GOVERNMENT OF KARNATAKA

PROJECT PROPOSAL
ON
TRIBAL HEALTH
FOR
WORLD BANK FUNDING

BY

DR. G.V. NAGARAJ
PROJECT DIRECTOR (RCH)

OFFICE OF THE PROJECT DIRECTOR (RCH)
DIRECTORATE OF HEALTH &FW SERVICES,
ANANDA RAO CIRCLE BANGALORE - 9.
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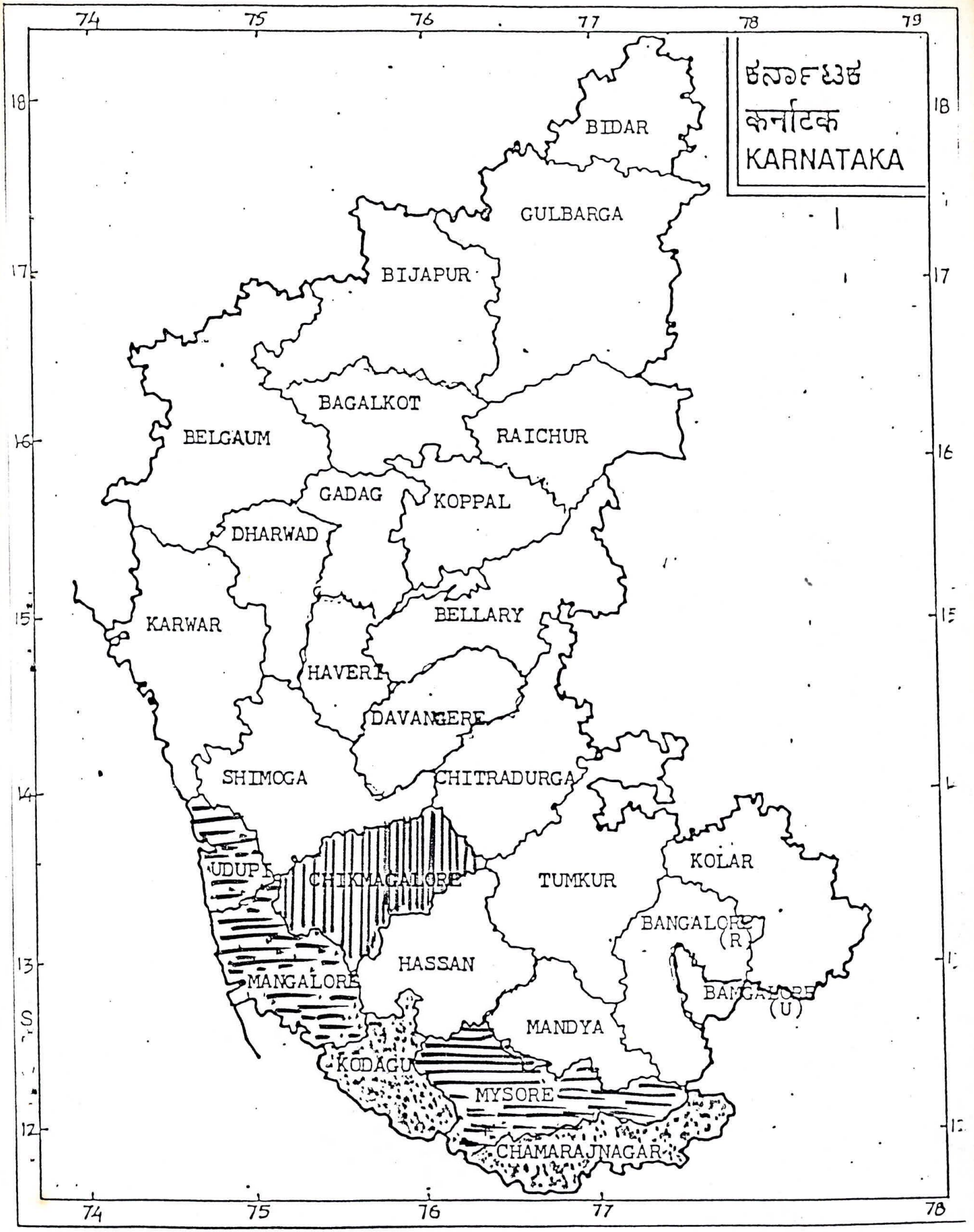
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PROJECT ON TRIBAL HEALTH

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PROJECT PROPOSAL ON TRIBAL HEALTH

1. INTRODUCTION :

The tribes for centuries lived in isolation and had limited contacts with other societies. Though this had helped them to preserve their culture and tradition, they remained practically under developed. Indian constitution makes a special provision for the welfare of tribal population. Under this provision, various schemes and programmes were initiated to improve their living conditions with special emphasis on education and employment.

2. BACKGROUND :

The Ministry of Health & Family Welfare, Government of India, is planning to support a Project for the tribal Health specially Reproductive and Child Health, with financial assistance from the World Bank. The Ministry of Health and Family Welfare has requested the State Governments to prepare the proposal keeping in view the guidelines provided by it in November, 1996.

3. FAMILY PLANNING PROGRAMME TO REPRODUCTIVE & CHILD HEALTH :

India' Family Planning programme (renamed as Family Welfare in 1978) has had a single objective for nearly 30 years, to reduce fertility as quickly as possible. The programme has sought to achieve this goal through a strategy based on contraceptive targets and cash incentives to acceptors and providers.

The objective of the Family Planning Programme is to reduce the birth rate. Contraception is only an instrument for bringing about reduction in birth rate. The success of the programme, with reference to the objective can be judged only on the basis of the reduction in the birth rate. The contraceptive target monitoring has led to a situation where the achievements of contraceptive targets has become an end in itself. Although there is successful performance in sterilization there has been no corresponding reduction in the birth rate.

Since the past few years, the Govt. of India recognized that contraceptive targets and cash incentives have resulted in the inflation of performance statistics and the neglect of quality of services.

The 1994 Cairo International Conference, on population and development, formalized a growing international consensus that improving reproductive health, including family planning, is essential to human welfare and development. This consensus recognises a crucial distinction between the overall goals of population policy and those of a reproductive health programme.

The principal goal of a reproductive health programme is to reduce unwanted fertility safely and to provide high quality health services, thereby satisfying to needs of individuals as well as stabilising the population.

A growing body of evidence and the consensus achieved in Cairo suggest that India's present system of numerical, method specific targets and monetary incentives for providers should be replaced by a broader system of performance goals and measures that focuses on a range of reproductive health services. The evidence also suggest that setting a broad range of reproductive health goals reduces fertility and enhance clients satisfaction and health. Govt. of India strongly supports the Cairo programme of action and Reproductive health approach.

