INDIGENOUS PEOPLES’ DEVELOPMENT PLAN (IPDP)

Objectives

The IPDP aims to ensure that tribal people (i) receive appropriate and adequate benefits from the project; and (ii) participate in project planning, implementation and monitoring to ensure that project activities are culturally acceptable and effective. It would also (iii) mitigate any potential adverse impacts of the project on tribal people; and (iv) redress any grievances. The Indigenous Peoples’ Planning Framework (IPPF) would be used at district and state levels to ensure that adequate attention is paid to tribal people in local activity planning to achieve these objectives.

Coverage

The IPDP covers all districts in the project that have tribal people. The 152 districts included in the project cover areas endemic for malaria (100 districts) and kala azar (52 districts) and many of them have populations that are more than 50% tribal. The IPDP is to be applied to all tribal people, and not only to designated tribal or ‘Scheduled’ areas.

Action Plan

Several interventions are planned by the project to reduce the social and economic constraints due to VBD and their control operations among tribal people including supply-side improvements to increase access to services and activities to increase demand for care.

I. Improving Access to Services

Shifting from a Target-Based to a Need-Based Approach. The districts currently use a target-based approach (using population figures) for blood-slide collection, examination and treatment. The project would support VBDCP’s efforts to address the needs of high-endemic districts through specific plans to improve access to malaria and kala azar case management, vector control, surveillance and monitoring. The project would improve diagnosis and treatment of malaria in high-risk tribal and other project areas. Access to early diagnosis using RDKs and effective treatment using ACT for confirmed Pf cases and newer drugs would be improved in 50 malaria endemic and 16 kala azar endemic districts during the first two years. An implementation review planned before the end of the second year -- which would assess improved access to VBD services of tribal populations and women in addition to other aspects -- would provide the basis for further expansion of project inputs to the remaining endemic districts during the third year. Interventions for different blocks within each district would be tailored to their risk of Pf malaria, and partnerships with networks of non-governmental organizations and private providers would be forged to reduce delays and optimize service delivery. This would enable districts, for example, to take migrant populations into account, which is especially relevant to tribal people who move in search of work.

Increasing Availability of Staff. The project would support initiatives to enhance the core skills of volunteers at village level such as Accredited Social Health Activists (ASHA) and Anganwadi

1 These districts are additional to 94 malaria endemic districts in the North-east region of the country which are already covered by the program with support from the Global Fund for AIDS, Malaria and TB. The North-east has a predominantly tribal population.
2 Miltefosine and Paramomycin (after approval).
Workers (AWW) to offer quality case management services. It would increase staff with specific skills such as Malaria Technical Supervisors to ensure the quality of case management and vector control, VBD consultants to support decentralized planning with a special focus on tribal populations, and enhanced monitoring at district and sub district levels. Additional staff with skills in entomology, BCC, financial management, procurement and M&E would be provided at the zonal and state levels. To increase the overall availability of service providers, vacant positions would be filled by contract staff.

Public-Private Partnerships (PPP): In all project districts, a basic education program would be carried out to encourage the private sector to implement up-to-date malaria case management guidelines, including fever algorithms. In the first two years, a more intensive program of social marketing of RDKs and ACTs would be trialed in a sample of these districts. Assessment of its outcomes and lessons learned in implementation would determine the future of this activity.

Additional PPP initiatives include: (i) networking with private practitioners, particularly in tribal areas where the availability of government services is low, to improve reporting of malaria cases and deaths and response; (ii) organizing camps through NGOs for the treatment of community-owned bed-nets; and (iii) making informal service providers (who are trusted by tribal people) aware of VBD prevalence, and availability of correct diagnosis and treatment measures through well-designed IEC, short courses and sensitization programs. Health NGOs would be empanelled so that they could be involved in the program systematically and strategically. Outsourcing or franchising of services (such as diagnostics) to the private sector would be explored.

Gender Equity. To ensure that both women and men are reached equitably by program interventions project field staff would include women and, depending on the cultural context, program planning consultations would be carried out by women facilitators with women, separately from men. Household surveys would investigate changes in health status and health service utilization among women and men as well as tribal populations. Data from sentinel surveillance sites would provide data on malaria and kala azar incidence disaggregated by gender, age, SC and ST status.

II. Enhancing Demand

Social Mobilization. Tribal communities would be mobilized to participate in planning and implementing the VBDCP. In areas where populations that are highly vulnerable to kala azar reside, community-based mobilizers would identify suspected cases, inform them about the availability of free quality services and motivate them to use the services. Women’s groups/health societies, local voluntary organizations and panchayat health committees would be encouraged to support local VBD control programs. For example, during ‘malaria month’, PRIs would deal with areas where water collects, with spraying activities, and would be facilitated to publicize VBD control.

