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sure cure for **TB.**

Revised National Tuberculosis Control Programme

TRIBAL ACTION PLAN

(Proposed for the World Bank assisted
RNTCP II Project)



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Introduction

Tribals constitute 8.08% of the country's population, which makes India the second largest concentration of tribal communities in the world (**Census 1991**). There are 635 tribes in India located in five major tribal belts across the country. Seven Indian states account for more than 75 percent of the tribal population. The main concentration of tribal people is the central tribal belt in the middle part of the India and in the north-eastern States. However, they have their presence in all States and Union Territories except the State of Haryana, Punjab, Delhi and Chandigarh. The predominantly tribal-populated States of the country (tribal population more than 50% of the total population) are: Arunachal Pradesh, Meghalaya, Mizoram, Nagaland and Union Territories of Dadra & Nagar Haveli and Lakshadweep (**IDSP 2003**). There are 533 tribes (with many overlapping types in more than one State) as per notified Schedule under Article 342 of the Constitution of India in different States and Union Territories of the country with the largest number of 62 being in the State of Orissa. The prominent tribal areas constitute about 15 percent of the total geographical area of the country and correspond largely to under developed areas of the country (**IDSP 2003**).

Tribal people live in geographical isolation mostly in remote, inaccessible hilly areas. They are referred to as backward, due to their lack of capacity to utilize the opportunities of development offered to them. They are illiterate, have traditional beliefs and constitute the poorest of the poor segment of the Indian population (**Mutatkar RK 2004**). In view of this, the RNTCP needs to make specific efforts to address the problem of access and utilization of TB services by this socially and geographically marginalized group. Poverty and poor infrastructural development in tribal dominant areas have been the main reasons contributing to inability of the RNTCP in reaching out to tribal populations. Though outside the purview of RNTCP, mobilization of the people in these regions in collective action for poverty alleviation will pave the way for a better and sustainable model for TB control in tribal-dominant areas.

Current Achievements

Inadequate database of tribal population based disease burden and health care utilization poses severe constraints to effectively plan and or evaluate any health care intervention in tribal areas (THDP 2003). With the coming up of Integrated Disease Surveillance Project (IDSP) which would cover phase-wise all states of India such database would become available soon (**IDSP 2003**).

The analysis of the RNTCP data over a one-year period from 3rd quarter 2002 to 3rd quarter 2003, shows that the performance in terms of case detection and cure rates in a sample of predominantly tribal districts in the tribal-dominant states of India, was similar to the rest of India. However, in view of the recent implementation of RNTCP in most of the tribal districts across the tribal belt, these findings need to be viewed cautiously over a longer period of time before arriving at any conclusions. The delayed start in the implementation of RNTCP in the predominantly tribal districts throughout India, also throws light on the difficulties encountered by the RNTCP in covering these populations.

- 1) Despite the Government of India's special provision in the tribal sub-plan areas which include additional health facilities, viz., one PHC catering to 20,000 persons instead of 30,000, one sub-centre for 3000 instead of 5000 people, provision of more mobile clinics,

allopathic, homeopathic, ayurvedic, unani and siddha dispensaries, access to health care is a problem for tribals (**IDSP 2003**).

- 2) The remoteness of many tribal villages from the nearest PHC / General Hospital, inadequate accountability and monitoring of health service delivery to tribal populations, unhelpful attitudes of health service personnel, manpower at health facilities either not available or available only for a very small window of time have been documented as constraints to access and utilization of health services in tribal areas (**THDP 2003**). Besides, poor or incorrect knowledge among tribal population also dictates inadequate health seeking behaviour.

- 3) Some of the problems faced by programme managers while implementing RNTCP in tribal areas based on data from Keonjhar district in Orissa (**AC Nielsen-ORG 2005**) are as follows:
 - a) Significant proportion of tribal population live in small settlements and there is lack of adequate health staff for extension of services at an accessible distance to this population
 - i) Limitations of non-tribal health workers in motivating the tribal patients to complete treatment by mobilizing the community support.
 - ii) Inadequate transport facilities make it difficult for patients to reach health functionaries/health centers on time.

 - b) In order to overcome these problems community-based DOT has been introduced by involving the Anganwadi Workers (AWWs) who are the community based child health workers under the Government's Integrated Child Development Scheme (ICDS). These women with at least primary education belonging to the same village where they are expected to serve, provide IEC, identify chest symptomatics, provide DOT and undertake defaulter retrieval. Their activities are monitored by the multipurpose health workers of the local PHC, the STS under RNTCP, the Medical Officers and the ICDS supervisors. The AWWs receive an honorarium of Rupees 500 per month towards their services relating to ICDS but are not paid extra for TB related services. Several problems have, however, been reported like increased work load, poor commitment due to lack of monetary rewards and their low educational attainments and poor training resulting in their poor comprehension levels and professional skills.

