Feasibility Assessment of Community Health Workers and Community Health Volunteers

Introduction

Tuberculosis (TB) is one of the major health problems in Indonesia, with an estimated 969,000 people affected by TB in the country. Unfortunately, until the year 2022, only about 720,000 of them have been identified. Therefore, the active case finding strategy is crucial to locate these missing cases. Active case finding involves actively and intensively identifying cases within families and communities. This approach is carried out through the empowerment of the community, both on an individual level and through civil society organizations or community-based organizations. The strategy emphasizes maintaining high-quality and standardized services to ensure effectiveness.

The issue of TB is not solely the responsibility of the government; it requires collaboration and synergy between various stakeholders. Cooperation and coordination between Primary Health Centers (Puskesmas), hospitals, and the Health Department are essential, with the Health Department taking a leading role. Additionally, community health workers, commonly referred to as health cadres or "Kader Kesehatan," play a vital role as a bridge between healthcare services and the community.

Community plays a crucial role in the success of TB control efforts. Empowerment and involvement of the community are essential to raise awareness, willingness, and ability to break the chain of TB transmission. The participation of community health workers in promotive and preventive efforts in several regions has been impactful in carrying out contact investigation, case detection, and patient support during treatment, leading to an increase in the recovery rate. However, when it comes to tracing and supporting MDR TB patients with initial Loss to Follow-Up (LTFU), the geographical spread of patients is vast and requires focused support until they are willing to start treatment or are taken to health facilities. Currently, community health workers' role is not considered an option due to limitations in their geographical reach.

Given the mentioned circumstances, it is necessary to develop alternative community-based incentive resources that can provide TB services. Currently, there are limitations regarding community health workers, but in practice, synergy with them should be built and maintained. In the future development, there could be possibilities to upgrade the competencies of selected health cadres to become Community Health Workers (CHW).

The purpose of this assessment is to obtain information about the current practices of health cadres and opportunities for developing a model of Community Health Workers (CHW) and Community Health Volunteers (CHV) in providing TB services in the community.

Methodology

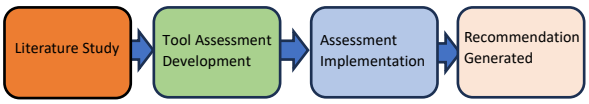

Figure 1. Steps in conducting the assessment

The series of steps conducted through a literature study on the concept of community-based healthcare workers implemented in several countries with situations similar to Indonesia involves the following process: starting with a review of existing literature, followed by the development of assessment tools to evaluate the extent of the role of cadres or community health workers that have been operational thus far. The aim is to gather information and propose a plan for the future development of the community health worker concept, as depicted in the figure 1.

Data collection and analysis the method used for data collection involved conducting in-depth interviews and guided focused group discussions led by a consultant. Informed consent (verbal or written) was obtained before conducting the interviews and guided focused group discussions. The data analysis utilized a qualitative approach using descriptive methods. The descriptive method was employed to explain specific conditions related to the involvement of TB cadres in the implementation of activities within the designated area, as well as the achieved outcomes.