4. REPRODUCTIVE & CHILD HEALTH :

Family Welfare Programme is being implemented from April, 1996, on the basis of Target Free Approach (TFA). Besides, the focus of the National Family Welfare Programme is to undergo a change from a segregated approach of Family Planning and Maternal Child Health Services to that of integrated approach under Reproductive Child Health Services in future. This means that RCH is equivalent to Family Planning and Child Survival & Safe Motherhood and Prevention of RTIs & STIs & AIDS.

Dr. Fathalla, in 1998, has defined Reproductive Health as 'A state in which people have the ability to reproduce and regulate their fertility, women are able to go through the pregnancy and child birth safely. The outcome of pregnancy is successful in terms of maternal, infant survival and well being and couples are able to have sexual relation free of the fear of pregnancy and of combating the disease'.

The 1994 Cairo ICPD Conference defines Reproductive Health as 'A State of complete physical, mental and Social well being and not merely the absence of disease of infirmity in all matters relating to Reproductive System and its functions and processes'.

The Reproductive and Child Health Services covers a wide range of services from womb to tomb as a life cycle approach in women's life. Infact it is a new agenda to improve 'Women's Health Status'.

5. NATIONAL HEALTH POLICY :

For the first time, in 1983, a National Health Policy was evolved. Having identified certain lacunae in the existing situation such as health manpower development, quality of services, policies, strategy and programmes, the policy strongly recommends the need for providing Primary Health Care with special emphasis on the preventive, promotive and rehabilitative aspects. It has been reiterated further that "In the establishment of the re-organized services, the first priority should be accorded to services to those residing in the tribal, hill and backward areas as well as to endemic diseases affected population and the vulnerable section of the society."

6. HEALTH & NUTRITIONAL STATUS OF TRIBALS :

As per our Constitution, schedule tribe means such cases, races or tribes or parts of or groups with in races of tribes as are declared by the President of India to be scheduled tribes under Article 342 of the Constitution.

Due to the exploitation, both socially and economically, characterised by extremely low level literacy and pre-agricultural level of technology, the tribal groups lag behind the rest of the society, both socially and economically. Their socio-economic backwardness is also reflected in their health condition/status.

There is very little baseline or epidemiological data available which can demonstrate that the health status of tribal people is much poorer than the general population. However, in a number of studies, both official and non-official, reports are available reflecting that the health problems commonly found among the tribal are nutritional deficiency among the children and anaemic among mothers, haematological disorders, sickle cell anaemia, seasonal disease like diarrhoea, among children below 5 years of age. Malaria, Tuberculosis, skin diseases, leprosy, goitre yaws is also prevalent in certain tribal pockets.

The Health problems among primitive tribes, are a cause for greater concern. The Health and nutritional survey of tribals in various states, have indicated problems like cervical lymphadenopathy, respiratory infections, genu valgum, goiter, sickle cell haemoglobin, and malaria.

Another health aspect of the tribal population that needs careful understanding and handling, is Reproductive Health Keeping in view the strong traditional socio cultural values of many tribal groups, the issues related to reproductive health of the tribal needs to be looked from different perspective. In many cases the approach has to be tribe specific, rather than general, as sexuality and reproductive behavior is favoured by tribal masses. In the context of decentralized participatory planning and Community Needs Approach, family planning itself becomes an issue to be debated upon by different communities. As such tribe specific approaches with a given geographical areas would obviously need to be devised. It is a fact that even the tribal group in the same state do not constitute a homogenous group . They are charactersed by marked differences in their culture, tradition, social status and even health behaviour. Considering the health status of this population, there has to be a specific strategy through which the health problems including reproductive health of the tribal population can be tackled.

Various available studies showed that tribal groups are characterized by high level of fertility and mortality. It also reflects that nutritional status of women is poor and anaemia is widely prevalent specially in pregnant women and is a serious health problem. The tribal people have also been found as deficient in calcium, Vitamin 'A', Vitamin 'C' and animal protein. As such there is a high incidence of malnutrition which is a serious health problem particularly for those having closely spaced pregnancy. Women are also affected by Reproductive tract infections and other pregnancy related diseases.

On account of large scale deforestation, tribal women have to walk longer distances to collect fire wood. Given the increasing work load women in advanced stages of pregnancy continue to work as usual.

The 1984 UN report on Health status of women mention that in developing countries atleast half of the nonpregnant and two thirds of the pregnant women are anaemic. In fact, most women in rural India suffer from nutritional anaemia and in the tribal regions the situation is even worse. It is said that anaemia lowers resistance to fatigue, affects working capacity and increases susceptibility to diseases. Diets of south Indian tribes are deficient even in respect of calories and total protein.

The nutritional status of tribal pregnant women directly influence their reproductive performance and birth weight of these children is crucial to infant chances of survival, growth and development.

7. TRIBAL AND MODERN SYSTEMS OF HEALTH CARE :

Both these systems of health care were found to be prevalent in tribal areas as tribal people live close to nature. Traditional system of medicine based on herbs, ayurveda, unani, siddha, naturopathy are existing hand in hand with modern allopathic system in different tribes. Basically, tribal systems of medicine is composed of three dominant components herbal, psycho-somatic and magico-religious and in most tribes, this is respected by people due to the belief and their low cost and access factors.

8. FAMILY WELFARE PROGRAMME IN TRIBAL AREAS :

The status of acceptability of family welfare programme is available in different tribal areas. Studies have shown that the rate of growth have not been uniform but have varied. Some of the smaller and remote tribal have been reported to be declining in population or living at a static level. At the other end of spectrum are some major ST group where rate of growth is said to have been exceeded the all India figure. It seems that the tribal demographic canvas calls for differential approach. The message of family planning need to be broadcast deep and wide to those groups which are multiplying faster than the norm and simultaneously small groups facing the prospect of decline which may ultimately lead to their extinction, need to be fostered. Such a differential approach necessarily implies precedent demographic studies focused on each ST group to gain knowledge of the growth rate and nutritional status.

9. RECOMMENDATIONS MADE BY NATIONAL COMMISSION FOR WOMEN (NCW)

1. Special attention needs to be given to the health problems of scheduled tribe women and children in pockets / districts identified by Central Planning Committee.
2. Training of tribal youth in primary health care.
3. To associate traditional tribal medicine - men leader's, witch doctors and bring them into the fold of health delivery system after training and equipping them appropriately.
4. Family Planning should be oriented to the demographic and social cultural milieu of the respective scheduled tribe. These family planning practices should not be propagated which are likely to do more harm than good.
5. To take necessary action to stop the spread of STD, HIV / AIDS
6. To conduct operational research in the field of health and nutritional status of the tribals including the various systems of medicine.
7. To conduct surveys to determine the morbidity pattern of tribal women.