- 4) The social assessment survey conducted in 3 tribal districts – Nandurbar in Maharashtra, and Jhabua and Mandla in Madhya Pradesh (**AC Nielsen-ORG 2005**) found the following:
 - a) The only facilities available in the tribal villages, which were scattered across 1- 4 hamlets (50 – 150 households) were a primary school and Anganwadi Center. Most of the facilities like bank, post office, bus stop etc were located outside the village within a radius of 1 – 6 km. Railway stations were far (20 – 65 km) from the villages. While some of the facilities were situated at a walk-able distance and some were connected through bus. In the study villages of Mandla, the health services were delivered to selected villages through the sub centre and PHC within the village itself, whereas in Jhabua, these services were reported to be available within 1 – 2 km distance. More or less all the villages were approachable through a kutchra road from the main traffic road.
 - b) Barring a very few, most of the tribals were illiterate. A majority of them were employed as agriculture labour. They had been staying in the same village since birth.
 - c) Stigma was relatively less among this population compared to the vulnerable population in urban areas.
 - d) The first point of help seeking for most tribal TB patients, as documented by the survey, was traditional healers following home remedies, the gap between onset of symptoms and

- help seeking ranging between 4 and 5 months. A study in Vizianagaram district of Andhra Pradesh (**Banerjee A et al 2004**) also demonstrated similar health seeking behaviour among tribals. The delay between onset of symptoms and initiation of treatment under the RNTCP was 8 months or more for 30% of the patients in this study. This study also documented that though the majority of the THs were not aware of the cause or spread of TB, more than 90% believed TB is curable and most preferred to refer patients to a PHC or private allopathic practitioners when they were unable to treat their clients rather than another TH.
- i) The methods most often employed by traditional healers was witchcraft using pulses and other seeds, for both diagnosis and treatment.
 - ii) Tribals usually resorted to these kinds of treatment because of local beliefs, cost and lack of awareness about treatment options.
- e) Patients in tribal areas had to travel long distances to reach Microscopy and DOT centers.
- i) Patients traveled between 1.5 to 10 km to reach the DOT centers in the 3 districts studied.
 - ii) Inaccessibility was an issue to tribal patients more when they had to visit a facility for initial diagnosis, though later on the treatment facility/ DOT provider was relatively close to them.
- f) Community participation in the RNTCP was very poor, public-private partnerships were in the infancy.
- i) The traditional healers, who are an integral part of the tribal community and can influence large sections of the population were also not integrated into the programme.
 - (1) The study from AP (**Banerjee A et al 2004**) found that public health functionaries felt THs would be good DOT providers because of their status in the community. THs were also perceived by these functionaries to be always available and hence easy to supervise.
 - (2) Most NGOs contacted in this study (**Banerjee A et al 2004**) were working with THs in the area of health and IEC, though none of them was collaborating with the RNTCP. They were willing to mediate between THs and RNTCP management for effective implementation.
- g) Community volunteers and opinion leaders were not aware of the programme. This could be attributed to the lack of IEC activities in tribal areas.
- h) Exposure to IEC on TB, DOTS and RNTCP was very low among these groups, relatives, friends, government hospitals and subcentres being the sources of information reported by most of them.
- i) The AP study (**Banerjee A et al 2004**) found that NGOs were willing to mobilize and motivate the community with the help of IEC, according to the local needs.

Issues to be addressed

- Poor physical access of tribal population to diagnosis and treatment under the RNTCP
 - Difficult terrain and sparsely distributed tribal population in forest and hilly regions
 - Locational disadvantage of PHIs
 - Weak primary health care infrastructure including diagnostic equipment
 - Vacant Posts at PHIs
 - Non availability of staff for supervision and monitoring
 - Long distances to travel to reach to Microscopy centres and PHIs
- IEC activities not in tune with the tribal vocabulary, beliefs and practices
 - Lack of conviction among patients about the curability of the disease
 - Focus on “duration of TB treatment” in IEC activities
- Non involvement of traditional healers and weak community participation

- Inadequate involvement of NGOs and CBOs
 - Inadequate social mobilization and poor community participation
- Public health services not being client friendly in terms of timing and cultural barriers inhibiting utilization
 - Attitude of para medical staff towards patients needs improvement
- Lack of integration with other health programmes and other social and developmental sectors

Action Plan proposed:

The Revised National Tuberculosis Control Programme already has special enhanced norms for tribal areas in that there is relaxation for setting up Designated Microscopy Centres and Tuberculosis Units as compared to the non-tribal areas. Whatever is proposed in this plan is additional. The existing norms would continue as they are.

For assistance in implementing this plan, the STCSs and DTCSs will collaborate closely with the local ITDA (Integrated Tribal Development Agency). These bodies go by different names in different states and wherever allusion is made to the Tribal Development Agency in this plan, it refers to the governmental Tribal Development Agency in that locality. NGO bodies working for tribal development are considered as separate entities. The DTCS will correspond with the ITDA to identify a nodal person, who will thereafter liaise with the DTO to carry out activities related to the Tribal Action plan.

