

Annex 11

SAFEGUARD POLICY ISSUES

VULNERABLE COMMUNITIES' PLAN

A. Legal and Institutional Framework

The term 'vulnerable community' describes groups with social, cultural, economic and/or political traditions and institutions distinct from the mainstream or dominant society that disadvantage them in the development process. 'Indigenous people' (known as 'Scheduled Tribes' (ST) or 'tribal groups' in India) are recognized as vulnerable communities, and so too are the 'Scheduled Castes' (SCs) and economically poor ('Below Poverty Line' or BPL), including those belonging to minority religions. 'Scheduled Castes' are those who remain outside the four main Hindu castes. The Indian Constitution (Articles 341, 342) recognizes several communities as STs and SCs and confers a special status on them to make up for their disadvantages. Other amendments include SCs professing Buddhism or Sikhism in this special category view of their continued socio-economic deprivation. A number of provisions in the Constitution aim to abolish all forms of discrimination against STs and SCs, and many public development programs target them and/or BPL people. However, the majority of STs and SCs continue to be vulnerable as reflected by their socio-economic characteristics such as low literacy, prevalence of poverty (46% of STs in rural areas and 35% in urban areas are estimated to be BPL). In India around 8% of the total population is ST and 17% is SC. About 27% of the total population is BPL.

The Indian Government designates areas where more than 50% of the population is tribal as 'Scheduled Areas' (under Fifth Schedule of the Indian Constitution). In these areas, the interests of STs are especially protected. For all-round development of STs, a Tribal Sub Plan (TSP) Strategy has been adopted. Under the TSPs, almost all areas inhabited by a tribal majority are addressed by one of the following development programs (depending on their population percentage: (i) Integrated Area Development Project; (ii) Modified Area Development Approach; (iii) Clusters; and (iv) Primitive Tribal Groups. The systematic use of protective measures and other powers available to the executive in 'Scheduled Areas' are recommended by government in TSP areas as well for the effective implementation of development programs targeting tribal people. Consequently, since 1976 the boundaries of Scheduled Areas have been made co-terminus with TSP areas, and this is reviewed from time to time. Many districts or parts of districts in the proposed project states of Andhra Pradesh (A.P.), Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh (M.P.), Maharashtra and Orissa are 'Scheduled Areas' (Table 1) and other tribal areas are TSP areas.

There are no specific laws relating to the provision of health care to STs and SCs. However, they are a key focus of National Health Policy which recognizes that improving the health of these vulnerable groups is critical to achieving national health goals. Tribal habitations are concentrated in remote, forest or hilly areas for which the Government has reduced the population norms for health care infrastructure: one health Sub-center staffed by Male and Female Multipurpose Health Workers (MPHWs) is to be provided for every 3,000 (instead of 5,000) people, a Primary Health Center (PHC) with two doctors for 20,000 (instead of 30,000) and a Community Health Center (CHC) with four medical specialists for 80,000 (instead of 100,000). The National Rural Health Mission (NRHM) launched in 2005 is improving access to health care by strengthening the public health system notably with a village-based worker known as the Accredited Social Health Activist (ASHA), greater engagement of the private sector, and increased and flexible financing. It is enhancing community demand for and ownership of services, and coordinating planning and implementation across related sectors such as Women and Child Development and Tribal Affairs. Currently all sectors are mandated to allocate and spend 'population percentage proportionate' funds on ST and SC programs.

In many tribal areas, traditional panchayats and Tribal Councils deal effectively with tribal issues. In addition to these traditional leadership systems, the 'modern' system of panchayats has been extended to Scheduled Areas through special legislation, the Panchayat Extension to Scheduled Areas Act. The NRHM has enhanced the ability of local panchayats to address local needs and priorities to improve health by providing untied funds to Village Health and Sanitation Committees (VHSCs). Additional flexible funds are provided to Sub-centers and

Female Multi-Purpose Health Workers (also known as Auxiliary Nurse Midwives, ANM) and local panchayats have been mandated to use these resources to meet urgent local health needs..

B. Baseline Information

Information on the major tribes inhabiting the proposed project states and salient demographic and development data are presented in Table 1. There is great diversity in their ethnic and cultural identities, and the geographic and environmental conditions in which they live. Their unique myth and belief systems, family and kinship structures, food and dress habits, housing conditions, political organization and economic pursuits and status influence their concepts of health and sickness, health-seeking behavior, and the pace and magnitude of their acceptance of ‘outside’ interventions.