10. PROFILES OF THE STATE:

10.1 Population,size & growth:

Population of Karnataka which stood at 14 million in 1901 increased to 20 million by 1951 and to 45 million in 1991. Thus the population in the State has increased by three and half times during the last ninety year period. The current population size (in 1997) is estimated to be close to 51 million and projected to be 56 million by 2001 A.D. which accounts to 5.31 percent of Indias population.

The State with an area of 1,91, 791 sq.kms. accounts for about 5.85 percent of country's total area of 32, 87, 263 sq.kms. Karnataka is the Eighth largest State in India in both area and population.

There are four revenue divisions in the State with headquarters at Bangalore, Belgaum, Gulbarga and Mysore. There are 27 districts in four divisions.

The sex ratio of 983 (in 1901) has declined to 960 (in 1991). However there are large variation between the districts.

The density of population has increased from 68 percent in 1901 to 101 by 1951 and 235 by 1991. Population growth in Karnataka has been close to natural average. Population growth rate which was less than 1 percent per annum upto 1931 increased to 1 percent during 1931-51 and exceeded 2 percent since then. There is a sharp decline in the growth rate during 1981-91.

10.2. Population distribution :

In 1901 the share of urban population was only 13 percent whereas it has increased to 31 percent in 1991.

10.3 SC & ST POPULATION :

One fifth of the total population in the State belongs to scheduled castes (16.38%) and scheduled tribes (4.2%). Over the years their share in the total population has varied.

Population	1981	1991
S.C.	15.07	16.38
S.T.	4.91	4.26
Total	**19.98**	**20.64**
NON SC/ST	80.02	79.36

There appears to be reduction in the ST population in 1991 as compared to 1981 census.

10.4 Literacy :

According to 1991 census, over half of the population (56%) aged 7 years and over are literate in the State Over two thirds of males (67%) and 44% of females have attained literacy by 1991.

10.5 Age at Marriage:

Age at marriage for females has been increasing gradually over the years at a very slow pace. singular mean age at marriage was 26 years for males and 19 years for females in 1981 and 19.4 in 1992.

10.6 Vital rates :

Estimates based on census data have indicated that crude birth rate has declined from 33 (1970) to 28.0 by 1990. There are seven districts where the level of CBR has reached 25 or below, 8 districts where CBR ranges between 25-29 and in 5 districts it is higher than 30. Since independence crude death rate has declined from a level of about 20 to 7.6 in 1998 The infant mortality rate has reached a level of 58 in 1998 from 89 in 1971 .

The recent SRS estimates (1998) has revealed the following rates :

Crude Birth Rate	22.0
Crude Death Rate	7.6
Infant Mortality Rate	58.0

expectation of life at birth has risen to 65 for both the sexes in 1990 from a level of 46 in the 60s.

10.7 Contraceptive acceptance :

There is an inter-district variation in contraceptive acceptance. However in general as of 1998, the contraceptive prevalence has touched 57% and the method mix is as follows :

	1997-98	Percentage
Sterilization	45.74	79
IUD	8.63	14
C.C.Users	1.91	4
O.P.Users	1.98	3
Total	58.26	100

10.8 Per Capita Income :

Per capita income in the State has increased from Rs.1557/- in 1980-81 to 5898 by 1991-92 at current prices.

10.9 Per Capita Expenditure :

As of 1989-90 the per capita expenditure (public sector) on health (Medical & Public Health) including water supply and family welfare is as follows :

	Health	Family Welfare
All India	69.85	13.18
Karnataka	54.15	11.42
		(in rupees)

10.10 Other Facilities :

Out of a total of 26857 villages and hamlets in the State, 171 villages were without any kind of road. There are 18,605 fair price shops.

11. THE PROJECT :

Government of Karnataka is proposing a SPECIAL PROJECT FOR TRIBAL AREAS' in the ITDP taluks of Mysore, D.Kannada, Kodagu and Chikkamagalur districts and requesting the financial support from World Bank through Govt. of India.

11.1. Objectives of the Project :

The following are the objectives of the Special programme in the tribal pockets of the State.

1. To sensitize the tribal and scheduled caste member of the community towards their health needs and to empower them to initiate, manage and sustain health action.
2. To improve access and utilization of health services by tribal and scheduled caste people especially women.
3. To train health-volunteers from the local SC/ST community members for provision of basic health services, immunization and safe delivery.
4. To take actions to reduce malnutrition through nutrition counseling and networking with ICDS.
5. To bring in integration of health delivery system services provided by Primary Health Care system and local tribal and indigenous systems of medicine at the community level.

11.2 Areas for investments :

Urgent action needs to paid to tribal pockets in the districts of Mysore, D. Kannada , Kodagu and Chikkamagalur.

11.3 Project Districts :

11.3.1 Population : The ST population in the project district as per 1991 census is as follows

Sl.No.	Districts	% ST Population to General. Population
1.	Mysore	3.23
2.	D.Kannada	3.94
3.	Kodagu	8.25
4.	Chikkamagalur	2.81

11.3.2: Project districts profile :

The tribal sub plan (TSP) stategy came into operation from 5th Five year plan. This is being implemented through 23 integrated tribal development projects (ITDP) together from 4 districts. These projects have been setup in blocks where there is concentration of ST population.

11.3.3 : BASELINE SURVEY OF TRIBAL POPULATION IN KARNATAKA (JUNE 1995)

The population centre Bangalore has under taken tribal survey in the districts of Chikkamagalur, D.Kannada, Kodagu and Mysore . The Salient findings of this survey are listed

* The accessibility to tribal settlements remain restricted due to less number of vehicle movement and also difficult in use of mud roads during rainy seasons.
* These tribes are living mainly in the interior areas, many do not have access to natural source like river, tank etc. A small proportion mainly who are living in the tribal colonies have tap water facility (about 9 percent).
* Only 8 percent of the total settlement have an allopathic doctor and about 6 percent have ayurvedic doctor.
* Health facilities available to the tribal population under the study were not adequate.
* The visits by the health workers were grossly inadequate. It was only about 33 percent of the total settlements received weekly visits, about 17 percent received fortnightly visits and about 27 received monthly visits.
* Crude Birth Rate comes to about 26 per 1000 population.
* Crude Birth Rate was about 30 among the households where the heads of the household were illiterate and about 25 among the households where the heads of the household were literate.
* Birth rate decreased as the household income increased.
* GFR, of the tribes was higher than in the State as a whole.
* GMFR of the Hasalaru and the Koragas were higher than the State average
* The TFRs of the tribes were slightly lower than that of the State.
* The crude death rate was highest among the Hasalaru and lowest among the Soligas.

