

TRIBAL ACTION PLAN

Operational Guidelines

NATIONAL AIDS CONTROL
ORGANISATION

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Clinic
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ARV	Anti Retro Viral
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CCC	Community Care Centre
CHC	Community Health Centre
CMHO	Chief Medical & Health Officer
CMIS	Computerized Management Information System
CSW	Commercial Sex Worker
DACO	District AIDS Control Officer
DAPCU	District AIDS Prevention and Control Unit
DHS	District Health Society
DOTS	Directly Observed Therapy Services
DTA	Department. of Tribal Affairs (of State/UT)
DTWO	District Tribal Welfare Officer
HIV	Human Immuno-deficiency Virus
HRG	High Risk Group
ICMR	Indian Council for Medical Research
ICT	Integrated Counseling & Testing
ICTC	Integrated Counseling & Testing Center
IEC	Information, Education & Communication
IDSP	Integrated Disease Surveillance Programme
IDU	Intravenous Drug User
IEC	Information, Education and Communication
ITDA	Integrated Tribal Development Agency
ITDP	Integrated Tribal Development Project
KAP	Knowledge, Attitude and Practice
MADA	Modified Area Development Approach
MoTA	Ministry Of Tribal Affairs
NACO	National AIDS Control Organization

NACP	National AIDS Control Programme
NARI	National AIDS Research Institute
NE	North East
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NRHM	National Rural Health Mission
OI	Opportunistic Infection
PD	Project Director
PHC	Primary Health Centre
PP	Private Practitioners
PLHA	People Living with HIV / AIDS
PPTCT	Prevention of Parent to Child Transmission
PTG	Primitive Tribal Group
RCH	Reproductive & Child Health
RMRC	Regional Medical Research Institute (for Tribals, Jabalpur)
RNTCP	Revised National TB Control Programme
SACS	State AIDS Control Society
SCA	Special Central Assistance
SHG	Self Help Group
SMO	Social Marketing Organization
ST	Scheduled Tribe
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Tribal Advisory Council
TB	Tuberculosis
TI	Targeted Intervention
TOR	Terms of Reference
TRG	Technical Resource Group
TRI	Tribal Research Institute
TSP	Tribal Sub Plan
TSU	Technical Support Unit
UT	Union Territory
VCT	Voluntary Counseling & Testing
VCTC	Voluntary Counseling & Testing Center
W&CD	Women & Child Development

Executive Summary

The Social Assessment study commissioned for the NACP – III found tribals especially vulnerable to HIV/AIDS because of their sexual networking patterns, migration both into and out of their habitats, poor penetration of media and low level of awareness and lack of availability of health services in general and HIV/AIDS related services in particular. Tribal world view is reflected in their health-seeking behavior. Like other societies, the care seeking was constrained by stigma & shame associated with it.

Under NACP-II, there were no specific interventions among tribals except in NE States. There was also a dearth of IEC material in local dialects. ORG – MARG in its abovementioned study proposed a four-fold response. The NACP-III Tribal Action Plan included scaling up of activities in the NE states through a strong GO-NGO partnership. In other states with designated sub-plan areas, it focused on increasing access to services especially preventive activities namely STD care, ICTC, condom promotion. It was to be underpinned by mapping of tribal communities at risk in collaboration with ITDP/TRI for focused response including those affected by migration. Behavior change is deemed central to these efforts and therefore activities to develop material in languages easily comprehensible by tribal communities. Orientation of community leaders is planned for preparing an enabling climate. Access is to be enhanced by collaboration with private providers, MoTA sponsored health units, unqualified providers and tribal healers. The role of last two set of providers is more of referral and behavior change. Guidelines are also proposed for reimbursement of travel & incidental expenses of the patient & companion so as to remove financial hardship as a hindrance to access of NACP services.

The mainstreaming of HIV/AIDS in the tribal development programs and other areas of government in tribal areas is also an important plank of Tribal Action Plan. AEP for residential school/hostel inmates, preference in admission to wards of dead or destitute AIDS patients, IEC through animators/programs of ITDP, monitoring of migrational patterns and mitigation of adverse impacts are some of examples, which this Guideline addresses.

Capacity development is another crucial element of Tribal Action Plan(TAP). Accordingly, the Guidelines provide for sensitization of programme officials, facility heads & health workers to tribal situation so that they reach out and provide services more sensitively. The manpower constraints is sought to be overcome through contracting and training of private providers of all type including tribal healers. To enhance the capacity of tribal development and allied sectors for mainstreaming HIV/AIDS, orientation of their officials as well as those of NGOs engaged in the sector is proposed. The Tribal Research Institutes will be developed as Center of Excellence by induction of experts and training of their faculty. In order to take up TAP activities, Cells

are planned in NACO, Ministry of Tribal Affairs (MoTA) and State Department of Tribal Affairs (DTA). Proposals have also been formulated to have a Joint Steering Group of MoTA & NACO for providing technical advice and guidance. A Steering Group is planned for MoTA to steer the mainstreaming work. Similarly a Task Force is proposed for DTA. Cross-representation in the decision making bodies of the counterpart institutions is also proposed for better integration of the two sectors, including in Tribal Advisory Council.

The evidence base of NACP –III activities for tribal population is inadequate. In order to enhance it, TRIs will also carry out an assessment of risk factors with the assistance of ITDPs. More evidence is proposed by inclusion of tribal attribute in behavioral surveys and biological surveillance and monitoring & reporting systems for the tribal majority states and ITDP areas. Since districts are the units for organization of data in most surveys and reports, it is proposed that surveys or surveillance or MIS will collect and report this for the entire district even though ITDP may cover only a part thereof. Reviews and documentation of the implementation of the NACP-III interventions in the tribal areas & for tribal people will be carried out including through TRIs. A set of indicators are proposed for measurement of progress made in implementation of TAP. Consolidated Annual Progress Reports of the TAP will be prepared at central/state/project level for both HIV/AIDS and Tribal sectors.

The Guidelines are based on the premise that the TAP supplements regular action plan i.e. activities included on the basis of universal guidelines and those included in the TAP taken together constitute the complete set of activities taken up in tribal majority states of the NE and tribal sub-plan area in other states.

The guidelines also describe briefly the channels of submission of plans, scrutiny thereof, fund-flow, timeline of activities.

The organization of chapters in this Guideline follow the pattern of the document National AIDS Control Program, Phase-III: Strategy & Implementation Plan. This makes it easy to consolidate this action plan with that prepared on the basis of existing guidelines.

Chapter 1

Introduction

1.1. The Need for Tribal Action Plan

The Social Assessment study commissioned for the NACP – III found tribals especially vulnerable to HIV/AIDS because of their sexual networking patterns, migration both into and out of their habitats, poor penetration of media and low level of awareness and lack of availability of health services in general and HIV/AIDS related services in particular. The study also found out that tourism, mining, displacement and other external influences increasing lured tribal women/girls into commercial sex work /trafficking.

Except in Manipur, by and large, the tribal communities were unaware of STIs and HIV/AIDS. Awareness was lower among women. In all states except Manipur, the awareness regarding services for prevention, diagnosis, treatment and care for STIs and HIV/AIDS were low amongst tribal people. Condoms were generally not used, as these were disliked. Treatment seeking behavior for most health problems including STIs, revealed initial resort to home remedies or self medication by buying medicines over the counter from grocery or petty shops (in Manipur), followed by visits to the traditional healers. Health facilities like the CHC/PHC were reported to be visited only when the problem became unbearable. Private health facilities were used, particularly when the location of public sector facilities was not convenient.

Studies have also indicated that tribal world view of close linkage between man, nature and spirits also was an important factor influencing their health seeking behavior and the interventions need to be worked out around this fact although the contact with outside world also influenced it. Some studies have also indicated that some groups of diseases were believed to be caused by spirits and therefore treatment by spirit healers or traditional healers. Other studies have also reported that due to stigma and shame associated with RTIs/STDs women suffering from RTI / STIs did not consult any physician unless the problem became very acute. Non-availability and/or lack of access to health care facilities were the main factors inhibiting modern health seeking on the part of tribals.

Under NACP-II, there were no specific interventions among tribals except in NE States. Wherever the interventions designed for the high-risk (CSW and migrants) and other groups overlapped the tribal people, these populations were covered under the interventions. Very few NGOs were reported to have been working specifically with tribal population on HIV/AIDS. Except in places where TI programmes for tribals were being undertaken, there was a dearth of IEC material communicating in local dialect of tribal communities.

1.2. The NACP – III Strategy

Based on their Social Assessment study, ORG-MARG proposed four-fold strategies for strengthening the HIV/AIDS related activities among the tribals. Its first plank was to integrate tribal development issues at all levels and conducting advocacy and sensitization for eliciting appropriate response. The second component dealt with enhancing the evidence base of the activities through research, assessment of the interventions as also awareness activities through BCC focus. The third leg of the strategy related to increasing access to HIV/AIDS services through opening of more number of effective service delivery outlets, advocacy about services and IEC/BCC activities promoting behavior change. Fourth area dealt with partnering with a range of agencies & organizations.

These recommendations as well as other inputs have been taken into consideration in developing the Tribal Strategy of the NACP - III. The thrust of these activities is on the one hand involvement of tribal development set-up in problem assessment, integration of HIV/AIDS activities in the ongoing activities as well as to formulation & execution of appropriate communication activities. On the other hand, the response of the HIV/AIDS sector is to be aligned with the special needs of tribals. The health delivery system as also inter-linkages among the sectors and different stakeholders are proposed to be strengthened for more effective response. For more details, para 5.9 of Chapter – 5 of the National AIDS Control Programme, Phase III: Strategy and Implementation Plan may be referred.

1.3. India's Tribal Population, Institutions

The tribal population of the country, as per the 2001 census, is 8.43 crore, constituting 8.2% of the total population. Barring the states of Haryana, Punjab, Delhi & UT of Chandigarh, all other states have tribal population. Indian Constitution has provided for certain safeguards and protection mechanisms. To them, new instruments have been added over time. The net result is a dense & complex network of Institutions, mechanisms and structures. Of these, the ones that are relevant to the prevention & mitigation of HIV/AIDS are given below.

1.3.1. Tribal Population and its distribution

The tribal population of the country, as per the 2001 census, is 8.43 crore, constituting 8.2% of the total population. Barring the states of Haryana, Punjab, Delhi & UT of Chandigarh, all other states have tribal population. Majority population in some states in the North-East viz. Arunachal

Pradesh, Mizoram, Meghalaya, Nagaland and UTs of Dadra & Nagar Haveli & Lakshdweep are tribals. In the States of Madhya Pradesh, Chhattisgarh, Maharashtra, Orissa, Rajasthan, Jharkhand and Gujarat, the tribals do not constitute the majority, yet their population is substantial. In fact, about three-fourth of the India's Scheduled Tribe population is concentrated in these States. Even in these states/UTs, in pockets, which have been declared as Scheduled Area or MADA area (cluster of more than 10000 tribal population with tribal being majority of the population) or clusters (similar to MADA but tribal population being more than 5000), the tribal population constitutes a majority.

The distribution of the tribal population in different States/ UTs of India has been shown below:-

Sl. No.	State	ST Pop as % to Country Pop
1	Madhya Pradesh	14.51
2	Maharashtra	10.17
3	Orissa	9.66
4	Gujarat	8.87
5	Rajasthan	8.42
6	Jharkhand	8.40
7	Chhattisgarh	7.85
8	Andhra Pradesh	5.96
9	West Bengal	5.23
10	Karnataka	4.11
11	Assam	3.92
12	Meghalaya	2.36
13	Nagaland	2.10
14	Jammu and Kashmir	1.31
15	Tripura	1.18
16	Mizoram	1.00
17	Bihar	0.90
18	Manipur	0.88
19	Arunachal Pradesh	0.84
20	Tamil Nadu	0.77
21	Kerala	0.43
22	Uttarakhand	0.30
23	Himachal Pradesh	0.29
24	Dadra & Nagar Haveli	0.16
25	Sikkim	0.13
26	Uttar Pradesh	0.13

While the tribal population in some States is low when calculated as the percentage of the total tribal population of India, in the State or UT itself, within the State, the tribal population constitutes the majority (e.g. in Lakshadweep, Mizoram, Nagaland, Meghalaya, Arunachal Pradesh and Dadra & Nagar Haveli) or a very sizeable segment (Chhattisgarh, Tripura, Jharkhand, Orissa, Sikkim, Madhya Pradesh). The tribal population as a percentage of the total population of the states/UT is indicated in **Fig 1.1**, while their share to total tribal population of the country is shown in **Fig 1.2**.

Tribal communities live in about 15% of the country's areas, in various ecological and geo-climatic conditions ranging from plains and forests to hills and inaccessible areas. The main concentration of tribal people, however, is in the central tribal belt in the middle part of the India and in the north-eastern States. These correspond to underdeveloped areas.

There are over 700 such tribal groups. Tribal groups are at different stages of social, economic and educational development. Some tribal communities have adopted a main stream way of life. At the other end of the spectrum, there are certain scheduled tribes (75 in number) known as Primitive Tribal Groups (PTGs), characterized by very low literacy, subsistence economy, pre-agriculture level of technology etc. The diversity in ethno-lingual make-up, faith, culture, customs, socio-economic, cultural, educational levels etc. is both enormous and outstanding. Over the years, displacement and rapid acculturation of this population has led to changes in their socio-cultural and value systems.

1.3.2. Administrative Set UP in the Tribal Areas

The Constitution of India has recognized special needs of the tribal communities arising out of their isolation, differences in culture, values and customs, educational & economic backwardness etc. and made special arrangements for their uplift by way of providing for reservation in legislatures, educational institutions and public jobs. In addition, It identified certain areas where there was tribal majority and scheduled them in its Fifth & Sixth Schedules and made special arrangements for safeguarding their interests in lands, money lending and application of laws to these areas. In addition, there has been extensive institutional development in the period thereafter.

The administrative architecture, planning & coordination mechanisms and other resources relevant to tribal population and HIV/AIDs is described below:

1.3.2.1. Central Level

At the central level, the interests of the tribals are articulated and safeguarded by the Ministry of Tribal Affairs. It coordinates with the Planning Commission, other ministries, states and other agencies concerned with tribals. It not only plays

advocacy roles, but also supplements & catalyses states efforts by providing grants to promote educational, infrastructural and economic development, supports NGO activities in educational, health, economic and other fields for tribal communities, promotes ethnographic, programmatic and other research and documentation of tribal people,

In the Planning Commission, there is a position of Tribal Advisor. Another significant institution is Anthropological Survey of India, a sub-ordinate office of Ministry of Culture. Its role is to conduct varied research of the different communities of India, especially tribal communities of India. ICMR has created a special institute named Regional Medical Research Center for Tribals, located at Jabalpur.

1.3.2.2. State Level

In states with substantial tribal population, there is often a department to look after the issues of tribals. In other states, this issue is dealt by Department of Welfare, where the mandate also extends to Scheduled Castes, Other Backward Classes and Minorities. Proviso to Article 164 (1) mentions that there shall be a Minister specifically to look after tribal matters in the States of Madhya Pradesh, Jharkhand, Chhattisgarh and Orissa. Their role is in policy making, budgeting and expenditure control, higher level personnel management and coordination. The implementation of the plans is entrusted to Directorates or Commissionerates. Their staffing is related to functional roles of the Department. The role of tribal development machinery is largely related to educational & economic development, assistance of various kinds viz. legal, protection of land, regulation of money-lending, preservation of culture, reservation in appointments and educational institutions, Their role in health is limited to usually running of schemes of medical assistance or running of some dispensaries. The latter role has weakened with intensification of primary health care by the health deptt.

The **Tribal Research Institutes** were established by the state governments in many states with support of central government. Under the scheme, so far 17 Tribal Research Institutes (TRI's) have been set up in the States of Andhra Pradesh, Assam, Chhattisgarh, Jharkhand, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, West Bengal, Uttar Pradesh, Manipur, Tripura and Andaman & Nicobar Islands, although the last one is yet to start functioning. These institutes are engaged in the work of providing planning inputs to the State Government, conducting research and evaluation studies, collection of data, conduct of training to officers of Tribal Development Department or functioning in tribal areas, seminars and workshops, documentation of customary laws, setting up of tribal museum for exhibiting tribal artifacts, and other related activities. Their Involvement in conduct of health status or programme evaluation studies or training is minimal, largely because the focus has not been on health and there is no internal competency to conduct such research.

Tribal Advisory Councils (TAC) are required to be established in States having Scheduled Areas, though these could also be established in other states having Scheduled Tribes on the direction of the President of India. The role of TAC is to advise the State Government on matters pertaining to the welfare and advancement of the Scheduled Tribes in the State, as may be referred to it by the Governor.

The **Governors of the states having Scheduled areas** are empowered to make regulations on some subjects, limit or bar the jurisdiction of some legislations to scheduled areas and required to make a report to the President of India on the administration therein.

1.3.2.3. Field level set up

The field set-up of the tribal development deptt. is organized along administrative structuring of the States. At the district level, usually there is an officer specifically empowered to look after the tribal interests. Overall, the District Officer is entrusted with protection and welfare responsibilities for the tribals, and coordinates the efforts of other departments in this regard.

From the fifth plan onwards, the clusters of tribal majority population have been identified and specially targeted. These are detailed below:-

1.3.2.3.1. ITDP areas (195 Nos.), which are generally contiguous areas of the size of at least a *tehsil* or block in which the ST population is 50% or more of the total population. These are now coterminous with Scheduled Areas. Starting with Andhra Pradesh, many of the projects have been constituted as agencies, to which substantial functions of the government have been entrusted. In other words, the departmental activities are integrated at the Agency level. Special Central Assistance and Grants-in-Aid under Article 275(1) of the Constitution are now specially made to these areas as also to other areas listed below.

1.3.2.3.2. MADA pockets (259 Nos.) & Clusters (82 Nos.), which are identified pockets having 50% or more ST population with a minimum ST population of 10,000 & 5,000 respectively. These are mainly attended to by the District level Officer for welfare/tribal welfare.

1.3.2.3.3. Primitive Tribal Groups (75 in numbers), characterized by a low rate of population growth, a pre-agricultural level of technology and extremely low levels of literacy. Special programs for their initiation to settled life, agriculture besides education, health and awareness building are arranged mainly through the district level offices and in some cases through agency or projects.

1.3.2.3.4. Dispersed tribal population – those which fall outside the categories at S. No. 1 to 4 above.

The state-wise list of ITDPs, MADAs etc. is appended as **Table - .**

1.3.3. Tribal Areas

The term, “tribal areas” generally means areas with a preponderance of tribal population. However, the Constitution of India recognizes the tribal areas within the States of Assam, Meghalaya, Tripura and Mizoram, as those areas, which are specified in Parts I, II, IIA & III of the table appended to paragraph 20 of the Sixth Schedule. In relation to these areas, Autonomous District Councils, each having not more than thirty members, have been set up. These Councils are elected bodies and have powers of legislation, administration of justice apart from executive, developmental and financial responsibilities. The State wise details of tribal areas are as under:-

Assam

- 1.The North Cachar Hills District
2. The Karbi-Anglong District
3. The Bodo Land Territorial Area District

Meghalaya

- 1.Khasi Hills District
- 2.Jaintia Hills District
3. The Garo Hills District

Tripura

- 1.The Chakma District

Mizoram

- 1.The Mara District
- 2.The Lai District

1.3.4. *Panchayats* in Scheduled Area

The provisions of the *Panchayats* (Extension to Scheduled Areas) Act, 1996 (PESA), vide which the provisions of *Panchayats*, contained in Part IX of the Constitution, were extended to Scheduled Areas. These contain special provisions for the benefit of Scheduled Tribes, including empowerment of Gram *Sabhas* & adequate representation in *Panchayat* bodies.