Table 1. Number of Scheduled Areas and Important Tribes, ST Population (as percent of total population) and some Indicators of their Development in the Project Districts

State/Union Territory	Number of Project Districts (a)	Number of Scheduled Areas (b)	Number of Important Tribes in Project Districts	ST percent of total population	Development Indicators of ST populations		
					Sex ratio	IMR	Literacy Rate
Andhra Pradesh	M: 5	M: 4	10	6.6	972	104	37.0
Bihar	KA: 33	None	9	0.9	929	82	18.9
Chhattisgarh	M: 17	M: 10	15	31.8	1013		52.1
Goa	M: 1	None	4	0.04	893		55.9
Gujarat	M: 12	M: 7	12	14.8	974	60	47.7
Jharkhand	M: 10, KA: 2, M and KA: 5	M: 7, KA: 1, M and KA: 5	10	28.7	987		27.5
Karnataka	M: 8	None	12	6.6		85	
Madhya Pradesh	M: 19	M: 11	17	20.3	975	101	41.2
Maharashtra	M: 4	M: 2	16	8.9	973	74	55.2
Orissa	M: 14	M: 11	17	22.1	1003	99	22.3
Rajasthan	M: 2	None	5	12.6	944	95	44.7
Tamil Nadu	M: 1	None	Urban Area	1.0	980		41.5
Uttar Pradesh	KA: 1	None	None	0.1	934	83	35.1
West Bengal	M: 2, KA: 10, M and KA: 1	None	15	5.5	982	85	43.4
A& N Islands	M: 1	None	3	8.3			

Notes: (a) M: number of districts for malaria control; KA: number of districts for kala azar elimination. (b) Scheduled areas are districts or parts of districts with more than 50% ST population.

Sources: Census of India 2001; National Family Health Survey 2 (2002)

C. Summary of Social Assessment

A Social and Beneficiary Assessment (SABA) was carried out by an independent agency during project preparation to enable tribal communities to participate in preparation of the proposed Project and ensure that the Project is designed and implemented in accordance with their health and socio-cultural needs. It also aimed to achieve a clearer understanding of tribal communities to facilitate their informed participation, assess whether the Project would have any adverse impact on them, and help with the preparation of a Vulnerable Communities’ plan. The SABA was undertaken in four states: A.P., Chhattisgarh, M.P. and Orissa. It included a synthesis of available information, interviews with relevant workers and officials, and a household survey

using a mix of open- and close-ended questions. In addition, tribal groups were consulted through focus group discussions. The key findings and recommendations of the SABA are summarized below, and additional inputs from the consultations are provided in the next section.

Surveillance, Case Diagnosis and Management

- Personnel at health Sub-centers, village volunteers, functioning laboratories at PHCs/CHCs, and mobile vans are contributing to improvements in health services and disease surveillance. Rapid Diagnostic Kits (RDKs) and anti-malarial blister packs have also contributed to quick diagnosis and treatment compliance. However, in difficult locations there are deficiencies in supplies, personnel and monitoring which steer the care-seeker to traditional healers or the unorganized private sector. These often dispense non-standardized diagnosis and treatment and may entail greater expenditure. Filling up critical vacancies at peripheral health centers (qualified practitioners, lab technicians, health workers), ensuring that drugs are not stocked out, and frequent monitoring are needed to ensure timely diagnosis and effective treatment.
- Public-private partnerships (PPP) have been initiated in many areas. Private nursing homes and clinics report malaria cases to the District Programme Officer on a monthly basis and in the event of increases remedial measures are taken by the public health system. This system requires scaling up.
- The risk of VBDs varies seasonally. A Seasonality-based Action Plan was recommended at district level to ensure adequate coverage with drugs/ITNs and reduce the risk of epidemics. Intensified surveillance and information to the public (about what is being done and what it needs to do) using various communication channels were recommended.
- *SWOT analysis.* The role of health workers/volunteers in implementing programs with a focus on women and children was seen as major strength. It was suggested that they be better skilled and equipped and provided performance-based incentives to enhance effectiveness. Active involvement of panchayats was also seen as strength. Weaknesses to be addressed included: inadequacies in health care system, inter-sectoral coordination, monitoring, and stakeholder involvement in planning, implementation and monitoring. The NRHM was viewed as an opportunity to improve health infrastructure, stakeholder participation, community empowerment, capacity of health/non-health sector staff to address local needs and priorities, use of resources, and M&E. Potential threats were: inappropriate treatment by unqualified service providers, inadequate community mobilization and capacity-building, sub-optimal use or misuse of available resources and staff, and adverse impacts of unplanned development projects.
- *Capacity building.* Training and regular reorientation were emphasized as ways to remove some of the deficiencies noted in service delivery especially in tribal areas. This would also prevent indiscriminate use of drugs, incomplete treatment and drug resistance. Health worker training to support the efforts of doctors in developing local strategies and planning was also mentioned.

Integrated Vector Management

- Insecticide-Treated Bed-Nets (ITNs) had been distributed free of cost to the very poor by the Government. Others were charged highly-subsidized prices between USD 0.25 and 0.50. Along with health workers and volunteers, panchayats were involved in ITN distribution and in educating communities about the use of nets, precautions and re-treatment of nets. However, bed-net use ranged from about one-third to two-thirds of those who received them. In tribal communities, the use was particularly low on account of the habit of sleeping in the open, and the traditional belief that forbids sleeping under a 'foreign' object such as a roof or net. Because of crowded housing conditions (families have an average of five members), sleeping under one bed net was not feasible. There was also a lack of perceived benefits. Nevertheless, during a malaria epidemic in some villages, children were encouraged to sleep under bed nets. Although bed-nets were reportedly purchased from the market as well, there was very little information on community-owned bed-nets. About one-half of community members expressed their willingness to pay for ITNs supplied by the government. It was recommended that areas be prioritized for bed-net distribution on the basis of risk, a high proportion of *Pf* cases, and inaccessibility for indoor residual spraying (IRS).
- Social marketing was recommended to increase access to ITNs and other health products and services.
- Some positive traditional practices were mentioned such driving away mosquitoes by burning neem leaves, other forest herbs, cow dung or paddy stubble. Some tribes use repellent body oils.

