2022 CLA CASE COMPETITION

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Case Title:

Improving health seeking behaviour with regard to TB among vulnerable groups in India

Name: Ms. Shramana Majumder

Organization: KHPT

A TB survivor shows a TB free certificate, one of the behaviour change solutions given to those successfully completing TB treatment. Credit: KHPT

Summary:

In 2020, 10 countries collectively accounted for 74% of the global gap between estimated TB incidence and the number of people newly diagnosed with TB, and India was one of the three top contributors at 24%. In order to identify and treat missing TB persons, there is a need to develop diverse approaches. Breaking the Barriers (BTB), a USAID-supported project, has adopted a community engagement approach, with a special focus on communities that are vulnerable to TB. These include the urban vulnerable, migrants, tribal populations, mining, industrial, and tea garden workers, which have a higher risk of developing TB compared to others due to occupational hazards, geographical limitations, socio-economic inequalities, stigma, and gender discrimination. However, owing to various barriers at individual, family, community and system level, there are delays in diagnosis, treatment initiation and completion. BTB focuses on innovating, testing and demonstrating a set of behavioural change solutions designed to address unique context-specific barriers to health seeking behaviour among these vulnerable groups. In implementing this project, KHPT has applied the CLA approach since its inception, with repeated networking with government and non-government partners, learning exchanges among various stakeholders, and constant adaptation to the contexts of the specific vulnerable population groups. The learnings that emerge from this project has enhanced the knowledge of vulnerable populations and the barriers they encounter when attempting to access health services related to TB. Additionally, the pilot of these behavioural change solutions resulted in the development of successful operational models that reinforce health seeking behaviour, TB detection and improved treatment outcomes among the groups, thereby accelerating the TB response at the national level.

Which two subcomponents of the Collaborating, Learning & Adapting (CLA) Framework are most reflected in your case? Please reference them in your submission.

- Internal Collaboration
- External Collaboration
- Technical Evidence Base
- Theories of Change
- Scenario Planning
- M&E for Learning
- Pause & Reflect
- Adaptive Management
- Openness
- Relationships & Networks
- Continuous Learning & Improvement
- Knowledge Management
- Institutional Memory
- Decision-Making
- Mission Resources
- CLA in Implementing Mechanisms

1. WHAT: What is the general context in which the case takes place? What organizational or development challenge(s) prompted you to collaborate, learn, and/or adapt?

It is estimated that four million new tuberculosis (TB) infections occur in India every year and without further action and investment, 24 million new TB household infections will occur by 2025. The Government of India ' s National Tuberculosis Elimination Programme (NTEP), which envisions the elimination of TB in India by 2025, recognizes that diverse approaches addressing the varying needs of different vulnerable populations for increased case notification and improved successful treatment outcomes of both drug-sensitive and drug-resistant TB need to be developed in order to detect and treat ' missing ' persons with TB,.

In this context, and in the absence of any proven models that successfully demonstrate addressing barriers to TB elimination within the unique socio-cultural and economic contexts of vulnerable populations, the BTB project has been piloting innovative models of behaviour change solutions based on behavioural economics since 2020.The project is being implemented in four states of India- Assam, Bihar, Karnataka and Telangana - each with a distinct socio-cultural milieu to address unique context-specific barriers to health, and specifically to TB, among the urban vulnerable, migrants, and tribals, as well as mining, industrial, and tea-garden workers

Employing a socio-ecological approach and empowerment framework that positions interventions at four mutually reinforcing and interdependent levels: individual, interpersonal, community and societal, BTB has evolved a set of innovative behaviour change models that address the social and structural barriers that impede health seeking behaviour among these vulnerable groups. While doing so, the project has drawn on external and internal collaborations, working closely with communities, and representatives of the national and state government NTEP. The interactions with community structure members, representing vulnerable communities, frontline workers and the government have equally informed the design of the BTB project, making it community-centred and, more importantly, adaptive in nature, catering to specific socio-cultural and geographical contexts of the above-mentioned vulnerable communities.

2. WHY: Why did you decide to use a CLA approach? Why was CLA considered helpful for addressing your organizational or development challenge(s)?