* highest proportion of death was observed for both males and females due to senility.
* percentage availing treatment from government allopathic doctors was higher than private allopathic doctors.
* Only very small proportion of respondents were availing treatment from other systems like Unani, Ayurveda and Homeopathy.
* indigenous system of medicines were also popular among the tribes.
* 77 % of respondents expressed their first preference for private allopathic doctor.

* proportion of heads of household who did not encounter any problem was high.

Problems encountered	Hasalaru	Koraga	Jenukuruba	Soliga	All tribes
Medicine was not available	53.7	46.7	56.9	60.0	54.3

* About 34 percent of respondent expressed that the health staff demanded money.
* The most important problem expressed by the heads of household was the non-availability of medicines.
* About 22 percent of heads of household expressed that they have to wait for long time in the health institutions.
* The average time required to wait at the health centre was about 50 minutes.
* Most of the women may like to have about three or more children.
* There was strong preference of son.
* 78 percent of the respondents were in favour of practicing family planning methods by married couples.
* About 66 percent of the respondents expressed that their husbands approved the practice of family planning methods
* Attitude towards the small family size was favourable among the tribes.
* About 94 percent of the respondents are aware of vasectomy as against about 87 percent of tubectomy.
* Regarding different temporary methods such as condoms, IUD and Oral Pills the awareness is about 42 percent only.
* Awareness of temporary methods is lowest among the women
* 52 percent were not using any family planning method.

* About 48 percent are using family planning methods.
* The users of temporary methods was only about 1.2 percent.
* 71 percent of the women/or their husband of the total acceptors accepted family planning methods due to motivational effort made by the health staff.
* 23 percent of the acceptors were self motivators.
* Government institutions were the main place where the family planning services were availed.

* Role of private hospitals in adopting family planning methods was not very high
* The average number of living children of the sterilization acceptors was 3.0.
* Desire for more children is the main reason for not accepting family planning methods.

* preference for one more son was also one of the reasons for non-acceptance.
* 74percent of them were registered for ANC.
* 77 percent of the pregnant women had received TT during their ante-natal period.
* 76 percent of the women did receive the iron and folic acid tablets.
* 61 percent of the women who delivered during the reference period were registered for PNC services.
* 73 percent of the children are given first dose of DPT and Polio.
* 57 percent got full quota of three doses of DPT and polio drops.
* The extent of immunization against measles was about 27 percent.
* occurrence of diarrhoea among the children was not very high
* more than 43 percent of respondents have listened radio programme during last 6 months prior to the survey about family planning, immunization and ORS.
* Therefore, it may be necessary to provide them with better accessibility of health and medicine, better education and employment before their further decline in growth rate.

11.3.4 : RCH SURVEY :

The Institute for Socio Economic Change (ISEC) has carried out RCH survey in 1998 in 10 districts and the findings for 4 districts having tribal population have been summarized.

DISTRICTS PROFILE

A - General

Item	Mysore	D.Kannada	Kodagu	Chikkamagalur	Total
1. ST Population (1991 census)	0.83 (Lakhs)	1.06 (Lakhs)	0.40 (Lakhs)	0.26 (Lakhs)	2.55 (Lakhs)
2. No.of ITDP Talkus	8	8	3	4	23
3. No.of Villages	528	585	400	173	1686
4. PHCs in ITDP Taluks	33	48	12	10	103
5. No.of Sub centres in the ITDP taluks	460	594	109	328	1491
6. Dais	166	179	72	37	444

B - Key indicators* of Project Districts**

Indicators*	Mysore	D.Kannada	Kodagu	Chikkamagalur	State average (10 districts)
1. % of Girls marring below 18 yeas.	Not Available	4.5	22.0	37.0	35.2
2. % of Births order 3 and above	NA	32.0	18.8	26.1	27.8
3. CPR	NA	63.7	70.6	71.4	58.1
4. Unmet need	NA	16.1	8.5	8.1	18.1
5. % of Preg.Women with ANC	NA	98.5	100	91.7	89.3
6. % Prg. of Preg.Women with full ANC	NA	84.9	88.4	68.2	27.2
7. % of Institutional Deliveries	NA	76.6	67.7	62.4	52.5
8. % of Safe delivery	NA	91.5	79.4	78.0	62.3
9. % of Child with complete immunization	NA	86.0	94.8	83.5	64.9
10. % of child with no immunization	NA	0.5	0.5	0.0	8.3
11. % of Females with symptoms of RTI/STI	NA	24.2	21.1	20.5	18.8
12. % of Males with symptoms of RTI/STI	NA	2.8	4.2	5.5	4.4
13. % of Females aware of HIV/AIDS	NA	78.4	74.9	66.5	60.7
14. % of Male aware of AIDS	NA	85.7	90.9	90.4	73.1

* This will not show true picture in the tribal pockets of the districts

** Rapid house hold survey, Phase-I, 1998

11.3.5 : LITERACY STATUS (%) OF ST POPULATION IN THE STATE.

Population	Total	Rural	Urban
General Population	56.04	47.69	74.20
Tribal Population	36.01	32.57	55.08

12. STRATEGY :

Improving of lives of tribal women means improving their health. In addition long term improvements in Education and Employment opportunities for women will have a positive impact on the health of the women and children. In the short term, significant improvement can be expected if existing health care services for tribal women are strengthened and expanded to meet their specific needs.

There is an indication that the female sex ratio in the ST population in 1991 in the State is showing a declining trend compared to 1981 census. In 1981 it was 971 and 1991 it is 961.

The strategy of providing effective and efficient services can be planed by analyzing the existing problems and taking up various interventions keeping in view the objectives spelt out under para 11.1.

12.1A: Problems and needs of Tribal Population : The NFHS' 1992 survey data has revealed various vital indicators of the state in general. The Phase-I, RHS - 98 survey has been completed in 10 districts and the data is applicable to the districts in general including ST population. (Refer 11.3.1 - B) except the baseline tribal survey conducted by population centre in 1995, there is no specific and recent baseline data available throwing light on the Demographic and vital indicators among the tribal population *per se*. Further, data on the morbidity pattern in the tribal population is not available particularly in the ITDP taluks either by NFHS or RHS survey. The information on any count is not available for Mysore district as this district has not been covered in the phase -1 RHS survey.

