

# **Integrated Disease Surveillance Project**

**Tribal Development Plan**

## Strategy for Tribal Populations

The Integrated Disease Surveillance Project (IDSP) covering all states in India, seeks to assist the central and state governments to shift from a centrally driven, vertically organized disease surveillance system to one which is coordinated by the center and implemented by the states, districts and communities. Since the tribal population constitute the poorest and the most vulnerable of the social groups in the Project, a Tribal Development Plan is proposed as an integral part of IDSP. World Bank's Operational Directive 4.20 related to Indigenous People is triggered in IDSP.

There are 635 tribes in India located in five major tribal belts across the country. Based on 1991 Census data, tribals account for 8.08 percent of the country's population (68 million out of 846 million). 7 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 predominant 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. 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 (details in annex 1). 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, wherein tribals inhabit isolated villages and hamlets.

### **Tribals in IDSP**

Widespread poverty, illiteracy and malnutrition, lack of personal hygiene, absence of drinking water, sanitary living conditions and health education, poor maternal and child health services, and ineffective coverage by national health and nutritional services, have been identified as conditions responsible for poor health status of the poor. Tribal settlements tend to be small and isolated and difficult to reach with facilities and services. Even when rural tribal people live in larger villages, they may be separated in hamlets. However, there are some tribal people who are relatively well integrated into the communities and access and utilize facilities as other sub-groups do. Some tribal groups are nomadic and undertake seasonal migration in response to the need for livelihood or employment. In addition, economic development is forcing out-migration from traditionally tribal areas into cities, and often to the margins of such agglomerations. The ways in which the project would reach these different residential situations are outlined in the sections on **Institutional mechanisms** and **Implementation and Local Participation**.

The project seeks to involve all stakeholders including tribals in disease surveillance to enable rapid identification of disease conditions and outbreaks to prevent large scale impacts and also is geared towards a quick response from the health system to this information. Involvement of tribals in the project would contribute to improved health status among them.

For tribal populations this means that there is (i) strengthened link between the tribal communities and the health system leading to greater credibility of the health system, (ii) less reached and unreached areas where the tribals live are brought into the fold of disease surveillance; (iii) increased disease identification and reporting by tribal communities overcoming their socio-cultural and economic barriers; (iv) improved health awareness for disease prevention and treatment amongst the tribals; and (v) improved surveillance of the health of the tribals – project is expected to monitor a set of communicable and non-communicable diseases.

### **IDSP**

The project covers the entire country though the coverage will be phased with Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Mizoram, Madhya Pradesh, Himachal Pradesh, Kerala and Uttaranchal to be taken up in the first phase. Many of these states have substantial tribal populations.

The major project objectives are:

- (i) the establishing of state-based system of surveillance for communicable and non-communicable diseases and their risk factors so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level, and
- (ii) to improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

The project also acknowledges that disease surveillance cannot be sustained unless the community supports data collection and the health system recognizes them as true partners.

The project has four major components:

**Component 1.** *Coordinate and decentralize disease surveillance activities.* This component will address the constraints of lack of coordination despite central control of surveillance activities and the need for changing the diseases included in the system. Effective coordination (as compared to control) of disease surveillance activities depends on establishing the appropriate processes and institutional arrangements at the central level. This will be done through the creation of a small disease surveillance unit to support the states' disease surveillance efforts.

**Component 2.** *Integrate and strengthen disease surveillance at the state and district levels, and involve communities and other stakeholders, including the private sector.* This component will address the constraints imposed by lack of coordination at the sub-national levels, the limited use of modern technology and data management techniques, the inability of the system to act on information and the need for inclusion of other stakeholders.

**Component 3. *Improve laboratory support.*** This component will address the constraint imposed by inadequate laboratory support for surveillance through provision of equipment, minor renovation of laboratories and state level programs for quality assurance of laboratory data.

**Component 4. *Training for disease surveillance and action.*** The changes envisaged under the first 3 components will require a large and coordinated training effort to reorient health staff to an integrated surveillance system and provide the new skills needed.

The core set of communicable diseases, non-communicable disease (NCD) risk factors, and environmental factors included in the surveillance system are: malaria, acute diarrheal disease (cholera), typhoid, tuberculosis, measles, polio, plague, meningoen­cephalitis, hemorrhagic fevers, HIV, road accidents, water quality, outdoor air quality and NCD risk factors (height, weight, physical activity, blood pressure, tobacco, nutrition and blindness).

### **Project Benefits**

Project **beneficiaries** would consist of all the tribal population in the project states and districts. The major benefits from the decentralization of disease surveillance mechanisms to the state, district and community levels would be increased interaction between the health system and the community, enhanced community knowledge of the community of disease and control measures, and improved monitoring and tracking of the disease burden of tribal groups. The propensity of sub-groups such as tribals and women to seek the necessary treatment is low for various reasons:

- their knowledge regarding symptoms is inadequate;
- myths, superstitions and stigma associated with many diseases are widely prevalent;
- there are widespread misconceptions about the cause and method of spread of diseases;
- there is low awareness of availability of treatment/drugs, and there is greater reliance on indigenous medical practices.