Social Marketing and Franchising. The project would also support innovations to enhance the access of rural and urban slum populations to VBD control services and products by contracting social marketing organizations and using other channels such as ICDS in addition to their own distribution networks. Networks of NGOs and private health providers would also be involved in delivering standard preventive services through franchising techniques. Specific interventions and free or subsidized distribution would be designed for low-income and high-risks groups, ensuring ethical practices and appropriate monitoring. Strong evaluation of these innovations would be built into the project design, and effective reach of VBD services to highly vulnerable populations would be used as a criterion for scaling-up these interventions.
**Behavior Change Communication.** The project would strengthen capacity to plan and implement effective BCC/IEC. In doing so, several issues are expected to be addressed. (i) To increase understanding among tribal groups whose literacy is low, IEC material would be in the local tribal language/dialect and include pictorial depictions; and local media such as folk dance/drama/puppet/music shows, etc. would be used. (ii) To ensure that traditional practices and beliefs (which vary from place to place and community to community) are respected, culturally-appropriate methods would be used. (iii) To improve gender equity, women’s groups and other community organizations would be involved in spreading messages related to VBDs. (iv) To continuously improve effectiveness the efforts in tribal communities would be benchmarked and assessed periodically. Three household surveys are planned under the project to provide information on changes in KAP related to VBDs.

**III. Increasing Community Participation and Management**

The NRHM envisages several activities to enhance community participation in health programs including: activating Village Health and Sanitation Committees and involving more stakeholders, particularly women and members of marginalized communities; appointing and training women from the community as Accredited Social Health Activists (ASHAs) to mobilize people and support village health planning and action; and increasing the involvement of ANMs, AWWs, and workers from other departments in village-level health activities.

Local self governments (Panchayati Raj) Institutions (PRIs) would be involved in vector control activities such as the distribution of larvivorous fish and IEC material, monitoring spray operations, impregnation and distribution of bed-nets, and other VBD campaigns. PRI members would be encouraged to identify fever cases and direct them to trained village-based volunteers, public health services and franchised providers, and they may be given responsibility to monitor VBD control operations in their areas and provide timely feedback to designated health authorities about any suspected outbreak.

Inter-Sectoral Collaboration would be substantially strengthened, especially with the ICDS and public health engineering departments. AWWs would be trained to identify fever cases, use RDKs to diagnose malaria, and provide treatment. They and others would be advised to refer cases to ANMs or doctors for proper diagnosis and treatment. Improved linkages with authorities responsible for water, sanitation and drainage would help reduce water-logging and stagnation.

**IV. Mitigating Potential Adverse Impacts of the Program**

The IPDP would also address any unforeseen or unintended effects of the project that may increase tribal peoples’ vulnerability to VBD and its control operations. Two potential adverse impacts are insecticide resistance and drug resistance which may be caused by improper use of treatment agents. The program includes various activities to reduce these risks.

To minimize the risk of insecticidal resistance, the project would support efforts to restrict IRS operations to high risk areas. Micro-stratification of districts would be undertaken based on epidemiological and ecological data and the use of IRS would be limited to high-risk areas, where ITNs are unacceptable to the population, or where there is evidence for its superior effectiveness. IRS would also be used to control epidemics with due focus on quality and completeness of coverage.
The project would also support GOI’s policy to systematize insecticide rotation for IRS and ensure implementation of good pesticide management practices. Regular monitoring of vectors and their resistance to insecticides would be undertaken by entomologists supported by the project.

To minimize the risk of developing drug resistance, the project would promote efforts to use ACT for confirmed malaria cases and introduce innovations such as treatment cards to monitor compliance. The project would 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 would support efforts to intensify monitoring of the therapeutic efficacy of ACT and quality of pharmaceuticals.

Finally, micro-planning would be undertaken at the district level to ensure that local needs are addressed appropriately. This would include environmental management of water bodies and minimizing the impact of on-going development projects. PRIs and other community-based organizations would be sensitized, participate in planning, contribute to vector control, and take responsibility for monitoring interventions and effects. Targeted BCC activities would focus on making the affected/surrounding communities aware of the causes and methods of prevention of VBDs.

