Swasthya (Anamaya)
20	Village-wise sample collection from the line listed persons with presumptive TB	Paramedic Community Mobiliser	Piramal Swasthya (Anamaya)
		ASHA (in support role)	District Health Department
21	Transporting the samples safely to the nearest Diagnostic Centre and IEC regarding TB	Paramedic Community Mobiliser	Piramal Swasthya (Anamaya)
22	Preparation of micro-plan for IEC activity and sport sputum sample collection at haat/ bazaar (weekly marketplace), Gram Panchayat (GP) level	ASHA	District Health Department
		Community Mobiliser Paramedic	Piramal Swasthya (Anamaya)
23	Conducting IEC activity at haat/ bazaar	Community Mobiliser	Piramal Swasthya (Anamaya)
		ASHA	District Health Department
24	Collection of two spot samples at the haat/ bazaar from persons with presumptive TB	Paramedic	Piramal Swasthya (Anamaya)
25	Transporting the sample to the nearest Diagnostic centre	Paramedic Community Mobiliser	Piramal Swasthya (Anamaya)
26	Testing of the sputum samples at the diagnostic centre: Designated Microscopy Centre (DMC) or TB Unit (TU) through microscopy or Molecular test (CBNAAT/TrueNat)	Lab technician (LT)	District Health Department
27	Follow-up of diagnostic test and communication of results to the community, initiation of treatment for those who test positive	LT STS STLS ASHA	District Health Department
		Paramedic Community Mobiliser	Piramal Swasthya (Anamaya)
28	Data collation, reporting, regular monitoring, and providing supportive supervision to	District Supervisor MIS Coordinator/ Data Operator	Piramal Swasthya (Anamaya)

	Paramedic and Community Mobilisers		
29	Monitoring and supervision	DTO STO	State and District Health Department
		State Lead, Tribal TB Initiative	Piramal Swasthya (Anamaya)
30	Reporting, dissemination of insights	District Supervisor State Lead NTSU Knowledge Management team Strategic Communication team	Piramal Swasthya (Anamaya)
		DTO STO	State Health Department

6. Aashwasan Results:



7. Aashwasan Success Factors:

Aashwasan's success is not a result of a lot of innovations in its approach but a strong execution of a detailed, realistic, context-suitable operational plan at the district levels. Each of these plans has been developed collaboratively at the district level and based on the overarching implementation strategy that is rooted in the guidelines outlined in the Active Case Finding Guidance Document put together by the Central TB Division, technical guidance of USAID, and the knowledge about the context and tribal communities brought in by the Ministry of Tribal Affairs at the implementation partner Piramal Swasthya (Anamaya, the Tribal Health Collaborative).

A few noteworthy success factors of Aashwasan are outlined hereinbelow:

a) An efficient sample collection and transportation mechanism

A comparatively stronger Sample Collection and Transport (SCT) mechanism has enabled Aashwasan to reach significant outputs and outcomes. The elements that make Aashwasan's SCT mechanism operationally sound are:

- A trained Paramedical Staff in each pair of outreach team who is thoroughly trained on sputum collection, quality check, and safe and secure packaging of the sample.
- A detailed route plan charted on a detailed calendar/ Gantt. that is shared with all key stakeholders including the District TB Officer (DTO), block-level officials, TU/ laboratory staff, and FLWs of the public health system.
- The community influencers with prior information about outreach activities from the FLWs.
- The DTO, the Senor Laboratory Supervisor, and Aashwasan's District Supervisor's collective effort to ensure the readiness of the TUs/ laboratories by mitigating identified resource gaps to the fullest possible extent.
- The route plans drafted by including the specific TUs/ laboratories that are ready to cater to Aashwasan's needs.
- Negligible sample rejection at the TUs/ laboratories helping Aashwasan field staff maintain their morale and credibility among community members.
- Ensuring the collected samples are delivered to the laboratory within 48 hours of collection by mapping each village to the nearest TU/ laboratory.
- Fixed vehicle support removes the transportation challenges (which are significant in tribal districts) that are otherwise faced by the staff who carry out ACF outreach activities.

b) Additional HR who are familiar with the local context

The additional HR of District Supervisors who are familiar with the local socio-political context has helped in the realistic planning and implementation of the campaign. One Community mobilizer and one Paramedical Staff have been hired and trained from each block and they have carried out the campaign activities in their home blocks. Their familiarity with the cultural context and fluency of languages spoken by local communities have helped minimise the communication gap and improve the acceptance of the campaign staff by community members.