- Although it was widely known that mosquitoes cause malaria, there was little knowledge of mosquito breeding habits. Only in one study area were people aware of the need to cover stored water, spray kerosene oil over stagnant water, etc. Given open drainage systems, garbage disposal and ‘toilets’, the need to address environmental sanitation and personal hygiene to reduce vector-borne diseases was discussed.
- Some villages had not been sprayed for a year or so. Lack of advance information for IRS reduced its coverage. However, tribal people were also reluctant to allow their homes to be sprayed as tradition holds that family deities and ancestors’ souls live inside and protect surviving children. The entry of strangers is considered polluting. The involvement of PRIs, however, has led to improved acceptance. In addition to IRS, some villages (especially in Chhattisgarh) are using biological control measures (e.g., larvivorous fish).

Community Awareness, Attitudes, Beliefs, Practices.

- In inaccessible villages with deficient services, the dependence of tribal people (particularly ‘primitive’ tribes) on practitioners of traditional medicine is absolute. However, traditional knowledge about herbs, plants, etc. is eroding with time. About half of the tribal people interviewed/consulted voiced a dependence on traditional beliefs, customs and practices, including tribal priests and medicine men. They mentioned consulting public health staff or local doctors only when they were not able to get any relief. However, this is changing gradually in villages that are close to PHCs or have qualified health workers/doctors.
- Awareness generation campaigns by the government in the past few years did not reach about half of the sample villages. Not unexpectedly, therefore, about half of all respondents continue to have traditional beliefs about the cause of malaria [e.g., the ‘wrath of God’ (20%), witchcraft (15%), strolling in the forest (4%), eating stale food (2%), drinking bad water (1%), etc.]. Although a majority of respondents recognized fever as a symptom of malaria, around one-sixth did not. Similarly, vector breeding sites, prevention and treatment measures, etc. were not widely known. The most common route of information was counselling (inter-personal communication) by health workers or doctors. Tribal people had limited access to radio/TV and posters/newspapers also had minimal reach. Intensified campaigns and improved access to facilities were recommended.

D. Summary of Consultations with Affected Indigenous Peoples

Free, prior and informed consultations were held with tribal communities in the proposed Project areas during project preparation. The project background, objectives and purpose of the discussions were explained to the target groups to set the context for consultation. Focus group discussions and individual interviews were conducted. Interactions were also held with non-governmental organizations (NGOs) and community-based organizations (CBOs) such as Self Help Groups or women’s groups (Mahila Mandals), Panchayati Raj Institutions (PRIs), Tribal Councils, etc. that represented tribal groups and were working on public health related programs or issues. Their main points and recommendations are given below.

Surveillance, Case Diagnosis and Management

- Service delivery related to VBDs is inadequate in many tribal areas. During the monsoon many PHCs are unable to handle the patient load and replenish stocks. Examination of blood smears for malaria and treatment are often delayed (for three days or more), and hence there is always a risk of the disease spreading. In some PHCs delays occur on account of the lack of a laboratory technician. Multi-purpose Health Workers collect blood smears and provide treatment, but their domiciliary visits are somewhat irregular, as they have to cover a large dispersed population. Their capacities and efforts to sensitize and mobilize communities are often limited. The effectiveness of Fever Treatment Depots (FTDs) is also inadequate. Radical treatment is started as soon as fever cases are confirmed positive for malaria, but only at PHCs. Treatment compliance is frequently a challenge as tribal communities tend to take low dosages and resort to local herbal medicines. The Anganwadi Workers (AWWs) under the Integrated Child Development Services Scheme give vector-borne disease control activities lower priority as they are heavily engaged in maternal and child care.
- Faster and better quality services should be ensured, partly by filling up staff vacancies. The focus of PHCs, Health Workers (HWs) and Volunteers on VBDs needs to be reinforced from time to time through reviews. Information campaigns could help to build people’s trust in HWs and FTDs and should be intensified along

with the workers' capacity building. Stock outs of drugs should not be allowed. Laboratory technicians should be posted full-time in tribal PHCs. Fever detection camps and clinics should be conducted regularly during monsoon months. The roles and responsibilities of AWWs need to be review and prioritized, especially in view of the engagement of ASHAs under NRHM.

Integrated Vector Management

- Preventive measures such as insecticide spraying are delayed even when a malaria positive case is diagnosed due to inadequacies in resources, storage space, spraying equipment, etc. Spraying should be timely as well as focal. Spraying activities are undertaken with DDT, malathion or synthetic pyrethroids (in keeping with insecticide policy) but synthetic pyrethroids are preferable because of their quick knockdown effect against vectors. Malathion leaves stains on walls and furniture and is not favored. Micro-planning should be done to ensure timely resource mobilization, adequate infrastructure and equipment, optimal coverage and quality of IRS. The insecticide policy should be reviewed in view of community resistance/acceptance of different types.
- The supply of free or subsidized ITNs to BPL households in highly endemic areas is inadequate. Bed-nets are used only by those who realize their benefits and can afford to buy them. Tribal people, especially the poor, are yet to understand the benefits of bed-nets in the absence of a sustained information campaign. Health care personnel are uncertain that even free bed-nets would be used. The demand for free or subsidized ITNs to BPL households in highly endemic areas should be met and coupled with promotional activities involving PRIs, Tribal Councils, NGOs, CBOs and/or volunteers in communicating the benefits. APL families should also be encouraged to use nets.
- The importance of biological control using larvivorous fish is being understood increasingly. However, tribal communities expect the initiative to be program-driven with support from the Fisheries Department. PHCs should map water sources and implement biological control measures, possibly as a planned seasonal activity.