Some of the data available for the tribal population at the National level are as follows

1. Literacy among schedule tribes as per 1991 census is only 29.6% (Male, 40.65%, Female 18.19%).
2. Fertility of ST women (3.5) is slightly higher than the fertility of other women (3.4).
3. The unmet need for spacing birth (11%) and the unmet need for limiting births (9%) for the tribal women is same as of the National level. (20%)

4. Only 18.5% of ST women received Antenatal care at home during pregnancy
5. 56.2% pregnant women didnot receive any TT where as only 40.2% for given IFA.
6. 79% were home deliveries without proper hygienic care and no professional help when complication develop.
7. Despite the high level of female morbidity and mortality ST women do not seek medical help even in the late stages of problems.
8. Issues like RTI/STD, Menstrual disorders and unwanted pregnancy are also neglected due to lack of information, lack of accessibility of health services and poverty.
9. Pregnancy related risk and low birth weight with its consequent complications and mortality is high among tribal women.
10. ST women will be suffering from anaemia and malnutrition due to lack of Iron, portion, Iodine, vitamin 'A' etc.,
11. Lack of access to basic health care, to right food, low literacy rate, poverty are the causes for chronic ill health and early deaths.

12.1B : Demographic Profiles and Morbidity surveys : For the effective management of any health intervention. basic health data is essential. This is lacking for tribal areas. It is therefore proposed to carry out a rapid baseline survey in these specific areas with concentration of tribal population. The survey which will reveal not only micro level demographic data but also magnitude of various disease prevalent there, is proposed to be entrusted to reputed research organization

12.1C : Documentation and Service Delivery : The Health and FW Department has distributed the MCP (immunization) cards as per the requirement of the districts and the Eligible Couple Registers (EC Registers) at the rate of one register per thousand population. It is mandatory to collect a detail information from all the house holds and necessary entries are made in the EC registers. This work should be completed at the end of January / February, 2000 so that a complete information is available before start of the Project. Apart from the Health Staff, Volunteers can be hired for this work after a brief training and necessary documentation is proposed to be kept ready.

The MCP (immunization) cards and EC registers distributed have reached the service outlets and are under use. The necessary documentation work along with services are proposed to be followed up intensively for quality and coverage in RCH services.

13. INTERVENTIONS

13.1 : Service Delivery : Out reach health care services through Primary health care system is largely in place but implementation problems have been noticed due to difficult terrain in tribal areas. Travel time is an important factor to ensure adequate utilization of services in a health facility.

13.1.1 Problems in tribal areas.: The barriers for the utilization of health care services are :

1. Weak infrastructure particularly with regard to the accommodation because of which doctors and para - medical staff do not stay in these areas. Also the highly dispersed nature of the population, the sitting of the PHC s and subcentres and poor communication (transportation) has resulted in distance and so poor access of the health facilities. Many of the sub centres are stated to be non functioning in these areas.
2. Inadequate availability of local persons as para medical workers and high percentage of vacancies among doctors has resulted in non-implementation of many of the health and family welfare programmees and poor health services.
3. Lack of communication with tribal community because of which the tribals are not aware of the existing health facilities and along with other existing barriers such as distance poor transportation etc.,The health facilities are thus under utilised . Generation of awareness and community participation would increase the utilization of the existing health facilities.

13.1.2 : To improve the access and coverage in remote hilly and difficulty terrains where tribal people are often residing, it is proposed to provide additional Jr. health Asst. Female (ANM) after careful selection of the sub centre keeping in mind the tribal population to provide door to door service and education. An additional supervisor for existing primary health centres in the tribal area to supervise the ANMs and also Para Medical Staff in day to day work is proposed. The ANM would visit a every village / hamlet regularly on fixed days and provide essential health care services, guidance on nutrition and pregnancy related matter they would provide immunization services and health education. They would also train traditional birth attendants and local traditional practitioners.

The Job responsibilities as detailed under RCH guidelines will be scrupulously adhered. Each health worker will be provided with drug kit 'A' and drug kit 'B'. Linkages will be established with the Anganawadi workers in all the activities of on going ICDS programme.

It is proposed to appoint additional work force such as Jr. Health Asst. Female and Supervisors on contract basis for the project period of two years.

As the programme gets into operational mode, it is proposed to introduce "Red card" system for identified high risk pregnant clients, confirmation of the same and also referral to avail emergency obstretic care (EmOc) services. Further, it is proposed to bear transport charges for such referred emergency clients.

It is also proposed to activate the existing Mahila Swasthya Sanghas (MSS) to take up 'Awareness Generation' programmes by suitably restructuring the inputs for functioning of these sanghas. Their role will be made more realistic to the needs and wishes of the tribal population.

Many a times the tribals live in inaccessible / remote areas, cut off from quick means of transport and communication and in areas which often donot have enough easy and quick means for basic necessities of life and are at the same time susceptible to life and also to a variety of diseases. The problems of health and medical care can be tackled by bringing the tribal population under the umbrella of inexpensive preventative medical care through a set of para medical personnel and services.

A cadre of para medical personnel is proposed to be organized and set up for tribal areas in order to provide adequate medical coverage to the entire tribal population.

The paramedical functionaries will be assigned the role of an active health assistant and an eductionist to educate the tribals in matter of personal hygiene and health as well as sanitation.

Training of local teachers, post masters, village level workers, for 3 days to function as para medical personnel and training of Boys and Girls for 7 days is proposed to be takenup. In discharging this responsibility, they will be given remuneration. Each one will be visiting a tribal village in his jurisdiction every day and be available there for a period of time notified (at least 1-2 hours per day/week). This will be known to all the concerned. Dais will also be involved in maternity care after they are trained. Each one will be provided with both a Dai Delivery kit and Dai Drug Kit which will be specially assembled. Disposal Delivery Kits will also be supplied. Remuneration will be given for the identified tasks to be accomplished by each of the volunteers and Dais. Necessary funds will be released at the disposal of Gram Panchayat / village Committees proposed to be constituted.

In addition to the para medical worker, a qualified Doctor with a supporting staff is proposed to visit certain specified, important, and centrally located tribal village at lest once a week to conduct "village clinics" wherein the Doctor will hire of vehicle examine the clients referred by para medical worker and also get the investigation of their ailments. While conducting such clinics the delivery of integrated health services will be kept in mind to provide services according to the needs of the population. Additional drugs worth of Rs0.50 lakhs per PHC will be given .

Gender sensitivity will also be kept in mind to arrange conducting clinics by the Lady Medical Officer particularly in cases of essential obstretic care (EsOC) and also emergency obstretic care (EmOC) clients and also help Family in choosing family welfare methods. Addition Drugs worth of Rs.0.25 lakhs per PHC will be given to EsOC/ EMOC case.

13.2 : Mobility support :

The Health care institutions particularly Primary Health Centres are well placed in general in the ITDP blocks. Because of constraints, these institutions are yet to be strengthened with mobility support. As a beginning, it is proposed to provide four wheeler vehicles for priority and identified institutions. The drivers will be hired on contract basis for a period of two years. It is also proposed to meet the expenditure towards the cost of vehicles, drivers salary and fuel expenses out of the project funds. Increased mobility will have quantum leap in the benefits such as intense supervision of out reach services, organization of village health clinics, shifting of emergency cases of either mother or child, bringing clients for RCH services, conducting of tribal RCH sessions, intensification of IEC activities, arranging training programmes, community mobilization activities, survey work, and also evaluation.