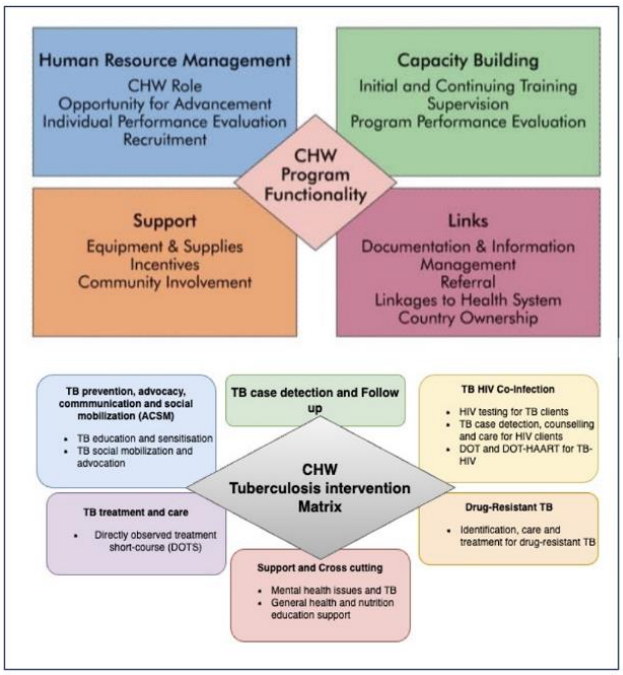

FIgure 2 Framework theory in developing CHW-CHV

Assessment tools A customized assessment tool was developed, deemed suitable for the situation and context in Indonesia. This tool represents an elaboration of the concepts of Community Health Worker (CHW) developed by USAID's Community Assessment and Improvement Matrix (AIM) in 2013 and 2018, as well as the World Health Organization (WHO) guidelines on health policy and system support to optimize community health worker programs in 2018. This tool serves as the foundation for creating an assessment matrix to formulate the concepts of Community Health Worker (CHW) and Community Health Volunteer (CHV) as depicted in Figure 2.

Results

Participants	n	%
Local health district officer	9	8,3%
Health care providers	12	11.1%
Health cadres	26	24%
Religious leaders and community figures	9	8.3%
Survivors, peer supporters, and case managers	29	27%
Patients and family	23	21%
Total	108	100%

Table 1. Number of participants involved

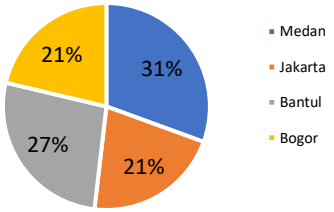

Figure 3. Participants based on locations

For respondent types, the largest proportion is the survivor group, Case Managers, and Peer Support, accounting for 27%, which is not significantly different from the proportion of cadres and patients/family members, while religious leaders and community figures constitute the smallest group (8%).From 108 respondents, the highest proportion of respondents is in Medan City (31%), followed by Bantul Regency (27%), while the proportion of respondents in South Jakarta City and Bogor City is the same (21%).

The information is provided below based on the analysed information from the participants. The findings will discribe the existing condition, while the participant recommendation tells the TB affected communities recommendation regarding the concept of CHW and CHV.

1. Cadres Recruitment

Findings	Participant Recommendation
1. The recruitment process for community health workers (kader) has been conducted through several mechanisms: a. Selection from Active Health Cadres: Health cadres who are already actively involved in various health-related activities b. Recruitment through Sub Recipients or Civil Society Organizations (CSOs) c. Voluntary Application 2. No formal contract is established with the health cadres as they are considered volunteers. 3. Many health cadres are "multi-cadres," meaning they not only assist primary health centers or local community organizations in tuberculosis-related activities but are also involved in other community-based roles. 4. Not all health cadres are residents of the local area.	1. The recruitment of CHW should involves the local authorities (Camat/Lurah) and is attached to the activities of the Integrated Health Posts (PKK/Posyandu) and the community-based health structure (Kecamatan/Kelurahan). 2. A clear distinction should be made between CHWs and CHVs The presence of CHWs does not replace the role of CHVs. 3. CHWs who receive monthly incentives are expected to relinquish their multi cadres' roles that they have been performing. 4. CHW candidates should come from the local community and be well-known and active in community activities. 5. Individual requirements for CHW candidates include no discrimination based on ethnicity, religion, or race. an age range preferably between

5. The existing criteria for health cadres do not include age restrictions, but the average age range is typically between 18 to 50 years.	18 to 50 years, at least a high school education (SLTA), proficiency in computer skills (Ms. Office), and preferably a background in the health field.

2. Cadres' roles

Findings	Participant Recommendation
1. The cadres work for all types of TB 2. Their roles include contact Investigation and health education to the community 3. Peer support for MDR TB patients, and drug taken observer for the sensitive TB patients 4. A few of them provide support to those with Latent Tuberculosis Infection (LTBI) until they complete their treatment.	1. Socializing Information on TBC: CHWs can actively disseminate information about TBC and its prevention, treatment, and control measures to educate families and communities. 2. Monitoring and Reporting: CHWs can monitor the situation and conditions in the field and report any issues or concerns observed in the community promptly. 3. Community Engagement: CHWs can actively participate in various community activities to promote TBC awareness and encourage early detection and treatment. 4. Regular Visits and Patient Follow-up: CHWs can conduct routine visits to patients to inquire about their progress, ideally at least once a week or every two weeks. 5. CHWs, with their training and experience, can provide guidance, support, and capacity-building for CHVs to enhance their effectiveness in delivering health services to the community.