Community Mobilization

- Behaviour Change Communication (BCC) or even Information, Education and Communication (IEC) activities are yet to be optimally implemented. BCC/IEC strategies and activities should take into account the social and cultural background of tribal communities to ensure effectiveness.
- Community participation in the program is weak. The constitution of VHSCs and engagement of women from the villages as ASHAs are positive steps in involving communities. They will be trusted while mobilizing their people and supporting village health planning and action. However, the burden of work on ASHAs needs to be reviewed and rationalized from time to time for effective implementation. The necessary tasks could be redistributed among health workers and others at the village level. ANMs and other departments' village workers (e.g., AWWs) should support ASHAs, and ANMs should be involved in village planning to enhance community participation. These and other grassroots workers need to be trained in community interaction, and local NGOs or CBOs should also be involved in community mobilization.

E. Framework for Consultations with Vulnerable Communities during Project Implementation

The framework for consultations with tribal people and other vulnerable communities in the project areas on issues related to malaria control and kala azar elimination is presented in Table 2. It includes details of the Facilitators proposed at different levels, methods and frequency during project implementation. These consultations will contribute to ensuring need- and demand-based, culturally-acceptable strategies, plans and implementation of interventions. The stakeholder consultations will be conceptualized and facilitated by a Consultant Agency with relevant expertise and experience at each level.

Table 2. Framework for Consultations with Vulnerable Communities during Project Implementation.

Consultation level	Facilitator (Worker or Organization)	Methods	Frequency	Key Areas for Consultation (a)
Village/	ASHA/FTD/AWW	Focus Group	Twice	1. Case management:

Sub-center	Tribal Council/VHSC/ NGOs/MPW/ANM/ Consultant Agency (b)	Discussions, Client visits (in a sample of villages)	annually (pre- and post- transmission season)(c)	<ul style="list-style-type: none"> - Awareness of disease and availability of services - Recognition of severe malaria - Access to diagnostic services and actual use - Access to treatment services and actual use: Non severe and Severe Cases - Use of public health services <p>2. <i>Vector Control:</i></p> <ul style="list-style-type: none"> - Awareness about vector (mosquito/sand fly) and breeding source reduction - Importance of IRS operations, acceptance, quality, precautions to be taken by household during and after IRS - Importance of bed net use and precautions to be taken at household level <p>3. <i>Grievances and solutions</i></p>
BPHC/CHC	MTS/KATS with District VBD Officer/Consultant Agency	Reviews, Meetings with Key Stakeholders (in a sample of BPHCs/ CHCs)	Twice Annually (pre- and post- transmission season)	<ul style="list-style-type: none"> - Program policy, strategy, guidelines for vulnerable communities - Harmonized VCP and State/District/Sub-District Action Plan (as relevant) - Preparedness and performance vis-à-vis case management, vector control in tribal areas - BCC, PPP initiatives - Presentation and review of reports on stakeholder consultations held at village/HSC level - Resource needs, constraints - Reporting and feedback mechanisms - Grievances and solutions
District	District VBD Officer/Consultant or Social Development. Consultant	Reviews, Workshop with Key stakeholders	Annually (pre- transmission season)	
State	Social Development and BCC Consultants	Reviews, Workshop with Key stakeholders		
National	National Program Officer and National Social Development and BCC Consultants	Reviews, Workshop with Key stakeholders		

Notes: (a) The topics for consultation will be fine-tuned according to consultation level and project progress. (b) VBD and Social Development Consultants will also participate in some Village and Sub-center consultations every quarter. (c) This will enable monitoring of awareness and informed action among caretakers, and readiness and performance among caregivers, and matching of these two to prioritize and address issues.

F. Action Plan

The Project's interventions are planned to ensure that tribal people and other vulnerable communities receive maximum benefits during implementation, to remove the constraints they face during VBD control operations, and to reduce VBDs amongst them. They entail supply-side improvements; increasing access according to need; socio-culturally appropriate and gender-sensitive planning and implementation; scaling-up of innovative approaches such as social marketing through Public-Private Partnerships; communication for demand generation, informed decision-making, and improved practices amongst affected communities; and monitoring by dedicated VBD experts and social development specialists.