1.3.5. Educational Institutions

The Tribal Welfare Department runs one of the largest chain of educational institutions and hostels from primary to secondary/post-secondary level specially aimed at tribals. Most of these institutions are residential in nature, where all expenses of education and boarding are met by the Govt. These institutions were established to improve the access of tribal children to education because of weak educational infrastructure in their habitats, poverty of their parents, linguistic barriers and remoteness and thus to bridge the educational gap. Hostels enable the tribal children to study in mainstream educational

institutions. The Central Government has also sponsored some of these institutions such as Ashram Schools or *Eklavya Vidyalaya* through the State Governments or through NGOs. These institutions are outside the control of the Education Departments of the State, thus initiatives undertaken through the latter do not usually percolate to them.

1.3.6. Tribal Sub-Plan

The Tribal Sub Plan strategy was developed for the rapid socio-economic development of tribal people and was adopted for the first time in the Fifth Five Year Plan. The strategy adopted continues till this day. Its salient features are:

- i.) Preparation of plan meant for the welfare and development of tribals within the ambit of a State or a UT plan is a part of the overall plan of a State or UT, and is therefore called a Sub-Plan.
- ii.) The funds provided under the Tribal Sub-Plan have to be at least equal in proportion to the ST population of each State or UT.
- iii.) Tribals and tribal areas of a State or a UT are given benefits under the TSP,
- iv.) The concept of Tribal Sub-Plan has now been extended to the Union Govt. also.
- v.) The implementation of this strategy is monitored by the Ministry of Tribal Affairs and the Planning Commission.

1.3.7. Special Central Assistance to Tribal Sub-Plan

Special Central Assistance to Tribal Sub- Plan (SCA to TSP) is provided by this Ministry to the State Governments as an additive to the State Plan in areas where State Plan provisions are not normally forthcoming to bring about a more rapid economic development of tribals in the States. The scheme was launched in the Fifth Five-Year Plan in the year 1974. Till the end of Ninth Five Year Plan, the SCA to TSP was meant for filling up of the critical gaps in family-based income-generating activities of the TSP.

From the Tenth Five Year Plan period, the objective and scope of SCA to TSP, has been expanded to cover employment-cum income generation activities and infrastructure incidental thereto. Besides family-based activities, other activities run by the Self-Help Groups (SHGs)/ community can also be taken up. The ultimate objective of extending SCA to TSP is to boost the demand-based income generation programmes and thus raise the economic and social status of tribals. The revised guidelines were issued in May, 2003.

SCA is provided to the 22 Tribal Sub-Plan States including the North Eastern States of Assam, Manipur, Sikkim and Tripura and 2 Union Territories. SCA is

released for economic development to ITDP areas, MADA pockets, clusters, primitive tribe groups and dispersed populations according to a formula that also factors in the area in case of ITDP areas. The SCA assistance is 100 % grant-in-aid and used for employment/income generating schemes and infrastructure incidental thereto.

1.4. Operational Guidelines

These Operational Guidelines are proposed for implementing the NACP – III strategy and are supplemental in nature i.e. supplement the ongoing interventions with ones that focus on tribal areas and tribal people.

Figure 1.1



Distribution of ST Population in the States, Census 2001



Figure 1.2

Chapter - 2

Tribal Action Plan

2.1 The Approach of Tribal Action Plan

The Tribal Action Plan is a sub-set of the NACP overall strategic plan. The response of the NACP is calibrated according to the epidemiological situation, availability of hot spots, vulnerabilities & risk factors of population/area & availability of other infrastructure and services. Accordingly it classifies different districts of the country based on HIV/AIDS incidence among attendees of ANC clinics or ICTC clinics or presence of hot spots in the 4 classes namely A, B, C and D. The schemes under the Programme are accordingly offered.

Table 2.1: District Category-wise Services

Category A Districts (High Prevalence)		
Level	Target Groups	Services Provided
Medical colleges /District, block and sub-divisional hospitals village/community	General population, HRGs & PLHA	All HIV related services will be made available under one roof. This will include: ICT, PPTCT, STD, OI and ART with necessary linkages CHC / not-for-profit private health institutions will provide: ICT, PPTCT, STD and OI with necessary linkages to prevention and care and treatment services PHC /identified private providers will be responsible for STD control, OI and condom promotion Mobile ICTC to reach hard to reach areas
Category B Districts (Concentrated Epidemic)		
District, block and sub divisional hospitals village/community	HRGs, general population, PLHA (services curtailed at the periphery)	all HIV related services will be made available similar to category 'A' districts Similar to category 'A' districts, supplies to be adjusted as per reduced load of patients 24 Hr PHCs will function as in category 'A' districts
Category C Districts (Low prevalence with increased presence of vulnerable populations)		
District, block and sub-divisional hospitals village/community	Vulnerable populations and HRG	As above - ART provision clinic will be added only for large districts and if not available within 6 hours travel by road. ICTC will be established in CHCs where the case load for testing is high (averaging more than 15/day including PPTCT). Where case load is less existing staff will be trained to provide counselling services. Drugs and supplies will be adjusted as per reduced case load in category 'C' districts PLHA related services – community care centres to be established only if there is a minimum of 50 PLHA identified in the district.
Category D Districts (Low Prevalence and low/unknown Vulnerability)		
District, block and sub divisional hospitals village/community	Basic service package	ART Services limited to medical colleges if available. CHC will provide STD and OI management but not ICTC Services limited to syndromic management of STD, IEC and condom promotion

(Courtesy: NACP – III, National AIDS Control Organization)

A comparative tabulation of location of ITDP areas and the district categorization has been done below:

Sl. No.	State	Districts	A & B Districts	ITDP(A)	In A/B Districts		Outside A & B	
					ITDP	Districts	ITDP	Districts
1	AP	23	23	10	10	17	0	0
2	Assam	23	1	19	1	1	18	16
3	Chhattisgarh	16	1	21	1	1	20	15
4	Gujarat	25	10	9	5	4	4	4
5	HP	12	0	5	0	0	5	3
6	Jharkhand	24	0	14	0	0	14	13
7	Karnataka	27	26	5	5	5	0	0
8	Kerala	14	2	7	0	0	7	7
9	MP	48	8	31	3	3	28	18
10	Maharashtra	35	32	16	16	11		
11	Manipur	9	9	5	5	5	0	0
12	Orissa	30	7	21	3	2	18	10
13	Rajasthan	32	7	5	1	1	4	4
14	Sikkim	4	0	4	0	0	4	4
15	Tamilnadu	30	27	9	7	4	2	2
16	Tripura	4	1	3	1	1	2	2
17	West Bengal	19	8	8	7	7	1	1
	Total	375	162	192	65	62	127	99

Table 2.2 ITDP(A)s within & outside A & B Category Districts

It is evident from the above table that about 1/3 of the ITDPs are covered under A & B category districts, where the NACP – III has gone for a saturation strategy. In such districts, the challenge before the programme is to improve access by addressing factors that come in the way of better utilization of services, e.g. the poverty, the IEC/BCC messages not reaching out to tribals, lack of information about the services & facilities, unique health seeking behavior of tribals or lack of adequate service points. It will also be desirable to supplement those efforts by utilizing the opportunities that present itself in the tribal areas such as those of hats/fairs, where a substantial congregation of tribals take place, traditional healers or unqualified doctors, working in tribal areas, which enjoy the confidence of the communities, residential schools or hostels to reach out to the young with prevention messages and as a conduit to their parents and communities.

In C & D districts too, the access issues remain similar to those mentioned for the A & B category districts. In fact, their role becomes critical because of lower intensity of activity in these districts. The critical challenge is there in the C category districts where there are known to be hot spots, such as mining centers or industrial units, which there might have a substantial congregation of migrant workers or trucker halting points along the highways. The design of the NACP – III interventions does not permit Link Worker Scheme to be taken up in these areas in villages with sub 5000 population. The NACP – III strategy is to saturate

all urban areas (as per Census 2001) with TI interventions. Since the Census 2001 definition of a town is an area where there is a population of more than 5000, 75 % or more people are engaged in non-agricultural activities and population density is more than 400 persons/sq km, many of the above mentioned hot spots may not be covered under TI interventions, firstly because of the fact that such growth might have taken place after the Census 2001 and secondly, the population may be less than 5000. Although, there might be a substantial tribal CSW population in such locations, the focus of the interventions for the bridge populations is not the CSWs themselves. Therefore, there is a need to devise interventions, at least in the tribal areas, for the CSWs in the hot – spots for the C category districts, which are not covered by any of the intervention for the bridge populations or HRGs.

Sexual networking patterns of tribals are also a major challenge before the programme. The Social Assessment study of the ORG-MARG documented these in great detail. Even if large scale interaction between the tribals and outsiders does not exist, such networks are a potent source for rapid buildup of the virus in the community. Thus, these require to be addressed in a non-stigmatizing way by mobilizing the public opinion and community leaders. A great deal of interaction & IEC/BCC activity is therefore called for in the tribal areas. Special initiatives are therefore called for over and above that in non – tribal areas.

Though a great deal of knowledge is available about the overall epidemiology of HIV/AIDS in the country, the data disaggregated by the group particularly for the scheduled tribes is not available. Neither the sentinel surveillance nor behavioral surveillance data is available for tribal populations at ITDP levels or even district levels, which could aid planning and monitoring of interventions. There is also dearth of data about the risk factors and vulnerabilities and respective role played by each such factor especially for migration. One of the key strategies planned for dealing with bridge populations is source to destination mapping of migration, so that the intervention such as pre-migration counseling or post-return check-up and counseling of them and the spouses could be planned. This is particularly dangerous, as the unique sexual networking among tribals pose special threats for the rapid build-up of virus in the community. The Social Assessment therefore called for knowledge management as a core strategy, which was included in the NACP-III document.

One of the core elements of Tribal Action Plans is to integrate HIV/AIDS related services/activities into the programs/structures of the Tribal Affairs wing of the government at various levels. The Ministry of Tribal Affairs runs schemes through NGOs such as Ten Bedded Hospital Scheme or Mobile Dispensary Scheme. The Tribal Research Institutes are already engaged in training of officials for tribal development, in addition to conducting researches into various aspects of tribal life and development. It is proposed to establish these as Centers of Excellence for HIV/AIDS related activities for tribals. ITDAs will play important role in conducting assessment of major risk factors such as migration, conducting orientation of its animators and grass-root health functionaries and

IEC activities. This way HIV/AIDS activities will be mainstreamed into the tribal development activities.

2.2. Assessment of Risk Factors and Vulnerabilities Tribals of to HIV/AIDS

An assessment of ITDP projects indicates that out of 192 projects located in the states, 65 projects are located in the A& B category districts. These districts have as per NACP – III design Link Worker scheme sanctioned there that targets rural areas and HRG populations as well as vulnerable women & youth. The programme interventions in peri-urban & urban areas are the TI Projects besides other NACP – III services. Thus, the needs of tribal populations in such districts would be met by these interventions, with appropriate targeting. The training of ITDP project authorities and NACP intervention personnel about the needs of tribal areas should therefore suffice.

The level of intervention in C & D category districts is lower in keeping with lower disease burden, risk and vulnerability. Nevertheless, the social assessment preceding NACP – III noted high degree of vulnerability of the tribal population given their larger sexual networks including with high risk outsiders migrating in their habitats, illiteracy and lack of awareness of STIs & HIV/AIDS & preventive measures, poverty, migration, health seeking behavior, gender bias and poor state of health services because of their remoteness and lack of political clout. It therefore suggested identifying and targeting socially disadvantaged people especially tribals and carrying out behavioral studies using ethnographic approach to better understand risks and vulnerabilities so that programmatic interventions could be designed to address the identified needs and thereby reduce risks and repulse onslaught of HIV/AIDS.

Out of the total 192 ITD Projects or ITDAs, only 65 projects fall within A & B category districts. (**Table 2.2**) The remaining projects are located in 99 other districts. It also does not include the tribal preponderant states of Arunachal Pradesh, Meghalaya, Mizoram & Nagaland or the 3 autonomous Sixth Schedule areas in Assam(2) / Tripura (1). 14 of their districts are off-course included among the A & B category districts. (**Table 2.3**) In the remaining areas, similar exercise as outlined above needs to be undertaken.

Table 2.3
District Categorization in 4 Tribal Predominant States

Sl No	State	Total Districts	A & B Districts	C & D Districts
1	Arunachal Pradesh	16	1	15
2	Meghalaya	7	0	7
3	Mizoram	8	3	5
4	Nagaland	11	10	1
	Total	42	14	28

This assessment of high risk groups and vulnerable populations is an essential pre-requisite of the targeted interventions relating to HRGs, bridge populations or Link Worker Scheme, nevertheless, the focus there is on finding such persons and providing them with appropriate service. The low prevalence of HIV/AIDS in other areas requires more of group focused actions rather than individual directed activities, thus, it is proposed to conduct assessment of risk factors and vulnerabilities for the tribal population and plan appropriate prevention and mitigation responses.

2.3. Components of Tribal Action Plan

On the basis of above discussion above, following approach will be followed in the formulation of Tribal Action Plan:-

- i. Assessment of data on epidemiology of HIV/AIDS & associated factors such as STI, KAP, risk factors and vulnerabilities, availability of services (prevention, Care, Support and treatment), shortcomings and their impact.
- ii. Based on aforesaid epidemiological and program assessment, formulation of Action Plan and identification of NACP – III norms/guidelines needing relaxation for more appropriate response.
- iii. Implementing new services or activities hitherto not included in NACP – III, designed to address specific needs of tribal areas/communities
- iv. Mainstream HIV/AIDS activities in the schemes/programs/structures targeted at the tribals & build their capacities to do so on a sustainable basis
- v. Strengthening linkages among the Tribal, Health & HIV/AIDS sectors for a more forceful response to HIV/AIDS

For ease of planning and processing of the proposals, different activities constituting them have been categorized in manner similar to that of NACP III Strategy and Implementation Plan document.

These components are detailed in the chapters that follow.

Chapter – 3

Interventions for Tribal Population

Although, the entire tribal action plan is in a sense a targeted intervention for the vulnerable tribal population, most of its components also fit into more specific categories such as prevention, human resource development, monitoring & evaluation etc. Such re-classification by revealing true nature of activity assists in building linkages among cognate items and assessing the progress & benefit accrued from related activities.

NACP – III services are deficient in tribal areas because of remoteness, deficiency of health infrastructure and their operations as also because of cultural & social factors tribals face while accessing mainstream institutions. The Tribal Action Plan proposes additional interventions of tribal communities/areas to supplement the existing bouquet of interventions. These focus more on increasing access to prevention services, as the tribal communities for the most part are less affected than other communities because of their relative isolation. As the guidelines also propose reimbursement of travel expenses and free ART/investigation services, the distance of care, support & treatment units would not be a major hindrance in the access of these services.

The access to preventive services are proposed to be enhanced by their (STD, condom promotion, awareness development) provision through mobile vans in fairs & hats, mobile vans and ten-bedded hospitals of MoTA supported NGOs and mobile ICTCs. Tribal marketing and distribution channels are to be bought out in the net of social marketing operations for improving access to condoms. Partnership arrangements are to be worked out with private hospitals, private practitioners, unqualified practitioners largely focusing on STD services. The range of services may be enhanced for private hospitals based on their competency and appetite. The tribal healers and unqualified healers are proposed primarily for increasing referral to ICTC, STD and ART related services. Guidelines for these find place in the **Chapters 4 & 6**.

The communication activities proposed herein focus upon orientation of tribal community leaders, and integration of HIV/AIDS in the IEC & other work of ITDPs. At the same time TRIs will help the SACS contextualize their IEC for the tribal people. These guidelines appear in **Chapter 5**.

The TRI will be developed as a center of excellence for HIV/AIDS programming among tribals. The guidelines find place in **Chapter 7**. Programme management guidelines in **Chapter 8** are meant for enhancing institutional capacity structures and creating forums for the implementation of plan. **Chapter 9** offers guidelines for enhancing knowledge about HIV/AIDS among tribals especially through study of risk factors and reworking monitoring & surveillance systems.

Among mainstreaming activities, the main ones are migrant education and counseling services, admission of wards of dead/destitute AIDS patients of ST communities to residential schools and reworking the mandate and operations of tribal institutions/activities. The guidelines find place in **Chapter 10**.

Some activities vital for the implementation of the Tribal Action Plan do not easily lend to the aforesaid chapterization. The main among them are national and state level workshops for generating consensus on need and nature of action, awareness activities in tribal education institutions and initiatives. These have been placed in **Annexure – 1**.

Chapter – 4

Prevention Activities

The NACP – III menu of preventive activities is quite comprehensive. The tribal areas, however, pose special challenge because of the lower level of functioning of the health infrastructure, remoteness and the tribal's world view. At the same time, it also presents opportunities, which are not present elsewhere. Fairs and hats are one example. The large scale presence of tribal population there makes it a good vehicle for delivery of preventive services. The marketing & distribution channels of the tribal affairs/development department or its agencies provides an excellent channel to Social Marketing Organizations for distribution of condoms. Mobile ICTCs are needed to ensure easy access to such services. MoTA sponsored mobile dispensaries and ten-bedded hospitals also offer additional outlets for preventive activities. These are described below.

4.1. Delivery of Preventive & Diagnostic Services in Fairs /Hats

Fairs and hats are an integral part of tribal's commercial and social life. As the tribal habitats are remotely located and sparsely populated, the commercial activity there remained limited. Fairs and Hats thus developed as important institutions for sale exchange of produce and items of daily necessity with the traders from outside. They also provided outlet for socialization and intermixing. It also served as an important source of partner selection. Despite development of townships and commercial hubs, the Fairs and *hats* continue to play a major role in the tribal life. Since the interaction between opposite sexes and between outsiders and tribals is socially permitted, lot of at risk activities including sex work takes place in these settings.

Because of their central role in the tribal life, many preventive & diagnostic services can be linked to fairs & *hats*. These could be awareness generation activities through posters, banners, street theatre, films etc. Not only a large audience is available, but it is also with largely homogeneous. Thus, the content, language & media can be chosen for very effective communication.

4.1.1. Main Services

Main services that could be delivered in fairs & *hats* are listed below:-

- i. Condom promotion & distribution to retailers or lower level outlets
- ii. Symptomatic diagnosis & treatment of Sexually Transmitted Infections (STIs)
- iii. General Health Check-up
- iv. Referrals to other NACP facilities like ART, PPTCT, CCC, ICTC etc
- v. DOTS services directly or through RNTCP clinics
- vi. Awareness raising activities

The aforesaid services which are normally delivered using a mobile van have been detailed by the NACP program and may be followed here with appropriate local modifications.

4.1.2. Role of the ITDP/ Tribal Authorities

- i. to assist the DAPCU/SACS in planning for the above by sharing of list of such fairs & *hats*, their characteristics in terms of periodicity, demographic, linguistic & ethnic profile of visitors, size of visiting population, inter-se priority and by facilitating issue of permission or license, if any.
- ii. Wherever the ITDP authorities or NGO or Health authorities have such mobile vans, they could be pressed into delivery of above services with complementary support in terms of IEC materials, testing kits & medicines, equipment, personnel etc. from NACP- III.
- iii. To participate in the monitoring & evaluation of the implementation of the activities.