V. Redressing Grievances

In view of the specific needs of tribal areas, and the difficulties faced in meeting these needs, the project would put in place a system to address grievances brought to light by local residents or workers. Core program staff at the state, district and sub-district level would be accessible through mobile phones to receive complaints on deficiencies in services and information about outbreaks, and service standards would be developed for proper responses to complaints. These mobile numbers would be widely publicized and their objective would be to enhance the access of tribal communities to the services of the project including bed nets, medicines, blood slide examination, reporting of VBD cases, IEC materials, fumigation services, other biological control methods.

Monitoring

Monitoring of the IPDP would be done in several ways.

- **Management Information System.** The project would support a revamping of the VBD management information system to ensure timely reporting and more efficient use of data for need based planning, program monitoring (especially of the reach of services to vulnerable populations and women), and for timely and appropriate local response. Supervision check-lists which would include random visits by MTS and VBD officers/consultants to households of high-risk populations would be built into the MIS system to assess changes in access to VBD services by these groups.

- **Household surveys** have been planned to assess achievements at the community and household levels. The baseline survey has already been completed and baseline data are available. Mid-term and end-line surveys would be carried out in Years 2 and 5, respectively.

- **Routine Program Monitoring.** At the state and district levels service data are collected regularly. They provide information about program inputs (e.g., staff, supplies and financial resources), processes (e.g., training) and outputs (services delivered). Over time this routine
monitoring provides a picture of increases and improvements or gaps, the achievement of stability, and so on. Data for tribal districts would be examined separately, and individual data would be disaggregated by SC/ST status.

- **The Geographic Information System (GIS)**. The project would help GOI’s efforts to introduce GIS to 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) would also help to plan appropriate actions at the local level, for example, to locate natural water bodies and use larvivorous fish.

- **Specific performance indicators** to monitor the IPDP are shown below. Several have been included in the Results Matrix. The data would be obtained as shown in the table.

<table>
<thead>
<tr>
<th>Process Indicators</th>
<th>Source of data</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of districts that have identified vulnerable groups and have included interventions for these groups in their PIPs (disaggregated for tribal/non-tribal districts)</td>
<td>District PIPs</td>
<td>Annual</td>
</tr>
<tr>
<td>Percentage of district and state program managers who have prepared, implemented and monitored district VBDCP Action Plans (of managers who have received training)</td>
<td>Project reports</td>
<td>Six-monthly</td>
</tr>
<tr>
<td>Percentage of households targeted for IRS in each district that have been completely sprayed in each planned spray round</td>
<td>Supervision checklists</td>
<td>Semi annual</td>
</tr>
<tr>
<td>Percentage of community-owned bed-nets treated/LLINs delivered to tribal populations as planned by the district.</td>
<td>Project reports</td>
<td>Annual</td>
</tr>
<tr>
<td>Number of NGOs and private sector institutions involved through PPP (disaggregated for tribal/non-tribal districts)</td>
<td>Project reports</td>
<td>Six-monthly</td>
</tr>
</tbody>
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<tr>
<th>Output/Outcome Indicators</th>
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</thead>
<tbody>
<tr>
<td>Percentage of diagnosed kala azar patients completing the standard treatment (disaggregated by M/F, age, SC/ST/General, and tribal/non-tribal districts)</td>
</tr>
<tr>
<td>Percentage of confirmed <em>P. falciparum</em> cases (excluding pregnant women in their first trimester) who receive correct ACT within 24 hours of diagnosis at a government facility (disaggregated by M/F, age, SC/ST/General and tribal/non-tribal areas)</td>
</tr>
<tr>
<td>Percentage of individuals belonging to ITN target populations who slept under treated bed-nets during the previous night (disaggregated for tribal/non-tribal areas)</td>
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Some economic indicators such as the time spent by patients in diagnosis, treatment and transportation to health care, cost of transportation to treatment centers, wages lost in visiting treatment centers, wages lost due to illness, would be included in the household survey in Years 3 and 5. These indicators would require very careful data collection and analysis.

**INDIGENOUS PEOPLES’ PLANNING FRAMEWORK FOR DISTRICT PLANNING**
Purpose. The Indigenous Peoples’ Planning Framework (IPPF) is intended to be used by all project districts when they are planning interventions for tribal people and areas. Its objective is to ensure that project benefits reach those in need, and that they are culturally acceptable, appropriate, adequate, and technically and environmentally sound.

Consultations. Before and during planning the districts should hold consultations with groups of key stakeholders, viz., members of the major tribes who reside in different areas of the district, especially women, CBOs and NGOs, formal and informal village leaders, and health staff who are familiar with the area and tribal health-seeking behavior. These consultations should be facilitated by persons who are appropriately trained and experienced and knowledgeable about the tribal people in the area. Feedback should be obtained on the performance of the program, on how the constraints faced by tribal people could be addressed and their preferences so that they could obtain the full benefits of the program, and on how they could assist the program.