The actions under each project component and sub-component, persons responsible for implementation at different levels, and frequency of implementation are presented in Table 3. The Action Plan is focused on tribal and other vulnerable groups (Scheduled Castes, etc.) but the activities are integral parts of the overall Project Implementation Plan. This 'Vulnerable Communities' Plan' (VCP) will be implemented in all project districts and states, commensurate with their vulnerable populations and in accordance with the overall phasing of the

Project. The Guidelines for District Planning which are to be used in the Project will provide clear directions for planning for vulnerable communities and appraisal of the plans. Mapping of tribal areas and VBDs will be ensured as the first and foremost step, using technologies such as GIS and databases such as the Census. National and state level Consultants will provide support to program/project personnel at district and sub-district levels for planning and management with a focus on the specific needs of vulnerable communities. Training modules and other materials/efforts for community participation and behavior change communication will focus on meeting the needs of vulnerable communities.

Implementation of the VCP will be carefully monitored using critical indicators listed in the table. These indicators cover the delivery of products and services (i.e., the supply side), actions to improve the 'demand side' to enhance timeliness and quality of care, and efforts to mitigate potential risks. Disaggregating data by age, sex, SC/ST/General population, Tribal/Non-tribal areas will provide robust information on the equity being achieved by the Project and facilitate remedial responses where and when necessary. In addition to these indicators, the Guidelines for District Planning will strongly recommend inclusion of supplementary process indicators to monitor vital actions at this level, especially those actions which are known to be fraught with deficiencies, so that the Project achieves tangible outputs/outcomes.

Table 3. Action Plan for Vulnerable Communities

Component 1: Improving Access and Use of Malaria Prevention and Control Services						
Sub-component and Actions	Implementation Level	Implementers	Implementn. Time point/ Frequency	Indicator and Description	Means of Verification	Time point/ Frequency of Verification
Improving Malaria Case Detection and Treatment: Estimate need for RDT, ACT; Capacity building and social mobilization; Early case detection and treatment with ACT	District, PHC, HSC, Village	DMO, PHC-MOs/ Paramedics, MTS, MPW/ ANM/ ASHA/ AWW/ Tribal healer	Continuously	<ul style="list-style-type: none"> Percent of <i>Pf+</i> patients treated with ACT in 24 hrs (excluding pregnant women in their first trimester) (disaggregated by gender, age, SC/ST/Genl, place of residence, Tribal/Non-tribal areas) 	Rapid assessment through sample surveys	Twice Annual
				<ul style="list-style-type: none"> Percent of villages in endemic areas having a permanent service providing confirmatory diagnosis and ACT within 24h (disaggregated by Tribal/Non-tribal areas) 	Monitoring by MTSs	Twice Annual
Effective vector control (IRS, ITN/LLIN): Identify target tribal villages for IRS and ITN/LLIN use; Supply appropriate insecticide, equipment and nets; Ensure safe storage and distribution; Involve NGOs/SHGs/PRI/Tribal Councils; Orient spraying staff in safe handling, quality spraying, insecticide treatment of nets; Organize BCC activities for community participation; Conduct spraying on schedule, distribute nets; Concurrent and consecutive supervision for IRS quality assessment; Monitor proper use of nets	Village	PHC, HSC, Village	Annually	<ul style="list-style-type: none"> Percent of houses targeted for IRS that have received complete quality spraying in each planned round (disaggregated by Tribal/Non-tribal areas) Percent of villages covered by ITNs/LLINs of those planned (disaggregated by Tribal/Non-tribal areas) 	Program monitoring on the basis of (disaggregated) data on operations	Annually

<p>Innovations to improve service delivery – BCC: Form and orient multi-disciplinary teams; Hire agency/ies for research/planning/ implementation/review; Identify behavior objectives based on Formative Research (on Knowledge, Attitude, Belief, Practices and current communication initiatives); Finalize behavior change objectives and segmentation of target groups; Develop strategy and plan; Design, pre-test and finalize training modules, BCC materials, kits and dissemination; Implement BCC plan; Review experience, update strategy and plan</p>	National, State, District, PHC, HSC, Village	National, State, District, PHC, HSC, Village; Agency	Continuously as planned	<ul style="list-style-type: none"> Number of Districts that have planned BCC activities for vulnerable communities according to the NVBDCP guidelines and implemented the plans 	Program monitoring, Specific reports on BCC, with focus on tribal areas and vulnerable communities	Twice Annually
<p>Innovations to improve service delivery – PPP: List partnership opportunities; Conduct orientation workshops for partners per PPP guidelines of NVBDCP; Invite and review LOIs, request proposals and sign MOUs with selected organizations; Implementation by organizations in identified districts; Review experience and expand PPP initiative</p>	District, PHC, HSC, Village	National, State, District, PHC, Agency	Annually	<ul style="list-style-type: none"> Number of NGOs/CBOs that have signed MOUs to implement project components in partnership with program and are focusing efforts on vulnerable communities 	Program monitoring, Specific district reports on PPPs (may be in Annual report on malaria by districts)	Annually
Component 2: Supporting Elimination of Kala Azar						
:						

