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The Tribal TB Initiative

TB-Free Tribes for a TB-Free India

Tribal communities of India and their state of health

India is home to around 104 million tribal peoples and constitutes 8.6% of the nation's population.

There are more than 700 unique tribal communities in India

About 90% of tribal peoples live in rural areas

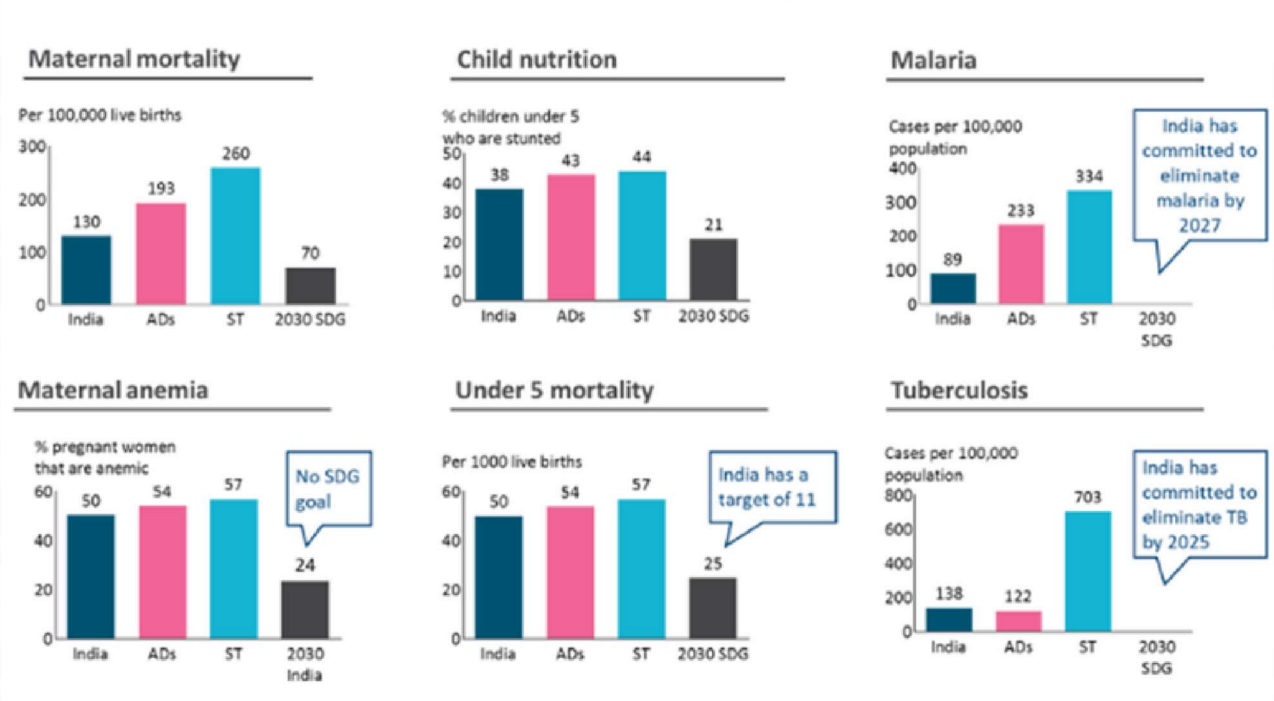
They speak over 300 languages (core and subsidiary)

Tribal areas of India account for 60% of the country's forest coverage

They have community-centric governance structures

They are the keeper of traditional knowledge and wisdom

28% of the world's tribal and indigenous people reside in India. Their state of health resonates with the global trend of impoverished indigenous health. A tribal individual in India has a life expectancy of about 4 years lower than the general population. They account for about 50% of malarial death. A tribal mother is twice as likely to die of childbirth when compared to non-tribal women in India. Tribal peoples in India constitute 8.6% of the country's population and yet 10.4% of all notified TB cases are from tribal communities. The prevalence of Tuberculosis (TB) among tribal peoples in India is 703 as opposed to the national average of 138.