Data and Targeting of Interventions. To ensure that benefits flow to the intended tribal people, robust data must be obtained on them and on tribal areas and used in planning and monitoring of activities. Data on the incidence and prevalence of VBDs in all areas would be generated and maintained through the routine monitoring systems, household surveys, GIS and MIS. The district and state authorities would target interventions based on evidence of need. Where program staff and infrastructure are insufficient (and rapid deployment of the public sector is not possible) they would bring private sector resources (including NGOs) on board to support the program through PPPs. The MIS would be used by program managers to track the availability of personnel, drugs and supplies, and manage their deployment effectively to meet the ‘normal’ needs of the area, as well as emergency needs when outbreaks occur.

Identifying Interventions. A number of critical needs are to be addressed under the VBDCP to ensure that its benefits flow to tribal people in the project areas. The most important of these are:

- Availability of and access to timely diagnosis and appropriate treatment (including RDKs, ACTT, CQ&PQ, functioning laboratories, and appropriate staff);
- Supply of appropriate drugs at all times through channels that are accessible to tribal people;
- Preventive measures (such as spraying and distribution of bed-nets) at the right times and locations, and adequate intensity to prevent the development of resistance; and
- Awareness and knowledge among tribal communities of vector-borne diseases, prevention measures, symptoms, treatment regimens, treatment facilities and expected program benefits.

Mitigation of Adverse Impacts: The project involves the use, storage, transportation and disposal of insecticides and pesticides. A detailed Environment Management Plan (EMP) has been developed and needs to be followed in every district, for which the district must make appropriate plans. In addition, the project raises the issues of drug resistance and risks due to development projects. The main mitigation measures which the districts must follow have been included in the IPDP, but these need to be planned to address the specific situation of the district and additional measures may be needed. Districts must identify pockets of drug resistance in their plans and follow the appropriate treatment guidelines in these areas. They must also ensure that the problem is not exacerbated by adopting the revised treatment regimens faithfully. Districts with development projects that may increase the risks of VBD should identify the areas at risk and make appropriate plans to address (eliminate or at least minimize) the risks. The EMP and IPDP have been disclosed on the websites of the World Bank and the NVBDCP.
Institutional Arrangements. Government Health Sector. The project would be implemented through the state DOHFW (VBDCP) functionaries and infrastructure. The districts and states must ensure that their institutional arrangements could produce plans, implement them, monitor them, evaluate their effects and address grievances in tribal areas. Health department personnel are to be trained in management and decision-making for integrated vector management, including the formulation of district plans and use of guidelines to select and evaluate vector control options. Training of grassroots workers such as ASHAs is to emphasize counseling and communication skills as these are of vital importance to ensure timely consultation and initiation of treatment, and compliance with treatment. Other capacity-building needs should be identified by the districts and states and plans must be made and implemented to fulfill these needs.

Private Sector Involvement. In all project districts efforts are to be made to draw the private sector in to support project implementation. Under the IPDP, a basic education program has been planned for the private sector to use up-to-date malaria case management guidelines, and social marketing of RDKs and ACTs would be piloted. Beyond these activities, the districts should identify and plan PPPs to involve NGOs and other private institutions in supporting specific activities. This is particularly important for tribal areas where public facilities are weak but private (e.g., faith-based) hospitals and clinics may be functioning.

Monitoring. The Project Implementation Plan calls for the following monitoring activities: (i) Development and use of a GIS to track the incidence, risk factors, response and logistics associated with NVBDCP at the district level; (ii) Quality control activities including monitoring of drug and insecticide quality through five sites in the country, a quality control unit in each state for quality assurance of diagnosis, and an independent inspection agency to monitor the quality of pharmaceuticals by testing random samples; (iii) Three household surveys by an independent monitoring agency, of which a baseline survey has been completed and mid-term and end-line surveys are planned; and (iv) a set of performance indicators has been identified to monitor the IPDP and is included in the Results Matrix (see Annex 3 of the PAD). These would measure overall project performance at the district level, including all tribal districts. The districts should identify the most useful indicators for their specific tribal situations and plans, monitor these closely, and use them to improve the program continuously.

Disclosure. The District and State Plans should be made available on the central and state VBDCP websites in a format that invites feedback. In addition the plans should be readily accessible to the public at District Health Offices, NRHM Societies, District Panchayats and other key health facilities in the district.