<p>Early diagnosis, complete treatment and referral of Kala Azar: Estimation of need for RDT (rk39) and drugs ensuring no stock out/expiry at service delivery points; Mobilization of PHC, HSC program staff; positioning of project staff; Capacity building and social mobilization; Case detection with RDT; Complete treatment with miltefosine in identified districts ensuring exclusion of pregnant women and women of reproductive age; in case of women not covered by miltefosine, ensuring standardized treatment; Filling up of treatment cards; Ensuring provision of food support for patients/attendants under NRHM; Monitoring proper use including pharmacovigilance</p>	District, PHC, HSC	District, PHC, HSC	Continuously	Percent of diagnosed Kala azar patients who have completed the standard treatment (disaggregated by gender, age, SC/ST/Genl, place of residence, Tribal/Non tribal areas)	Rapid assessment through sample surveys	Twice annually
<p>Effective Kala-azar vector control: Identifying high risk areas; Supplying appropriate insecticide and equipment and ensure safe storage Orienting spraying staff in safe handling, quality spraying; Organizing BCC activities for community participation; Conducting spraying as per schedule; Concurrent and consecutive supervision for quality assessment</p>	Village	PHC, HSC, Village	Annually	<ul style="list-style-type: none"> Percent of houses targeted for IRS that have received complete quality spraying in each planned round (disaggregated by Tribal/Non-tribal areas) 	Program monitoring on the basis of (disaggregated) data on operations	Annually
Component 3: Policy and Strategy Development, Capacity Building and Monitoring and Evaluation						
<p>Policy and strategy development: Conduct workshops for designing projects to assess operational feasibility and impact of innovative approaches on improving services for vulnerable populations (at least two projects for Malaria and two for Kala azar); Finalize study area and protocol; Allocate study and sign agreement; Finalize study tools and conduct study; Share action taken reports (policy review, feedback to state, etc.)</p>	National, State, District, PHC, HSC, Village	National, State, District, Agency (viz., ICMR Institutions)	Years 2 and 4; As planned for other policy and strategy development initiatives	<ul style="list-style-type: none"> Number of studies conducted (disaggregated by Tribal/Non-tribal areas or populations) 	Specific reports on studies	Years 3 and 5

<p>Program management and capacity building: Assess training load and needs at each level/category for detailed planning and implementing VCP; Develop curriculum, resource materials (modules, etc); Identify resource persons/institutions; Implement training program; Evaluate training</p>	National, State, District, PHC, HSC, Village	National, State, District	Annually	<ul style="list-style-type: none"> Percent of staff trained at each level over identified need for VCP (disaggregated by Tribal/Non-tribal areas) 	Program monitoring; Rapid assessment (sample surveys)	Twice Annually
<p>Monitoring and Evaluation: Develop and implement Management Information System (MIS) and Geographic Information System (GIS); Routine Program Monitoring; Rapid Assessment (sample surveys); Household surveys; Consultations</p>	All levels	All levels; Agency	As planned for Project	<ul style="list-style-type: none"> Disaggregated information on vulnerable communities in annual project performance reports. 	Program monitoring	Annually

Note: (a) Process actions will be monitored with the frequency given in column 4 or at least every six months for Bank review missions while Indicators will be monitored per frequency mentioned in column 7.

G. Institutional Arrangements and Capacity Building for Implementation of the Action Plan

The institutional arrangements for implementation of the Vulnerable Communities' Plan are given below.

National Level: As the Borrower is the Government of India, responsibility for overseeing implementation of the Action Plan will rest with the national (GOI) Directorate of National Vector-Borne Disease Control Program (NVBDCP) in the Ministry of Health and Family Welfare (MOHFW). The Directorate will be supported by a full-time Social Development consultant with a social science background who will provide technical assistance and monitor and evaluate the VCP. S/he will coordinate with State Programme Officers and state-based consultants and partner organizations. For effective and efficient implementation of the activities in the plan, other program officers and consultants responsible for BCC, Training, M&E, etc. will be consulted as needed.

State Level: The state NVBDCP Manager will be primarily responsible for the program and the VCP which is an integral part of it. A full-time Social Development consultant will provide technical assistance and carry out M&E. S/he will coordinate with the national level and provide support to the District VBD Officers and Consultants. As above, program officers and consultants responsible for BCC, Training, M&E, etc. will contribute as needed.

District Level: In all VBD endemic districts, the Project will primarily be the responsibility of the District VBD Officer. In project districts, an additional VBD consultant will be appointed to increase managerial effectiveness and three technical Supervisors dedicated to the program to improve quality and effectiveness at the sub-district level. The VCP will be implemented by the District VBD Officer with the support of the District VBD Consultant. This team will coordinate with the sub-district levels (in addition to the staff at PHC level – MOs/Paramedics/Health Workers, Malaria/Kala-azar Technical Supervisors and grassroots volunteers including ASHA), and report on progress, constraints and resource requirements to the state team.

Capacity Enhancement. The NVBDCP has an on-going training program to enhance the capacities of health workers and technical personnel at all levels. To build the knowledge and skills to implement and manage the VCP, the curriculum and modules will be expanded to include topics such as: socio-cultural (including gender) issues; the political and self-governance structures of vulnerable communities, their rights and policies; methods to assess and address their needs and priorities; social marketing and PPPs to enhance and sustain vulnerable communities' access to VBD control services and products, and so on. Social mobilization, counseling and motivation skills will be stressed. Training on the VCP will be integrated in the overall NVBDCP training. Reorientation will be carried out after assessment of capacities during project reviews. A database of experts with social science backgrounds and knowledge of tribal people and other vulnerable communities will be developed to ensure the availability of appropriate trainers and technical resources.