The tribal population trails behind the national average on several health indicators, with women and children being the most at risk.

TB among tribal communities

Evidence suggests that tribal peoples are the population subgroup with the lowest rate of economic upward mobility.

TB is often referred to as the barometer of social welfare due to the severe impact it has on the overall social and physical health and well-being of people.

TB is disproportionately high among tribal communities in India as they form 8.6% of the total population but accounts for 10.4% of all notified TB cases in India.

People with TB find themselves in a downward spiral of poverty. The disease prevents them from going to work and hinders a child from attending school for long periods of time. Patients or caregivers from the family often lose their jobs. This results in a significant loss of earnings, including future earning potential. Families affected by TB also experience widespread social exclusion.

> **Tuberculosis is a social disease with medical aspects.**
>
> - William Osler

Understanding the barriers

Access, availability, and utilization of TB care services for tribal communities are hindered by several barriers.

Hard-to-reach area: Tribal peoples predominantly live in remote, hard-to-reach areas such as hilly, landslide-prone, forested, flood-prone, conflict-affected, remote rural areas. The health system that is historically designed in an urban-centric manner faces difficulty to ensure access to quality healthcare in these areas.

Knowledge gap: There is a lack of information at various levels about disease impact and health-seeking behaviour among tribal peoples. This knowledge gap hinders optimum public health resource allocation and in turn, impedes Govt. efforts from reaching desired results.

Limited capacity of health facilities: Inconsistency in the information available at different government units leads to a discrepancy in need and availability of resources (eg. # of TB units < # of blocks in more than 50% of the tribal districts), limited services in facilities, irregular supply of equipment and consumables, lack of robust strategy and non-implementation of programs.

Limited capacity of health human resources (HR): Oftentimes lack of trained human resources weakens the functionality of the health care facilities. Multi-directional factors such as an imbalance in the distribution of workload, loss of optimism, absence of a humane connection with the people they serve, distance between workplace and home, etc. prohibit the staff from attaining from necessary efficiency.

Understanding the barriers

Heavy impact of malnutrition: TB and malnutrition catch people in a vicious circle. Both the issues of TB and malnutrition need to be addressed simultaneously.

Poor socio-economic status: Tribal communities of India have the lowest economic upward mobility among all the population subgroups. Heavy dependence on daily wages is one of the major reasons for them to often delay in seeking care.

Fear and stigma about TB due to linguistic limitations of IEC: Fear and stigma prevail with lack of information. IEC of TB and other diseases are not always available in tribal languages and this slows down the spread and absorption of necessaryinformation.

Inadequate community involvement: Dysfunctional community engagement platforms, dependence on informal labour leading to lack of time and scope, language barriers, prior experience of discrimination, lack of information about available services and their needs, etc. all result in inadequate community involvement in public health solutions.

Lack of context-suitable solution: There is not enough emphasis on the need to contextualise solutions. Contextualisation is crucial to designing solutions that are culturally suitable and efficient. For example, the intensity and duration of TB symptoms such as cough, fever, and weight loss are higher among tribal people in Jharkhand than in Sikkim. The solutions for these two states in this regard hence need to be contextualise based on the route cause.

Therefore, Tribal TB Initiative

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

This initiative is being implemented as one of the flagship project of Anamaya, the Tribal Health Collaborative. With technical guidance from USAID, Piramal Swasthya, as part of Anamaya is implementing the initiative across all tribal districts of India in collaboration with the state governments. A National Technical Support Unit for Tribal TB is established to provide technical and operational assistance to TB elimination programme.

The 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.

> Collaborative efforts made Aashwasan possible. It is very important to create awareness among tribal communities.
>
> — Dr Naval jit Kapoor, Joint Secretary, Ministry of Tribal Affairs

Tribal TB Initiative

The Tribal TB Initiative aspires to reduce the burden of morbidity and mortality from TB among tribal populations in India through

- Community empowerment and mobilization
- Expansion of services of TB prevention, diagnosis, treatment, and care.
- Strengthening the health system and health human resources

The Tribal TB Initiative is working towards

- Increasing TB case notification among tribal populations.
- Improving the treatment success rates among those with drug-susceptible TB (DS-TB) and drug-resistant TB (DR-TB) among tribal peoples (differentiated on age, gender, and geographic location).