The integration of the various disease surveillance programs would provide more complete and coherent health information, better monitoring of disease burden and improved health system response in the tribal areas too. In the tribal areas also, community-based information is a key input to the District Surveillance Unit (DSU) which will coordinate all the analysis, response and feedback of information. These should have a positive impact on the tribals and their health status.

### **Legal Framework**

The Fifth and Sixth Schedules of the Indian Constitution provide protection to tribal populations on account of their disadvantages. The Fifth Schedule designates ‘Scheduled Areas’ in large parts of central India in which the interests of the ‘Scheduled Tribes’ are to be protected. The “scheduled” or “agency” areas have more than 50 percent tribal population. The Sixth Schedule applies to the administration of the states of Assam, Meghalaya, Tripura and Mizoram in the North-East. This schedule provides for the creation of autonomous districts, and autonomous regions within districts as there are different Scheduled Tribes within the districts. The broad strategy that evolved from the constitutional mandates was the adoption of the Tribal Subplan since the Fifth Five Year Plan of the Government of India and the Integrated Tribal Development

Approach, adopted and implemented with some modifications by subsequent government programs.

Articles 46 and 47 of the Constitution of India provide a framework for tribal policy. Article 46, for example, provides the following directive: “The State shall promote with special care the educational and economic interests of the weaker sections of the people, and in particular, of the Scheduled Castes and Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation”. Article 47 states that it is the duty of the State to raise the level of nutrition and the standard of living of the people, as well as to improve public health.

An important objective of the National Health Policy, 2002 is the overriding importance to be given to ensuring a more equitable access to health services across the social and geographical expanse of the country and ensure that the access to, and benefits from, the public health system is ensured for tribals along with women, children and other socially disadvantaged sections of society.

In response to these Constitutional provisions, the health sector has generally treated tribal areas as requiring higher health facility: population norms and are provided service accordingly. There are no laws or statutes that would prevent or constrain tribal access to health care. And on the basis of available data, it does not appear that either traditional or modern laws affecting tribal livelihood patterns (e.g.; land tenure, access to forest produce) mobility or other aspects of social or economic status would in any way cause tribal people to suffer more from diseases or deny them participation in, or the benefits of, this project.

### **Methodology for Preparation of Tribal Strategy**

The following methodology was followed for developing this Tribal development plan.

#### **(a) Consultations with Communities and Health Workers**

Two Districts each from the states of Maharashtra (Thane & Nagpur) and Tamil Nadu (Vellore & Dharmapuri), one each from Uttar Pradesh (Agra) and Chattisgarh (Bilaspur) were selected for carrying detailed consultations with communities and with health workers. While both men and women from urban and rural areas were consulted in Maharashtra, Tamil Nadu and Uttar Pradesh; in Chattisgarh state, the focus of the consultations were on women mainly in the tribal areas.

A methodology based on rapid assessment procedures (RAP) was used because it permitted quick but systematic and valid data collection. Opinions, attitudes, constraints and suggestions regarding the surveillance activities of the respective areas from health workers as well as client were obtained through Focus Group Discussions (FGDs). Data was collected through focus group discussions (FGDs) with grass root level male and female health workers (ANMs, AWWs, MPHWs and health supervisors) and tribal, rural and urban clients. A total of 15 FGDs were conducted in the four selected states of which 5 were carried out in Chhattisgarh state with women. To ward off most of these limitations in RAP, professional training for practitioners of RAP is of paramount importance. The study design had laid great emphasis on initial training of the investigators along with in built mechanism of quality assurance measures.

## Quality Assurance Measures

Several quality assurance measures were implemented/adopted right from the time of conceptualization of the study so as to improve the validity and reliability of the observations and the inferences which included:

- Guidance notes for Focus Group Discussions (FGDs) prepared by a multi-disciplinary team with diverse professional backgrounds, training and socio-demographic variability; who also analyzed the data;
- Guidance notes translated into local languages (Hindi/ Marathi/ Tamil) to help investigators;
- FGD notes piloted with mothers attending pediatric out-patient and in-patient services of All India Institute of Medical Sciences, New Delhi;
- All FGDs were conducted in the presence of at least two CCT members, one from the partner medical college and another from the team at AIIMS, CEU;
- During FGDs it was ensured that the discussion site was easily accessible and acceptable to all the respondents; respondents screened to ensure client category and socio-cultural group, homogeneity;
- Help was sought from experienced facilitators to guide (focus) the discussion in the right direction;
- Consent was obtained from the respondents and all the discussions were tape-recorded. The transcripts written during the discussion were supplemented from the audiotapes. The translation and interpretations were accordingly carried out with group consensus.

The details of FGDs conducted in the four states and client characteristics are given in table 1.