H. Measures to Address Potential Adverse Effects

The Vulnerable Communities' Plan will address any unintended or unforeseen effects of the Project that may increase peoples' vulnerability to VBDS or its control operations. The potential adverse impacts could be related to vector management or case management and include insecticide resistance, drug resistance, poor health and environmental contamination caused by improper use, handling, storage, etc. of treatment agents. The program includes several activities to reduce these risks.

Integrated Vector Management (IVM). All vector management activities entail some environmental risks although they provide health and economic benefits.

The use of insecticides and insecticide-treated materials is essential for public health, but systematic and meticulous management is required to ensure safety. To minimize the risk of insecticide resistance, the Project uses a strategy to restrict IRS operations to high-risk areas with a focus on quality management and completeness of coverage. Districts will be micro-stratified on the basis of epidemiological and ecological data,

supported by GIS mapping, identify high-risk areas. Other criteria for implementing IRS in high-risk areas will be: low acceptance of ITNs on account of socio-cultural habits or environmental constraints, and evidence for its superior effectiveness over environmental and biological control strategies that have limited capability to mitigate outbreaks. The Project will also support GOI's policy to systematize insecticide rotation for IRS and ensure implementation of good pesticide management practices. Similar policies, strategies and actions will be ensured in the use of larvicides. Regular monitoring of vectors and their resistance to insecticides/larvicides will be undertaken by entomologists supported by the Project in coordination with institutions such as the National Institute of Malaria Research.

Scaling-up LLIN use for personal protection is a core component of IVM under the Project. However, in many areas insecticide treatment of existing community-owned bed-nets will continue for some time. Measures will be taken to reduce the potential adverse effects of insecticide use, storage and disposal among health workers and community members, including communication efforts.

An Environmental Management Plan has been developed to ensure safeguards at different levels of implementation. It includes minimizing the impact of on-going development projects through health impact assessments. The departments/sectors that can contribute to managing vector-breeding conditions will also be made aware and involved in prevention and control of VBDs.

Case Management. To minimize the risk of developing drug resistance, the Project will promote efforts to use Artemisinin-based Combination Therapy (ACT) for confirmed malaria cases, and introduce innovations such as treatment cards to monitor compliance. The Project will also support GOI's recent policy to eliminate presumptive treatment of malaria with sub-optimal doses of medicines, a practice that has contributed significantly to drug resistance over time. The Project will support efforts to intensify monitoring of the therapeutic efficacy of ACT and quality of pharmaceuticals. In addition, quality assurance of diagnostic tools such as microscopy and Rapid Diagnostic Kits will be ensured. The Project will also support scientific studies on the efficacy of existing drugs against kala azar and potential resistance, and will monitor the quality of drugs. The contra-indications, side effects and consequences of improper use of drugs that are due to be scaled-up, such as ACT and Miltefosine, will be made known to health care providers as well as patients. A pharmacovigilance system will be put in place to monitor adverse effects and initiate corrective steps if necessary.

Micro-planning of all interventions will be undertaken at the district level to ensure that local needs are addressed appropriately. Health volunteers, PRIs, Tribal Councils and other CBOs will be sensitized, will participate in planning and implementation, and take responsibility for monitoring vector control, treatment interventions and effects. Another pragmatic step will be to form an association of informal service providers and build their capacities for appropriate treatment and reporting. BCC activities will be targeted to make the affected and surrounding communities aware of the causes and methods of VBD prevention and of diagnosis and treatment options, and to stimulate appropriate behavioral responses. The BCC will also build in information on the potential adverse consequences of use, non-use and improper use of drugs and insecticides. The capacity building, supervision and monitoring activities planned under the Project will also help to avoid/minimize/mitigate/compensate for adverse effects.

G. Costs and financing of Vulnerable Communities' Plan

A focus on vulnerable communities is an integral part of the Project and the actions, responsibilities, time frame, and indicators for M&E have been indicated in the Action Plan (Table 3). The costs of the service delivery activities for vulnerable groups are included in the costs of such activities for the population at large. A minimum of 20% of the project budget spent on services will be targeted to vulnerable communities and the Guidelines for district planning and appraisal will categorically include this. The NVBDCP will guide the states/districts and ensure that they allocate funds and other resources to service the high risk population living in tribal areas at least in proportion to their percentage of the total high risk population. The district planning guidelines will also advise that service delivery allocations to vulnerable communities be commensurate with the disease burden borne by them in a given district/area.

In order to ensure that vulnerable groups are effectively reached by services, some special efforts will be made to focus the attention of program managers, elicit demand from communities, and foster regular oversight by community institutions. Some innovations such as conditional cash transfers that have shown positive impacts on service use by vulnerable groups in other national health programs (such as the Reproductive and Child Health program) will also be developed in the NVBDCP. Table 4 lists the additional special actions that will be implemented in the Project to ensure services for vulnerable communities. It identifies the action, who is responsible, the time frame and the specific costs (in this case, separated from general program costs).