It has carried out a thorough situational analysis to map the strengths and gaps of the health system in the delivery of TB care and support services. In-depth interactions with community representatives have also been conducted to collate insights from the ground.

Following the same, Aashwasan, a 100-day campaign to jointly fight the spread and impact of TB and COVID was launched.

About Aashwasan

Aashwasan is a campaign aiming at jointly addressing the spread and impact of COVID-19 and TB among tribal populations. It is being implemented across all tribal districts in India. It focuses on the blocks with more than 25% of tribal population.

Community mobilisers and paramedics from local communities or who are familiar with the local terrain and context, have been recruited and trained for the campaign. They reach tribal households in hard to reach areas, conducts awareness sessions to inform people about the two infectious diseases of COVID and TB, screen and collect samples from household level.

The team is guided by micro-plan collectively developed by district level officials and Tribal TB Initiative's district team. The campaign is being run with active support of state and district officials, frontline workers, PRI and SHG members, etal.

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

Highlights from Aashwasan

Geographic and population coverage

174

Districts covered

1,66,77,804

People reached

1,03,84,538

People screened for TB

Key outputs and outcomes

3,82,251

4% People with presumptive TB identified

2,80,259

73% samples tested

10,249

4% new TB positive patients found through Sputum test & X-Ray

Aashwasan success factors

Efficient sample collection and transportation (SCT) mechanism: Ensuring preparedness of TB Unit (TU), mapping functional TUs against villages, trained Paramedical staff in each outreach team, fixed vehicle support, etc. have helped Aashwasan with an efficient SCT mechanism.

Additional HR who are familiar with local context: Additional HR hired from the local communities has strengthened the existing state efforts.

Strategic hiring of women, TB survivors, and tribal people: Aashwasan has emphasised creating a field team that can cater to the needs of different community stakeholders. With 45% female, 48% people with tribal identity and 7% TB Survivors, the Aashwasan team has been able to engage with community members effectively.

Micro plan and route map charted on a Gantt: Aashwasan team at each block has drafted a micro plan in consultation with the block & district health department. The plan has been shared with all key stakeholders including the community influencers to ensure optimum participation and contribution from all.

Involving community influencers: Engagement with community influencers has enabled the campaign to not only widen the reach but also improve collective awareness of TB and enhance community participation in a sustainable manner.

The 100-day duration: Aashwasan has observed a steady week-on-week rise in the ability of the field teams to carry out campaign activities which stabilize around the fifth and/or the sixth week and is maintained until the completion of the campaign activities. Health system process optimisation also takes three to five weeks.

Sputum collection, Visakhapatnam District, Andhra Pradesh

Aashwasan success factors

Adaptability and contextualisation: While the Aashwasan team has been prepared with a detailed micro plan, an agile approach has been consistent throughout the campaign. Whenever a significant change in situation has been observed or witnessed, collectively the campaign team and the health department responded with a suitable solution.

Implementation of X-ray follow-up: 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.
About 20% of the sputum negative people have had X-ray shadows suggestive of TB and hence treatment has been initiated for them.

Inclusive language usage: 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.

Community Awareness Session, Odisha

Learning Dissemination Conclave - Aashwasan Campaign

A 'Learning Dissemination Conclave - Aashwasan Campaign' was organised on the 24th of August 2022 to deliberate on the rich experience and learnings of the Aashwasan campaign. It was co-hosted by the Ministry of Health and Family Welfare and the Ministry of Tribal Affairs in collaboration with USAID and Piramal Swasthya Management and Research Institute (PSMRI). The conclave took place at the National Tribal Research Institute, New Delhi.

More than 200 attendees from across the country joined in-person and online. The dignitaries formally released the Process Document of the Aashwasan Campaign at the Conclave. The document captures the various campaign activities and outlines its key learnings.