Table 1: Details of FGDs conducted and client characteristics

| S No | Status         | Location       | District    | (Urban/Rural/tribal) | State         |
|------|----------------|----------------|-------------|----------------------|---------------|
| 1.   | Female Clients | Gopalpur       | Bilaspur    | Tribal               | Chattisgarh   |
| 2.   | Female Clients | Goodbani       | Bilaspur    | Tribal               | Chattisgarh   |
| 3.   | Female Clients | Talapar        | Bilaspur    | Rural                | Chattisgarh   |
| 4.   | Female Clients | Koni           | Bilaspur    | Urban                | Chattisgarh   |
| 5.   | Female Clients | Vikas Nagar    | Bilaspur    | Urban                | Chattisgarh   |
| 6.   | Male H W       | Lalapet        | North Arcot | Rural                | Tamil Nadu    |
| 7.   | Female H W     | Lalapet        | North Arcot | Rural                | Tamil Nadu    |
| 8.   | Male H W       | Dharmapuri     | Dharmapuri  | Urban                | Tamil Nadu    |
| 9.   | Female H W     | Dharmapuri     | Dharmapuri  | Urban                | Tamil Nadu    |
| 10.  | Male H W       | Fatehpur Sikri | Agra        | Rural                | Uttar Pradesh |
| 11.  | Female H W     | Bich puri      | Agra        | Rural                | Uttar Pradesh |
| 12.  | Male H W       | Thane          | Thane       | Urban                | Maharashtra   |
| 13.  | Female H W     | Thane          | Thane       | Urban                | Maharashtra   |
| 14.  | Male H W       | Gumthala       | Nagpur      | Rural                | Maharashtra   |
| 15.  | Female H W     | Kalmeshwar     | Nagpur      | Rural                | Maharashtra   |

### *Major findings*

The major findings based on consultations with women clients in the tribal areas, as well as in the rural and urban areas are captured below.

1. Socio-cultural and economic barriers: Many of the prevalent beliefs about diseases and treatment prevented people from using the existing health facilities particularly in public sector. Both men and women expressed that since they were shy and embarrassed to talk about diseases related to sex and reproductive organs, particularly if they did not have a good rapport with the health workers. Thus, information related to HIV-AIDS, RTI, and STD was difficult to elicit. Similarly, tuberculosis and leprosy were considered diseases with social stigma. Occasionally mothers would not tell the illness of their children to health workers because they feared further wrath of evil spirits on their offspring. Limited cooperation from community and facilitators (Gram Panchayats, RMPs, NGOs etc) were also barriers in approaching health care systems.
2. Decision making process about health issues : Elders in the families influenced decisions regarding the place, type and timing of seeking health care especially in tribal areas. Tribal women perceived their education and financial status as important factors in taking independent decisions in matters of health for themselves and their children. Education and jobs for women was perceived by all as a necessary factor to bring about changes in their status and role in the society. Interestingly there were a few tribal and rural women, especially those in nuclear families, who mentioned that husband and wife took all the decisions jointly as both were equal.
3. Seeking health care : Due to poverty, poor accessibility to health facilities and various socio-cultural beliefs, home remedies are first resort. When symptoms do not ameliorate, help was sought from traditional healers. Thus, it was often quite late when they reached existing health facilities for their illnesses. However, for diseases that were perceived as serious in the community, patients were taken to hospital early. Use of herbal cures is more prevalent among tribal households.
4. Socio-Cultural factors in the care of sick: Illnesses are often viewed as a curse for which gods have to be placated by making offerings at the local temple. The offerings ranged from fruit and flowers to goat, chicken and liquor. Use of emulets, etc was also quite prevalent.
5. Gender barriers: Discussions with women in tribal areas consistently brought out the gender disparity to seek health care. When men fell sick, family got worried, and treatment was promptly sought. In contrast, attention was not given to the initial symptoms in women. If the symptoms did not subside on their own or with home remedies, then they were taken to health care providers. When it came to visit to hospital or doctor the males wanted their wives to accompany them but did not reciprocate this gesture. The women had to not only go alone for their illness but also had to take children, without their husbands accompanying them. Women face social, physical and economic barriers to seeking healthcare and are often seen to accord very low priority to their health needs. Further, the indifferent attitude of the doctors in the public health system, often force women to approach private providers –

unregistered and registered. As a result, the surveillance data most often does not capture the conditions of women

6. Credibility of health system : Tribal women perceived that doctors in public sector health facilities did not provide good care to them because they were poor. Patients were either not given medicines or inadequate medicines were dispersed. The women also felt that whole treatment was ineffective because injections were given less often at government health facilities. Another reason for not visiting public health facilities was the lack of any health center near their homes.
7. Information sharing: While there was no voluntary sharing of information on symptoms and diseases, on enquiry there was sharing of information. Especially women expressed that no disease could be concealed for long and moreover concealment may lead to deterioration in the condition. However, tribal men did show resistance to information sharing.
8. Participation in Surveillance : Greater involvement of Panchayats, overall improvement in government health services in their area, greater awareness generation on disease surveillance through campaigns, were identified as important steps in enthusing communities for getting involved in reporting of various health conditions of public health significance.
9. Common health conditions/illnesses in the community: The Health conditions considered important by men and women in different settings are placed in table 2 below.