3. Training

Findings	Participant Recommendation
1. Some of the health cadres have received basic training on TB. 2. The geographical and socio-economic conditions do not affect the training methods. 3. Not all cadres are involved in every training session. 4. Not all cadres receive certificates after training.	1. Training on TB is regularly provided to new cadres, and there is an annual refresher training for existing cadres to boost motivation and update them with the latest information on TB. 2. In addition to TBC-related content, extra training covers communication skills, psychosocial aspects, patient empowerment, IT training, community advocacy, and addressing stigma and discrimination. 3. On-The-Job Training (OJT) should be conducted for new cadres by cadre coordinators or case managers. 4. Competency certificates are highly beneficial in supporting cadre activities in the field. 5. Training methods should preferably be offline and include practical applications to enable immediate implementation.

4. Supervision

Findings	Participant Recommendation
1. The supervision activities are currently not well-structured, and there is no documentation of the findings from supervision visits or follow-up actions taken based on those findings. 2. The lack of regular and structured supervision by the cadre coordinator on their subordinates is a concerning issue, with only around 40% of the cadres being monitored. The challenges mentioned, such as the vast geographic area and the absence of transportation, contribute to this problem 3. There is a Coordination Meeting (RAKOR) at the primary health center (puskesmas) which is usually conducted once a month.	1. Involving community representatives from the sub-district/village (Toga Toma) in conducting supervision. Supervision should ideally be carried out for a period of 3-6 months. 2. CHWS can be supervised by the Puskesmas officers

5. Performance Evaluation

Findings	Participant Recommendation
1. Assessment for cadres has never been formally conducted; feedback has only been provided verbally by the cadre coordinator or case manager when cadres encounter challenges or fail to meet their targets. 2. There is currently no reward system for high-performing cadres, and there are no certifications or certificates of recognition for cadres involved in the TB program.	1. There is a need to establish a performance evaluation system based on the set targets for individual cadres. 2. Implementing a reward system based on target achievements is crucial to motivate cadres in their work. 3. Local authorities can be involved in the monitoring and evaluation of CHWs' performance, providing feedback, and supporting improvement efforts.

6. Incentives

Findings	Participant Recommendation
1. The current amount of incentives received is considered insufficient because many patients are located far away, requiring more transportation costs. 2. There is a sense of disparity among cadres in the field due to the fact that penabulu cadres receive more incentives than cadres from the primary health center 3. When contact cannot be reached or found, even after the cadre has made a visit, the cadre cannot receive reimbursement for transportation costs.	1. Incentives for CHWs) can be adjusted according to the region's prevailing Minimum Wage . 2. It is crucial for the cadres to receive transportation support to facilitate their activities. 3. By linking incentives to performance metrics, such as the number of cases handled, successful contact investigations, or health outcomes achieved, CHWs are incentivized to strive for better performance and outcomes in their roles. 4. CHW should not be the multiple cadres

7. Community Engagement

Findings	Participant Recommendation
1. A lack of active support from the local community for TBC cadres. 2. Involving stakeholders from the neighborhood community organization (RW/RT) can be a valuable approach to mobilize TB patients who are unwilling to take their medication.	1. Local authorities can help CHWs with the socialization process by introducing them to the community, introducing their roles and responsibilities, and emphasizing the importance of their work. 2. Local authorities can advocate for the CHWs within the community, endorsing their roles, and highlighting the significance of the services they provide. 3. Local authorities can assist in allocating necessary resources, such as information materials, training facilities, and logistic support, to support CHWs in their tasks. 4. Local authorities can work together with CHWs to mobilize the community.