4.1.3. Implementing Agency

DAPCU / NGOs chosen by them

4.1.4. Implementation Sequence

- a. ITDP/DTWO will share with DAPCU list of such fairs & *hats*, their characteristics in terms of periodicity, demographic, linguistic & ethnic profile of visitors, size of visiting population, nature of transactions etc. (a cattle hat or fair would be less preferred compared to one in which grocery/miscellaneous transactions takes place) and indicate the inter-se priority among them for starting the services.
- b. ITDP will facilitate issue of permission or license for starting of service, if any and also arrange for a public building in the hat premises if such exists or erect a structure through its own funds, from which service can delivered.
- c. The mobile vans with ITDP authorities or Health authorities would, subject to availability, be pressed into delivery of above services. DHS/ITDP will issue orders to this effect. Similar arrangements will be explored with vans available with NGOs.
- d. It shall invite different agencies for a workshop wherein the operationalization of present proposal will be discussed and agreements will be arrived at regarding the packages of services to be offered through the dispensaries, support needed there-for, timetable for different activities including capacity development, area and frequency of coverage of the target area, reporting formats & frequency, handling of referrals for HIV/AIDS services and logistics.

- e. DAPCU will assess the complementary support required for mobile vans of ITDP/Health Deptt./NGO in terms of IEC materials, testing kits & medicines, equipment, personnel, training etc. from NACP- III.
- f. If the existing vans are unable to ensure delivery of service in the short-listed fairs & hats, then the requirement of new mobile units will be assessed on the norm of one van for 20 days of work/month. The requirement of personnel, equipments, drugs and consumables, POL etc. will be determined for the new units
- g. The DAPCU will prepare a roster of work for different mobile vans with the approval of ITDP and start the service. It shall also work out referral arrangements with RNTCP, NACP centers.
- h. For better utilization of service, the services shall be publicized through the ITDP/PHC network as well as through posters, publicity & mike announcement in the hat itself & by contact with the NGOs, community leaders in the area etc.
- i. The DAPCU will evolve reporting formats for adherence to the advertised schedule and the quality and quantum of service. ITDP will devise a system for independent monitoring of services in the fairs & hats through its own network and feed it back to DAPCU. The progress would be monitored on a monthly basis. Joint review by ITDP/DAPCU will be made every quarter of progress being made in this intervention.

4.2. Improving access to counseling & testing services through Mobile Medical Vans

In para **4.1.** of this Chapter relating to use of fairs /hats, the role of mobile medical vans is described in great detail, therefore, it is not elaborated here. It is noted that the NACP – III guidelines relating to ICTC include mobile ICTCs. An integrated planning will be made for providing mobile medical van based ICTC & other services taking into account the availability of such vans with Health Deptt. or Tribal Welfare Deptt./ITDA. It is proposed to supplement the availability through NACP –III in the following manner:-

4.2.1. Implementation Steps

4.2.1.1. Hard to reach areas will be mapped for all ITDA areas /Tribal states. In such mapping due importance will be given to the hot-spots of high risk activity such as fairs, hats, halting points or dhabas on important trucking routes, developing mining centers or industrial clusters. From among those, areas more than 30 kms away from the static ICTCs will be chosen and prioritized according to size of the affected population and the intensity of high risk activity. According to the nature of such place, the frequency of provision of mobile ICTC service will be decided.

4.2.1.2. Mobile vans available with the health or tribal programs will be located and the possibility of their being upgraded to ICTC through supplementary inputs from NACP will be assessed. As the tests deployed under the ICTCs are

rapid testing kits, which could be performed at room temperature in field conditions without separation of components, the critical requirement is that of necessary manpower and space for waiting, counseling and testing. The mobile van need not provide all that space. Available public buildings or if that is not available, tents could create necessary space. Foldable tents are available. They could be supplied or sufficient contingency made available in order to hire them.

4.2.1.3. For a C category district 1 mobile ICTC unit will be provided, if the same cannot be arranged from the existing vans or proposed for delivery of NACP – III services in the fars/hats. This is in view of the hot spots located therein. In such district, the static ICTC unit is generally at district level. As hot spots are populated by HRGs, who are very poor off or having insufficient time, district level ICTC may not be used by them. For A & B category districts, the number of such vans will be determined on the basis of mapping,

4.2.1.4. Although no vans are proposed for Category D districts having the ITDAs, the requirement of deployment of mobile ICTC will be met by pooling units available in other districts, especially B & C category districts.

4.2.1.5. Such mobile units will also provide services of STD treatment, condom promotion and create awareness about HIV/AIDS.

4.2.1.6. The utilization of the units may be assessed on a regular basis for continuing with the service and measures for improving accessibility including linkage with the local NGOs/CBOs for publicity.

4.2.2. Implementing Agency

DAPCU/DHS

4.2.3. Linkages with mobile units of other deptts.

DAPCU should coordinate the ICTC activities when carried out from mobile vans of other departments. Standard reporting formats as applicable to NACO's own mobile ICTC units will be used for this purpose. They will also participate in the planning & review meetings organized by the DAPCU/DHS and submit budget for supplementing personnel, contingencies and POL etc. They shall also requisition the DAPCU/DHS for drugs, consumables, publicity material, stationary etc.

4.3. Social Marketing of Condoms

Social marketing of condoms is a proven way of increasing access to condoms & condom promotion. The traditional distribution channels of condoms do not work in tribal areas, as the social and commercial life is organized somewhat differently in these areas. Thus a modified approach is needed.

In order to supplement the normal marketing channels as also to regulate dysfunctional markets, many channels for sale & purchase of produce have been opened in the tribal areas, e.g. Large Area Multipurpose Cooperatives in Jharkhand, Bihar; *Girijan* Cooperatives (GCC) in Andhra Pradesh etc. These agencies have deep access in the tribal areas. These agencies can also serve as distribution channels for condoms as well as for IEC messages. Social Marketing Organizations (SMOs), therefore, need to liaise with tribal authorities to tap additional channels in consultation with DAPCUs / SACS.

4.3.1. Implementation Arrangements

- a. ITDP will map tribal marketing & distribution channels. Their potential for distribution of condoms and awareness generation activities will be analyzed in discussion with ITDP, marketing & distribution agencies and DAPCU. On the basis of analysis of potential & cost efficiency, plans for expansion of social marketing network will be prepared by the SMOs.
- b. The incremental expenses on account of creation of extra storage facilities & handling of supplies, training of personnel of marketing & distribution agencies, additional supervision will be assessed.
- c. The SMO will aggregate the same for each state and present the same for review & recommendation by the SACS.
- d. The implementation shall be monitored by the DAPCU/ITDP.

4.4. MoTA Scheme of Mobile Dispensaries

MoTA supports a NGO scheme. One of the permitted activities therein is the operation of mobile dispensaries. The aim of this scheme is to meet gaps in delivery of health services in the tribal areas, where on account of remoteness, lack of trained manpower, infrastructural deficiencies, etc. the services either do not exist or are deficient. No specific guidelines are provided to NGOs as to how they will operate the mobile dispensaries. This sub-scheme provides for the following:-

- 1 Medical Officer (MO)
- 1 Compounder /Nurse
- Staff to operate the ambulance & office
- POL & vehicle maintenance
- Medicine
- Contingency

The state governments as well as many other NGOs operate such mobile dispensaries. It has not been possible to collect details of them. It is suggested to the SACS/DAPCU to collect details and with the support of the CMHO of the district do a mapping of the service areas so that gaps in health service delivery are addressed to the best possible extent.

4.4.1. Objective

The main aim of the mobile dispensary is to provide routine health services to its target population. The HIV/AIDS related services are a sub-set of the package of services. Because of smallness of medical staff, the package to be provided is limited. Following services are proposed to be provided through the Mobile Dispensaries.

- Information and education on HIV/AIDS and the services available.
- Syndromic management of STDs
- Condom Promotion and Distribution
- Referrals and linkages for HIV testing and other services

4.4.2. Support from NACO

- Training to Medical Officer and paramedical staff
- IEC materials (leaflets, posters, banners, music cassettes, videos etc.)
- Drugs, condoms and other consumables for use/distribution in its visits
- Reporting formats
- Information to its other partners about provision of HIV/AIDS services through the Mobile Dispensaries.
- Referrals made by them to other centers to be recognized.
- SACS/DAPCUs to include the requirement in their planning and logistics exercises.
- Any other support incidental to the above.

4.4.3. Support from Ministry of Tribal Affairs

- Information to NACO/SACS of sanctions of schemes for establishing necessary linkages.
- Seeking inputs from DAPCU/SACS at the time of renewal of grant.
- Making it mandatory for the NGOs to include these among the services for considering extensions or renewals and informing its clients.
- To require, if these organizations have also been sanctioned economic development schemes, NGOs to offer psycho-social support as well as coverage under such schemes, if needed.
- Revision of the monitoring formats to reflect above services and inclusion in the TOR of the evaluation of the NGO.

4.4.4. Implementation Steps

4.4.4.1. The DAPCU will play a critical role in broadening the package of services of the mobile dispensaries. It shall seek the details of the NGOs and other organizations operating mobile dispensaries.

4.4.4.2. It shall invite them for a workshop wherein the operationalization of present proposal will be discussed and agreements will be arrived at regarding the packages of services to be offered through the dispensaries, support needed therefore, timetable for different activities including capacity development, area and frequency of coverage of the target area, reporting formats & frequency, handling of referrals for HIV/AIDS services and logistics. It shall also invite the officers of the health departments to the workshop.

4.4.4.3. After the approval of the plan, it shall implement the above decisions. DAPCU shall also arrange to supervise the MO so far as delivery of STD control services is concerned. In addition, it shall ensure uninterrupted logistical arrangements.

4.4.4.4. The NGO shall maintain close liaison with the DAPCU & Health authorities for performing its tasks and participate in the trainings, meetings and workshops in so far as they are relevant.

4.4.4.5. The DAPCU shall send its comments on the performance of the NGOs as regards the HIV/AIDS related services to SACS/Tribal Affairs Department/ITDP for consideration during renewal of the assistance.

4.5. 10-bedded Hospital Scheme

Among the schemes run by Ministry of Tribal Affairs is a scheme of 10-bedded hospital through NGOs. These schemes are now permitted mainly in the 5th or 6th Schedule areas having large tribal population and meant for remote and inaccessible areas where the reach of the public health care system is not good. Some salient features of the scheme are described below.

- Medical staff admissible per 10 bed module
- MOs- 2 no.
- Consultations by specialists – 8days/month
- Compounder -1
- Dresser – 1
- Nurse -2
- Ward Boy -2

Ambulance -1 (with driver & POL)
Drugs for outdoor & indoor patients
Diet allowance for indoor patients
Rent, electricity & water charges

4.5.1. Services

The staffing approved for the above health facility is quite low. Although the number of beds approved is 10, higher than 6 of PHC, It is only 1/3 of that approved for CHC. In such cases, only such activities as are performed by the PHCs under the NACP-III may be performed by such institutions namely:-

- i. STD control and condom promotion
- ii. Testing and counseling for HIV
- iii. Treatment and prophylaxis for OIs
- iv. ANC & counseling for prophylaxis
- v. In case of greater than 50 PLHAs in the district, this agency can serve as Community Care Centers.

4.5.2. Implementation Steps

4.5.2.1. The DAPCU will play a critical role in broadening the package of services of the Ten Bedded Hospitals. DTA will inform the SACS about such hospitals, which in turn will inform the DAPCU.

4.5.2.2. DAPCU shall invite them for a workshop wherein the operationalization of present proposal will be discussed and agreements will be arrived at regarding the packages of services to be offered through the hospitals, support needed therefore, timetable for different activities including capacity development, area and frequency of coverage of the target area, reporting formats & frequency, handling of referrals for HIV/AIDS services and logistics. It shall also invite the officers of the health departments/ITDP to the workshop.

4.5.2.3. Following support will be extended for delivery of NACP –III services by the Hospital:

- i. Staffing: Lab Technician and counselor, as these are not supported under the NGO Scheme.
- ii. Training of personnel: The officers & the staff of the Hospital may be provided training covering attitudinal aspects, basic modules for the treatment for STDs & OIs, BCC & counseling, infection control & blood safety besides protocols for documentation and monitoring. They may also be provided refresher trainings under NACP – III.
- iii. Drugs and consumables for the above.
- iv. Supervision and quality assurance services.
- v. Referrals made by them to other centers to be recognized.
- vi. To arrange for the linkage of such institutions with RNTCP for offering anti-TB services/DOTS as TB is among the most common diseases among the AIDS patients.

vii. Any other support incidental to the above.

Note: As per NACO norms

4.5.2.4. After the approval of the plan, it shall implement the above decisions. DAPCU shall also arrange to supervise the MO so far as delivery of STD control services is concerned. EQAS applicable for STD clinics will also be extended. In addition, it shall ensure uninterrupted logistical arrangements.

4.5.2.5. The NGO shall maintain close liaison with the DAPCU & Health authorities for performing its tasks and participate in the trainings, meetings and workshops in so far as they are relevant.

4.5.2.6. The DAPCU shall send its comments on the performance of the NGOs as regards the HIV/AIDS related services to SACS/Tribal Affairs Department/ITDP for consideration during renewal of the assistance.

4.5.3. Support from Ministry of Tribal Affairs

- i. Enhancement of level of support to accommodate increased personnel & other medical requirements/expenses, including for additional personnel viz. 1 each of laboratory technician & HIV/AIDS counselor.
- ii. Information to NACO/SACS for establishing necessary linkages.
- iii. Seeking inputs from DAPCU/SACS at the time of renewal of grant.
- iv. Making it mandatory for the NGOs to include these among the services for considering extensions or renewals.
- v. To require, if these organizations have also been sanctioned economic development schemes, NGOs to offer psycho-social support as well as coverage under such schemes, if needed.
- vi. Revision of the monitoring formats to reflect above services and inclusion in the TOR of the evaluation of the NGO.

Chapter – 5

Communication Activities

IEC activities in the tribal areas pose unique challenges to IEC programme managers because of dearth of knowledge about the KABP about the communities themselves, wide diversity among communities regarding their customs, languages, social structures; lack of penetration of conventional media channels and remoteness of their habitats. It is one area where the argument for working together with the tribal authorities is very compelling. In para **7.1.2.2.** of this document, proposal has been made to build capacity in the TRIs who in turn will support the planning & implementation of communication activities. The TRIs will also work with the ITDAs & DAPCUs on the IEC activities. As there is a very comprehensive guideline issued for conducting IEC activities, only those items unique to tribal areas are detailed.

5.1. TRI' Support to Communication Activities

The TRIs have lot of experience in social-cultural as well as linguistic anthropology because of staff education and work handled by them. Furthermore, most of the TRIs have personnel having fluency in major tribal languages of the state. Thus, they are in a position to advice SACS or their communication agencies or DAPCUs or ITDPs in development of communication materials and campaigns. As part of capacity development in the TRIs, the faculty members of the TRI would also be oriented on communication activities. They can render following support in this regard:

- i. Message development
- ii. Pre-test of the IEC material
- iii. Translation and rendering of the IEC material into major tribal languages
- iv. Associate in the IEC related training of the personnel of the ITDPs
- v. Participate in IEC strategy development
- vi. Prepare template & guidelines for IEC activities by the ITDPs & provide technical assistance to ITDPs from time to time.

5.1.1. Implementation Sequence

5.1.1.1. The TRI would chose a ITDP to prepare an inventory of IEC opportunities in the areas mentioned in para and draft a model plan/guidelines for implementation.

5.1.1.2. The same would be reviewed with SACS/its IEC agency to avoid duplication & ensure technical correctness.

5.1.1.3. The TRIs would develop prototype IEC materials with support from SACS IEC agency.

5.1.1.4. TRI would provide technical assistance to the ITDPs from time to time.

5.1.2. Fund Requirement

A sum of Rs. 2 lacs placed with the TRIs to carry out the aforesaid work. under the MoTA assistance.

5.2. IEC activity by ITDPs

The ITDPs maintain very close links with the tribal community through one-stop delivery of services & coordination of works of the sectoral departments. Their interactions with communities' socio – cultural leaders are quite intense, which are necessary for designing, planning and implementation of schemes, articulation of their interests etc. This interface can be leveraged to mobilize the community for action against HIV/AIDS. Major activities likely to be taken up by the ITDPs are outlined below:-

5.2.1. Orientation of community heads, village chiefs and such other respected community leaders on HIV/AIDS

Advocacy with and social mobilization of community opinion leaders is very essential in order to raise the awareness of HIV/AIDS as a collective threat to the community, promote environment supportive of behavior changes especially related to sexual networking, use of condoms and greater care of young girls for preventing their exploitation, reduction of stigma and collective action against risk factors. The IEC operational guidelines for IEC allude to it but do not elaborate.

The tribal villages have often worked as autonomous self-governing entities. There used to be well established decision making structure, which played important roles in regard to settlement of disputes, collective ritual activities, enforcement of customs and practices, taking up inter-village matters etc. With

increasing contact with outside world some of such institutions have lost their central role in tribal life. However, they continue to be influential. Developments like PESA Act have restored some of their importance. In states like Jharkhand, the traditional leaders like Munda – Manki continue to head Gram Sabhas, which have been empowered to take up developmental activities. As explained above, advocacy with such leaders will bring substantial visibility to the program and lead to a more informed and enabling environment.

5.2.1.1. Tribal Community Leaders

Such community leaders may include:-

1. Village headmen such as *Munda, Mahato*
2. Village priests such as *Pahan*
3. Cluster leaders known as *Parha Raja, Manki*
4. PRI leaders in the tribal areas
5. Heads of cooperatives in the scheduled areas known as Large Area Multi-Purpose Society (LAMPS) or equivalent bodies
- f. Animators employed by the ITDPs for carrying out their activities
- g. Community health functionaries functioning in the ITDPs

5.2.1.2. Implementation Sequence

5.2.1.2.1. The ITDP or DTWO will compile list of such community leaders who are influential within their communities and need to be oriented. Their willingness to undergo the training will also be ascertained.

5.2.1.2..2. The TRIs will help adapt the module for civil society for the tribal community leaders. It shall pay attention to the language, customs so that the orientation is received well. It shall also take up training of trainers so that uniform standards could be maintained during the training. They will also assist in overseeing the conduct of the training programs.

5.2.1.2.3. The ITDP/DTWO will organize the orientation programme with the support of TRI & district training institutions or through the NGOs. The trainers identified for this purpose will be oriented by the TRI in the module for achieving quality and consistency of messages.

5.2.1.3. Issues Covered

The orientation may include topics such as

- a. The HIV/AIDS, routes of transmission and methods of prevention
- ii. The risk factors and vulnerabilities including that of trafficking or exploitation of young women
- iii. Need for behavior change e.g. reduction of partners & casual sex, use of condoms

- iv. Availability of NACP services & facilities including financial support
- v. Respect for human & legal rights of the AIDS patients and creation of an enabling environment.

5.2.1.4. Outcome

Following outcomes are expected:-

- i. Sensitization of the community towards the need for behavior change
- ii. Community mobilization for mitigating the risk factors & its adverse consequences
- iii. More humane & enabled environment towards the AIDS patients
- iv. Higher off take of NACP services, use of condoms etc.

5.2.2. Field/Outdoor publicity in the institutions controlled by the ITDPs

The institutions under the ITDP control are very vigorously used by tribals, therefore they can serve as places of field and outdoor publicity. ITDPs will arrange to get these material developed in their own languages with the support of DAPCU IEC officials and TRIs. Type of such materials could be hoardings, posters, banners, pamphlets, brochures, stickers etc.

5.2.2.1. The aforesaid material could be displayed or made available in major ITDP facilities and institutions such as:-

- 1. ITDP offices and sub-offices
- 2. Cooperatives and sales depots of tribal or forest cooperatives functioning in the ITDP area
- 3. Schools including residential schools and hostels functioning under ITDP area
- 4. Places of cultural activities there-under

5.2.2.2. The TRI/ IEC agency for the SACS under NACP – III will prepare the prototypes for such materials. The prototypes will be adapted by the ITDP with assistance from DAPCUs.