Table 2: Health conditions perceived as important in Bilaspur District, Chattisgarh State

| Client Categories for Surveillance | Tribal  | Rural   | Urban   |
|------------------------------------|---|---|---|
| Men                                | Fever<br>Jaundice<br>Malaria<br>Cough                       | Fever<br>Jaundice<br>Malaria<br>Cough                       | Flatulence<br>Chest Pain<br>Diminished vision<br>Depression<br>Diabetes<br>Hypertension |
| Women                              | Dysentery<br>Fever<br>Body ache<br>Headache<br>Stomach ache | Dysentery<br>Fever<br>Body ache<br>Headache<br>Stomach ache | Goitre<br>Diarrhoea<br>Joint pains<br>Increase in weight<br>Allergies                   |
| Children                           | Malaria<br>Cold<br>Diarrhoea                                | Malaria<br>Cold<br>Diarrhoea                                | Diarrhoea<br>Allergies<br>Pneumonia<br>Eczema<br>Ear ache<br>Cough                      |



In order to ensure active involvement of the tribals and that they benefit in a culturally-compatible manner, the project would ensure that:

- Focal social mobilization efforts in the tribal areas to elicit cooperation from the tribal community including the tribal leaders and tribal panchayat members;
- Training and involvement of local tribal volunteers in awareness generation campaigns for the tribal community; and for information collection in coordination with the health system staff
- Sensitization of health system staff working in the tribal areas and health facilities in the tribal sub-plan areas to develop a good working relationship with the tribal population;
- Design and use of culturally-compatible IEC material in the tribal areas;
- Monitoring and evaluation based on data disaggregated by tribal status and gender to allow tracking of efficacy of the IDSP among these groups.

#### **(b) Study of community-based disease surveillance systems**

In order to better understand the basic principles that would govern the setting up of community-based surveillance systems under this project, an in depth study was undertaken of the strengths and weaknesses of existing efforts across the country. Of the systems studied were the North Arcot District Health Information Network (NADHI), Kerala Government project on District disease surveillance program, BAIF surveillance, the Gadchiroli health program, Comprehensive Rural health system project, among others. The findings from this study, point towards the need for the following basic tenets as critical for involving communities including tribals in disease surveillance under the IDSP. Some of the key findings related to:

- Communities that are involved in the program are convinced and are confident that this effort is for their common good, People's collectives like self help groups could be effective partners and their involvement could help sustain the process;
- local volunteers could be trained to assist in disease surveillance especially in difficult to reach areas where the presence of health staff is limited;
- Training of health staff for collection of high quality data, proper supervision;
- Integration of communicable and non-communicable diseases in the program;
- Selection of conditions that have significant association with public health action;
- Translation of information into public health action initiation and flexibility to, where necessary, modify prevalent approaches based on this information;
- Integration of private practitioners and Medical colleges in disease control efforts would strengthen the state's effort;
- Higher level of technology – computerization with networking across CHS/Block/PHC levels;
- Appropriate automated and predetermined responses built into the system based on trigger levels;
- Establishing systems for efficient sharing of information across vertical disease control programs and stakeholders belonging to departments other than health;
- Good laboratory support is to establish clinical rather than symptomatic evidence of disease occurrence.

## **Institutional Mechanisms**

The Government of India's special provisions in tribal sub-plan areas include additional health facilities. In tribal areas, one Primary Health Centre caters to 20,000 persons instead of 30,000 and one sub-centre to 3000 instead of 5000 people. Tribal areas are also provided with more mobile clinics, allopathic, homeopathic, ayurvedic, unani and siddha dispensaries. In the project, the health workers at these facilities will be trained to be responsive to the tribals, provide them treatment and counseling activities, will help identify and train tribal volunteers and ensure information collection and response to the tribals with the tribal volunteers.

The National and state-level Project Implementation Plans identify tribal populations as a target group with unique problems of physical and social access requiring culturally sensitive strategies. The project emphasizes two institutional initiatives which would address the needs of the tribal people:

1. Decentralization of planning and implementation to the state and district levels. This would increase the involvement of states and build capacity to manage and administer the IDSP over the long term. Guided by local needs, states will prepare and implement state-specific annual plans with emphasis on the needs of special groups. This includes carrying out special mobilization campaigns in the tribal areas; and
2. Better relationship between the health system and the tribals through volunteers will lead to improved geographical coverage, particularly in remote and unreachable tribal areas.

The project will coordinate with other health activities being carried out by the State Health Directorates for tribal areas. Representatives of Tribal Development Departments (TDD) would be included in state/district committees in those areas where tribal population is significant. TDD would assist in providing mapping and group-specific socio-cultural information on tribal groups and channels to expand outreach. They could also play a role in the participation of tribal groups. Population specific information will be used to develop culturally sensitive IEC materials for both public and providers.