Having the additional HR in temporary roles to carry out ACF activities has also helped strengthen the existing government efforts. Generally, ACF activities are carried out by existing FLWs who are already thinly stretched with multiple responsibilities and can only partially focus on ACF activities.

c) Strategic hiring of women, TB survivors, and tribal people as field staff

Aashwasan's field staff recruitment has strategically focused on finding suitable candidates who are women and/ or from tribal communities and/ or survivors. 46% of the staff are women, 50% are tribal, and 8% are TB Survivors. Screening of women is often delayed due to various socio-cultural factors. The women who have led the outreach in the field have enabled Aashwasan to engage with the women in the community deeply and encourage them for screening and testing. Staff hailing from tribal communities have helped the campaign be culturally sensitive and inclusive to a large extent and also decrease communication errors. Aashwasan has also witnessed that TB survivors play a significant role to help people fight their stigma. Their lived experience brings people closer to the idea that TB can be cured and that brings hope.

d) Development of the micro plan and route map charted on a Gantt. collectively

The success of any large-scale campaign depends heavily on how minutely every detail is charted and the level of role clarity of each stakeholder involved in the process. In Aashwasan, every block has developed a detailed micro plan starting with the prioritisation of blocks and villages based on criteria such as density of tribal population, hard-to-reach areas, villages with Particularly Vulnerable Tribal Groups (PVTG), people who have discontinued treatment or people who are yet to get tested after the primary screening, etc. Simultaneously, the TUs/ laboratories are identified, prepared and mapped against the villages. A detailed route map incorporating the suitable vehicles (two-wheeler or four-wheeler) is put in place based on the terrain type. Finally, everything is tied in a Gantt. which informs everyone what is to be done by whom and when.

Each micro-plan has been developed collectively by the block-level officials, and Aashwasan District Supervisor with necessary guidance from the DTO and information and inputs from other stakeholders such as the FLWs and Aashwasan field staff. Every stakeholder including the community influencers has been informed about relevant aspects of the micro-plan in a timely manner to ensure the optimum output from each day of the campaign. The micro-plan has also ensured the efficient implementation of the monitoring and supportive supervision mechanism.

e) Engagement with the community influencers

The first step of village-level outreach in Aashwasan is engaging with and getting the buy-in from the community influencers including the Sarpanch/ village head, tribal leaders, SHG members, PRI members, healers, school teachers, and any other influential person from the village. Once the influencers understand the objectives of the campaign and are onboarded, a WhatsApp text from an SHG leader and/ or an announcement by the Sarpanch or the Munda/ Gaonboora (traditional village head/ leader of a community) mobilise the wider section of the community members at a significantly accelerated pace. Community influencers have also played a crucial role in convincing individuals reluctant to take part in screening and diagnosis even after having symptoms, ensuring that the campaign team's work is not hindered by challenges such as facing inebriated people at the time of community meetings or household visits. Along with helping in achieving the immediate objectives of the campaign, engagement with community influencers also ensures an enhancement in the collective awareness of TB and available services and brings the community and public health system closer to each other.

f) 100 days of Active case finding for TB in each tribal / hard-to-reach block

For remote tribal areas, the campaign duration of 100 days is likely to yield better results than a campaign spread over only two to four weeks. Aashwasan has observed a steady week-on-week rise in the ability of teams to cover villages, screen individuals, detect presumptive TB and collect samples which stabilizes around the fifth and/ or the sixth week and is maintained until the completion of the campaign activities. It also takes three to five weeks for the health system at the block levels to optimise process efficiency and properly cater to the increased number of samples and manage the information flux. On the community front, peoples' participation also increases over a period of three to four weeks as information about the campaign is spread through designed IEC activities as well as organic communication architectures of word-of-mouth, information sharing via messages and WhatsApp etc.