8. Career Progression

Findings	Participant Recommendation
1. There is no offer/promotion for cadres with good performance yet. There is no transparent performance assessment system for cadres.	1. Having awards or recognition for CHWs with excellent performance, such as promoting a community CHW to a coordinator role, can be a motivating factor and provide an incentive for other CHWs to strive for better performance. 2. The selection of CHW coordinators from among active and high-performing CHWs is a logical approach

9. Health System Integration

Findings	Participant Recommendation
1. Referring patients to healthcare facilities if there are complaints, usually through telephone notifications. 2. Informed by healthcare service personnel if there are positive patients who need to be followed up by the cadres. The Puskesmas staff also provides data for the CHWs to conduct contact tracing 3. Cadres consistently report back to the Puskesmas staff.	1. Creating a referral network or communication platform between community leaders and the Puskesmas (primary healthcare center) for health-related issues can be highly beneficial for improving healthcare coordination and community engagement

10. Data management

Findings	Participant Recommendation
1. There is no standard format, and there is currently no feedback system for the documentation reports provided. 2. The cadres are still incomplete in filling out the TB16 form (one of TB form documentation)	The CHWs need to provide reports to the stakeholders in the neighborhood regarding the TB situation and issues in the field. They do not need to mention their names; aggregated data is sufficient

11. Government Support

Findings	Participant Recommendation
1. The government is collaborating with Civil Society Organizations (CSOs) to provide various training programs for cadres 2. Puskesmas, as part of the government healthcare service, has incorporated cadres as an integral part of the healthcare delivery. The Puskesmas has allocated a budget for cadres' activities, although it is limited to meeting packages and does not cover transportation fees.	A routine meeting between patient, patients' supporters and health care workers is needed to motivate the patient to be patient supporter once they finished their treatment

Apart from the information above, several other information was generated regarding current condition of TB services

a. **Health education :** The education regarding TB is still limited, even though the cadres have provided education targeting neighbors and schools. The education given by cadres is limited to basic facts and general information about TB, but it does not address stigma/discrimination and the broader impact of TB. Additionally, the cadres have not reached vulnerable populations such as people with HIV for providing education.

b. Advocacy and Mobilization : The cadres do not have a coordination system with policy stakeholders. Currently, the cadres are only involved in community mobilization for access to services and not in policy advocacy.

c. Case findings and follow up : The cadres are now capable of identifying populations at risk of TB, including those who have contact with TB patients (cadres conduct screening for this population). Additionally, after receiving information about new index cases, the cadres are able to perform contact investigation. Most of the cadres are involved in mobilization and home visits for diagnosed TB patients to initiate treatment.

d. TB Treatment and Care Supporters: The cadres assist in administering medication to patients and also accompany patients' families to ensure the medication is taken properly. However, they currently lack sufficient knowledge in assessing nutritional status and other healthcare needs. Additionally, the cadres play an active role in monitoring drug side effects, providing counseling on infection control and prevention, promoting healthy behavior practices, and tracing patients who have missed their appointments.

e. TB-HIV : The role of cadres in the population of people with HIV is still very limited, as they are currently unable to provide counseling for HIV testing, administer ART medication, conduct TB screening for people with HIV, provide IPT for people with HIV, and coordinate with the HIV community.

f. MDR TB : In the management of MDR TB patients, the cadres are actively involved, such as tracking patients who have not started treatment, tracing patients who have missed treatment, directly observed therapy (DOT), monitoring side effects, and referring patients to healthcare services. Additionally, the cadres assist patients in accessing psychosocial and nutritional support and provide education on infection prevention and control (IPC).

g. Tuberculosis Preventive Therapy : Currently, the cadres are only involved in mobilizing contacts to undergo latent TB testing at the health center and mobilizing those with positive ILTB for initiating IPT (Isoniazid Preventive Therapy).

h. Other supports : The cadres assist in facilitating patients to access support for nutrition and transportation to the health facilities. However, the cadres have not yet provided support for mental health counseling and gender/human right issues.

Recommendation for practice

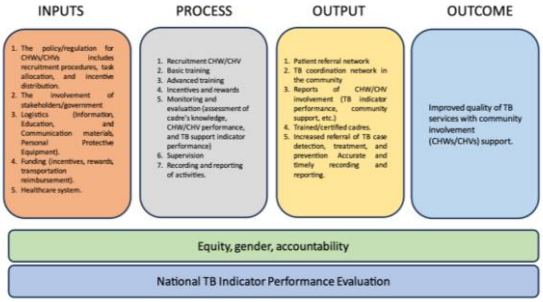

Figure 4. Framework design for CHW-CHV

a. There is a need to develop a model for cadres based on the program indicators (NSP and GF).