## **Implementation and Local Participation**

The project seeks to address this by:

- *Social mobilization strategies:* Disease surveillance cannot be sustained unless the community stakeholders support the data collection and the health system recognizes them as true partners. Therefore, a well planned social mobilization strategy is to be put in place to obtain valid and reliable data with high sensitivity. The focus would also be on tribals and their collectives including tribal women self-help groups and mahila mandals;
- *Preparation of simple case definitions for diseases:* for use by tribals including women can use;
- *Sensitization and training programs:* planned under the project will be adequately "gendered" so as to sensitize field level staff to the special needs of tribal women;

- *IEC plan* : That specifically addresses the tribal perspective, will be developed by based on the state-specific context.

Social mobilization campaigns under the IDSP are for:

- Creating awareness among the partners, notably the private practitioners, NGOs and the community about existing health programs, IDSP, the potential benefits, areas in which their participation will be solicited;
- Establishing an institutional mechanism to involve community and their leaders;
- Developing a system of providing regular feedback to the community about disease occurrence, the responses to surveillance and impact of disease control programs;
- Designing IEC to address all the issues that are likely to improve the sensitivity of the surveillance data, particularly the prevalent socio-cultural beliefs and gender disparities;
- Increasing the reach of the campaign, all channels of communication are to be used; these will include electronic media, press, hoardings, hand bills, posters, and inter-personal communication through health providers at all levels;
- Creating targeted campaigns in terms of content and messages for health workers and private practitioners; and for the community, panchayat members, local influential persons and NGOs.

At different levels of the project; the following will be undertaken:

**Central level:**

- Organizing a media campaign for creating mass awareness about the usefulness of the surveillance, about core disease surveillance, dispelling common socio-cultural beliefs and gender disparity
- Sensitization and mobilization meetings for central and state level functionaries of IMA and other professional bodies to solicit their support for the program
- Some IEC material for health functionaries and selected sentinel private practitioners, highlighting technical issues

**State Level**

- Organizing a media campaign for creating mass awareness about usefulness of the surveillance, about core and state specific disease surveillance, dispelling common socio-cultural beliefs and gender disparity
- Sensitization and mobilization meetings for state and district level functionaries of IMA and other professional bodies, medical colleges, NGOs involved in health, to solicit their support for the program
- IEC material for health functionaries and selected sentinel private practitioners highlighting technical issues
- IEC material and messages to be prepared within the local context and in the locally comprehensible language
- Bring out periodic reports on surveillance data and the consequent responses by the health department as feedback to the community and local leadership

## **District Level and Periphery**

- Organize sensitization and mobilization meetings at district head quarters for local IMA executive members, prominent practitioners, NGOs in health, elected representatives of the local as well as state bodies, district panchayat board members, teachers
- IEC material and messages to be prepared within the local context and in the locally comprehensible language; put up hoardings, posters, distribute hand bills to create wide spread awareness. The IEC material has to be displayed in schools, all sentinel sites, prominent locations in the village and busy street crossings in urban areas, and in all places where mass human gatherings occur e.g. festivals, melas, exhibitions

## **Village and Block level**

- organize meetings between medical officers of the area, health workers and village health committees once in three months, with the purpose of revitalizing this institution;
- enhance community participation in all health related matters and identifying the community as partners in the planning and decision making process.

While some of the activities like strategies for mobilization and training are common, the case definitions across states for common disease identified for surveillance would be similar but each state will develop state-specific definitions for the specific conditions that they will be tracking. Similarly successful approaches of IEC already being implanted in the states will be used for furthering disease surveillance.

### *Cost estimate and financing plan*

No separate costing or financing plan has been prepared for tribal populations, because the project addresses all groups including marginalized groups such as tribals and women.

## **Monitoring and Evaluation**

Sampling design of evaluation studies would include tribal districts/blocks on a representative basis. The project will monitor increased knowledge of communities and their involvement in surveillance activities. Community monitoring, a key project issue, would strengthen inputs to M&E by helping to capture information that would have gone unrecorded due to socio-cultural barriers and gender discrimination faced by communities, especially vulnerable groups. These data would demonstrate the extent to which tribal people have participated in and benefited from the project.