Table 4. Special activities for Vulnerable Communities, Responsibility, Time frame and Costs

Action	Responsibility	By When	Cost (INR)
Development of training modules on detailed planning for and management of VCP and of booklets to sensitize community institutions such as VHSCs	NVBDCP with consultant agency	April 2008	Rs. 1,000,000
Sensitization workshops for VHSCs, PRIs, RKSs and State and District Health Societies	District VBD Officers	Once every two years beginning in Year 1	Block level: Rs. 10,000/Block District level: Rs. 25,000/District
Workshops and consultations to design projects to assess operational feasibility and impact of innovative approaches on improving services to vulnerable populations	NVBDCP with NIMR	April 2008	Rs. 1,000,000
Implementation of pilots and assessing their impact (at least two projects for Malaria and two for Kala Azar)	NVBDCP through a consultant agency	July 2008- November 2009	Rs. 100,000,000/pilot
Facilitating periodic consultations and preparing summaries of the consultations, including annual district, state and national summaries	NVBDCP through a consultant agency	Continuous (as per the frequency mentioned in Table 2)	Rs. 5,000,000
Resources earmarked for special focus activities on vulnerable communities in district plans	Districts	Continuous	Rs.1,000,000/district
Salaries for staff dedicated to monitor VCP (Social Development Consultants at central and state levels)	NVBDCP through consultant agency/ies	Continuous	Rs. 30,000,000

I. Grievance Redressal Procedures

In India, poor rural and tribal areas are disadvantaged in terms of access to quality health care on account of their remoteness, difficult terrain, poor infrastructure including health facilities, inadequate service providers, and so on. Furthermore, the social, cultural and economic characteristics of tribal and other vulnerable communities, coupled with social exclusion even of their leaders and deficient health promotion and outreach activities, contribute to gross under-utilization even of available services.

In view of the specific needs of such areas, the Project will establish a system to bring out and redress grievances related to lack of access to or availability of curative and preventive VBD services and information. First, the regular MIS on cases, outbreaks, stock-outs of drugs, backlogs of unexamined blood slides will be validated by the technical supervisors who will also gather information on availability of bed-nets, coverage and quality of insecticide spraying, adequacy of BCC/IEC activities and report upward every month. In addition to

internal monitoring and reporting by the health system, individuals, community volunteers (ASHAs, AWWs), local self-government (Panchayats/Tribal Councils), VHSCs, NGOs/CBOs, the autonomous societies managing PHCs and CHCs (Rogi Kalyan Samitis, RKS), and District and State Rural Health Missions can express their grievances through a variety of means. Telephone/mobile phone numbers of core program and project staff will be provided for calls, addresses for postcards, etc., and help desks at District Hospitals and District VBD office for personal interactions. To record grievances and remedial measures taken, registers will be maintained at these help desks and central phone and post receiving units. These registers will be open to scrutiny by the public and reviewed by independent agencies during routine and special reviews. The Project will give wide publicity to inform vulnerable communities and others about these grievance redressal procedures. Efforts will also be made to include tribal and other vulnerable community representatives in stakeholder committees (if they are not already present) to recognize and address issues from within the system.

J. Mechanisms and Benchmarks for M&E and Reporting

The Vulnerable Communities' Plan will be monitored as follows.

- **Management Information System (MIS).** The Project will support revamping of the VBD management information system, especially for monitoring the reach of services to vulnerable populations and women, and of timely and appropriate local responses. Individual data will be disaggregated by age, sex and SC/ST/General categories, enabling checks on equity in service provision. Check-lists used by Malaria Technical Supervisors and VBD Officers/Consultants for supervision will include random visits to households of high-risk population groups. These will be integrated with the MIS system to assess changes in access to VBD services by these groups. Data from sentinel sites and partners will also be fed into the MIS to obtain a fuller picture. These data will be triangulated with the data from Sentinel sites and rapid assessments.
- **Geographic Information System (GIS).** The Project will facilitate GOI's efforts to introduce GIS to map and monitor the distribution of VBDs in tribal areas, analyze time trends, ensure available health resources, and forecast epidemics. GIS data (in the form of maps) will also help to plan appropriate actions at the local level, for example, to identify high-risk areas for IRS.
- **Routine Program Monitoring.** At the state and district levels, service-related data collected regularly provide information about program inputs (e.g., staff, supplies and financial resources), processes (e.g., training, communications) and outputs (services delivered). Over time this routine monitoring provides a picture of increases or decreases, improvements or gaps, the achievement of stability, and so on. Data for tribal districts will be examined separately. The data will be cross-checked on the spot during routine supervisory visits by Program/Project Officers/Consultants, especially in tribal areas. In addition, VBD issues will be included in the agenda of local panchayat meetings, stakeholder committees, District and State Missions, etc.
 - **Specific performance indicators** to monitor the Vulnerable Communities' Plan were given above and several are included in the Project's Results Matrix. Rapid Assessments using standardized sampling techniques will be carried out periodically for the purpose.
 - **Household surveys** have been planned to assess achievements at the community and household levels. The baseline survey has been completed, and mid-term and end-line surveys will be carried out in Years 2 and 5, respectively, by an independent agency. They will include participatory methods and approaches to gain a comprehensive picture of service delivery to, acceptance of interventions by, and accrual of project benefits to the vulnerable communities.
 - **Consultations**, which will be held periodically with vulnerable communities, will use participatory methods to review planning and implementation and assess benefits to them.