Drug Sensitive TB (case findings and patient supporter)	**Drug Resistant TB (supporter and treatment enrollment/retention)**
Community Health Workers	Case Manager
Community Health Volunteers	Peer Supporter

The difference between CHW and CHV

Community Health Workers	**Community Health Volunteers**
1. A work contract will be provided by the sub-district/village. 2. Targets for program indicators (community and health center) will be given. 3. Monthly incentives will be provided based on the adjustment of working hours to the Regional Minimum Wage and the existing community health	1. There is no work contract. 2. No program indicator targets are imposed. 3. They will receive rewards based on the needs and outputs of activities to support CHWs in achieving the national indicator targets (e.g., community education, screening for TB index cases, patient treatment support) 4. They can be involved in

workers. 4. Preference will be given to those bound by a work contract as TB cadre, receiving monthly incentives. 5. They will act as supervisors/coordinators for 5-10 volunteer health workers (CHV) in achieving the target indicators. 6. They will be eligible for rewards if they exceed the set targets.	multiple roles as cadres.

b. A structured cadre recruitment system is needed.

1. **CHW Recruitment**

   The recruitment of cadres should be conducted by the sub-district/village with the establishment of a contract (letter of appointment) for a minimum of 1 year, which will be renewed based on periodic evaluations (every 3-6 months). This contract should be attached to the sub-district/village administrative structure.

   Criteria for CHW:

   I. Minimum education of high school diploma or equivalent.
   II. Proficiency in operating Ms Office.
   III. Age between 18-50 years, with exceptions considered based on specific needs.
   IV. No gender, ethnicity, or religious restrictions.
   V. Willing to be contracted for 1 year.
   VI. Preference will be given to candidates from the local community who are active in community activities, have a background in health education, and possess good communication skills.

2. **CHV Recruitment**

   Criteria for CHV:

   I. Able to read and write.
   II. No gender, ethnic, or religious restrictions.
   III. From the local community and actively involved in community activities.
   IV. Willing to undergo training.

c. Creating a division of roles between CHWs and CHVs can be based on the training received by each cadre. CHWs, who receive monthly incentives, will have a more prominent role in providing TB services compared to voluntary CHVs. CHWs will act as supervisors/coordinators, assigning tasks to CHVs. If CHWs are recruited from the community and have a background in healthcare education, their roles can align with the competencies of healthcare professionals under the coordination of health center staff. The division of roles can be found in the **appendix I**.

d. The determination of the required number of cadres is based on recruitment, taking into account the workload of the area and the number of patients to be handled. The recruitment system can utilize workload analysis based on the population size and target case detection in each area, considering the number of index cases that need investigation or support. This approach ensures that the number of cadres is sufficient to effectively carry out their tasks in the community. (example of workload analysis can be found in the **appendix II**). Besides, considering the funding to pay for CHW is also needed (find the example of the estimated funding to pay for CHW in the **appendix III**)

Conclusion

The implementation of the CHW and CHV systems is highly feasible, but it requires adequate budget formulation. Additionally, to ensure that CHWs and CHVs can contribute to the progress of TB control efforts in Indonesia, sufficient inputs are crucial, such as supportive policies, availability of logistics, multi-stakeholder involvement, funding, and an integrated healthcare system. The presence of CHWs and CHVs will provide a more meaningful framework for community engagement.

APPENDIX I

A. Roles between CHWs and CHVs can be divided based on the field conditions.

1	**Education on TB and sensitization for the community, PLTB and their family**	**CHW**	**CHV**
	TB campaign & mobilization activities	V	V
	Education on TB facts, prevention, treatment & care	V	V
	Education on TB-HIV & TB high-risk populations	V	
	TB Education based on a specific community / DRTB	V	
	Education on stigmatization, discrimination and impacts to PLTB and their family	V	
2	**Advocacy and mobilization**	**CHW**	**CHV**
	Conducting coordinations with DHO/PHC and local leaders for TB program & policy strengthening	V	
	Conducting communal mobilizations to endorse TB program & policy strengthening	V	V
3	**TB case finding & follow-up**	**CHW**	**CHV**
	Identifying TB high risk population/community	V	V
	Implementing TB screenings for TB high-risk population	V	V
	Implementing contact investigations for PLTB	V (KS)	V (KE) IK Non RT
	Conducting mobilizations and home-visit for newly diagnosed PLTB to initiate treatment	V	V
4	**TB treatment and care support**	**CHW**	**CHV**
	Tracking PLTB not initiated treatment	V	
	Assistance of drugs delivery		V
	Assistance as treatment supporter (observing medication)		V
	Assessing nutritional status and other treatment needs	V	
	Drugs side effects monitoring	V	V
	Supporting extended counseling which includes TB IPC for TB prevention	V	
	Providing PHBS (behavior of clean & healthy life) counseling, including on smoking and nutritions	V	V
	Treatment monitoring and evaluation	V	
	Tracking lost-to-follow-up PLTB		V
5	**TB-HIV**	**CHW**	**CHV**
	Providing counseling on HIV test	V	