5.2.2.3. The ITDPs will be responsible for production and installation/display of the communication material.

5.2.3. Incorporation of the HIV/AIDS in the non-health activities of the ITDP.

Mainstreaming of HIV/AIDS in the activities of other sectors is one of the key strategies of the NACP-III. As ITDP acts as single window of service to tribal communities in large number of states, where it exists, a similar approach could be adopted as far as awareness generation is concerned. Some such activities could include:-

- i. Orientation of SHGs on HIV/AIDS,
- ii. Inclusion of material of HIV/AIDS in publications, events, outdoor materials of different sectors under ITDP
- iii. Orientation of JFMCs & similar bodies on HIV/AIDS and ensure discussion in their meetings
- iv. Celebration of World AIDS Day by ITDP
- v. Advocacy meeting with different stakeholders viz. traditional leaders such as chiefs, religious & GP representatives, MP/MLAs, NGOs, college principals, doctors & other influential members from the tribal communities

5.3.1. Implementation Sequence for all 3 aforesaid activities

5.3.1.1. The TRI will make an inventory of such IEC opportunities in a typical district and propose activities to be taken up by ITDP. Since most of the activities are common across the state, therefore, this exercise would help ITDPs to prepare their plans conveniently.

5.3.1.2. Based on the above, ITDP will draw up their proposal for IEC activities. TRI would also include in their template, guidelines for carrying out included therein and some sample materials. Based on the above, after approval of the plan, ITDP will execute the plan.

5.3.1.3. The progress would be reviewed every quarter jointly with DHS/DAPCU.

5.3.1.4. The DAPCU & the IEC agency of the SACS would provide the technical assistance as & when needed.

5.3.1.5. To start with, a lump sum grant of Rs. 5 lac will be placed with the ITDPs for the 3 activities mentioned above. On development of detailed proposals, the releases will be made as per the requirement.

Chapter – 6

Public Private Partnership

The public health system is weak in the tribal areas for a variety of reasons. Not only there is a lack of physical infrastructure but also human resources. The norms of establishing institutions are relaxed, yet they are not always easily accessible. In such conditions, private health providers of all types are accessed by the tribals.

Various studies carried out in India have indicated a high level of STI burden in the tribal societies, primarily resulting from sexual networking, low level of reproductive hygiene and condom usage and other related factors. Because of lack of awareness about them, shame associated with discussions of issues of sexual health and reluctance in general to seek health care, lot of tribal men & women continue to suffer from STDs. As the prevalence of STDs heightens the risk of HIV infection, treatment of STDs is one of the crucial preventive actions. In addition condom promotion, treatment of OIs, referrals are some of other preventive or curative activities, which might be undertaken by the private sector in the tribal areas.

A range of providers exist in tribal areas starting from tribal healers to unqualified providers (but using allopathic medicine) to doctors of various systems running their clinics to hospitals. Each has its area of strength. The guidelines propose different roles for different providers. Common to all of them is capacity building and mutual cooperation. These are described in the following sections.

6.1. Private Practitioners

The study of STD treatment seeking among tribals by A. Mohammad (**INDIAN J SEX TRANSM DIS 2005; VOL. 26 NO. 1, 17**) pointed out that about 1/6 of respondents of the study sought treatment from allopathic doctors. About the same proportion got treatment from *Ayurvedic* doctors. Approximately 3 % of the patients sought treatment from homeopathic doctors. Since *Ayurvedic* doctors are generally working outside the public health system, it is quite likely that they would be private practitioners. It is also very likely that some of the allopathic doctors may also be private practitioners. Thus there is a need to tap this valuable resource not only for STD treatment but also for other HIV/AIDS services.

It is proposed to seek only those practitioners who are formally trained under a graduate program. Such academic training pre-disposes them to higher level of service.

6.1.1. Role

1. Diagnose & provide syndromic management of STDs including counseling, partner notification & OIs
2. Provide referral to NACP services such as ICTC, PPTCT, OI, STD, TB etc.
3. IEC/BCC activities
4. Condom promotion
5. Could also supervise the work of other PPs

6.1.2. Implementation Steps

6.1.2.1. CMHOs of the districts or the officer – in – charge of health services of the ITDP will get a survey conducted of such practitioners. If the mapping of services reveals gaps in geographical coverage and such practitioners are available, then those having had formal training will be invited to a workshop at the level of DAPCU. About one such practitioner will be identified for a population of 15,000. If a medical institution is available, it will be given priority over others. Allopathic PP will in turn be given priority over PPs of other disciplines.

6.1.2.2. The purpose of the workshop will be to orient the participants to the scheme and seek their cooperation for this. The DAPCU may enter into a formal agreement with them for delivery of services after a formal orientation & training.

6.1.2.3. The DAPCU will assess the requirement of drugs & consumables, incentive payment, training, forms & stationary, IEC material etc. for the units contracted.

6.1.2.4. Training modules for syndromic management for the STIs, OIs and IEC will be administered to such practitioners by the training institution earmarked for the district.

6.1.2.5. DAPCU shall also arrange to supervise the MO so far as delivery of STD control services is concerned. EQAS applicable for STD clinics will also be extended. It shall also ensure uninterrupted supply of required items.

6.1.3. Payment Mechanisms/Supervision

RNTCP has a well developed payment mechanism for engaging private providers. It is proposed to adopt a similar structure of payment in this case too. This are suggested subject to NACO's approval as below:-

- Referral fees @ Rs. 150 per referral. Protocol similar to that followed for unqualified provider will also be followed.
- Successful treatment of each syndromically treated case @ Rs. 250 per patient. In order to ensure that the success in accurately reported, quarterly meeting with STD experts in the clinic settings will be arranged,

- with some of the treated patients. Interaction with treated patients and their examination will verify the claim of success in the treatment. Visit to the clinic settings would also afford opportunity to its general arrangement, practices followed, documentation, drug storage and dispensation practices etc. Thus, it would also be a supervision tool.
- Quarterly payments would be made in order to minimize the administrative burden.

6.1.4. Role of DAPCU

- Coordinate the identification of PPs, assess eligibility.
- Provide training for PPs
- Provide guidelines for syndromic treatment and other literature and IEC material, as available and appropriate.
- Provide free anti-STD drugs for patients
- Provide records, referral slips etc. as required.
- Provide honorarium for individual providers as per NACP norms.
- Arrange for necessary supervision and oversight.

6.2. Tribal Healers

Tribal healers hold an important place in their communities and are respected for their knowledge of local medicine as well as spiritual & supernatural prowess. He is one who is consulted in cases of illnesses, which can't be managed by home remedies. The usual risk with reliance of this line of treatment is that the patient loses valuable time before he is referred to the formal medical system and thus difficult to cure. The benefits of the tribal healers are that they are locally available, price their services according to community's capacity to pay and have community approval besides also attending to psycho-social dimensions of healing. There is no mockery or disdain of the patient's dress, community or such other features of the formal system.

The above mentioned profile of the tribal healers make them an attractive channel for carrying out preventive, promotional and referral activities of the programme. Their illiteracy, conflict of interests, age, gender (almost all healers are male) come in the way of the fulfillment of their potential.

6.2.1. Role

A brief description of the tasks proposed for the tribal healers is attempted below:-

- i. Educate community members about the disease, modes of spread, preventive methods and availability of services & referrals through use of his service delivery sessions, ritual occasions & festivals,

- ii. Be aware of the counseling, testing and service delivery centers and the symptoms for referrals and accompany the person to those delivery points. Also work towards reduction of barriers to accessing services.
- iii. Counsel for & monitor for treatment adherence.
- iv. Provide counseling & palliative care, referral for STIs, OIs, TB and other ailments
- v. Mobilize community for reducing fear of HIV/AIDS and stigma and discrimination against PLHAs
- vi. Link up with other service providers, agencies for improving access to other health services and logistics such as condoms etc.
- vii. Condom promotion
- viii. Help the health authorities to locate HRGs and bridge communities and
- ix. Also lead the community efforts towards behavior modification for reduction of vulnerabilities.

6.2.2. Training Duration & Timing

10 days. As most of the healers are peasants or agriculturists themselves, therefore, in order to ensure better attendance, the training programs should be designed for periods of lean agricultural activity.

6.2.3. Training Topics

The training would be modeled on the pattern of link workers. The Technical Resource Institutions recruited by the SACS will work with the Tribal Research Institutes of the MoTA/State Govt. to adapt the module for training of the traditional healers. The training will not only provide information on the various facets of disease, the manner in which it affects the fabric of the community, the services and the facilities being made available under NACP-III, but also engage them in reflecting upon the social, reproductive, health related customs, social norms, behaviors etc. that have a bearing upon health & HIV/AIDS status and what they could do about these. They will be taken to different service delivery sites to facilitate understanding. Gender sensitization would also form a key component of the orientation, as tribal healers are mostly male & ingrained biases may hinder its full benefits.

6.2.4. Training Mode

The orientation would be interactive in nature. The resource persons must include a person having deep understanding of the tribal community. This could be faculty member of the TRI, officer of the tribal welfare deptt., teacher or research scholar or officer of the Anthropological Survey. The program could also work as a workshop for development of messages, IEC materials such as flip charts, posters, songs, slogans etc. and pre-testing thereof. Such activities would make them feel valued and utilize their vast and deep knowledge of the community. The program should be ended with distribution of certificates and/or some other form of honour.

6.2.5. Incentive for tribal healers

Although the involvement of tribal healers is being sought on a voluntary basis, nevertheless incentives are necessary in order to sustain their interest. Recognition of their services appropriately, trainings and refreshers are some such incentives. In order to encourage referrals, a payment of Rs. 100 will be made besides traveling allowances to compensate for their lost income during the period, they accompany service seekers.

6.2.6. Implementation Steps

6.2.6.1. Implementing Agency: Although NACP – III programme is the bridgehead for engaging with the traditional healers, it is expected that the tribal development/health & medical department would make use of them for their other activities, thus it is preferable that ITDPs/DTWOs, wherever the delivery of health/FW services are integrated therewith or DHS (NRHM structure at the district level) implement this activity. If the structure is by itself unable to handle the programme, services of NGO could be hired on the basis of their own guidelines or if such guidelines are not available, then on the basis of NGO Selection Guidelines for the NACO.

The implementing agency's key personnel should undergo a two-day orientation workshop by SACS. The TRIs (both technical resource institution and tribal research institute) in partnership with SACS & Health Department will conduct the orientation, during which the role of tribal healers, operational modalities should be fully explained. Action plan for implementation of the scheme and timeline should be drawn in this workshop. The members of DAPCUs /District Health Committees wherever established should also be part of this workshop.

6.2.6.2. Selection of tribal healers: Though traditional healers are very well established in their communities, many a times there is no record with the tribal welfare authorities. In such cases, a survey –cum-contact drive needs to be made by the officers of the ITDP/tribal welfare in their areas. Prior to this, they themselves need some orientation by the TRI/DAPCU authorities as to the purpose of the survey, so that they could explain the purpose during the above exercise. Furthermore, the contact details and convenient time for their orientation may be ascertained from them during it.

6.2.6.3. Training: The District Resource Person (DRP)s (of the Link Worker Scheme) could also be assigned the responsibility for training of the tribal healers along with ITDPs/DTWOs. In other places, the Tribal Research Institute/ District Training Institution may assist in this work. Preferably, the batches should consist of tribal healers from one community only as it would help delivery of training in the relevant tribal language. As the literacy level may be low, it may be useful to focus on use of audio-visual material and training techniques that emphasize discussion and reflection.

This training should be followed by refresher trainings to reinforce the learning.

6.2.6.4. Supervision: It is important to maintain regular contact with the healers in order to reinforce the messages & work practices as also to maintain motivation. In category A & B districts, Link Worker Scheme supervisor can also work as supervisor. In other districts the field supervisors of the Health deptt. or ITDP/Tribal Welfare Deptt., whichever might be acceptable, may be oriented to perform this work. The role of the supervisor's will be to undertake visits to the healers, reinforce their technical knowledge, seek their feedback on activities undertaken, facilitate coordination between them and other community level workers/PRI/health & educational institutions and also act as resource persons for activities that might be undertaken by the healers. Furthermore, they might also act as sources of supply of IEC material, referral forms and SMO materials. They would also be oriented about their role by the same agency that undertakes the orientation of tribal healers.

6.2.6.5. Monitoring & Evaluation: As most of the tribal healers are not well educated, therefore, formal monitoring systems which rely on submission of reports pose a major challenge. With this in mind, the system design would be simple and yet capturing the essence of their work. It is proposed to use printed postcards with monitorable items being printed thereon. These will have addresses of the supervisor pre-written. Further more, monthly meetings could also be organized on the hat days. There shall also be a system of periodic contact with healers in their settings to keep up the motivation and improve upon their counseling & referral roles. Therefore, initially quarterly refresher meeting-cum-reviews will be organized in the first year. From, the second year onwards, the contact will be on a half-yearly basis.

6.3. Unqualified Medical Practitioners

The formal public health system is not very functional, if not dysfunctional, in areas that most tribals live in. various studies have revealed that unqualified health providers abound in such locales and very readily accessed. A study on STDs among tribals by A. Mohammad reported about 22 % respondents seeking treatment from such practitioners as compared to about 17 % from the allopathic doctors. About the 20 % tribal respondents sought treatment from *ayurvedic*/homeopathic doctors. (**INDIAN J SEX TRANSM DIS 2005; VOL. 26 NO. 1, 17**).

The Training Manual for State & District Surveillance Officers under the Integrated Diseases Surveillance Project also noted, "There is increasing evidence from published literature that the preferred first contact physician is private practitioner rather than doctors working in public sector. This is even more so for some diseases like STD. The advantages include better accessibility, privacy and lack of facilities in the public sector units. While in theory public sector units provide free medical service, in practice both private and public sector units provide services on payment as out of pocket expenses." (http://www.nicd.nic.in/IDSP_docs%5CTRAINING%20MANUAL%5CDistrict%20Surveillance%20Team%20Training%20Manual%5CModule4.pdf)

In view of the above evidence, there is a strong case of involving private unqualified medical practitioners, even though there might be fears of their misusing the association with NACP – III. With appropriate orientation, incentive structure and supervision many of such fears may be addressed and thereby the access to STD services greatly enhanced.

6.3.1. Role

The role envisaged for the unqualified providers is quite similar to that of traditional healers, but for provision of syndromic management of easier forms of STDs by the former. For STDs involving complicated diagnosis or tests, referral needs to be encouraged. Such practitioners may not come from the tribal communities; therefore, their role in behavior change process may not be as prominent.

6.3.2. Implementation Steps

6.3.2.1. Implementing Agency It is proposed to entrust this work to the DAPCU itself as the number may not be large enough. It may draw up a panel of supervisors, from PHC MOs to private practitioners and after suitable orientation may entrust them with this work.

6.3.2.2. Engagement of Providers ITDP authorities/CMHOs of the districts in tribal majority states would survey such practitioners, who are reasonably popular in their areas and explain to them the purpose of the scheme. They will be invited to a workshop at the DAPCU/STD clinic, where the purpose of the intervention, their role, protocol for recordkeeping, reporting will also be explained. On their willingness to work for the intervention, they will be admitted to the intervention and initial training arranged. About 1 such provider per 5000 population should be selected.

6.3.2.3. Training In view of the above role, the training mode, topics and agency may be similar to those of traditional healers. A greater degree of time may need to be spent on training segment of syndromic management of simple forms of STDs, therefore, STD experts need to be associated with the training programme. SACS/ Training Resource Institutions may work out the module for such training programme. The training programme should emphasize upon the important role they are playing, and from that vantage should motivate them to cooperate with the NACP.

Refresher courses may be needed from time to time.

6.3.2.4. Incentive A variety of incentive mechanisms exist starting from monetary, psychological, recognition to more complex ones. A mix of these

mechanisms needs to be employed because of their diverse needs. Following are proposed:-

- i. The training itself will serve as a psychological incentive. Refresher trainings, supervisor visits etc. may serve as additional incentives.
- ii. Supply of IEC material, drug kits etc.
- iii. No payments are proposed for the referrals in view of the capacity building & other supplies proposed here.

6.3.2.5. Supervision The supervision is proposed to be entrusted to a selected Medical Officers, drawn from the public health system or the non-government agencies or even independent private practitioners. They could also come from the doctors belonging to *ayurvedic* or homeopathic streams, available in the area. This training would be arranged by the DAPCU through its training agency. Once a quarter, a meeting could be arranged at the level of STD clinic to which they are tagged to review different aspects of STD service provision. As explained above, this occasion would also be used to serve as refresher training. Once every year a review meet may take place at the level of DAPCU, where in addition to review of their functioning, their interface with the STD clinics could also be discussed and their knowledge could be refreshed.

6.3.2.6. Necessary supplies will be arranged through the STD clinics to which they are tagged.

Chapter – 7

Human Resource Development: Building Capacity

There is all-round capacity constraint in the tribal areas. This is also true of the HIV/AIDS programme. Another dimension of this constraint is lack of understanding of the magnitude of the HIV/AIDS problem and ways of dealing with it. Since response to the HIV/AIDS has to be multi-sectoral, therefore, this deficiency is going to affect its effectiveness. Furthermore, the health sector's interaction with the tribal affairs has not been as intense as it ought to be, therefore, exposing officers dealing with HIV/AIDS or related programmes need to be exposed to the structure, values etc. of the tribal society as far as they impact its performance of NACP – III.

TRIs act as the research and training arm of the tribal sector in the state. The NACP proposes to develop their capacity in order to supplement the training resources of NACP – III. TRIs would be developed as centers of excellence in tribal sector for HIV/AIDS.

There are many elements of capacity building needed for successfully implement the Tribal Action Plan and are mentioned in the relevant segment of this Guideline. These have also been compiled to give a fuller picture of capacity building needs.

7.1 Capacity Building & Use of Tribal Research Institutes

The TRIs are a very important wing of tribal development machinery in the country, variously known as tribal research & development institute or Tribal Research & training Institute, underscoring different functions these institutions carry out. Basically, these are aimed at carrying out research on different aspects of tribal life, especially on cultural, anthropological, linguistic aspects, providing orientation to officers and staff dealing with tribal development, research into attributes of tribes and verification of tribal status etc. About three years ago an attempt was made to streamline their functioning by prescribing minimum activities, i.e. few national level themes, some state specific research themes and some seminars.

The TRI's involvement with the health sector has been very limited, partly because tribal focused programming has not been attempted on a sustained manner. HIV/AIDS related programming is one area where the expertise of the TRIs might be very helpful, since tribal attitude to sex, marriage or health seeking behavior or communication patterns etc. are quite distinct requiring a response adapted to their situation. Hitherto, these factors had not been considered adequately. TRI's expertise can bridge that gap in knowledge in programming.

7.1.1 Role of TRIs

Some of the important ways in which this could be achieved are listed below:-

- i. Sensitization of the officers of the Tribal Welfare Deptt. or ITDAs or agencies about the HIV/AIDS situation and services and programs and providing technical assistance to them in mainstreaming of HIV/AIDS in Tribal Welfare programs and activities. Annexure -2 provides detailed guidelines in this regard as also for sensitization of Health & HIV/AIDS programme officials and functionaries.
- ii. Similar sensitization of the health& HIV/AIDS authorities and functionaries on the aspects relevant to HIV/AIDS programming such as tribal sexual & reproductive practices, health seeking behavior, social and gender relations, communication styles and relations with outsiders.
- iii. To also actively participate in development of tribal action plan under NACP – III and supporting implementation.
- iv. Undertaking or supporting assessment of risk factors & vulnerabilities to the HIV/AIDS and suggesting measures for reduction thereof.
- v. Assist in development of communication strategies, IEC materials and media, pre-testing etc. for HIV/AIDS communication activities.
- vi. Undertaking studies and assessments of implementation of NACP-III and related measures.