## Major Tribes of India

| <b>STATES</b>                   | <b>TRIBES</b>   |
|---------------------------------|---|
| Andhra Pradesh                  | Bhil,Chenchu, Gond, Kondas, Lambadis, Sugalis etc.                                |
| Assam                           | Boro, Kachari, Mikir (Karbi), Lalung, Rabha, Dimasa, Hmar, Hajong etc.            |
| Bihar & Jharkhand               | Asur, Banjara, Birhor, Korwa, Munda, Oraon, Santhal etc.                          |
| Gujarat                         | Bhil, Dhodia, Gond, Siddi, Bordia, etc.   |
| Himachal Pradesh                | Gaddi, Gujjar, Lahuala, Swangla, etc.   |
| Karnataka                       | Bhil, Chenchu, Goud, Kuruba, Kammara, Kolis, Koya,Mayaka, Toda, etc.              |
| Kerala                          | Adiyam, Kammmar, Kondkappus, Malais, Palliyar,etc                                 |
| Madhya Pradesh and Chhattisgarh | Bhil, Birhor, Damar, Gond, Kharia, Majhi, Munda, Oraon, Parahi, etc.              |
| Maharashtra                     | Bhil, Bhunjia, Chodhara, Dhodia, Gond, Kharia, Nayaka, Oraon, Pardhi, Rathwa etc. |
| Meghalaya                       | Garo, Khasi, Jayantia, etc.   |
| Orissa                          | Birhor, Gond, Juang, khond, korua, Mundari, Oraon, Santhal, Tharua, etc.          |
| Rajasthan                       | Bhil, Damor, Garasta, Meena, Sahariya etc.  |
| Tamilnadu                       | Irular, Kammara, Kondakapus, Kota, Mahamalar, Palleyan,Toda etc.                  |
| Tripura                         | Chakma, Garo, Khasi, Kuki, Lusai, Liang, Santhal etc.                             |
| West Bengal                     | Asur, Birhor, Korwa, Lepcha, Munda, Santhal, etc.                                 |
| Mizoram                         | Lusai, Kuki, Garo, Khasi, Jayantia, Mikir etc.                                    |
| Arunachal Pradesh               | Dafla, Khampti, Singpho etc.  |
| Goa                             | Dhodi, Siddi (Nayaka)   |
| Daman & Diu                     | Dhodi, Mikkada, Varti, etc.   |
| Andaman & Nicobar Islands       | Jarawa, Nicobarese, Onges, Sentinelese, Shompens, Great Andamanese                |
| Dadra & Nagar Haveli            | As in Daman & Diu   |
| Uttar Pradesh & Uttaranchal     | Bhoti, Buxa, Jaunsari, Tharu, Raji  |
| Nagaland                        | Naga, Kuki, Mikir, Garo, etc.   |
| Sikkim                          | Bhutia, Lepcha  |
| Jammu & Kashmir                 | Chdddangpa, Garra, Gujjar, Gaddi, etc.  |

### **Integrated Safeguards Data Sheet (Updated)**

#### **Section I - Basic Information**

Date ISDS Prepared/Updated: 04/25/2003

#### **A. Basic Project Data (from PDS)**

##### **I.A.1. Project Statistics**

Country: INDIA

Project ID: P073651

Project: Integrated Disease Surveillance Project  
Authorized to Appraise Date: April 28, 2003  
Bank Approval: July 1, 2003

Task Team Leader: Peter F. Heywood  
IBRD Amount (\$m):  
IDA Amount (\$m): 75.30

Managing Unit: SASHD  
Lending Instrument: Specific Investment Loan (SIL)

Status: Lending

Sector: Health (40%); Sub-national government administration (20%); Central government administration (20%); Information technology (15%); Other industry (5%)  
Theme: Fighting communicable diseases (P); Health system performance (P); Other human development (P); Decentralization (S)

#### I.A.2. Project Objectives (From PDS):

The objective of the project is:

to contribute to improved health outcomes by providing specific, timely information on selected priority health conditions and risk factors in order to plan and manage programs to prevent them.

The project will assist the Government of India and the states and territories to

- surveil a limited number of health conditions and risk factors
- strengthen data quality, analysis and links to action;
- improve laboratory support;
- train stakeholders in disease surveillance and action.
- coordinate and decentralize surveillance activities
- integrate disease surveillance at the state and district levels, and involve village populations and other stakeholders, particularly the private sector.

#### I.A.3. Project Description (From PDS):

This five-year project will assist the central and state governments to shift from a centrally driven, vertically organized disease surveillance system to one which is coordinated by the center and implemented by the states, districts and communities. The project has 4 components:

**Component 1.** Coordinate and decentralize disease surveillance activities. This component will address the constraints of lack of coordination despite central control of surveillance activities and the need for changing the diseases included in the system. Effective coordination (as compared to control) of disease surveillance activities depends on establishing the appropriate processes and institutional arrangements at the central level. This will be done through the creation of a small disease surveillance unit to support the states' disease surveillance efforts.

**Component 2.** Integrate and strengthen disease surveillance at the state and district levels, and involve communities and other stakeholders, including the private sector. This component will address the constraints imposed by lack of coordination at the sub-national

levels, the limited use of modern technology and data management techniques, the inability of the system to act on information and the need for inclusion of other stakeholders.

**Component 3.** Improve laboratory support. This component will address the constraint imposed by inadequate laboratory support for surveillance through provision of equipment, minor renovation of laboratories and state level programs for quality assurance of laboratory data.