	Providing partner counseling on “status transparency”	V (health worker)	
	Assisting HIV test result reading	V (health worker)	
	Providing counseling on positive prevention	V (health worker)	
	Observing anti-TB & ART medication intake	V	V
	Implementing TB screenings on PLTB contacts among HIV high risk populations	V	
	Conducting TPT education for PLTB contacts with HIV high risk	V	V
	Conducting TPT for PLHIV	V	
	Conducting coordination with HIV communities regarding PLTB-HIV	V	
6	**DR-TB**	**CHW**	**CHV**
	Tracking for PLTB uninitiated treatment		V
	Tracking for PLTB lost-to-follow-up		V
	Treatment supports (Observing medication intake)		V
	Drug side effects monitoring	V	
	Referral to health facility for extensive monitoring	V	
	Psychosocial and nutrition support	V	
	TB IPC counseling	V	
	Counseling for family/treatment supporter regarding TB IPC, universal vigilance and TB prevention	V	
7	**TB prevention therapy**	**CHW**	**CHV**
	TB Susceptibility test	V (health worker)	
	TB Susceptibility test result reading	V (health worker)	
	Contact mobilization to initiate TPT	V	V
	TB prevention therapy medication intake observation	V	V
	Drug side effects monitoring	V	
	Referral to health facility	V	V
8	**Other TB supports**	**CHW**	**CHV**
	Mental health counseling support	V	
	Nutritional/transportation to health facility helps	V	
	Public services access and social acceptance	V	V

	Gender & Human Rights Support	V	

B. Roles for CHWs with a background in healthcare education (scenario 1) and non-healthcare education (scenario 2).

Scenario 1	Scenario 2
- Optimizing Health worker-based talents for CHW - Monthly incentive is subject to the Provincial Minimum Wage (50% with a 20 hour/week time contract commitment) - Can perform TST injections on the spot during home visits and TST readings - Can take sputum on the spot if the screening symptoms are positive - Have counseling skills and more in-depth knowledge of TB	- Optimizing non-health based talents for CHW - Monthly incentives are subject to the status quo (900 thousand / month) with a time commitment of 20 hours / week. - Take sputum on the spot - Requires continuous training - Requires regular assistance - Have counseling skills and more in-depth knowledge of TB

APPENDIX II

Example A: Workload analysis for community health workers with activity indicator for Contact Investigation

It takes 220 minutes to conduct an Contact Investigation in 1 index case with a target of 3 household contacts. If the amount of available monthly incentive is 25-50% of the Provincial Minimum Wage, the time commitment requested from CHWs is 10-20 hours per week with an estimated index case target of Contact Investigation as much as 3-5 index cases or 9-15 home contacts per week. The number of index cases of Contact Investigation per year based on the time allocation provided (12-20 index cases per month) is 144-240 TB cases for 1 CHWs. The workload calculation is shown in the following table.

IK and TPT activity	**Time (minutes)**	**Frequency (time/person)**	**Time needed (minutes)**	**Notes**
First visit				
Education and counseling for index case	30	1	30	In 1 week and 40 hours of work (2400 minutes), time dedicated for Contact Investigation is 25-50%, 600-1200 minutes (10-20 hours) or in other words, time needed is 220 minutes. 600-1200 minutes/220 minutes = 3-5 index cases per week, or 12-20 index cases per month, or 144-240 index cases per year Notes: Routine main activity for CHW
Screening for sign and symptom for home contacts case	10	3	45	
Recording of household contacts referrals to health facilities	5	3	15	
Recording of 16K TBC	10	1	10	
Second visit				
Contact counseling and education for house contact in health facilities	30	1	30	
Follow up for Contact Investigation result				
Coordination with TBC officer in health facilities including submitted data validation	30	1	30	
On job training for cadre regarding IK and TPT	60	1	60	
Total time required			**220**	

Example B: Workload analysis for community health workers indicator of Drug Resistant TB activities

If the Case Manager is given a 100% monthly incentive, the time required to support TB RO activities is 265 minutes.