7.1.2. Implementation Sequence

Following sequence of activities is proposed for implementing this cluster of activities.

- i. National Workshop of Tribal Affairs Secretaries of the States & Directors of the TRIs on involvement of TRIs in NACP-III Activities.
- ii. Development & implementation of action plans for capacity building of TRIs for the above. It is proposed to develop the existing faculty through orientation as well as by placement of external resource person.
- iii. Training Needs Assessment & develop of curricula and training modules:- For this a workshop will be arranged by TRI with support of SACS/TSU. The draft curriculum/modules developed there would be reviewed at a national consultation. Based on the inputs received there, the trining material will be finalized.
- iv. Formulation of proposal by TRIs for their involvement in NACP-III activities & submission to SACS
- v. Implementation of the approved plan
- vi. Joint monitoring & evaluation of the implementation.

For details of item i-iii, Annexure 2 may be referred.

7.2 Assessment of Adequacy of Training Resources

All the capacity building requirements proposed under Tribal Action Plan have been tabulated below. From the perusal of the table, it is seen that the main burden of training is on district training institutions and TRI. It is difficult to state whether the institutions will be able to cope up with the load with the existing staff, as their existing commitments are not known. It is therefore essential that the potential of the institutions to undertake the proposed training activities & need for additional resources be assessed. If the institutions are not able to take up the proposed load even with augmentation of resources, alternatives will need to be explored. SACS along with its Training Resource Institution and Tribal Research Institutes will jointly make this assessment. The additional resource requirements for enhancing the capacity of the existing institutions and/or new institutions will also be described & budgeted by the SACS/DTA. There would be a specific statement by both the agencies in their Action Plans.

Table 7.1
Trainings Activities under Tribal Action Plan

Sl No	Intervention	Ex. Agency	Trainees	Trg. Agency	Nature of Training
1	AEP in residential schools/vocational courses	DTA/NGO	Head Master / Warden/ head of Vocational institutions / Supervisors	SACS/TSU	Sensitization
2	Orientation of Tribal Community leaders	ITDP/DTWO	Tribal Community Leaders	Dist. Training Agency. Training of Trainers by TRI	Orientation.
3	NACP services in fairs/hats (including Mobile Dispensary Scheme)	DAPCU/NGO	Medical Officers/ Compounder/Nurse	Dist. Training Institution	Skill development
4	Mobile ICTC services	DAPCU/NGO	MO/Lab Technician/Counselor	Dist. Training Institution	-do-
5	Social Marketing thru Tribal Marketing Channels	Social Marketing Organization	Key staff of tribal marketing channels	SMO	-do-
6	Ten Bedded Hospital Scheme	NGO	MO & paramedical staff	District Training Agency	-do-
7	Private Practitioners for STD Care	DAPCU	MO & paramedical staff	-do-	-do-
8	Orientation of Tribal Healers for NACP - III	ITDP/DTWO	Tribal Healers	DRP/TRI/ District Trg. Institution	Orientation
9	Unqualified Medical Practitioners for STD Care	DAPCU	Unqualified Medical Practitioners	-do-	Orientation and skill development
10	Orientation of Tribal staff on NACP	TRI	Distt/Sub-distt. Official of DTA/ITDP/allied agencies/NGOs	Tribal Research Institute	Orientation
11	Orientation of Health/NACP staff on tribal issues	-do-	Distt. Program Officers/NACP facility heads	-do-	-do-
12	Orientation of TRI Faculty/Experts	NARI/TRI	TRI Faculty & Resource Person	NARI/TRI	-do-

Chapter 8

Programme Management

In order to implement Tribal Action Plan, administrative set-ups & linkages will need to be developed among the tribal, health & HIV/AIDS programme structures at all levels for improved coordination in policy, strategy, planning, cross-utilization of institutions, programs and personnel, data collection & interpretation etc. Though, both the organizations seek to protect and promote the interest of tribals, the linkages and interest in other's programs have been weak. Such coordination would not only lead to economy in implementation, but also enhance the effectiveness of interventions. Although joint work on HIV/AIDS would require collaborative team action in many areas and on many themes, the permanent or standing structures are described here.

8.1. Tribal Cell/Unit in the NACO

In order to implement the Tribal Action Plan, a focal unit in the NACO is necessary for providing necessary administrative support. Following tasks are proposed for this unit.

8.1.1. Functions

- i. To serve as a nodal unit for implementation of Tribal Action Plan
- ii. To serve as Secretariat to joint TRG on tribals
- iii. To liaise with MoTA and other related agencies for this purpose
- iv. To seek & monitor data, analyses and reports on the state of HIV and response among tribals and prepare various reports related thereto
- v. To act as clearing house of materials on tribals and HIV
- v. Any other work incidental to the above tasks.

8.1.2. Staffing

It is proposed that this cell function under the Joint Secretary (IEC), with Joint Director (IEC) & Joint Director (Monitoring & Evaluation, Research & Development) reporting to him. Two officer/consultants in the former's unit and one in the latter's unit will be assigned independently with this providing necessary administrative support for this task. Out of the two proposed for the JD (IEC), one officer will be assigned for internal coordination within NACO. The other person will be dealing with matters related to coordination with external agencies.

8.2. Joint Technical Resource Group on HIV/AIDS issues related to tribals

This body will be a technical counterpart to the cross – participation in the program management through the aforesaid Board.

8.2.1. Functions

The functions of this body will be to offer advice on all aspects of implementation of Tribal Action Plan, scrutinize and vet various operational guidelines and annual plans, identify data gaps and suggest ways to address them in a cost effective & programmatically relevant manner, examine the implementation capacity & propose development of institutional structures, linkages & capacity building activities as also map external resources, advise on research agenda, methodologies and institutions, and offer its advice on any other matter that may be referred to it or it considers important.

8.2.2. Composition

Following composition of the Technical Resource Group is proposed:-

1. Secretary, Ministry of Tribal Affairs – Chair
2. AS & DG, NACO _ Co- chair
3. Joint Secretary, Deptt. of Health looking after tribal health – member
4. (Principal) Adviser Tribal Affairs / Health, Planning Commission – member
5. 2-3 Directors, TRIs nominated by MoTA - member
6. 2-3 PDs of the SACS with substantial tribal population, at least one of which would be from the North- East States – member
7. Representative from NARI, Pune / RMRC for Tribals, Jabalpur – member
8. Representative from Anthropological Survey of India, Kolkata – member
9. 3 prominent researchers from the medical anthropology active in HIV/AIDS from Universities / Research Institutions
10. Experts and representatives from donors & international technical agencies
11. 2-3 prominent NGOs working on HIV/AIDS in tribal areas to be chosen by NACO (e.g. MYRADA, Mysore, CINI, Ranchi etc.)

8.3. HIV/AIDS Cell & Steering Group in the MoTA

As the scale of activities under the Tribal Action Plan will be substantial, spread across the country, It will need extensive hand holding & coordination not only of states but also with NACO & allied agencies. Two fold arrangements will be needed.

8.3.1. HIV/AIDS Cell

The first structure will be a cell or unit to oversee & support the implementation of the tribal action plan on a continuing basis. It will be headed by a director or deputy secretary rank person, to which experts with knowledge of working on issues of HIV/AIDS among tribals will be appointed on contract. The NACO or donor partner may sponsor 2-3 such positions.

8.3.2. Steering Group

The other structure will be a Steering Group to provide policy directions to the MoTA in this area.

8.3.2.1. Composition

The Steering Group may have following members:-

1. Secretary, Tribal Affairs – Chairman
2. Joint Secretary (ies) MoTA – members
3. Joint Secretary/Addl. Project Director, NACO – member
4. 2-3 state secretaries i/c Tribal Affairs - member
At least one of which will be from NE
5. 2-3 Directors, TRIs
6. 2 NGO representatives active in field of tribal health
7. 2 Experts from Universities, Academic Institutions in the aforesaid areas etc.

8.3.2.2. Terms of Reference

Its Terms of Reference will be as below:-

1. To take stock of spread of HIV/AIDS among tribals, the factors behind the spread and the efforts by NACO
2. To assess the areas of synergistic action among the tribal & aids control programs, as also the institutions, programs, human resources who could be involved therein. The Steering Group will also formulate guidelines, modifications, norms of financing to make it possible.
3. To determine the manner in which HIV/AIDS related activities could be mainstreamed, and the enabling decisions to let that happen.
4. To review progress in the implementation of tribal action plan, especially the component pertaining to MoTA activities and direct remedial actions.
5. To consider any other matter having a bearing on HIV/AIDS among tribals.

8.4. Task Force in the DTA and a Unit in the Directorate of Tribal Affairs in the States

The Department of Tribal Affairs or their equivalents in the states have traditionally not focused on the health issues. So is the case with their implementing arms i.e. Directorates or Commissionerates of tribal welfare or their equivalents. Therefore, they need to be empowered in order to steer this work. One of the important tasks would be to create a Task Force or Steering Group within the State Departments on a similar pattern as at the center in the MOTA. Since, the task at the state level is more on implementation, therefore, a cell also requires to be created in the Directorates or their equivalents to guide and monitor the implementation of the action plan on a regular basis. The technical inputs for its work will be provided by the TRIs, who are proposed to be empowered under the Tribal Action Plan.

These components are elaborated below:-

8.4.1. Task Force at the State level

This is a State counterpart of the Steering Group at the MoTA. Its role is mainly to set the administrative & policy framework for the implementation of the TAP. It will also monitor the progress from time to time and take up corrective steps to steer its course.

8.4.1.1. Terms of Reference

The Terms of Reference of the Task Force is detailed as below:-

- i. To take stock of the HIV/AIDS situation, the routes of its spread & the risk factors
- ii. To analyze the requirement of facilities and services vis-à-vis their availability & the role of health, tribal affairs & other depts. in its augmentation
- iii. To analyze the ongoing programs of the deptt. and formulate modifications to them for increasing the bouquet of services
- iv. To formulate action plans for mobilizing public opinion among tribal leadership and structures for preventive action against HIV/AIDS as well as for destigmatization & removal of discrimination.
- v. To consider modifications in the charter of responsibilities of authorities at different levels and development of linkages among its authorities and other deptts. in so far as HIV/AIDS among tribals is concerned.
- vi. Any other matter necessary for more effectively response to HIV/AIDS among tribals.

8.4.1.2. Composition

Following composition of the Task Force is proposed.

- i. Secretary, Deptt. of Tribal Affairs – Chairman
- ii. Director, Tribal Welfare -- Convener
- iii. PD, SACS -- Member
- iv. Director, TRI -- Member
- v. Director, Secondary Education -- Member
- vi. Anthropologist / Public Health -- Member
Expert with HIV/AIDS background
- vii. 2 NGOs working on Tribal Health -- Member

8.4.2. HIV/AIDS Cell in the Directorate or its equivalent

As explained earlier, their capacity at this moment to be able to plan, implement and monitor the activities included in the TAP is almost non-existent. It is therefore proposed to create a cell therein, which will be headed by one of the senior deputy /joint director and would include 1-2 experts having knowledge about HIV/AIDS & masters level education in anthropology or public health or social work. For such expert, experience of working in tribal areas or for tribals would be desirable. The expert would be chosen by SACS in consultation with the DTA and positioned there. Gradually, the Directorate would be expected to create its own position.

8.4.3. Tribal Research Institute

The third leg of the administrative framework is TRI. TRI will act as technical support unit for the Directorate. As TRI is being developed as technical resource unit for conduct of training, risk factor assessment, studies and evaluations, it will not need any further up-gradation. In addition to the training of its faculty, provision is also being made for appointment of an expert to assist the TRI. This should be sufficient for the purpose.

8.5. Strengthening of links between the Tribal, HIV/AIDS & Health sectors

The two sectors of tribal affairs & AIDS control have not developed as many linkages as they ought to at different levels. This impedes a common perception of the need and synergistic action. The success of the TAP will lie in

intensification of the linkages, a goal for which the two sectors have been striving. Without listing the existing ones it is proposed to build following new linkages:-

8.5.1. National Level

- i. MoTA will be represented in National Council on AIDS ,
- ii. The Joint Technical Resource Group will be constituted headed by Secretary, Tribal Affairs besides having representation of the TRIs and the Advisor in the Planning Commission looking after Tribal Affairs.
- iii. The Steering Group in the MoTA will have representation from NACO.

8.5.2. State Level

- i. DTA will be represented in the governing body of the SACS in States with large tribal populations & Director, Tribal Welfare or his equivalent in its Executive Committee.
- ii. PD, SACS will be represented in the Task Force proposed in the DTA.
- iii. PD, SACS be invited to attend the meeting of Tribal Advisory Council.

8.5.3. District/Project level

- i. In the A & B category districts and if the state so decides for other category districts, District level functionary in charge of AIDS control will be represented in ITDA Executive Body.
- ii. The Project Officers of ITDPs or DTWO will be represented in the DHS/DAPCU.

8.6. Involvement of tribal sector functionaries in strategizing, planning and monitoring of the NACP interventions

The involvement of the officers of the tribal welfare department is critical to success of the NACP – III objectives for the tribals as their access, acceptability and in-depth knowledge of the tribal communities is of a high degree. It is therefore necessary to ensure their full participation in strategizing, planning and monitoring of the NACP activities. This is sought to be achieved by building cross-linkages among the two sectors described in detail in aforementioned paras

as well as by vesting concurrent supervision responsibilities for different interventions. Both NACO and MoTA will issue instructions to their respective state counterparts to engage fully for the above mentioned activities.

Chapter - 9

Monitoring & Evaluation, Surveillance & Research

9.1. The Need

In the discussion on the approach of the Tribal Action Plan, it was pointed out that there is a lack of data about the epidemiology of the HIV/AIDS among the tribal communities. The two surveillance initiatives dealing with biological or behavioral markers or factors do not provide data disaggregated for the tribals. Similar is the situation with regard to information on risk factors and vulnerabilities and respective role played by each such factor, especially migration. One of the key strategies planned for dealing with bridge populations is source to destination mapping of migration, so that the intervention such as pre-migration counseling or post-return check-up and counseling of them and the spouses could be planned.

Since interventions have hitherto not been planned for the tribals per se, therefore the evaluation and documentation of the programme interventions vis – a – vis tribals have not been taken on a systematic basis. It is also true however that lot of research works or assessment/documentation of interventions have been done in isolation. The development, management and dissemination of these knowledge inputs would be of great value to the policy makers, implementers and researchers.

The Social Assessment therefore called for knowledge management as a core strategy, which was included in the NACP-III document. Various components included under this strategy strand mentioned earlier are detailed below:-

9.2. Components

9.2.1. Inclusion in the surveillance system & surveys, additional of tribal status in the district having ITDP areas or states with majority tribal population. To advocate similar decisions in surveillance systems of associated diseases such as TB.

Currently the behavioral or sentinel surveillance system does not capture the tribal status of the respondents or subjects. Therefore, the HIV/AIDS status or linked attributes such as risk perception of the disease of the tribal population is not captured. The corresponding data of districts with ITDP projects or in tribal majority states is taken as proxy for the tribal related indicator. A substantial population in such areas is non-tribal, whose characteristics may be different from the tribal communities. It is therefore important to disaggregate the data relating to tribal communities. Since ANC surveillance and PPTCT surveillance are linked to overall HIV surveillance, inclusion of tribal status may also be built into there.

The compromised immune system increases the likelihood of an AIDS patient to develop a disease if infected. They can become life threatening and require urgent medical attention. Various scientific bodies including NACO have compiled a list of such opportunistic infections. Some of the prominent ones among them are tuberculosis, malaria, STIs etc. Integrated Disease Surveillance Project of the Ministry of Health & family Welfare has prepared a list of diseases for surveillance based on the disease burden. The aforementioned diseases are included in the said list. Since increased levels of said diseases are linked to AIDS disease or predispose a person to HIV infection, it is important to include the tribal status in the said surveillance systems to corroborate the result from HIV surveillance as also to make efforts for strengthening the curative systems. Interpretation of such data may also be fine-tuned so as to correct for weaknesses of the health system in tribal areas.

It is therefore proposed that for the ITDP areas and tribal majority states, the tribal status may also be included as a parameter in the HIV, STI, TB and malaria surveillance systems. In order to keep it simple it is proposed that the surveillance be carried out on a district basis for the above areas. Since MADA areas form a very small proportion of the district population, no tracking is proposed in those areas.

9.2.2. Review of MIS to include tribal status

As mentioned in the afore-going paragraph, the data pertaining to spread of and response to HIV/AIDS for the tribals are not directly tracked. Only indirect estimates are available. Such data is not very handy either for planning, policy making or taking corrective measures. The CMIS and other reporting systems thus need further development to capture the tribal attribute. The dissemination of the results also needs to focus upon the status of disease and response among the tribals. As explained earlier, such data would be captured for the districts in which ITDPs are located or the districts of the tribal majority states.

The changes in the reporting and monitoring systems would need to be concomitantly reflected in the forms, registers and databases. Thus, all the divisions of NACO would need to review their recordkeeping and database maintenance operations and modify them appropriately. This would need to be disseminated to all the SACS, who will in turn issue suitable guidelines to the DAPCUs, various projects and other concerned. The SACS and the project units will orient their staff responsible for the same through in-house efforts.

NACO & SACS will include a chapter in their annual reports dealing with the response to the HIV/AIDS in the tribal areas, as will the MoTA and the DTAs do for their own reports.

9.2.3. Assessment of Risk Factors and Vulnerabilities to HIV/AIDS

The assessment of risk factors and vulnerabilities of the tribal communities to HIV/AIDS was referred to in para **2.2. of Chapter 2**. Such assessment is key to evidence based planning, which at the moment is based on macro picture or extension of general populations' behaviour to tribal people. Thus, it is proposed to conduct assessment of risk factors and vulnerabilities for the tribal population and plan appropriate prevention and mitigation responses.

9.2.3.1. Objective of the Assessment

The assessment would cover behavioral and socio-economic factors that enhance the risk of HIV infection or cause somebody to undertake risky behavior. It shall also identify hot-spots in the assessment area. Furthermore, the interactions between different socio-economic factors enhancing vulnerability, awareness of risk, disease, services, health seeking behavior etc. will also be explored. In particular the assessment shall determine for the study area:-

1. Sexual patterns, number and type of partners, relationship with marriage, variation with age & time, sexual activity with outsiders, sexual activity during special events such as festival & fairs, social norms and values regarding type of partners, marriage & cohabitation, sex for consideration, Motivation for sex as also the role of coercion & violence
2. Status of women, livelihood situations, social support systems and their linkages with CSW & high risk behavior
3. Perception of risky behavior & associated risks (STI, HIV/AIDS etc.)
4. Awareness & Perception of STI symptoms & their causes
5. Health seeking behavior (when, with whom, cost, symptom linked)
6. Knowledge of HIV, risks, routes of transmission & services including family life education in educational institutions & adolescents in other settings
7. Nature and extent of migration, nature of sexual activity of migrants & spouses during this period; also patterns of in-migration, their sexual networks & interactions with tribal society
8. Nature & extent of addictive & associated risky behavior, perception of risks & preventive behavior

9.2.3.2. Implementation Steps

9.2.3.2.1. Finalization of tools: Though the mapping & assessment methodology for implementation of TI for HRGs or bridge populations or Link Worker Scheme is well laid out, the same will not be as useful for the task under consideration, as the focus thereof is to find individuals, whether at high risk or vulnerable in concentrated pockets, whereas the purpose of this task is to understand the types of risky behavior and the context and social settings in which such takes place in low prevalence areas. The latter's focus is more on data gathering than the former, the assessment there being an implementation activity. In view of this, fresh tools will need to be developed.