13.3 TRAINING OF HEALTH CARE PROVIDERS

One important factor for the poor utilization of health facilities in tribal areas has been the non-availability of curative and preventive services when an emergency sick client approach the health post. It is therefore imperative to increase professional skills of local TBAs, Local Traditional practitioners and also create a force of young health volunteers who belong to the tribal community and are physically present in the area at all times. It is proposed that the selection of the volunteers will be made by the concerned village Panchayat.

* Training for volunteers will be organized closer to their houses. Training would be participatory building on their knowledge with emphasis on practice and learn by doing. The duration of the training is proposed to be for a period of one week.

* The training content for tribal girls will cover areas such as maternal care, child care, treatment of anaemia, diarrhoea, reproductive tract infection, immunization and family welfare. Tribal Health Kit will be provided for each of the volunteers.

The training content for tribal boys will cover areas such as diseases specific to local area, malaria, case detection and examination of slides, tuberculosis, treatment of diarrhoea, pneumonia, leprosy and environmental sanitation.

Remuneration will be given for the identified tasks to be accomplished by each of the volunteers. Necessary funds will be placed at the disposal of Gram Panchayats/Village Committees proposed to be constituted.

* Training of Traditional Birth Additional assumes greater importance since the practice of ante-natal and post-natal care among tribal population will be different from amongst general population. Whatever may be the practice, the out come of pregnancy and delivery should be safe. Hence the TBAs will be given 'Hands on Training' in the nearby institutions identified for the purpose for ensuring child survival and safe motherhood status.

The duration of the training will be for a period of 7 days both at the institutional and field level. Each Dai will be provided with a 'Dai kit' containing essential items to be used for ensuring 'Five cleans'.

Credibility of the services by the trained traditional Dais (TTDs) will be further enhanced by providing each one of them with a 'Dai Drug Kit' which is proposed to be specially assembled for this purpose containing basic items such as Analgesics, Eye drops/Ear drops, Bandage, cotton, etc.,

* Training of locally available personnel to function as part time para medical worker is also proposed which will last for 3 days during which time the local teachers, post masters, village level workers will be oriented towards preventative and curative health services so that they can act as change agents in the respective community. They will be given remuneration for the part time work they turnout.

Training materials will be developed / reproduced depending upon the duration of training and also relevant to the trainees. Appropriate resource persons will be drafted for the training, keeping in mind the local field experiences and best practices. Models, charts, pictures, mapping gowns, will be developed locally for easy convey of the contents of Health & FW Services.

It is necessary to focus attention on traditional tribal medicine practitioners/ healers and bring them under the fold of public health care delivery system by identifying them, contacting them and training them appropriately and equipping them with appropriate drug kits.

Refresher training is also proposed during the second year with reduced duration

13.4 Drug Kits :

While we detailed the service delivery aspects in para 12.1 it is very essential that each category of personnel involved in service delivery must be equipped with necessary inputs such as basic items for maternity care and also drug kits consisting either of nutrients or medicines. The credibility of the Health staff and also of the programme lies on this crucial input. Availability ensure better confidence and response from the community side. Different types of Health care Provider needs different types of inputs as follows :

1.	ANM (JHAF)	Drug Kit 'A" Drug Kit 'B'	Outreach services
2.	Doctor	Drugs for Primary Health Care	Village clinics.
3.	Lady Doctor	ESOC & EMOC Drugs	Village clinics
4.	Trained Tribal Boy Trained Tribal Girl	Tribal Health Kit	Outreach Services
5.	Trained Dais	Dai Delivery kits, Dai Drug kits	Outreach services
		Disposable Delivery Kits	Outreach services
6.	MSS	MSS Kits	Outreach services

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13.5 INFORMATION EDUCATION & COMMUNICATION ACTIVITIES :

Given the situation of low literacy rates among tribal population, it is worth investing in IEC activities in creating demand generation for the preventive and promotive health care services.

Providing health education, information on sanitary environment, best health practices, disease control measures, preventing diseases and motivate for participation in improvement of their own health needs are the areas proposed for intensification of IEC activities.

Programmes will be developed to suit the local culture and ethos of the tribal population. The local community will be involved while developing the programmes.

Interpersonal communication and interspousal commutation are proposed to be taken up as priority issues.

Folk artists will be identified and their talent will be fully tapped.

Audio-visual health programme intermixed with entertainment will be taken up in the most inaccessible pockets of the tribal areas in the form of TV spots through A.V. vans.

Health exhibition in the form of display boards in AV vans will be arranged at strategic points to attract the community and seek health behaviour changes.

Health fairs tagged with services are also proposed in the tribal areas .

Health message campaigns once a month from each PHC will be taken up in remote and backward villages.

Interactive group meetings / orientation camps both for men folk and women folk will be repeatedly arranged to do away with superstition and myths.

Local talented persons will be encouraged to involve as 'message provider' in health and family welfare programmes particularly child health and maternal health interventions.

13.6: Project Management (Refer Organization Chart)

* At each Gram Panchayat level, a Committee consisting of Local Medical Officer, Gram Panchayat head/member, women (preferably ST) a Teacher will be made responsible for planning, implementation and monitoring of the programme.

* At PHC level, the Medical Officer will not only be responsible for planning, implementation and monitoring the activities in his jurisdiction but also maintain coordination with the activities outside his jurisdiction. He will use the monthly meetings as the right and best opportunity for improving coverage and quality.

* At Taluka level, the taluk health officer will supervise the programme during the visit of the PHCs / villages but also during the monthly meetings.

* There will be a Nodal Officer at district level preferably a Medical Officer borne under this Project who will be made exclusively responsible for planning, implementation, monitoring and logistics for the entire district under this special programme. This tribal project officer (TPD) will be working under the control of District Health & FW Officer and coordinate with district RCH officer. Hiring of special accommodation and stores is also proposed during the project period

* A vehicle preferably a jeep with a Driver and POL expenses for each of the district is proposed for focussed attention in the project management. The expenditure towards this is proposed under the project funds. As an alternative it is proposed to go in for hiring of the vehicles for this purpose. A well designed calendar of programme schedule will be drafted every month and strictly adhered.

This continuous and intensified supervision which is lacking in the present health system will result in perceptible change in the health care delivery system both in terms of coverage but also in quality which are the crucial twin objectives of RCH programme.

* The District Health & FW Officer as chairman of the Tribal Health Committee involving District Social Welfare Officer, Assistant Director (W&C), Deputy Director (Public Instruction), district publicity Officer, District RCH Officer as Members and the Tribal Project Officer as Member Secretary will meet once a month / on a by-monthly basis and review all aspects of the programme for bettering in subsequent months.