**Component 4.** Training for disease surveillance and action. The changes envisaged under the first 3 components will require a large and coordinated training effort to reorient health staff to an integrated surveillance system and provide the new skills needed.

The core set of communicable diseases, non-communicable disease (NCD) risk factors, and environmental factors included in the surveillance system are: malaria, acute diarrheal disease (cholera), typhoid, tuberculosis, measles, polio, plague, meningoenephalitis, hemorrhagic fevers, HIV, road accidents, water quality, outdoor air quality and NCD risk factors (height, weight, physical activity, blood pressure, tobacco, nutrition and blindness).

I.A.4. Project Location: (Geographic location, information about the key environmental and social characteristics of the area and population likely to be affected, and proximity to any protected areas, or sites or critical natural habitats, or any other culturally or socially sensitive areas.)

The Project will cover all States and Union Territories in India with the objective of establishing surveillance systems down to the Community Health Centre levels. Project will be implemented in existing buildings/land and there are no new structures planned under this project.

***B. Check Environmental Classification: B (Partial Assessment)***

*Comments:* To address the environmental and health risks associated with the handling of active/live biological agents in the disease surveillance laboratories, the project will facilitate the MOHFW in developing Standard Operating Procedures to ensure good practices and efficient waste management systems in laboratories.

***C. Safeguard Policies Triggered (from PDS)***

(click on  for a detailed description *or* click on the policy number for a brief description)

| <b>Policy</b>   | <b>Triggered</b> |
|---|------------------|
| <b>Environmental Assessment (OP 4.01, BP 4.01, GP 4.01)</b>         | Yes              |
| <b>Natural Habitats (OP 4.04, BP 4.04, GP 4.04)</b>                 | No               |
| <b>Forestry (OP 4.36, GP 4.36)</b>                                  | No               |
| <b>Pest Management (OP 4.09)</b>                                    | No               |
| <b>Cultural Property (OPN 11.03)</b>                                | No               |
| <b>Indigenous Peoples (OD 4.20)</b>                                 | Yes              |
| <b>Involuntary Resettlement (OP/BP 4.12)</b>                        | No               |
| <b>Safety of Dams (OP 4.37, BP 4.37)</b>                            | No               |
| <b>Projects in International Waters (OP 7.50, BP 7.50, GP 7.50)</b> | No               |
| <b>Projects in Disputed Areas (OP 7.60, BP 7.60, GP 7.60)*</b>      | No               |

## **Section II - Key Safeguard Issues and Their Management**

*D. Summary of Key Safeguard Issues. Please fill in all relevant questions. If information is not available, describe steps to be taken to obtain necessary data.*

II.D.1a. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts.

### ***Environmental Assessment***

Disease Surveillance Laboratories carry out testing for infectious and contagious diseases, such as malaria, typhoid, cholera and hepatitis, tuberculosis and HIV/AIDS. These laboratories therefore generate waste which includes infected human tissues and blood samples, microbes, discarded chemicals, sharps, etc. Such waste, if not managed properly, carries the risk of infection for waste handlers and to the larger community and is also a potential environmental hazard, through pollution of land, water and ground water. While it is recognized that the quantum of waste generated from such laboratories is small, its varied and hazardous composition requires comprehensive management of the waste lifecycle, from source to disposal, to prevent adverse impacts on the environment and public health.

### ***Indigenous People***

Owing to the variable and largely weak presence of public health infrastructure and personnel in the tribal areas, there is sub-optimal interaction and service delivery for tribal communities. The project seeks to strengthen the linkages between the tribal communities and the health system by brining into its fold the less reached and unreached areas where tribals live. The tribal volunteers, community and health workers implementing different disease control/elimination programs are to be trained and motivated to work closely with tribals to increase disease identification and reporting. Culturally sensitive IEC material based on successful initiatives underway in each state, would form the basis for reaching out to tribals.

II.D.1b. Describe any potential cumulative impacts due to application of more than one safeguard policy or due to multiple project component.

Not Applicable

II.D.1c Describe any potential long term impacts due to anticipated future activities in the project area.

Not applicable

II.D.2. In light of 1, describe the proposed treatment of alternatives (if required)

Not Applicable

II.D.3. Describe arrangement for the borrower to address safeguard issues

### **Environmental Management Plan:**

The Environmental Management Plan (EMP) includes a outline Standard Operating Procedure for good practice management and mitigation measures for the various types of wastes expected to be generated in laboratory operations and construction sites. The EMP also includes an implementation framework for introducing the appropriate SOP at various state levels, and a monitoring framework. The implementation details will be developed under the project. To refine the implementation arrangements, all states will conduct a baseline assessment in the first year of the project, to assess the type of waste generated at each laboratory and its management from source to disposal. The MOHFW is developing Operational Manuals which will incorporate the SOP.