The duration of 100 days has also helped Aashwasan have proper vehicle hiring arrangements. As the campaign focuses on difficult terrain, often the vehicles face minor damage or get stuck in a location due to changes in weather conditions, etc. It is difficult for small vehicle vendors from these areas to manage the cost associated when the duration is

too short and hence hiring vehicles would be complex should that be necessary for a campaign like this.

g) Timely preparation of the line list of people with presumptive and confirmed TB

Although Aashwasan has carried out intensive outreach and has screened a significant number of people, it has not been able to achieve a hundred per cent collection of samples from among the people with presumptive TB based on the primary screening. Some have denied giving sputum samples and some have not been available at the time of sample collection. To ensure that the screening output can be optimised during and after the completion of the campaign, a line list with necessary details (name, address, contact) has been prepared for each district and shared with the DTO so that further follow-up mechanisms can be put in place. Feedback to the STS, STLS, and ASHA is helpful to support the government health functionaries to respond in a timely manner.

In Jharkhand, the 104 Health Information Helpline has been used to follow up with people with presumptive as well as confirmed TB to encourage the people with presumptive TB to access the diagnosis service and motivate people with TB to start and/ or continue the treatment regime. It has shown the potential to improve campaign efficiency and help sustain the impact.

h) Ensuring X-ray for people with clear symptoms and yet test sputum negative

A few weeks into the campaign, the Aashwasan team starts finding that a significant number of people are testing sputum-negative even after having vivid symptoms. After observing such a trend, the field team consults the DTOs of their respective districts and they collectively decide to follow the step of follow-up X-ray. A quick operational plan is put in place and implemented to facilitate the mobilisation of these people to the nearest centre with an X-ray facility. The follow-up X-rays are done on a case-by-case, region-by-region basis. About 20% of the sputum-negative people have had X-ray shadows suggestive of TB and hence treatment has been initiated for them

i) Language inclusion is crucial:

While many tribal communities have learned some or other official languages (the dominant or the state language in most cases) to meet the basic needs of communication and livelihood, deeper engagement aiming at any level of behaviour change in the context of practices and norms impacting the state of health and nutrition needs to be in the language of comfort. People's familiarity with the languages of the majority also decreases with the increase of the remoteness of an area. Aashwasan IEC put in conscious efforts to create content in different languages used by various tribal communities in a particular area. The recruitment of local people, familiar with the context as well as local and tribal languages has also enabled the campaign to have a deeper and lasting reach.

8. Way forward:

Building on the success of the Aashwasan campaign, the Tribal TB Initiative is now ready to take the next plunge towards TB elimination. In line with the spirit of Azadi ka Amrut Mahotsav and anchored by the vision of a TB-free India, the Initiative is focusing on reaching the milestone of TB-free tribal districts of India within the next three years.

Engaging with community influencers during the Aashwasan campaign has yielded a significant amount of community participation. Building on this experience, the Tribal TB Initiative is going to invest further efforts toward healthcare demand generation among community members through deeper engagement with tribal healers, PRI members, SHG leaders, et al. Developing a larger and stronger cadre of TB champions is also going to be prioritised to fight stigma and boost community participation. TB forums are to be created as platforms to listen to the voices of tribal communities which is crucial for interventions to be designed in a context-relevant manner.

Based on the insights gained about the gaps remaining on the supply side, research is to be carried out to thoroughly map the resource deficiencies to optimise resource allocation. NTEP is to prioritise mitigation of the supply side gaps in the tribal districts through improving process efficiency, functionality and efficacy of diagnostic and TB care centres through refined resource and process plans. In this joint effort, the Ministry of Tribal Affairs' support is to be utilized to cater to the resource inadequacy as well.

Annexure

1. **Annexure I** List of districts phase-wise
2. **Annexure II** CTD Letter to STOs for ACF campaign
3. **Annexure III** CTD Letter-Extension to 182 Tribal districts
4. **Annexure IV** Ministry of Tribal Affairs letter to Principal Secretary, District Collectors and Principal of EMRS
5. **Annexure V** Madhya Pradesh and Manipur STO letters to respective DTO
6. **Annexure VI** Ladakh CMO letter to BMO and Meghalaya DTO letter to MOICs
7. **Annexure VII** Sikkim DTO to Panchayat President
8. **Annexure VIII** JD of Field Staff
9. **Annexure IX** Training Deck
10. **Annexure X**
    a) Annexure X.I Monitoring and Data Collection Tools
    b) Annexure X.II Supervision Checklist
11. **Annexure XI** Draft Micro Plan
12. **Annexure XII** List of consumables for specimen collection and transport

To access the Annexure documents please scan the QR Code below

Contact
Central TB Division at

tbcindia.gov.in

1800-11-6666

Swasthya Tribal Health
and Nutrition Portal

Contact
Anamaya at

anamaya.org.in

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