It is proposed that a Technical Resource Group consisting of NARI, IIPS & Programme Officers of TI related to Migrants & HRGs of NACO/ selected SACS, Link Worker Scheme, MoTA, TRIs, RMRC, ICMR Jabalpur, NGOs/experts/anthropologists working in field of tribal health, esp. reproductive health, is constituted. The TSU attached to NACO will work under the guidance of TRG to work out guidelines for this assessment. It may associate the experts from TRIs and NARI in the development of tools.

The guidelines will detail the tools to be used, the data sources, procedure for estimation of manpower required, respective roles and likely costs, competencies/experience needed to execute the task, timeline and supervision arrangements.

These will be disseminated in a Workshop to be attended by the TRI experts and SACS/TSUs of the concerned states so that they could together develop an understanding of the guidelines/tools.

9.2.3.2.2. Selection of the assessing agencies & orientation thereof the Key Personnel

The TRI in consultation with the SACS/ TSU & DTA of the concerned state will decide upon the assessment load and the fraction thereof that can be conducted by internal resources of the TRI/SACS and that which needs to be outsourced. The TRI should advertise Expression of Interest (EOI) from NGOs in two leading local dailies, one in English and the other a vernacular newspaper. The EOIs should be short-listed and the organizations contacted for discussion, after which the interested organizations should be asked to submit a detailed proposal with action plan. The guidelines for the assessment should be shared with them. A committee should be constituted to review the proposals. This could constitute of SACS, TRIs and State level experts on HIV/AIDS. Involvement of ITDP officials will be extremely useful at this stage.

In the event of an NGO being the preferred implementing agency, its selection should be in accordance with the NGO Selection Guidelines of NACO. Anthropological Departments of the College/ Universities should be encouraged to apply and should be given preference over others, all other things being equal.

The key personnel of the selected agencies should be invited to a 2 day workshop organized by the TRI in consultation with SACS/TSUs along with DTA/ITDP Project officials. The workshop will on the one hand orient the key personnel of the selected agencies and also undertake adaptation, if any, and translation of the tools, questionnaire etc.; on the other hand will orient the ITDP officials on the scope of work being undertaken and the support needed from them in completion of the task.

Where TRIs are not there, SACS will utilize these tools for conducting these assessments assisted by TSUs.

9.2.3.2.3. Assessments by TRI own/contracted teams

9.2.3.2.4. Discussions between TRI/TSU representatives, Project Authorities of ITDP, CMHOs, DAPCU, Assessment Team, other concerned regarding the draft findings & response required

9.2.3.2.5. Dissemination Workshop at the State level: The Workshop will be attended by the DTA, DoHFW, ITDP officers, District Aids Control Officers, state level experts, members of TRG and others concerned along with SACS/TSU representatives. It will be organized by the TRI.

9.2.3.2.6. Review of Action Plans & Implementation

9.2.3.2.7. Supporting ITDP/DAPCU officials for Follow-up Assessment of Risk Factors

9.2.4. Review and Documentation of Ongoing Interventions and Researches on HIV/AIDS etc. among Tribals

NACP – III has developed an elaborate system of evaluation with different periodicities, agencies and sources of information. These results provide the evidence base for programme management, planning and communication/advocacy activities. The Tribal Action Plan ought, therefore, be supported with appropriate evaluation activities. At the time of development of NACP – III interventions, a working group was formed to develop strategy and implementation approaches. This Working Group will be revived to study the research and evaluation needs for implementation of Tribal Action Plan and its integration with the overall framework and systems for the NACP – III. It would also assign responsibilities for different items of work depending upon the experience and competency of agencies including those of MoTA/DTAs, NGOs, universities and other scientific bodies working for tribals.

The TRIs would have developed adequate knowledge and experience of the NACP – III through training of its faculty and placement of experts as well as from its roles in training, assessment of risk factors & vulnerabilities and communication activities, thus it would also be in a position to assist the SACS as well as DTA of the states in undertaking studies on different aspects of implementation of the NACP-III among the tribals and tribal areas including the impact. Furthermore, some of these assessments ought to be mainstreamed into the research agenda of the TRIs. SACS should convey its suggestions in this regard to TRI.

This would be reviewed from time to time by the Technical Resource Group proposed under this Action Plan for coordinating the dissemination of results, application of these results into further programme management and planning and future evaluation activities.

Chapter - 10

Mainstreaming of HIV/AIDS in the Tribal Structures & Programming

One of the core strategies of Tribal Action Plans is to mainstream HIV/AIDS related services/activities into the programs/structures of the Tribal Affairs wing of the government at various levels. Mainstreaming will ensure long term sustainability of the HIV/AIDS related activities without the need for an external stimulus.

The Ministry of Tribal Affairs runs schemes for delivery of health services in remote tribal areas through NGOs such as Ten Bedded Hospital Scheme or Mobile Dispensary Scheme. The Tribal Research Institutes are knowledge development and dissemination centers as well as capacity development units for officials for tribal development on various aspects of tribal life and developmental initiatives. NACP – III envisages these to be groomed as Centers of Excellence for HIV/AIDS related activities for tribals.

ITDPs have merged as key administrative-developmental institutions functioning in the areas outside the tribal majority states, whose population is largely tribal. These agencies have not only a substantial presence in the said areas, but also enjoy a high degree of credibility and have also developed in-depth understanding of norms, institutions, livelihoods etc. of the tribal life. Therefore, they will play a major role in mainstreaming of HIV/AIDS interventions in their jurisdictions not only through participating in planning, strategizing, supporting or monitoring of the NACP – III interventions, but also through conducting assessment of major risk factors such as migration, conducting orientation of its animators and grass-root health functionaries and IEC activities.

Other items including capacity building of the institutions through which the mainstreaming could be achieved have also been enumerated in the following write-up. All the foregoing items are elaborated below.

10.1. Enrollment into residential schools/hostels/vocational centers of wards of dead/destitute AIDS patients

10.1.1. Admission of ST Children of Dead/Destitute AIDS Patients

The children orphaned by death of their AIDS affected parents are often stigmatized. As the most AIDS death take place among people in their prime

productive and reproductive ages, their children are young. As the poverty is quite widespread among the tribal communities, the relatives are often not in a position to look after such orphans, even if they are willing. The children thus have a very uncertain future and in serious need of state help. The AIDS disease, because of its debilitating effect on health and substantial expense on treatment & nutrition, also impoverishes the parents, thus affects their ability to look after their children. In such cases, state support for education of children is called for.

The Tribal Affairs Departments in the states run large number of residential schools for meritorious ST children by different names viz. *Eklavya Vidyalaya*, *Ashram* schools, *Gurukulam* etc. The objective of such schools is to provide good schooling facilities to children who would be otherwise unable to receive good quality education on account of remote locations, poverty and illiteracy of their parents and thereby mainstream them as well as bridge the educational gap.

10.1.1.1. Implementation Steps

It is proposed to mould the scheme of residential school/hostels to meet the above need in the following manner:-

10.1.1.1.1. MoTA will organize a meeting of the Secretaries in –charge of Tribal Affairs with participation of NACO & SACS to sensitize the states on this issue and seek their willingness to remodel the scheme to serve the orphans or wards of aforementioned AIDS parents.

10.1.1.1.2. DAPCU/ ITDP authorities/ District Tribal Welfare Officer (DTWO) or equivalent will conduct a survey to find out such children. The DAPCU & ITDA (P)/DTWO will evolve a system to exchange data about such children on a regular basis, with inputs from TI Projects, ART centers, DOTS centers, OI clinics etc.

10.1.1.1.3. The MoTA will advise states to admit such children in residential schools irrespective of their educational attainments or age to an appropriate class. DTAs will issue necessary orders.

10.1.1.1.4. Once these children are admitted, schools authorities will get an assessment made of health, nutritional, educational, psychological status of these students. The status of parents will not be disclosed to fellow students and information limited to those who require such information for functional purposes. Remedial classes, special nutrition and regular health check-ups will also be arranged. Special provisions will be made with regard to nutrition, health check-up, educational and psychological support for such children so that they can cope with their new situation.

10.1.1.1.5. Teachers & others will be oriented by their educational authorities to eschew any discrimination, stigma or ridicule. Teachers will be earmarked to act as guides for providing social and educational support to them.

10.1.1.1.6. In holidays, if guardians are unwilling to take the children home, arrangements will be made for their stay at the residential schools itself or with their teachers or at especially selected residential schools.

10.1.1.1.7. For college going children, NACO/SACS to advocate with the University Grants Commission/Universities to offer admission to such children, if necessary by increasing the seat strength. Such students to be offered admission to the hostels run by the Tribal Affairs Deptt. or those run by the colleges or Universities.

10.1.1.1.8. The rate of post-matric scholarship is rather low and it does not ever cover the expenses of college education. This would be a major handicap in the way of their education, given the fact of almost total lack of parental or other support and the fact that there might be additional medical expenses of such persons. Thus, an enhanced level of scholarship at twice that of current rates may be paid. MoTA will issue orders.

10.1.1.1.9. The school/college supervisory authorities as well as educational authorities in the tribal welfare department may in their inspections specifically look into the functioning of the scheme and issue necessary directions to the relevant authorities. Copies of such reports may also be made available to DAPCU/SACS authorities. This may also be reviewed from time to time.

10.1.1.1.10. Without disclosing the identity of or even admission of any such students, the Hostel authorities may sensitize the hostel inmates of the HIV/AIDS & the precautions that they should take in their relations as well as the need to treat it as any other disease and respect the human and other rights of the HIV/AIDS patients and their children.

10.1.1.1.11. DTA will commission evaluation of the functioning of this scheme after a period of one year and share the findings & the steps taken with SACS.

10.1.1.2 Implementation Agency

1. ITDP / DTWO/ DAPCU
2. Residential Schools/ Hostel Wardens

10.1.1.3 Funding

No additional funding is required. The DTA/MoTA's existing budgets will be used.

10.1.1.4 Monitoring

ITDP /DTWO authorities/ DTAs

The results will be shared with SACS/DAPCU on a quarterly basis and with MoTA/NACO on an annual basis.

10.1.2 Preference in Vocational Education

The grown up children orphaned by the death of the AIDS affected parents in many cases may require skill development so that they may be able to earn their livelihood. Many tribal affairs departments run programmes for vocational training. In addition, such trainings are also supported by the Special Central Assistance to the TSP. DAPCUs and associated organizations may sponsor such cases to the ITDP / DTWO/ Commissioner Tribal Welfare. The MoTA/DTA may issue directions to give priority to such children.

10.2. Integration of HIV/AIDS in mandate of Tribal Sector Institutions

The health issues have generally been out of the radar of the institutions dealing with tribal matters, like Tribal Research Institute, Tribal Advisory Council or ITDPs. The HIV/AIDS being newer to the health concerns, this is not even discussed. In order to mainstream HIV/AIDS in the tribal affairs sector, it is important to enmesh this in institutional space of this sector at all levels.

As explained earlier, the States with scheduled areas are constitutionally bound to create Tribal Advisory Councils as apex deliberative forums to discuss issues of tribal protection and development. Other states with tribal populations may also create such bodies on Presidential directives. They are to deliberate such issues as may be referred to them by the Governor. Consisting as it does of a large body of tribal legislators and eminent persons, its deliberations and recommendations not only guide decision making in the tribal activities, but also serve as a channel for mobilizing public opinion.

Thus, a letter from President of India to Governors in this regard may be required. This letter could also direct Governors of the Fifth Schedule States to include in the Annual Reports on Administration of the Scheduled Areas, the efforts made in this regard.

10.3. Inclusion in Annual Reports of MoTA, Governors, DTAs, TRIs, ITDAs of their work on HIV/AIDS among tribals

Inclusion of HIV/AIDS in annual reports of the institutions dealing with tribal matters is a natural corollary of broadening their mandate to HIV/AIDS. Two reports are worth mentioning:-

i. Annual Report prepared by MoTA/DTA/ITDA or TRIs. A segment of such report may exclusively deal with the activities of the institution in combating HIV/AIDS.

ii. Governors of the states with scheduled areas are required to submit a report annually on the governance and administration of those areas. This report may also contain a section describing its efforts regarding HIV/AIDS. As discussed in the earlier segment, MoTA may arrange to convey this to the concerned Governors.

10.4. Revision of SCA guidelines to include HIV/AIDS as an admissible item of expenditure

It is being proposed as an enabling provision, so that the resources of the tribal affairs deptt. / ITDAs are supplemented for taking up taking up non-NACP services as enumerated above.

10.5. Revision of Guidelines for the MoTA Scheme for TRIs to permit HIV/AIDS related work

As explained in the para 7.1 of Chapter 7, the TRIs are to be developed as centers of Excellence. The TRIs will be taking up orientation of the personnel of tribal affairs & health departments and assessment of risk factors/vulnerabilities besides doing studies for evaluation of performance of programs, behavioral research etc. Although it is expected that a large part of the grants will come from the NACP – III, it will need to be supplemented and gradually phased out by funding from the MoTA/State Govts. It is in this background that the revision of the guidelines for funding of TRI activities is proposed.

10.6. ITDPs / TRIs to study and monitor the migrational patterns into / from tribal areas and mitigate impact

Study of risk factors in ITDPs or tribal majority states would reveal the places from where there is a substantial out-migration taking place. Migration is a well known risk factor for spread of HIV/AIDS. This problem is still more acute because of sexual networking patterns among the tribals. Not only spouses are at risk but other sexual partners with which returning migrant may have sexual relationship. It is with this in view that NACO has decided not only to work in the destination areas of large migrant population, but also on the source areas. This strategy will pay not only in terms of prevention of HIV/AIDS but also for better preparation of migrants towards the new place of work in terms of better awareness of health, labour and other infrastructure.

The Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979 (30 of 1979) was enacted with the purpose of ensuring respectable conditions of work and laid down a framework for its

implementation, which includes action both at the source, destination and the routes. This legislation has not been implemented in the intended spirit. Even if the Act were to be successful, it would have only partially addressed the current problem, as lot of migration is also intra-state in nature. Action both at source and destination is necessary, and lack of legislation at the source end for intra-state migration will hamper the realization of minimizing the adverse impacts of migration.

The assessment of risk factors of HIV/AIDS is one of the important activities of the Tribal Action Plan. As this gets completed, there would be substantial data about the important source areas for migrants. This data would be corroborated with information provided by TIs related to migrants. Labour Deptt's data and other data sources would also be taken into account. The data would be triangulated to arrive at a list of important source areas of migrants along with some guesstimates of population involved and destination areas.

10.6.1 Implementing Agencies

ITDPs / DTWOs or their counterpart agencies in the tribal majority states will be the implementing agencies for this initiative. It is proposed to work with NGOs in order to address this issue. As the intervention would require working with communities and Govt. departments and other opinion leaders, those already working may be preferred as supplemental investment and time required to start this initiative will be less. These NGOs may be working in the fields of education, health, livelihood issues, enforcement of social securities or any other area that requires them to work with the above stakeholders. In other cases, a new initiative may be approved, which addresses this along with other issues.

Existing NGOs implementing programs in areas identified having large out-migration will be invited to present their work before a committee consisting of project officer, ITDP or equivalent, CMHO, District AIDS Control Officer, District Labour Officer looking after agricultural labour, District *Panchayati Raj* Officer and Astd. Director IEC/NGO in Category III states/UTs and NGO Coordinator of DAPCU in other states. Based on their outreach and field presence, understanding of issues, linkage with PRIs and other stakeholders. In case, no such agency is found, NGO guidelines of NACP – III may be applied to select NGOs.

Extension of contract may be based on evaluation of satisfactory performance by the same committee.

10.6.2 Implementation Steps

It is proposed that the concerned NGO undertake the following activities for implementation of this intervention.

10.6.2.1 Locate families and communities, which have had migration in the recent past and learn from them the difficulties and problems faced by them

during the process, esp. in areas of payment of wages, health care, protection from violence, coercion, transfer of funds, living conditions, dispute resolution etc. and seeking areas of improvement of migratory process and working conditions.

10.6.2.2 Dialogue with the stakeholders such as MPs/ MLAs , government agencies, PRI representatives, ITDP officials or their counterparts, labour officials, police, social welfare, health and other agencies, tribal leaders, NGOs etc. in their source areas and if possible with those of destination areas attracting large number of migrants for sensitizing them about the existing conditions of migration, and need for better tracking of migration, ensuring necessary entitlements and services in destination areas and protection from exploitation and evolution of a common action plan.

10.6.2.3 Link up with District Administration, labour authorities of and TI NGOs for migratory population or DAPCU/DHS functioning in the destination areas and establish protocols for joint action.

10.6.2.4 Provide migrant identification cards to the potential migrants with the endorsement of District/ITDP Administration and to arrange for registration with the labour authorities in case the provisions of the aforesaid Act are attracted.

10.6.2.5 Educate the potential migrants and their spouses about the HIV/AIDS & STDs, routes for transmission, the precautions they might take to avoid the disease and services available. To also counsel them the need for health check-up after their return to home communities.

10.6.2.6 Develop existing field formations of their programs such as youth resource centers, farmers cooperatives etc. as migrant education & counseling centers. If no such centers exist, create one for clusters of villages having 50,000 populations and to orient such resource persons regarding such initiative.

10.6.2.7 Sensitize grassroots workers such as *Anganwadi* workers, SHG leaders, link workers, ASHA, village education committee etc. about the purposes of the initiative and the facilities/services offered.

10.6.3 Funding

It is proposed that MoTA or DTAs fund the same as the initiatives will have multi-sectoral focus. MoTA may evolve norms for funding the same and include this as a permissible NGO activity. It may also include them as activities allowed under the Special Central Assistance to the Tribal Sub Plan.

10.6.4 Monitoring & Supervision

The ITDPs or their counterpart agencies may supervise and monitor the implementation of the activity. The DAPCU or SACS representatives may be given concurrent supervisory responsibility.

Chapter – 11

Implementation Arrangements

Although the implementation arrangements have been fairly well detailed, it is necessary to consolidate the same in order to enhance understanding of the process. The present chapter elaborates the main issues in the implementation of this Action Plan.

This Action Plan proposes to intervene in HIV/AIDS among tribals through a multi-sectoral manner, employing tribal sector programs, networks and institutions. The tribal sector has no specific programme or budgetline, specifically to deal with HIV/AIDS. Given the rigidities of planning & budget-making processes in context of a mid-plan change, most of the funding of the Tribal Action Plan will come from NACP – III. This should not be a problem, given the fact that all programs are required to earmark a certain proportion of funds for tribal oriented activities under Tribal Sub Plan and NACP – III has a budgetline for STs and vulnerable groups.

The fund-flow arrangements for the NACP – III structures and programmes are very well worked out. Even under this plan, most of the interventions are to be executed by the SACS/DAPCU, the approval, fund flow and reporting etc. need not be described. The activities/institutions of the tribal sector requiring funding from NACP – III, thus, will be elaborated here.

It is worth noting that the NACP – III is a tightly structured programme. Although, it offers scope of taking up innovative activities at the state and the district levels, such innovations are to be approved by the NACO itself and are best introduced through annual budget exercises. Although the plan is available at the beginning of 2009-10 budget cycle, generating consensus and securing requisite approvals may take some more time. It is, therefore, likely that proposals for this may be readied after the approval of the annual plan of 2009-10 and will be taken separately. From 2010-11, these would form part of regular budget cycle of NACP – III.