**Tribal Development Plan:** The project specifically aims to involve and benefit the indigenous populations. The national and state-level PIPs identify tribal populations as a target group which are generally hard to reach due to their unique problems of physical and social access, requiring special culturally-sensitive strategies. The project's tribal strategy is aimed at increasing outreach to the tribal areas, provide culturally compatible IEC to promote health education and case definitions of diseases, train volunteers in tribal communities, utilize tribal youth as community mobilizers and communicators. The plan has been developed based on extensive interactions with tribal communities, with specific focus on women, NGOs working with tribals, other stakeholders including Health Department officials, medical professionals, medical colleges, and private providers. The plan seeks to build upon existing successful initiatives at community involvement and IEC initiatives of other disease control/elimination projects.

The project will benefit vulnerable groups and tribal groups and be in full compliance of safeguard policies. The project will strengthen the institutional network involved in disease surveillance in areas which include tribal populations. Training will be provided to tribal community health agents for improved disease surveillance and facilitating community monitoring.

**II.D.4. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.**

The key stakeholders are health workers, laboratory staff, communities, NGOs and private sector providers who will be involved in project implementation.

Extensive interactions were held with tribal communities, with specific focus on women, NGOs working with tribals, other stakeholders including Health Department Officials, Medical Professionals, Medical Colleges, and Private providers. Focussed discussions were carried out in tribal areas and specific projects being implemented by different agencies dealing with tribal health were visited and discussions held. National level workshops and state level consultations were held in Maharashtra, Uttar Pradesh and Tamil Nadu to elicit suggestions and views for reaching out to tribal communities. The consultations had representation from the grassroots along with the NGOs, Block and district level administration, representatives of the IMA, state level program staff and state health secretaries. Draft TDP was shared in these consultations and the same was finalized based on feedback.

***E. Safeguards Classification (select in SAP).*** Category is determined by the highest impact in any policy. Or on basis of cumulative impacts from multiple safeguards. Whenever an individual safeguard policy is triggered the provisions of that policy apply.

- S1. – Significant, cumulative and/or irreversible impacts; or significant technical and institutional risks in management of one or more safeguard areas
- S2. – One or more safeguard policies are triggered, but effects are limited in their impact and are technically and institutionally manageable
- S3. – No safeguard issues
- SF. – Financial intermediary projects, social development funds, community driven development or similar projects which require a safeguard framework or programmatic approach to address safeguard issues.

***F. Disclosure Requirements***

|  |                 |               |
|--|-----------------|---------------|
| <i>Environmental Assessment/Analysis/Management Plan:</i>  | <u>Expected</u> | <u>Actual</u> |
| Date of receipt by the Bank  | 8/20/2002       |               |
| Date of “in-country” disclosure  | 8/20/2002       |               |
| Date of submission to InfoShop   | 8/30/2001       |               |
| Date of distributing the Exec. Summary of the EA to the Executive Directors ( <i>For category A projects</i> ) |                 |               |
| <i>Resettlement Action Plan/Framework:</i>   | <u>Expected</u> | <u>Actual</u> |
| Date of receipt by the Bank  |                 |               |
| Date of “in-country” disclosure  |                 |               |
| Date of submission to InfoShop   |                 |               |
| <i>Indigenous Peoples Development Plan/Framework:</i>  | <u>Expected</u> | <u>Actual</u> |
| Date of receipt by the Bank  | 8/26/2002       |               |
| Date of “in-country” disclosure  | 8/26/2002       |               |
| Date of submission to InfoShop   | 8/30/2002       |               |
| <i>Pest Management Plan:</i>   | <u>Expected</u> | <u>Actual</u> |
| Date of receipt by the Bank  |                 |               |
| Date of “in-country” disclosure  |                 |               |
| Date of submission to InfoShop   |                 |               |
| <i>Dam Safety Management Plan:</i>   | <u>Expected</u> | <u>Actual</u> |
| Date of receipt by the Bank  |                 |               |
| Date of “in-country” disclosure  |                 |               |
| Date of submission to InfoShop   |                 |               |

If in-country disclosure of any of the above documents is not expected, please explain why.

|                                       |                                      |                    |
|---------------------------------------|--------------------------------------|--------------------|
| <b><u>Signed and submitted by</u></b> | <b><u>Name</u></b>                   | <b><u>Date</u></b> |
| Task Team Leader:                     | Peter F. Heywood                     | 07/17/2002         |
| Project Safeguards Specialists 1:     | David Hanrahan/Person/World Bank     |                    |
| Project Safeguards Specialists 2:     | Varalakshmi Vemuru/Person/World Bank |                    |
| Project Safeguards Specialists 3:     | Ruma Tavorath                        |                    |
| <br>                                  |                                      |                    |
| <b><u>Approved by:</u></b>            | <b><u>Name</u></b>                   | <b><u>Date</u></b> |
| Regional Safeguards Coordinator:      | L. Panneer Selvam                    | 07/17/2002         |
| <br>                                  |                                      |                    |
| Sector Manager/Director               | Anabela Abreu                        | 07/17/2002         |