The RNTCP Tribal Action Plan has the following objectives:

1. Encourage tribal populations to report early in the course of illness for diagnosis.
2. Enhance treatment outcomes amongst tribal populations
3. Promote closer supervision of tribal areas by RNTCP staff

Objective	Actions
Improve service coverage and provide quality RNTCP services	<ul style="list-style-type: none">• Encourage and support STS and STLS in tribal areas to reach peripheral areas, by providing additional incentives (like tribal area allowance).• Provide travel reimbursements to patient and one attendant for travel for follow-up and treatment• Organize local public felicitation of DOT providers and STS, STLS along with the staff contributing substantially to the RNTCP• Ensure availability of RNTCP-trained staff and infrastructure at the PHC level (filling up of vacancies, relaxation of appointment norms, dealing with staff turnover by having waiting lists, ensuring availability of microscopes and lab consumables). LTs posted at tribal DMCs will also be supported with tribal area allowance. The two-wheelers maintained at TUs having tribal DMCs will be allowed enhanced vehicle maintenance rates similar to that in other difficult areas.• Arrange IPC training to all cadres of providers for making them more sensitive to patient needs• Use available mobile units in place to increase outreach of DOTS in difficult to reach areas
Improve accessibility,	

<p>acceptability and utilization of the services</p>	<ul style="list-style-type: none"> • Train peripheral health workers in RNTCP • Introduce sputum collection and transportation <ul style="list-style-type: none"> ◦ Using community youth ◦ Using outreach workers like Anganwadi workers, ASHA etc • Seek help of locally available and employed volunteers trained in health in case detection and case holding • Seek help of cured TB patients and literate tribal youth in spreading awareness about treatment availability for TB • Offer sensitization and training to traditional healers regarding the uninterrupted and free availability of TB medicines under the RNTCP.
<p>Promote community participation and inter-sectoral coordination</p>	<ul style="list-style-type: none"> • Involve NGOs, traditional healers, private practitioners, AWWs, CHWs, cured patients, tribal youth and other community based volunteers in IEC activities and to provide DOT • Involve NGOs, PRIs, tribal heads, elected representatives, SHGs and CBOs in supervision and monitoring of DOT provision • Involve teachers and students in tribal residential schools (Aashram schools) in provision of DOT • Develop locally relevant IEC messages and patient education material using local vocabulary, prepared by taking help of local primary school teachers and members of PRIs • Use local chemists, grocery shops and other places frequently visited by tribals, to disseminate information on RNTCP and DOTS • Use the opportunity offered by village fairs and festivals as well as weekly market days to inform tribal population regarding DOT • Link IEC in RNTCP with the social mobilization campaigns held under the Integrated Disease Surveillance Project, which is being implemented in nine states in the first phase (Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Mizoram, Madhya Pradesh, Himachal Pradesh, Kerala and Uttaranchal)
<p>Undertake operational research</p>	<ul style="list-style-type: none"> • Qualitative study to understand the barriers in utilization of RNTCP services in tribal areas • Evaluation of IEC messages prepared in locally relevant tribal dialects / language • Cost benefit analysis of incentives provided to patients for taking DOT vis-à-vis treatment outcomes in tribal districts • Evaluate case detection and treatment outcome trend in tribal districts

Targets and Indicators

- Increasing trends of case detection and treatment success in a sample of pre-defined districts with higher proportion of tribal population
- Treatment success and default rates of female patients compared to male patients
- Locally adapted IEC messages and patient education material in place
- Operational research study results available to assist in further planning and implementation of RNTCP in tribal pockets

Newer Strategies

- Use community meetings of PRIs as a forum to initiate community-based activities like early detection, sputum collection, DOT, monitoring and social support for needy patients
 - Mobilize political will and involvement at local levels through involvement of local elected representatives, and PRIs.
 - The District Collector, BDO and gram sevaks could be used to institutionalize PRIs to garner support for community mobilization for DOTS
- Involving Aashram school teachers and students to provide DOT
- Involving primary school teachers in disseminating IEC material
- Using chemists, grocers' shops and other places frequented by tribals to disseminate information on DOTS

Resources required: Manpower and Finances

Costs involved in:

- It is proposed to pay a higher rate of salary to contractual STS and STLS posted at TUs with tribal area DMC, at the rate of an additional Rs.1000/- over and above the regular salary as a tribal area allowance.
- Two wheeler maintenance at TUs having DMC in tribal area will be allowed at the rate of Rs. 30,000 per annum.
- Training of community-based DOT providers approved at RNTCP rates for training.
- Sputum collection and transport - Rs.100 to Rs.200 per month per volunteer based on number of visits to DMC to hand over collected sputum. An amount of Rs.100 per month would be given if there is a minimum of one visit to the health centre per week with collected samples. For more than one visit per week to the centre, an amount of Rs. 200 per month will be paid to the volunteer.
- Travel costs as bus fares for patients and one attendant will be provided for travel for follow-up and treatment. To cover these costs the patients will be given an aggregate amount of Rs. 250/- which would be given on completion of treatment.
- Tribal area allowance for Lab Technicians who take up posting at tribal areas as enhancement of pay of Rs. 1,000 per month over and above the regular pay.
- Production and distribution of locally appropriate IEC material for patient and community like flip charts, information leaflets
- Supervision and monitoring of community-based treatment

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