In light of the 75th year of independence and the nationwide celebration of 'Azadi ka Amrit Mahotsav', a collective commitment to work toward having 75 TB-free tribal districts by 2025 was announced.

Stories from the field, Aashwasan Campaign

Alone we can do so little; together we can do so much.

— Helen Keller

Work together to work better: District administration and PRI members arrange safe stay for Aashwasan field staff

Soon after the campaign started, Aashwasan teams from across the states such as Madhya Pradesh, Jharkhand, etc. start witnessing that many people with presumptive TB are testing sputum negative. Upon discussion with the district health departments and NTSU, they learn about the standard procedure of following up with a chest x-ray. If the x-ray suggests significant evidence of pulmonary TB, the person is immediately started on medication.

While this approach has been theoretically charted out for long, in most cases this does not take place as x-ray facilities are available in a limited health centre and those are often far for many community members to reach. The district health department and the Aashwasan teams collectively identify the centres with x-ray facilities. A plausible operational plan to conduct x-ray follow-ups is put in place and implemented using the Aashwasan vehicles.

In the hilly terrains of states like Himachal Pradesh, Arunachal Pradesh, Manipur, etc. the travel duration is significantly high due to various factors. It is often not possible to commute to and fro between the block headquarters and a remote village of that very block for two consecutive days to carry out Aashwasan activities, as outlined in the overarching implementation strategy.

As soon as the Aashwasan team consulted the district administration, stay arrangements at available village-level circuit houses, guest houses, etc. have been promptly arranged by the administration for Aashwasan staff. In places where government guest houses were not available, the team received active support from the PRI members to help get a safe nest for the night.

Collaboration helps find way amidst resource crunch: District health department and Aashwasan team ensure x-ray follow-up

> **All failure is failure to adapt, all success is successful adaptation.**
>
> **— Max McKeown**

Reach the community when it is convenient for them: Aashwasan teams revise community visit schedule

Soon after the launch of the campaign, the Kinnaur Aashwasan team learns that they are not meeting enough community members as they are reaching the village at a time when most people are busy with their work away from their homes.

Recognising the need to reach at a significantly earlier time, the team reschedules their visit itinerary. They start leaving from block headquarters at 5.30 in the morning instead of the earlier time of 9.30 am. This way they reach the village when community members are there and have some time to spare and engage in an interaction. Additionally, the team also visits some of the villages on Sundays and conducts Aashwasan activities jointly with the village ASHA. The adaptive approach soon proved to be beneficial.

A community accepts a solution that they can relate to and connect with

The community members of a village named Paharchua in the Dumka district of Jharkhand have not been ready to let Aaswasan team members enter their village, initially. Most people here are from Santhal and Pahariya communities. Aashwsan outreach team's Paramedical Staff Arlina Soren, a Santhali woman herself, comes to the rescue in this situation. As Anita starts speaking in their mother tongue, the villagers listen to her and learn about the reasons for their arrival. Eventually, they welcome the team and participate in the campaign activities.

Aashwasan has made a conscious effort to adapt to the needs of the community and has focused on hiring local people to ensure that the campaign's approach is rooted and context-suitable.

A champion isn't made of muscle; a champion is made of heart.

— Liang Chao

TB Champion: once a victim now saving lives from impact of TB

Reshma, a resident of Pati block of Barwani district Madhya Pradesh, was diagnosed with Pulmonary Tuberculosis (TB). Her family significantly depended on her earnings from her job at the village Panchayat Bhavan. She had to discontinue her job as the disease progressed. Reshma, a mother of three children, felt devastated by the manifold challenges of TB. But she swam through the crisis and adhered to the treatment regime until she was recuperated.

Reshma has been helping the Anamaya team by connecting with people and encouraging them to access the Aashwasan campaign's screening and diagnosis services.

Bitmay Soren from the Pakur district of Jharkhand was infected with TB in her childhood. She survived the disease with proper treatment and support from her family. Remaining isolated and away from friends while she was battling the disease, left a lasting impact on her psyche. She understands the support necessary for someone to go through the six-month-long treatment regime while experiencing tremendous physical & mental discomfort.