Activity	**Time (minutes)**	**Frequency (time/person)**	**Time needed (minutes)**	**Note**
New patient				
Education and counseling for patient	30	1	30	In 1 week and 40 hours of work (2400 minutes), time dedicated for

Education and counseling, screening for sign to family	15	3	45	patient assistance is 100%, MK assists 5 PS, with 15 patients per PS, so maximal 75 per MK. PS assist with 4 times face-to-face and one of them is home visits
Recording of household contacts referrals to health facilities	5	3	15	
Recording of baseline data	10	1	10	
LTFU initial patient				
Education and counseling for patient	30	1	30	
House contact and close contact investigation	15	3	45	
Follow up and coordination				
Coordination with TBC officer in health facilities including submitted data validation	30	1	30	
On job training for cadre regarding DR-TBC	60	1	60	
Total time needed			265	

APPENDIX III Estimated funding to pay CHW

No	Districts	Estimated total case index with confirmed bacteriological (54%) in 2022	Estimated total case index of contact investigation (3 months piloting)	Provincial Minimum Wage	Total contact in 20 hours (referring to available budget allocation IDR 900.000/month)	Total CHW needed with targeted case index of contact investigation 20 person/month (60 person/3 months)	Total fund needed to pay CHW (during piloting)	Total KS that will receive TBC screening	Total KS suspected with TBC (15%)	Total KS diagnosed with TBC (3,6%) from total KS	Total KS given TPT (30%)
1	Medan City	7.128	1.728	3.624.117	900.000	30	80.194.787	5.346	802	192	1.604
2	South Jakarta City	5.976	1.494	4.901.798	900.000	25	67.230.000	4.482	672	161	1.345
3	Bogor City	1.952	488	4.639.429	900.000	8	21.960.000	1.464	220	53	439
4	Bantul District	1.415	354	2.066.438	900.000	6	15.918.750	1.061	159	38	318
	Total	**16.471**	**4.118**			**69**	**185.303.537**	**12.354**	**1.853**	**445**	**3.706**

With an incentive of IDR 900,000/month, CHW Tasks:

1. Conduct IK in index cases and TB screening in household contacts
2. Make referrals for TB infection management
3. Conduct sputum collection for KS suspected of TB and referral for TCM examination
4. Carry out mobilization for KS diagnosed with TB to get TB treatment and assistance in taking TB medication
5. Mobilizing ILTB-diagnosed KS to receive TB preventive treatment (TPT) and assistance in taking TB medication
6. Coordinate and train CHWs to be able to screen for TB in close contacts and refer TB suspects to health care facilities
7. Coordinate with local sub-districts to improve/access quality TB services for patients and families.

For CHV: Can be given activities that match the needs/requirements of the process indicators. For example:

1. Assist CHWs in conducting TB screening in close contacts of bacteriological TB index cases (5 people/index case) through non-household IK activities.
2. Assist in being a drug swallowing supervisor (PMO) for TB treatment and TB prevention.

To support this activity, CHV will be given transport reimbursement according to available fund resources.

TBRO Assistance Activities (with implementation for 3 months)

No	Districts	Estimated total DR-TB case (2,4%)	Incentive/month	PS reward/month	Total CHW (MK) to do assistance with maximal 75/MK	Total PS to do assistance with maximal 15/PS	Total fun for CHW needed/month	Total fund for PS needed/month
1	Medan City	171	3.600.000	600.000	3	12	10.800.000	7.200.000
2	South Jakarta City	143	3.600.000	600.000	2	10	7.200.000	6.000.000
3	Bogor City	47	3.600.000	600.000	1	4	3.600.000	2.400.000
4	Bantul District	34	3.600.000	600.000	1	3	3.600.000	1.800.000
	TOTAL	**395**			**7**	**29**	**25.200.000**	**17.400.000**