11.1. Preparation and Submission of plans

The SACS/TSU at the state level and the DAPCU at the district level will facilitate the development of plans by sharing the norms and the format of plans as well as sharing of relevant data. Vice-versa the tribal sector institutions will facilitate the plans formation by the SACS/DAPCU etc. This process will be overseen at the state level by the Task Force proposed to be set up in DTA at the state level and the SACS. At the district level this will be overseen by the DHS/ITDPs.

The Directorate of Tribal Affairs/TRI/ITDP proposals seeking NACP – III funding will be submitted directly to DTA with copy to SACS. The DTA will monitor the development of proposals by its institutions, so that the entire proposals are submitted quickly.

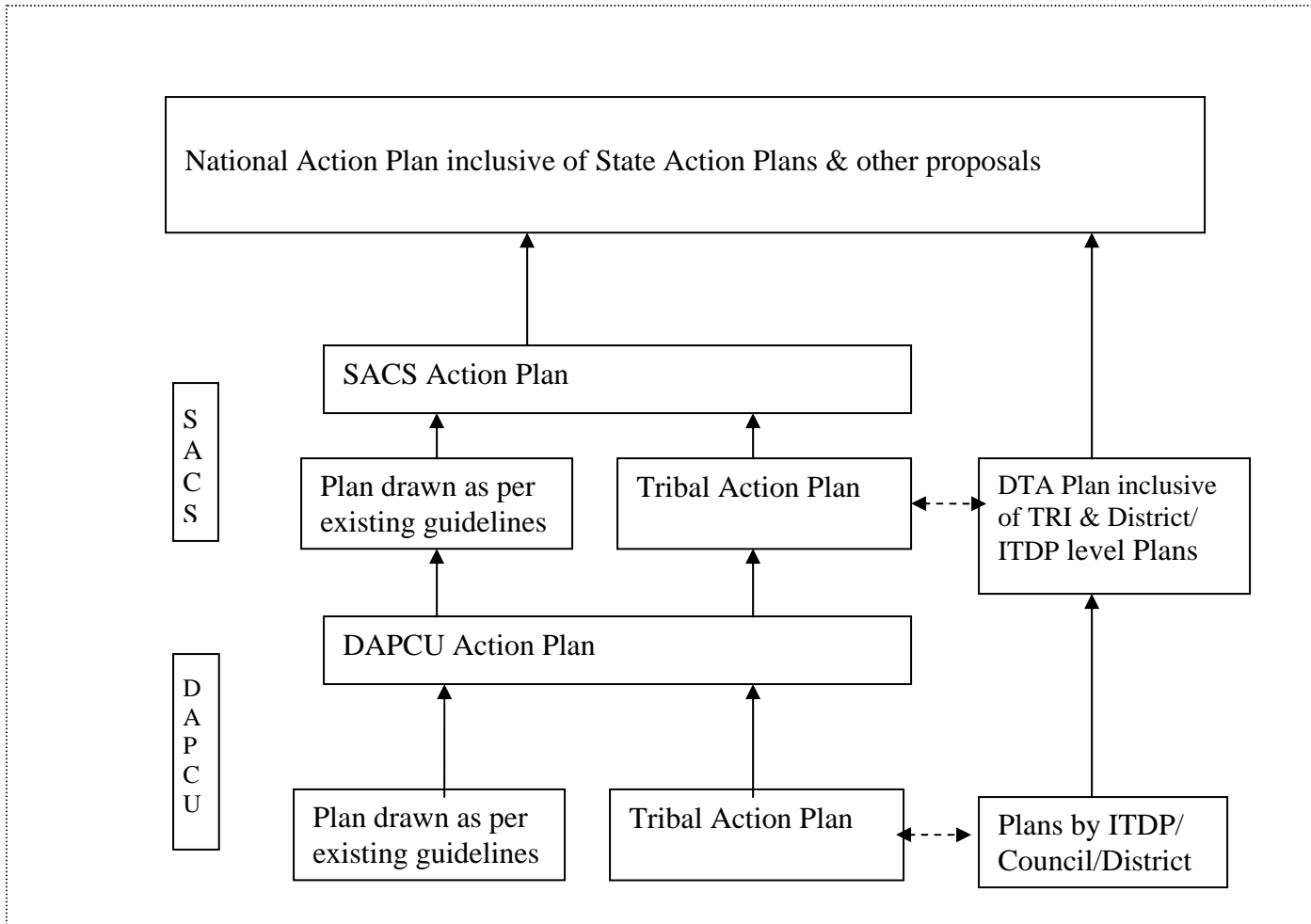


Fig 11.1: Diagrammatic Representation of Planning Exercise

11.2. Scrutiny

The proposals will be scrutinized by a joint committee of DTA & SACS. The proposals will be amended, if necessary, on the basis of results of scrutiny. On this basis, a consolidated summary proposal will be prepared by the DTA and submitted in 3 copies to NACO and 1 copy to MoTA. A copy of the same will also be sent to SACS, which will in turn send its comments to the NACO. NACO will also scrutinize the proposal in consultation with the MoTA.

As far as DTA proposal to MoTA and SACS proposal to NACO are concerned, they will be processed in the usual manner. The MoTA and NACO may also consult each other, if it is felt necessary.

11.3. Fund Flow

As SACS function as a registered society, the releases from the NACP – III to TRI/ITDP etc. through SACS is suggested instead of DTA, as budgetary difficulties of some states prevent timely release of funds. The release may be made in installments and linked to utilization. For activities to be carried out by the TRIs, funds would be released directly to it.

The expenditure report and utilization will be submitted to both DTA and SACS for the above set of agencies. The same will be monitored by the DTA for its correctness, efficiency and compliance with terms & conditions of the release. DTA will also ensure that the expenditures are audited and reported in time to SACS.

11.4. Monitoring, Reporting & Review

Close monitoring of the execution of the plan is critical to its success. It will occur at various levels including at the state and national levels by SACS/DTA and MoTA/NACO. The levels and frequency of monitoring have been indicated in detail in the description of activities in the preceding chapters. The monitoring inputs will be triggers to management decisions, in addition to indicators of progress being made.

The executing agencies will submit monthly physical and financial progress reports to both DTA/SACS. Both the latter bodies will be compiling reports for the institutions under their control and sharing with MoTA/NACO. The SACS will be preparing dashboard on a quarterly basis with inputs from DTA & others. The dashboard will be shared with both the national bodies as well as to others. A national level dashboard will be prepared by NACO with inputs from MoTA in a similar manner and widely disseminated.

The progress will be reviewed at quarterly, half-yearly and annual basis in appropriate forums at district(ITDP), state and national levels and necessary corrective and programmatic decisions taken.

11.5. Monitoring Indicators

The monitoring indicators for judging the progress & achievement of the plan is tabulated in **Table 11.1**. This includes both output, process and outcome indicators.

11.6. Timeline

The timeline for various activities listed in the annual plan is detailed in **Annexure 3**. The sequence of implementation of various activities has been kept in view in tabulating it. Adherence to the timelines is an important indicator of achievement.

11.7 Format of Plans

In order to assist development of plans, an outline indicating the features and detail required in respect of different ites is attached herewith as Annexure 4, separately for tribal and HIV/AIDS sector.

SI No	Indicator	Frequency	National/State /District	Data Source
1	% of tribals in identified district among new infections	Annual	N/S	SS
2	% of tribal population 15-49 who identify correctly information about HIV transmission & reject misconceptions	Annual	N/S	BSS
3	% of districts among identified tribal districts among A & B districts	Annual	N/S	NACO
4	Number of ICTCs(mobile included) functioning in identified tribal districts	Monthly	N/S/D	CMIS
5	Number of tribal testing positive in identified districts by age & gender	Monthly	N/S/D	CMIS
6	Number of STI clinics functioning in identified tribal districts	Monthly	N/S/D	CMIS
7	Number of tribals treated for STIs in identified districts	Monthly	N/S/D	CMIS
8	Number of fairs/hats covered with IEC & other NACP services in identified districts	Monthly	N/S/D	CMIS
9	Number of tribal leaders oriented on HIV/AIDS	Quarterly	N/S/D	DTA/MoTA reports
10	Number of STI referrals received from Traditional healers/unqualified practitioners	Quarterly	N/S/D	CMIS

11	Number of ST Residential Schools/Hostels with functional AEPs	Quarterly	N/S	DTA/MoTA reports
12	Number of non traditional outlets in identified tribal districts selling socially marketed condoms	Quarterly	N/S/D	SS(Retail Audit)
13	Number of service outlets providing ART services in Identified tribal districts	Quarterly	N/S	CMIS
14	Number of tribal PLHAs who initiate/are on ART	Quarterly	N/S/D	CMIS
15	Number of AIDS orphans admitted to residential schools	Quarterly	N/S	DTA/MoTA reports
16	Number of ICTC/ART outlets reimbursing travel costs to tribals	Quarterly	N/S/D	FPMIS
17	Number of TACs discussing HIV/AIDS in their last meeting	Annual	N	MoTA
18	Number of TRIs with trained faculty & resource person in place	Annual	N	MoTA
19	Number of DTAs with HIV/AIDS Cell established & staffed	Annual	N	MoTA
20	Number of meetings of Task Force held-statewise	Annual	N/S	MoTA
21	Number of Jt. TRG meetings held	Annual	N	NACO
22	Number of persons oriented by TRI - category & statewise	Quarterly	N/S	DTA/MoTA reports
23	Comprehensive review of critical gap in knowledge	Annual	N	NACO
24	Percentage of identified districts preparing TAP	Annual	N/S	NACO/SACS
25	Submission of MIS Reports of acceptable quality for tribal areas	Annual	N/S	NACO/SACS

Table 11.1 Monitoring Indicators

Annexure - 1

Other Important Activities & Interventions

There are some activities and interventions, which did not fit easily with the chapterization scheme of the Guidelines. They are critical to successful implementation of the Tribal Action Plan. These activities include national and state level launching workshops for the Tribal Action Plan, adolescent education activities in the residential schools/hostels/vocational centers, reimbursement of travel expenses of ST HIV/AIDS related service seeker. This section offers guidelines for these activities and interventions. It must be read together with the main text.

A1.1. National Workshop of Tribal Affairs/Health Secretaries of the States & PD, SACS on Tribal Action Plan of NACP-III

This workshop will act as the launchpad of the Tribal Action Plan, and therefore will be the first activity in this regard. Its successful completion will set the tone, clarify the roles and generate commitment of the stakeholders.

A1.1.1. Objectives of the workshop

- b. To generate awareness of vulnerabilities of tribal communities to HIV/AIDS
- c. To take stock of programs and initiatives in this regard & identification of gaps in programming
- d. To develop a consensus on a plan of action for addressing vulnerabilities including on policy changes and special treatment to AIDS devastated families
- e. To work out implementation framework and mechanisms for the above including roles for tribal sector institutions and need for capacity building

A1.1.2. Participants

- b. Secretaries of the States in charge of Tribal Affairs/Health Dept.
- c. Some selected PD SACS/Commissioner, Tribal Development or equivalent
- d. MoTA & NACO officials
- e. MoHFW Officer in-charge of NRHM/Tribal Health
- f. Planning Commission
- g. Experts working in field of tribal health/development
- h. Development Partners
- i. NGOs active in the field of tribal health (identified jointly by MoTA /MoHFW /NACO)

A1.1.3. Duration

1 1/2 days

A1.1.4. Funding

NACO

A1.1.5. Outputs

- i. Workshop Proceedings
- ii. Separate Guidelines & circulars by MoTA & NACO to their respective state counterparts for implementation of the Tribal Action Plan

A1.2. State Level Workshop for launching of Tribal Action Plan of NACP-III

This workshop will act as the launchpad of the Tribal Action Plan in the state. Since, the mainstreaming and advocacy efforts at the state level have not been to the extent at the center, therefore, it would be a crucial first step to highlight the issue and to convince different stakeholders especially those from tribal sector to undertake the implementation of Action Plan earnestly.

A1.2.1. Objectives of the workshop

- b. To generate awareness of vulnerabilities of tribal communities to HIV/AIDS in the state.
- c. To take stock of programs, initiatives and capacities in this regard & identification of gaps in programming
- d. To develop a consensus on a plan of action for addressing vulnerabilities including policy changes
- e. To work out implementation framework and mechanisms for the above including roles for tribal sector institutions and requirement of capacity building

A1.2.2. Participants

- a. State Ministers of Tribal Affairs/ Health
- b. Chief Secretary or his development counterpart
- c. Secretaries i/c tribal affairs, health, family welfare, education, labour, etc.
- d. PD SACS/Director, Health Services/Family Welfare/Tribal Welfare/Director TRI/Labour Commissioner
- e. Some PO, ITDPs/District AIDS Control Officer/CMHO
- f. NGOs working for Tribal Health/Development
- g. TSU/ Training Resource Institutions

- h. Experts working in field of tribal development/health
- i. MoTA/NACO representatives
- j. Development Partners

A1.2.3. Duration

1 1/2 days

A1.2.4. Funding

NACO

A1.2.5. Outputs

- i. Workshop Proceedings
- ii. Separate Guidelines & circulars by DTA & SACS to their respective district/project counterparts for implementation of the Tribal Action Plan

A1.3 Implementation of Adolescent education activities in the tribal residential schools and hostels

A1.3.1. Adolescent Education in ST Residential Schools/ Hostels

The residential schools of the Tribal Affairs Deptt. are normally not catered to by the educational authorities in the state, therefore, they are left out of the programmes of Education Deptt. As the adolescent education programme of the NACP- III is operated by the MHRD & its state counterparts, therefore cover the schools under the control of or affiliated to them, thus it is likely that students of the tribal schools or hostels might not receive such exposure, though substantial number of children study there, who are rather more vulnerable because of their socio-cultural background.

There are a substantial numbers of hostels run by Deptt. of Tribal Affairs, which are not tied to any particular school. These hostels are in most cases less supervised and therefore there is a greater degree of freedom in such hostels. The danger of risky behavior is higher in such hostels. The adolescent education program is therefore needed to a greater extent.

The methodology in this regard has been well established in the Consultation held on 29th Jul, 2008 in which both the State Directors of education and PD SACS participated. This approach may also be followed in this regard with forging of appropriate linkages with education authorities & development of required structures within the DTA. In particular following issues may be addressed:-

A1.3.2. Implementation Steps

A1.3.2.1. Inclusion of representatives of DTA in the State Core Committee under the chairmanship of Secretary, Education

A1.3.2.2. Identification of a nodal officer in the Directorate/ Commissionerate of Tribal Welfare to look after the Adolescent Education Programme

A1.3.2.3. Sensitization Workshop of DTA authorities of education, headmasters of schools, hostel wardens including assisted schools/hostels run by NGOs & their supervisory officers to be jointly organized by the DTA/SACS. This workshop will also develop supervisory tools as well as some guidelines within which the programme will be implemented.

A1.3.2.4 Advocacy with the Tribal Advisory Council & Minister of Tribal Welfare and parents may also be done in order to seek their informed consent.

A1.3.2.5. Such programmes may be conducted with appropriate sensitivity to the tribal customs and norms & without criticism of any particular community.

A1.3.2.6. As the program is to be rolled out in a relatively short time, the NGO support may be taken for implementation of the scheme. This will be especially necessary for the hostels unattached to any particular school, where there is no manpower who could be trained to perform the role of educator-counselor. In the long run, arrangement with district level training institutions like DIET will need to be worked out and a permanent arrangement put in place.

A1.3.3. Implementing Agencies

ST Residential Schools/ ST Hostels / NGOs/District Institute of Education & Training (DIET) or similar institutions

Directorate of Tribal Affairs/ Department. of Education/Tribal Affairs

A1.3.4. Funding

NACP-III through SACS

The DTA will work out a budget line for sustaining the activity.

A1.3.5. Monitoring

It will be undertaken by the following with specified periodicities.

Directorate of Tribal Affairs/ ITDP/DTWO officials on a monthly basis.

DTA/SACS on a quarterly basis.

MoTA/NACO on an annual basis.

A1.3.6. Evaluation

A Baseline evaluation will be carried out. At the end of NACP – III, an endline evaluation will be carried out. DTA will arrange for conduct of this evaluation.

A1.4. Inclusion of HIV/AIDS Module in Vocational Education

Vocational educational activities have been taken in a big way to increase the competencies of the ST youth in the job market in a wide variety of areas including traditional & modern. Most of these jobs take tribal youth away from of the native habitat. It encourages risk taking behavior. It is therefore appropriate that the trainees are oriented towards the danger of risky behavior and need to take precautions such as condoms. They should also be apprised of different services and symptoms or occasions, when they should access treatment. Curriculum of the vocational training therefore needs to be adapted accordingly.

A1.4.1 Implementation Steps

A1.4.1.1. DTA/TRI will prepare a profile of students of vocational courses in terms of their educational, socio-economic status and knowledge about body, health issues and life skills. TRI/TSU will adapt the existing modules according to availability of time and profile of the vocational students.

A1.4.1.2. Sensitization Workshop of DTA authorities, heads of the vocational courses will be jointly organized by the DTA/SACS. This workshop will also develop supervisory tools as well as some guidelines within which the programme will be implemented.

A1.4.1.3. Such programme may be conducted with appropriate sensitivity to the tribal customs and norms & without criticism of any particular community.

A1.4.1.4. As the vocational institutions usually do not have resource persons of appropriate orientation, NGOs will be hired to implement the program. They will be responsible for arranging resource persons, teaching & learning materials and supervision of the program. The NGOs will be hired through the NACP-III guidelines.

A1.4.1.5. DAPCU should also supply the IEC materials and informational brochure, pamphlets etc. for display in the classrooms or residential areas.

A1.4.2. Implementing Agency

Department of Tribal Affairs/NGOs

A1.4.3. Funding

NACP-III through SACS

The DTA will work out a budget line for sustaining the activity.

A1.4.4. Monitoring

It will be undertaken by the following with specified periodicities.

Directorate of Tribal Affairs on a monthly basis.

DTA/SACS on a quarterly basis.

MoTA/NACO on an annual basis.

A1.5. Reimbursement of Travel/Incidental Expenses for visits by Tribals to NACP –III Facilities & Waiver of Cost of CD4 Tests

A1.5.1. Scheme of Reimbursement of Travel Expenses

NACP-III has decided to reimburse the expenses of members of STs and one companion for their referrals to ICTC or STD clinics or ART centers. Such arrangement will also be made for PLHAs among those attending OI centers, TB clinics or PPTCT centers from funding under NRHM. Following guidelines will be followed in implementation of this scheme.

A1.5.1.1. Features of Scheme

A1.5.1.1.1. The travel expenses will be reimbursed on the same scale as the lowest class of government servant. One day's daily allowances will be admissible in case the attendee is able to return back. The daily allowance or minimum wage, whichever is higher will be paid. In case, he is required to stay for more number of days, for each such day he will be paid additional daily allowances. The same scale of payment will also be applicable for his companion.

A1.5.1.1.2. In order to make sure that such person is able to receive payment before his return from the medical facility, the person at the registration counter shall handover a TA reimbursement form along with the registration slip. The registration clerk or person from the administration/account wing will help the person fill up the form, which shall be in the applicable vernacular.

A1.5.1.1.3. In case of the repeated visits, previously paid amount could be paid, if the travel particulars are similar without need of detailed calculation.

A1.5.1.1.4. In case, the clinic is not able to pay the travel expenses before return the same shall be dispatched within next 2 days through money order, with commission being charged from the project funds.

A1.5.1.1.5. In order to facilitate identification as a tribal, a certificate by the BDO/*Tehsildar*, Ration Card, EPIC, driving licenses, freedom fighter ID cards, ID card issued by employer, MLA/MP/MLC or that issued by any gazetted officer or magistrate may be used.