The components of the CLA approach have formed the foundation of KHPT's approach to catalyzing change for the well-being of vulnerable communities. KHPT identifies itself as a learning organization, which engages with a variety of stakeholders to design and implement context-specific and evidence-based innovations, which address gaps in the system, and are flexible and scalable.
The BTB project, with its focus on specific vulnerable groups of that have definitive socio-cultural contexts, required a CLA approach. The success of the project is defined by several moving parts: the vulnerable communities we work with, the community structures that represent these vulnerable communities, and the components of the national and state NTEP. The project needed to incorporate the requirements of the vulnerable communities, the NTEP, the employers (in case of tea garden workers and mining and industrial workers), and frontline health workers involved in the program, as well as the health system. This cross-section of stakeholders rooted in different contexts have different operational mechanisms and do not always align or intersect. Bearing in mind the requirement of multiple stakeholders involved, the project needed to be flexible enough to ensure that all stakeholders are well-coordinated and share a common agenda of responding to the health care needs of the vulnerable groups. First and foremost, coordinating and working together with the national and state NTEP the frontline health workers was an essential step, to create a buy-in from the early stages, and to ensure their cooperation on the project implementation. Similarly, the employers of tea-garden workers, and mining and industrial workers were consulted to ensure a coordinated response. Most importantly, working alongside vulnerable communities has been the crux of the project. It is through the processes of learning and adaptation in diverse geographies and socio-cultural contexts that the project is being gradually shaped by the communities we are seeking to serve, and being owned by the government, one of the major stakeholders who can take the innovations to scale.

3. How: Tell us the story of how you used a collaborating, learning and/or adapting approach to address the organizational or development challenge described in Question 2.

BTB aims to develop innovative and effective behaviour change models that improve coverage of four specific vulnerable populations for increased case detection, notification, and improved successful treatment outcomes for persons with Drug-sensitive and Drug-resistant TB. There are no proven models/approaches that have demonstrated success to address TB in the unique socio-cultural and economic contexts of these populations, which are identified as vulnerable populations in the national guidelines. We believe that the learnings from this project can potentially help enhance the knowledge about these populations and the barriers they face, and showcase successful models that help detect TB and improve treatment outcomes, thereby accelerating the TB response at the national level.

Step 1: Theory of change: The project evolves suitable person-centered solutions, which included identifying and prioritizing unique needs, barriers to health seeking behaviour of the vulnerable populations, and applying principles of behavioural economics. Based on key findings from the research, a behaviour change matrix was developed, which in turn led to the development of behavioural change solutions for each of the vulnerable populations involved. As a project, BTB employs community engagement strategies that are uniquely defined for each of the vulnerable populations, and embed community involvement at all stages. Further, the project has co-created these behaviour change strategies through close engagement and consultation with not only the community members of the different population groups, but also of the field level staff, and the frontline health workers of the NTEP programme who understand the nuances and challenges of TB programs in the field, specifically with these populations.

Step 2: Discussions with key stakeholders- In this case, representatives of the vulnerable communities who were either persons with TB, TB survivors and/or caregivers, formed an integral part of the project. As part of the behavioural design approach, the project identified areas of Inquiry across three key elements of behaviour change: 1 Motivation: Knowledge levels, External Influence, Fears & Apprehensions 2. Ability: Perception of barriers, Ability to understand and act upon communication 3. Triggers: The timing, type of message and message content that prompts a user to act or ignore it. These areas of inquiry were then mapped against the five spheres of influence, which the project identifies as integral to the vulnerable population groups ecosystem: 1. Self 2. Home & Family 3. Community 4.
Work 5. Healthcare System. By adopting the above-mentioned approach, a set of socio-cultural barriers at the individual, family, community and system levels were identified. These were unique to all vulnerable populations. On the basis of these interactions, a set of enablers or behavioural solutions were implemented to improve health seeking behaviour among the populations.
Step 3: Internal and External collaborations: The project, across its geographies of Assam, Bihar, Karnataka and Telangana, has identified TB Units (TUs), in consultation with the state and district NTEPs, that correlate with high concentrations of vulnerable groups of a specific category. Internally the program, technical and the research teams have worked together to formulate an implementation plan, keeping in mind the diverse populations and geographies in which the project is operational.
Step 4: Adaptive management – Open and continuous interactions with the state NTEPs on the project has meant that across project geographies, all behavioural solutions are repeatedly reviewed and improved according to the need of the community, as well as the State NTEP programme. For instance, in Assam the design and content of one of the behavioural solutions, namely the ‘ Jaanch coupon ’ was revisited and substantially redesigned for the state NTEP to adapt the solution and bring it to scale
Step 5: Pause and reflect: The project has in-built monitoring mechanisms with a set of parameters that are reviewed monthly by the programme and M&E teams. This helps the project team in not only course correction wherever needed, but also to evaluate the progress made against a set of measurable indictors.
Step 6: The learnings from the BTB project are being continuously documented, and quantitative and qualitative research studies that are being undertaken as part of the project will be used to generate valuable insights into the feasibility and success of the project. At the end of the project, the key learnings from the same will be compiled into a technical brief, which then can be shared with the NTEP for further scale up.