* The Chief Executive Officers, of Zilla Panchayats will be appraised by the Dist. Health & FW Officer during the monthly meeting and seek necessary guidance and help in management of all aspects of the programme.

Sustained linkages will be established from the most peripheral village level upto State level with Women & Child Development Dept., Social Welfare and Education Dept.

* It is proposed to constitute a State Level Committee headed by Principal Secretary, HFWS, and the Secretary for Finance , Secretary Women & child Development Dept., Secretary Social Welfare Dept., Commissioner, HFWS., and Director of Health and FW Services as Members and Additional Director (Primary Health) as Member Secretary.

14. PROJECT COST

While estimating the cost of the Project the following assumptions have been made.

1. This project will be part of 100% Centrally Sponsored Scheme and there will be no State share in the budget.
2. The project will be implemented for a period of 2 years initially and continued beyond, subject to the success in the implementation.
3. Without waiting for any specific survey findings exclusively planned for the tribal population, the progress/activities will be started immediately after the project is sanctioned.
4. All the necessary pre-requisites will be fulfilled for immediate project take off .
5. The cost is subjected to variation depending upon the actuals at the time of implementation.

6. There will be no 'civil works' involved in this two years project.
7. The interventions that are proposed in the project are not part of any on going programme or earlier projects. Hence, there is no duplication.
8. The project cost will be (refer annexure for details)

Ist year	:	672.35 lakhs
IInd year	:	518.85 lakhs
Total	:	1191.20 lakhs

15. PROJECT OUTCOME

The success in the implementation of the programme can only be judged on the improvement of not only of 'Practices' but also on various demographic and vital indicators.

In the absence of any recent baseline data confined to tribal population, it is not desirable to identify bench marks at this Stage.

Hence the baseline survey needs to be takenup immediately. In the meanwhile higher client acceptance of services, client satisfaction, improvement in quality of services, reduction in morbidity and mortality could serve as yard sticks.

16. MONITORING & LOGISTICS :

The process of monitoring consists of deviations between actual and standards, diagnosing the causes of such deviations and taking necessary corrective actions.

Therefore the process of monitoring mainly depends on continuos feed back of the activities going on at different levels and of different activities in the form of reports from the service points.

As regards registers, the existing/ongoing programmes registers will be utilised at the field level.

A simple single sheet reporting format will be introduced and the information will be furnished by each of the Junior Health Assistant (Female) incorporating not only details about her activities but also of other Health Care Providers, such as Dais, Para-Medical Personnel etc.,

As far as possible care will be taken not to overload the personnel with too many registers and reports and thus minimises her wastage of time so that she will devote more time for service delivery.

The Tribal Project Officer at District level will compile statistical information from all the service points of the districts through primary Health Centres and keep the data ready for review in the meetings.

Logistics Management, drug kits, Dai kits, vaccines and contraceptives will be taken care by proper and timely receipt, proper documentation, appropriate storage, quick distribution and optimal utilization.

17. EVALUATION

Once the inputs are placed in position and implementation is progressing it is essential to have inbuilt evaluation mechanism both concurrent as well as terminal. It is proposed to have a reputed agency, negotiate with them, enter into contract and assign the evaluation work so that there will be no shocking surprises at the end.

18. SUSTAINABILITY

As there is a minimum creation of permanent assets, liabilities in terms of expenditure is not high. The contract personnel and the vehicle inputs can be deployed against the deficiencies contemplated at the end of the project period.

ANNEXURE

PROJECT COST

Sl. No.	Item of Expenditure.	Unit cost	No.	Ist year (Rs.in lakhs)	IInd year (Rs.in lakhs)	Total (Rs.in lakhs)
1.	2.	3.	4.	5.	6.	7.
1	*BASELINE SURVEY*		1	6.00	-	6.00
	Total			6.00	-	6.00
2.	*SERVICE DELIVERY*					
	a) Recurring expenditure for ANMs Salary	0.50L per annum	100	50.00	50.00	100.00
	b) Contractual Staff - LHV	0.72L per annum	25	18.00	18.00	36.00
	c) Remunaration to Health Volunteers			0	0	0
	I] Tribal Girls	@Rs.50/week for 52 weeks	1686	43.83	43.83	87.66
	ii] Tribal Boys	@Rs.50/week for 52 weeks	1686	43.83	43.83	87.66
	d) Remuneration to Paramedicals	@Rs.25/week for 52 weeks	500	65.00	65.00	130.00
	e) Red cards	Rs.5/ per card	1000	0.05	0.05	0.10
	f) Hiring of two wheelers for village clinics	@Rs.60/week for 52 weeks	103	3.22	3.22	6.44
	Total			223.93	223.93	447.86
3.	*MOBILITY SUPPORT*					
	a) Four wheelers (Diesel driven)	3.50 L	23	80.50	0	80.50
	b) Drivers salary	0.04 L per month	23	11.04	11.04	22.08
	c) POL expenses	0.12 L per annum	23	2.76	2.76	5.52
	Total			94.30	13.80	108.10
4.	*REFERAL TRANSPORT*	0.002 L	1000	2.00	2.00	4.00
	Total		1000	2.00	2.00	4.00

5.	*TRAINING*					
	a)1. Training of Health Volunteers (7days)	DA Rs.300/- candidate TA Rs.50/- candidate	3372 3372	10.12 1.67	10.12 1.67	20.24 3.34
	2. Remuneration to resource person (@ of Rs.700/- per person)	7 days x Rs.700 x 68 bathes	68 batches of 50 each	3.30	3.30	660
	b)1. Training of Para medicals (3days)	DA Rs.100/- candidate TA Rs.50/- candidate	500 500	0.50 0.25	0.50 0.25	1.00 0.50
	2. Remuneration to resource person	3 days x Rs.300 x 10 bathes	10 batch esof 50 each	0.09	0.09	0.18
	c) 1. Training of Dais (7days)	DA Rs.100/- candidate TA Rs.50/- candidate	500 500	1.50 0.25	1.50 0.25	3.00 0.50
	2. Remuneration to resource person	7 days x Rs.300 x 50 bathes	50 batches of 10 each	1.05	1.05	2.10
	d) Training Materials (printed models charts, maps, mapping gouns)	0	6 types	20.00	10.00	30.00
	e) Refresher training	0	0	35.00	15.00	50.00
	Total			69.29	39.29	82.58