Empowered by her experience, she is now passionate to make her community TB-free. Bitimay is now working as a TB Champion and motivating others to access treatment. She has supported the Aashwasan team to reach out to 10 villages in Pakur District from where 69 people with TB symptoms were found and connected with treatment.

TB Champion: Childhood experience motivates her to create TB free community

The three most important ways to lead people are... by example... by example... by example.

— Albert Schweitzer

Faith leader Disinang Malangmei dispels stigma against TB using his experience of fighting with the disease

Disinang Malangmei is a faith leader, who lives with his wife and five children in M. Khunou village, in the Noney District of Manipur. In the year 2018, he contracted TB. Since he is a faith leader he relied on the offering he got through the church for his earnings. Soon news about him having TB spread and the people stopped coming to him so did the offerings. With the help of the ASHA in the village, he received his medicines from the CHC and continued the treatment regime through all the hardships.

Upon recovery, he uses his position in the church to engage with the community to help all unshackled from the stigmas and fear associated with TB. He motivates everyone to get screened and understand that the disease is completely curable if treated in time.

Champa from Girvar village of Aburoad block in Sirohi district of Rajasthan has been reluctant to get her sputum tested despite suffering from TB symptoms even after her husband willingly gave his sputum sample. She was afraid of facing discrimination if tested positive.

The Anganwadi worker, sarpanch, and her husband needed to collectively convince Champa to take the test through a series of conversations and by sharing many examples of how people fought TB with timely diagnosis and thorough completion of the treatment regime.

She tested positive and started her treatment. This experience indicates a possibility of women being more affected by the fear or stigma of discrimination in the context of a disease such as TB.

Community influencers help fight stigma associated with TB in Sirohi

Where the mind is without fear
And the head is held high

— Rabindranath Tagore

counselling helped in dispelling fear and seeking help

Gandraipalem village's resident G. Rama Rao was initially afraid and unwilling to engage with the outreach team and share information about his condition. He did not share about his symptoms even after his neighbours updated the Aashwasan team about his decreasing state of health.

The Aashwasan team engaged with him and his family multiple times to counsel him for getting his sputum tested. He gave his sputum sample after the team's consistent effort and was diagnosed with multi-drug resistant TB. As soon as he learned that he needs to go to the hospital to access treatment, he resisted again. He could finally fight his fear and went to the hospital with the Aashwasan team after three consecutive days of counselling.

Despite the fear of the Naxalites the team did their job

Aashwasan team in Lohardaga district of Jharkhand visited Kerar village in Peshrar block. There had been a recent conflict between CRPF and Naxalites in the area very recently. When the team reached the village the atmosphere was tense. Despite repeated attempts, the villagers did not respond to their enquiries on the first day of their visit. But the team was not ready to give up.

They came back the next day and convinced the ASHA to help them connect with the Sarpanch. After spending hours with the Sarpanch and explaining the campaign, he agreed to help. The team then conducted screening and collected samples. A few people with presumptive TB tested sputum-negative. The team persisted further and ensured that they get the follow-up x-ray. Three people tested positive after the x-ray.

The Lohardaga Aashwasan team stood tall in a conflict-ridden atmosphere and set an example of enormous courage.

Glimpses of activities

Meeting with mitanin, Dakshin Bastar Dantewada, Chhattisgarh

Sahiya Orientation, Simdega Block, Jharkhand

TB awareness, Harda, Madhya Pradesh

Review meeting of Community Mobilisers and Paramedice, Bijapur, Chhattisgarh

Community outreach, Singrauli, Madhya Pradesh

Glimpses of activities

Screening of TB cases and awareness of TB and COVID-19, Lahul and Spiti, Himachal Pradesh