4. ORGANIZATIONAL IMPACT: How has collaborating, learning and adapting affected your team and/or organization? If it's too early to tell, what effects do you expect to see in the future?

The emergence of innovative models of community engagement, which have behavioural solutions at the centre, will help all stakeholders involved to progress towards the goal of improving TB case finding and treatment outcomes among these specific vulnerable groups, and eventually realize the goal of TB elimination.

The past 18 months of the project has been a remarkable journey for the project teams, during which there has been continuous learning and exchanges between communities and project teams, between communities, project teams and the NTEP, and between KHPT as an organization and the NTEP. At every step of the project, the teams have been collaborating and learning. Instead of merely imposing solutions on the communities, the community structure through several perspective building workshops are being empowered and enabled to be able to respond to TB. The learnings from the daily problem-solving by community structure leaders, the TB survivors, and persons with TB form the basis of the project. Today, the frontline workers, the field staff and the community structures are a valuable resource, and are making synchronized efforts to ensure persons with TB from the vulnerable segments reach successful treatment outcomes.
We are witnessing the community structures and the teams ' dedicated efforts to create an innovative and sustainable intervention in the interest of some of the most vulnerable groups. The project has enabled information sharing at numerous levels, ranging from ground-level realities from health facility staff to understanding the priorities of state TB authorities. The most encouraging part has been the two-sided communication between KHPT as an organization and the National and State NTEP leadership, and USAID. This system of transparent communication, through which on-ground developments are shared regularly, has ensured that the vision of BTB project is not seen as vision of KHPT, rather as vision of the NTEP programme.

5. DEVELOPMENT IMPACT: How has using a CLA approach contributed to your development outcomes? What evidence can you provide? If it's too early to tell, what effects do you expect to see in the future?

Most TB programs are activity-centric and medicalized, with the socioeconomic determinants of TB and health in general sidelined. Additionally, most approaches of health service delivery are to- down with the communities not consulted on the policies, practices or programs implemented for them. Employing the behavioural economics approach has helped the team on the ground to be cognizant of the complexities within individuals and social groups, further enabling them to engage with at- risk communities. These complexities were economical, socio-cultural or even political in nature and therefore required an empathetic, decentralized CLA approach where the needs and interests of all stakeholders involved have been considered.

The BTB project implementation strategy essentially follows the CLA approach, which has designed and implemented all behavioural solutions in consultation with communities, and community structures representing vulnerable communities. As a result, the project has been constantly evolving alongside rapidly-changing stakeholder scenarios: the community, the NTEP, public health sector and the employers. Combining the CLA approach with a steady inflow of quantitative and qualitative data has allowed the program team to tailor context-specific responses in real time. The responses and data were documented and shared with the NTEP and other development partners for course correction wherever required.
Over the past 18 months, we have seen that the implementation of innovative behavioural change solutions guided by behavioural economics approach has resulted in faster TB notification and better treatment adherence among vulnerable populations

We expect that learning from this system will enable governments and other TB partners to scale these solutions up in the future across different contexts and setting, including urban, semi-urban and high-risk areas. Through constant iteration, they can be honed to be efficient and cost-effective, while retaining their value as community-centred innovations with the potential to be a powerful tool in the arsenal of the End TB movement.

6. ENABLING CONDITIONS: How have enabling conditions - resources (time/money/staff), organizational culture, or business/work processes - influenced your results? How would you advise others to navigate any challenges you may have faced?

The BTB project team worked through a continuous cycle of setbacks and breakthroughs while implementing the project in diverse socio-cultural settings. Clear lines of communication and collaboration, which includes open discussions with the national, state and district NTEP, enabling a steady feedback flow and allowing teams to work around challenges which could not be easily surmounted, have been a hallmark of the project. Strong monitoring and evaluation mechanisms, with technical oversight from the program team, has enabled continuous learning and the creation of a holistic approach towards project implementation.

A strong leadership structure had to be instituted at the central and state levels, to develop a learning culture where field staff were empowered to make decisions, and allowing for quick changes to the system structure to overcome obstacles and project limitations, which were sometimes unanticipated,. These included gaining entry and acceptance into the mining industries, or even closed communities such as tea-garden workers, which could have meant a delay in identification of vulnerable groups. However, persistent advocacy and negotiation worked in favour of the project teams. In addition, skepticism from certain quarters of the government as to the cost-effectiveness and utility of the intervention were also addressed by repeated sharing of results and demonstrating real changes on the ground with TB survivors and persons with TB themselves vouching for the usefulness of solutions.

An open channel of communication from day one of project implementation between various stakeholders, and persistent advocacy with the national, state and district NTEP, has ensured that we are able to jointly work with the structures in addressing the challenges to health seeking behaviour among communities.