6	*DRUGS AND DAI KITS*					
	a) Kit 'A' Twice in a year	0.03 L	100	6.00	6.00	12.00
	b) Kit 'B' Twice in a year	0.01 L	100	2.00	2.00	4.00
	c) Tribal Health Kit one time	0.005 L	3372	17.00	17.00	34.00
	d) Primary Health Care	0.50 L/PHC	103	51.50	51.50	103.00
	e) ESOC and EMOC drugs	0.20 L/PHC	103	20.60	20.60	41.20
	f) Dai kits (Instruments)	Rs.300/-	500	1.50	0	1.50
	g) Dai drug kits	Rs.1000/-	500	5.00	0	5.00
	h) Disposable Delivery Kit (DDKs)	Rs.6/-	6400	0.40	0.40	0.80
	I) MSS kits	Rs.300/-	200	0.60	0.60	1.20
	Total			104.60	98.10	202.70

7.	*INFORMATION, EDUCATION & COMMUNICATION*					
	1) Workshop					
	a) Statelevel	1.00 L	1	1.00	1.00	2.00
	b) Dist. Level	0.50 L	4	2.00	2.00	4.00
	2) Folk artist programme (once in a month)	0.005 L	100/ PHCs	6.00	6.00	12.00
	3) Audio - visual vans (Once in 6 months)	1.00 L	4	8.00	8.00	8.00
	4) TV spots	0.25 L	10	2.50	2.50	5.00
	5) Health fairs at each taluk (23)	0.10 L	23	2.30	2.30	4.60
	6) Health Message campaign (Once a fortnight)	0.005 L	50/PHC	6.5	6.5	13.00
	7) Orientation camps (Once in a month)	0.005 L	100 / PHC	6.00	6.00	12.00
	8)Printed materials	3 types	0	5.00	5.00	10.00
	9. Photo display	0	0	10.00	5.00	15.00
	Total			156.80	156.80	313.60

8	*PROJECT MANAGEMENT*					
	1) Salary of Tribal Project Officer	0.12 L	1	1.50	1.50	3.00
	2) Four wheeler (Dist)	3.50 L	1	3.50	0	3.50
	3) POL expenses	0.15 L	1	0.15	0.15	0.30
	4) Driver	0.04 L	1	0.48	0.48	0.96
	5) Reports (monthly formats)	0	0	6.00	4.00	10.00
	Total			11.63	6.13	17.76

9.	*LOGISTICS*					
	1) Rent for Office accommodation	0.10 L / month	1	1.20	1.20	2.40
	2)Stores	0.05 L / month	1	0.60	0.60	1.20
	Total			1.80	1.80	3.60

10	*EVALUATION STUDIES*	0	0	2.00	3.00	5.00
	Total	0	0	2.00	3.00	5.00

	Grand Total			672.35	518.85	1191.20

TRIBAL PROJECT HEALTH MANAGEMENT

ORGANISATION CHART

STATE LEVEL COMMITTEE

↑

TRIBAL HEALTH COMMITTEE
(DISTRICT LEVEL)

↑

TRIBAL PROJECT OFFICER
(DISTRICT NODAL OFFICER)

↑

TALUK HEALTH OFFICER

↑

GRAMA PANCHAYAT COMMITTEE

Annexure - I

CONTENT AND COST OF M.S.S. KIT

Sl. No	Contents		Cost
1.	Programme Information kit per set on RCH	Rs.49.18	50.00
2.	Flip Book on RCH each copy	Rs.27.60	30.00
3.	Booklet on RCH each copy	Rs.9.50	10.00
4.	ORS pockets (20)		40.00
5.	Disposable Delivery Kits (10)		60.00
	Total		190.00

Annexure II

CONTENT AND COST OF DAIS DRUG KIT

Sl. No.	Contents	Quantity	Cost
1.	Paracitamal Tab.	1000 Tabs.	150.00
2.	Eye drops	10 botls.	50.00
3.	Antibiotic creams (2")	5 tubes	75.00
4.	Bandage cloths	25 roll	250.00
5.	Benzine benzite lotion	5 bottles	250.00
6.	Cotton roll (small)	1	140.00
	Total		915.00

(Total Ruppes Nine Hundred and Fifteen only)

Annexure - III

CONTENTS OF DAI KIT

Sl. No.	Contents	Quantity
1.	Cotton gauge sterilized	6 pockets
2.	Basin kidney tray	1
3.	Mucus extractor (disposable)	6
4.	Foetouscope	1
5.	Enema can	1
6.	Thread umbilical	1 (25 meter)
7.	Plastic sheeting	1
8.	Scissor	1
9.	Dais kit bag	1
	Total cost of each kit is Rs.300/- (Three hundred only)	

Annexure - IV

ITDP TALUKS AND MSS

Sl. No	Districts - Blocks	ITDP Taluks	No.of MSS
1.	H.D. Kote - Mysore	1. Chamaraj nagar	52
		2. Gundlupet	36
		3. H.D.Kote	40
		4. Hunsur	57
		5. Kollegal	30
		6. Nanjanagud	43
		7. Periyapatna	30
		8. Yeldur	20
2.	Ponnampet - Madikeri	1. Somwarpet	40
		2. Virajpet	40
		3. Madikeri	40
3.	Udupi - Mangalore	1. Udupi	40
		2. Beltangadi	24
		3. Karkala	31
		4. Kundapur	31
4.	Puttur - Mangalore	1. Puttur	24
		2. Sulya	17
		3. Bantwal	33
		4. Mangalore	30
5.	Mudigere - Chikkamagalur	1. Koppa	28
		2. Sringeri	12
		3. Mudigere	48
		4. N.R. Pura	20

Annexure - V

CONTENTS OF DRUG KIT A

Sl No.	Name of the Item	Quantity
1	Oral Rehydration Salt (O.R.S.)	150 packets
2	Tablet I.F.A. (large)	15000 tabs
3	Tablet I.F.A (small)	13000 tabs
4	Vitamin A solution	6 bottles of 100 ml each
5	Tablet Cotrimoxazole (Paediatric)	1000 tabs

Annexure - VI

CONTENTS OF DRUG KIT B

SL No	Name of the Item	Quantity
1	Tab Methylergometrine Maleate (0.125mg)	500 tablets
2	Tab Paracetamol (500 mg.)	500 tablets
3	Inj. Methylegometrine Maleate (0.2 mg/ml., 1ml ampoule (for I.M. use) in light resistant amber colour ampoules)	10 ampoule
4	Tab Mebendazole 100 mg.	300 tablets
5	Dicyclomine HCl 10 mg	250 tablets
6	Chloramphenicol Eye Ointment 1% w/w in applicaps. Each applicap to contain 250 mg. of ointment	500 applicap
7	Ointment Povidone Iodine 5%	5 tubes
8	Cetrimide Powder	125 gm
9	Absorbent Cotton	1 roll
10	Cotton Bandage (4cm wide x 4m length)	120 rolls