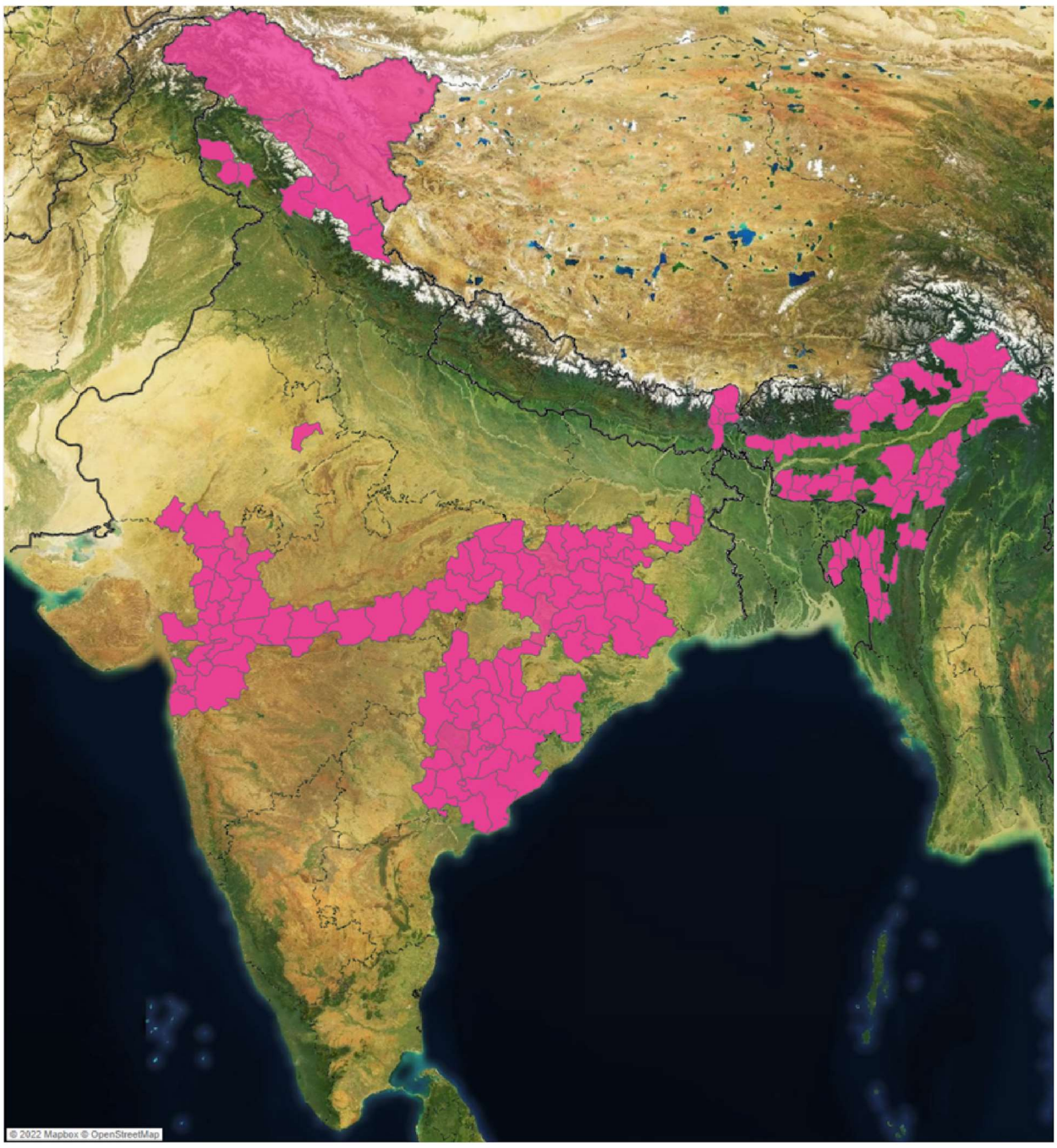
Community Mobilisation Ghadhaniy village, Ghatshila Block, Purbi Singbhum District, Jharkhand

Community engagement and IEC, Kinnaur, Himachal Pradesh

Door to door sample collection, Zirikingdeng, Karbi Anglong, Assam

Meeting with Tribal Healer, Makro Village, Littipara Block, Pakur District, Jharkhand

Aashwasan Coverage



Swasthya Tribal Health
and Nutrition Portal