A1.5.1.1.6. The requisition for funds shall be made to the SACS/DAPCU for 3 months in advance. The utilization of the funds shall be reported on a monthly basis. In case, the center or facility has used 75 % of funds as established from SOEs or UCs, additional tranche of funds may be asked.

A1.5.1.2. Implementation Sequence

A1.5.1.2.1. After clearance of the proposal by NACO, the State Government in Health Deptt./SACS will issue circular to the district/field units.

A1.5.1.2.2. This scheme will be given wide publicity through print media, communication to district/field officials/people's/panchayat representatives and to tribal organizations/PLHA networks.

A1.5.1.2.3. To ensure smooth operation of the scheme, joint meeting of the officer in charge of the different NACP facilities and their accounts officials will be organized to orient them on the features and purpose of the scheme. The recordkeeping and reporting requirements as well as the procedure for replenishment of funds will be explained.

A1.5.1.2.4. A sum of Rs. 2 lac will be initially provided to each district. Further replenishment will be done on 75 % utilization thereof.

A1.5.1.2.5. The DAPCU will cause each facility to be inspected at least once every six months to verify the proper utilization of fund, appropriate administrative arrangements and behavior of the staff.

A1.5.2. Waiver of Cost of CD4 Tests

The waiver would be necessary only when the institution is a private one. In all such cases an agreement would be entered into prescribing payment terms for conducting such tests. This agreement would also specify the documents required for waiving the cost of tests, which would as specified in Para

A1.5.1.1.5. above. Deduction on account of supply of reagent or test equipment etc. will also be made if the same is supplied by NACO. The implementation arrangements will be similar to the scheme of reimbursement of travel expenses.

Annexure 2

Description of HRD Interventions

Chapter 7 mentioned HRD activities being taken up under Tribal Action Plan. These include developing capacity in the TRIs for serving as a center of excellence for activities directed at the tribals, orientation of tribal, health and HIV/AIDS programme and field officials. These have been worked out in detail and are presented in this section.

A2.1. National Workshop of Tribal Affairs Secretaries of the States & Directors of the TRIs on involvement of TRIs in NACP-III Activities.

A2.1.1 Themes to be covered in workshop

- a. Situational Analysis of the HIV/AIDS in tribal areas & Identification of gaps in programming
- b. Identification of areas of engagement of TRIs in NACP-III activities & mainstreaming thereof in tribal programs
- c. Assessment of capacity needed to undertake the identified activities & requirement of support
- d. Sequencing of activities, administrative arrangements, fund flow etc.
- e. Reporting, monitoring & supervisory arrangements and determination of specific roles
- f. Model proposals for submission to SACS

A2.1.2 Participants

- a. Secretaries of the States in charge of Tribal Affairs Departments
- b. Directors of TRIs or equivalents
- c. Some selected PD SACS/Health Secretaries
- d. MoTA & NACO officials
- e. MoHFW Officer in-charge of NRHM/Tribal Health
- f. Planning Commission
- g. Experts
- h. NGOs active in the field of tribal health (identified jointly by MoTA /MoHFW /NACO)

A2.1.3 Duration

1 1/2 days

A2.1.4 Funding

NACO

A2.1.5 Outputs

- i. Workshop Proceedings
- ii. Separate Guidelines & circulars by MoTA & NACO to their respective state counterparts

A2.2. Development of Capacity in TRIs for Assistance to NACP-III Activities

The TRIs do not have much of an expertise in health and reproductive issues. Medical anthropologists or such other experts are largely absent in the TRI's permanent personnel. Nor substantial research has been carried out by them in the field of health. In light of above, substantial capacity development will be needed in TRIs for enabling them to undertake the expected functions. This will be one of the themes of discussion in the National Workshop to kick start this cluster of activities, thus would proceed in light of consensus arrived in the said workshop. In order to facilitate this process, broad areas of support are identified below:-

- Training of identified TRI personnel in HIV/AIDS situation and programs. This would be quite similar to the short term induction training to Programme Managers.
- Seconding of subject experts with the TRIs. This could be arranged by the Technical Resource Institutions identified by the SACS.
- Support for procurement of resource materials such as books, CDs, programme literature etc.
- Assistance in conducting Training Needs Assessment, development of curricula and resource materials.

These items are elaborated in the following segment.

A2.2.1 Training of identified TRI personnel

As mentioned above, the TRIs have not dabbled much in the health sector. Therefore, their capacity needs to be upgraded to handle this assignment. This training is similar to Short Term Induction Training for the Program Managers. Following particulars of the scheme explain key components thereof.

A2.2.1.1 Target Group: 2 TRI Officers each of rank of Assistant Director or above with experience or aptitude towards tribal health will be nominated by the TRIs. In addition, MoTA officers handling TRIs will also join the training programme.

A2.2.1.2 Issues Covered by the Training Programme

- HIV/AIDS etiology, effects on individual and society , prevention, management and cure
- NACP-III programme-approach, interventions, facilities and services
- Communication Planning and Management (Planning and Management of BCC);
- Planning and Management of Targeted Interventions;
- Monitoring and Evaluation and Impact Assessment;
- Vulnerabilities of the tribal communities to HIV/AIDS and factors impacting delivery and utilization of services
- Community Mobilization, Convergence and Partnership.
- Gender and equity, stigma, discrimination, human rights and legal aspects, and workplace environment.
- Training Needs Assessment & development of curricula & resource materials

A2.2.1.3 Training Program Goals

- Expose participants to current status of HIV/AIDS situation in India and ongoing program efforts especially in tribal areas as also to refresh them about NRHM and other health programs
- Sensitize them about the vulnerabilities, common to tribal communities, that affect the spread of the infection and delivery & utilization of services
- Develop an understanding of HIV/AIDS, Pathways of its spread, preventive and curative approaches for reversing or arresting its growth
- Develop an understanding of social dimensions of the disease/infection i.e. gender, stigma, discrimination, human rights and legal aspects
- Refresh their knowledge about training needs assessment, curricula and material development
- Develop skills and understanding to be able to analyze the tribe specific vulnerability to acquisition of infection and utilization of services as well as of the communication processes
- Develop an understanding of the role TRIs would be expected to play in implementing the tribal action plan
- Select TRIs and individuals who could be further developed as National Resource Agency(ies) or persons

A2.2.1.4 Duration

To be decided by the implementing agencies

A2.2.1.5 Implementation

National AIDS Research Institute (NARI), Pune in collaboration with Tribal Research & Training Institute, Pune and Department. of Anthropology, University of Pune. These institutions are proposed in view of the availability of

the requisite expertise and experience. They would work under overall supervision of the MoTA/NACO.

A2.2.1.6 Training Tools

Classroom activities

Visit to SACS, DAPCU of a tribal district, and TI sites in tribal areas

Project Work

A2.2.1.7 Follow-up

This training will be followed by refresher courses for the trained personnel. Besides, the identified institution will provide handholding support to the TRI personnel. In addition, TRI will network with technical resource institution of their state to augment their capacities. MoTA & NACO through their respective state level units will monitor the performance of TRI resource personnel in implementation of relevant part of action plan.

A2.2.1.8 Funding

NACO out of its training budgets.

A2.2.2. Placement of Resource Personnel with TRIs

NACP – III visualizes arranging for infrastructure and faculty outsourcing as one of the activities of Training Action Plan. Even though it is proposed to arrange training for the TRI existing personnel, there may be cases where existing resources of the TRI are not available for the work e.g. from vacancy or lack of availability of personnel of requisite aptitude and training. In such cases, it would be a must to augment their resources by placement of appropriate personnel. In other cases too, depending upon the workload, it would be desirable to place such resource personnel with TRIs.

A2.2.2.1 Key Responsibilities

- Apprise oneself of HIV/AIDS situation and NACP-III & other interventions & services in the tribal areas as well as the key risks and vulnerabilities of the tribal communities
- Develop an understanding of tribal sexual & reproductive behavior, health-seeking behavior, social structure, communication patterns
- Study the Tribal Action Plan for the HIV/AIDS & TRI's role therein
- Participate in or conduct Training Needs Assessment & develop training curricula and modules
- Develop an understanding of social dimensions of the disease/infection i.e. gender, stigma, discrimination, human rights and legal aspects

- Conduct studies for assessing the tribe specific vulnerability to acquisition of infection and utilization of services
- Act as resource person or as master trainer for training programs organized at TRIs
- Provide assistance in communication planning and management for greater receptivity among tribal(s)
- Monitoring and Evaluation and Impact Assessment;
- Mentor TRI resource personnel for developing competencies in the aforementioned areas
- Conduct studies on various aspects of HIV/AIDS vis-a-vis tribals on request from NACO/Tribal Affairs authorities
- Support ITDA, State Tribal Affairs Department & SACS in implementing Tribal Action Plan
- To do any other work connected with the Action Plan and warranted by Director or any other superior officer

A2.2.2.2. Qualifications

- PG Degree in public health/social/behavioral sciences. (Social Work, Rural Development, Sociology, Anthropology, Psychology etc.). Such degree in Medical Anthropology will be preferred.
- Minimum 5 years work experience in development sector, preferably in the areas of reproductive health, HIV/AIDS, training, epidemiology, M&E.
- Minimum 3 years of such work experience should be related to tribal communities.
- Ability to research, analyze, evaluate and synthesize information.
- Full proficiency in English and Hindi/relevant language and have demonstrated ability to produce professional reports/documents.
- Good working knowledge on various computer applications

A2.2.2.3 Selection

To be done by SACS in coordination with TRI & Technical Support Units.

A2.2.2.4 Compensation

As per NACO structure of remuneration for outsourced training faculty. To be made by TRIs out of budgets made available to them.

A2.2.2.5 Orientation

A 1 week orientation programme will be arranged by NARI, Pune or any other identified TRI. This training program will orient the participant on the job requirements, acquaint them with different dimensions of HIV/AIDS disease & NACP –III Program in India with special reference to tribal areas of the country and refresh their skills in the key areas such as training needs assessment, vulnerability assessment.

A2.2.2.6 Review of Performance

Annual review by a joint panel of TRI, SACS & TSU. The renewal of contract will be based on the outcome of the review.

A2.2.2.7 Reports

Monthly & Annual Performance Reports
Reports on various tasks assigned to him/her.

A2.2.2.8 Supervision

Director, TRI

A2.3. Training Needs Assessment & develop of curricula and training modules

For the training programs mentioned in items **A2.4.1.** & **A2.4.2.** , Training needs assessment is an important exercise and in fact the foundation of the entire exercise. This will lead to development of curricula and training modules for conduct of training.

A2.3.1. Implementation Steps

It will be carried in 3 steps as mentioned below:-

A2.3.1.1. State level workshop organized by TRIs. It will be a 3 day affair, which will be co-organized by SACS/TSU and will have participation of SIHFW, DTA/Department. of Health, Representative of NARI, Pune or Regional Medical Research Center for tribals, Jabalpur or Resource TRI, Some potential trainees, NGOs working in the field of tribal health, Experts.

A2.3.1.2.The draft will be reviewed in a Consultation Meeting organized by MoTA/NACO along with NARI, Pune/ Regional Medical Research Center for Tribals, Jabalpur, MoHFW, NGOs working on health & HIV/AIDS in tribal areas, experts etc. This will also foster exchange of ideas on content & instructional methods for further refinement.

A2.3.1.3.Thereafter it will be finalized by TRI along with SACS/TSU and utilized for training.

A2.3.2. Implementation Agency

TRIs / NARI, Pune

A2.3.3. Funding

NACO through SACS

A2.3.4. Output

1. Training Needs is identified
2. Development of curricula & training module
3. Development of capacity to conduct training needs assessment

A2.4. Capacity development of tribal/health/NACP program /NGO officials

It is proposed to orient program officials of ITDP and their supervisors as well as NGOs active in tribal development issues to enhance the understanding of HIV/AIDS issues and opportunities for mainstreaming. Likewise it is proposed to sensitize the health/NACP officials and service providers towards tribal health seeking behavior and constraints faced by them in accessing the services for more sensitive and easily accessible services.

A2.4.1 Sensitization of the officers of the Tribal Welfare Deptt. or ITDAs or NGOs on HIV/AIDS

The tribal affairs department. has largely focused on educational and economic developmental activities. Although health has also featured as one of the important themes, the traditional approach has been to start ISM dispensaries or sub-centers or promote NGOs for offering medical services from mobile vans or small hospitals providing routine services. The specialized or comprehensive health care has been generally been handled by the Health Department. in the states. This distribution of responsibilities is also mirrored in lack of expertise, monitored items or training of the departmental personnel. The reproductive health in general and HIV/AIDS in particular, is one area which has not been looked into by the DTAs.

DTAs also implement many schemes also on their own. However, because of their lack of exposure to RH in course of their training and work, they have not been able to explore extension of their schemes to also address RH wellbeing. There is need to orient the DTA officials to enable them to mainstream HIV/AIDS into their schemes.

The DTA have structures, mandate and personnel to look after the development, protection and welfare of the tribal people in a comprehensive manner especially in tribal / scheduled area. Because of their recruitment conditions, training and work-experience, their understanding of the tribal way of life, institutions and constraints is quite deep. Thus, they are in a better position to understand what works and what doesn't, thus, offer advice on the institutional resources, service

delivery models, client-provider interface for more effective HIV/AIDS programming.

This training is aimed at increasing comprehension of the HIV/AIDS disease and its effects, its prevalence esp. in tribal areas & risk factors and exploring ways of more effective & synergistic programming of DTA and NACO schemes.

A2.4.1.1. Training content

Following themes will be covered in this training program

- i. Orientation on disease, its consequences, routes of infection
- ii. Methods of prevention, control & management
- iii. HIV/AIDS situation in tribal areas & sources of vulnerability
- iv. NACP-III, facilities and services in such areas
- v. Social dimensions of the disease such as gender factors, discrimination, stigma, infringement of legal rights
- vi. Discussions on ways of reduction in vulnerabilities & delivery of HIV/AIDS related of services through tribal welfare activities
- vii. Discussions on development of linkages and coordination mechanisms for improvement in utilization of services

A2.4.1.2. Agency

TRIs will be the implementing agencies and will be supported by SACS/TSU of the State.

A2.4.1.3. Funding

MoTA/DTA of states will fund this capacity building effort. If need be, the resources will be supplemented by NACP – III.

A2.4.1.4. Trainees

Following categories of trainees will be covered by this training. Only those personnel, who have widespread activities in the tribal areas and are responsible for planning and supervision of services are proposed for this training and include

- i. Tribal Welfare authorities from Hq. level till Project/sub-district level
- ii. Officers of the Tribal cooperative agencies such as Girijan Cooperatives (GCC) or LAMPS till district/sub-district level
- iii. Key Officials in ITDA Projects
- iv. DFOs and other key officers of the Forest Deptt. in tribal areas
- v. Secretary or other key officials of NGOs working in Tribal areas

A2.4.1.5. Duration

3 days

A2.4.1.6. Curricula and Training Module

It will be developed by TRI along with State Institute of Health & Family Welfare (SIHFW), SACS & TSU with key DTA representatives, outside experts/tribal health NGOs, as the programs and structures are generally unique to the state. It will be reviewed in a Consultation Meeting organized by MoTA/NACO along with NARI, Pune, MOHFW, NGOs working on health & HIV/AIDS in tribal areas etc. This review will also spur exchange of innovative ideas & materials. The same will be finalized based on the inputs of the above Consultation.

A2.4.1.7. Oversight & Evaluation

NARI and identified TRIs could provide mentoring support to the TRIs. The SACS/DTA would oversee the implementation of the programs with regard to the participation, conduct of the programs and availability of necessary logistics and technical inputs. The feedback of the participants would be an important oversight tool. SACS would commission independent studies for assessing the impact of the training programs.

A2.4.2 Sensitization of the health & HIV/AIDS authorities/NGO functionaries on Tribal Matters

The Social Assessment carried out for the NACP- III pointed out low level of awareness of diseases, its etiology, its linkage with STDs or services available with the programme. It also pointed out lower intensity of infrastructure as also poverty as some of the other factors for the above. What was not very clearly emphasized was the need to take world view & socio-cultural construct of the tribal society into account in discussions of poor level of knowledge and lower utilization of services, which is rooted in close links among the man, nature and super-natural factors, which also accounts for continuing recourse to traditional medicine. It is amply clear from studies around the world as well as in India that the improvement in health care utilization would need to factor in aforesaid factors. Thus, attention would need to be paid to tribal health world view, traditional medicine & healers in designing services and schemes for IEC/BCC, delivery of services and facilities.

A2.4.2.1. Training Objectives

This orientation is aimed at increasing comprehension of the tribal world-view of etiology of diseases, preferred healers and reasons for preference, tailoring NACP – III services & facilities for improving accessibility and acceptability and improving awareness of other programs for tribal wellbeing and thereby encouraging better linkages for more effective & higher utilization of services.

A2.4.2.2. Training content

Following themes will be covered in this training program.

- i. Tribal world view and its implication on illness perception, choice of treatment & utilization of services, interaction with gender & social status etc.
- ii. Role of traditional healers in tribal health care
- iii. Other factors influencing acceptability & accessibility including socio-economic, health system design and practice
- iv. HIV/AIDS situation in tribal areas & risk factors for tribals
- v. Social Implications of HIV/AIDS, STDs etc. e.g. discrimination, stigma, infringement of legal rights
- vi. Tribal development strategies, structures and services
- vii. Discussions on development of linkages and coordination mechanisms for more efficient service delivery & efficient utilization of services

A2.4.2.3. Agency

TRIs will be the implementing agencies and will be supported by SACS/TSU of the State.

A2.4.2.4. Funding

NACP – III through SACS of states will fund this capacity building effort.

A2.4.2.5. Trainees

Following categories of trainees will be covered by this training. Although this training is proposed in context of NACP, the broad lessons are helpful to all program officials in the health sector. The attrition of program officials is an ongoing phenomenon, therefore, in order to build extra capacity within the system, it is proposed to train 2 more officials other than those who hold relevant posts at the time of the training. These include

- i. Chief Medical Health Officer or his equivalent, District Programme Officer (HIV/AIDS), District Programme Manager, Superintendent, District Hospital and 2 more health programme officials of the District/Sub-district/project level in tribal/scheduled areas
- ii. SIHFW or Regional Training Centers or other training institutions charged with training of health functionaries of the above areas
- iii. SACS Officials
- iv. Officer –in –Charge, STD Clinics/ICTC/ART Centers of tribal areas: The first 2 are being included, as these facilities might be the first interface between a potential HIV + person & the health system. The last one is suggested so that its services retain the infected persons.

A2.4.2.6. Duration

3 days

A2.4.2.7. Curricula and Training Module

It will be developed by TRI along with SIHFW, SACS & TSU with key DTA representatives, outside experts/tribal health NGOs, as the programs and structures are generally unique to the state. It will be reviewed in a Consultation Meeting organized by MoTA/NACO along with NARI, Pune, MOHFW, NGOs working on health & HIV/AIDS in tribal areas etc. This review will also spur exchange of innovative ideas & materials. The same will be finalized based on the inputs of the above Consultation.

A2.4.2.8. Oversight & Evaluation

NARI and identified TRIs could provide mentoring support to the TRIs. The SACS/DTA would oversee the implementation of the programs with regard to the participation, conduct of the programs and availability of necessary logistics and technical inputs. The feedback of the participants would be an important oversight tool. SACS would commission independent studies for assessing the impact of the training programs.

Annexure – 3

Timeline

Sl. No.	Activity	Primary Implementing Agency	Year 1				Year 2				Remarks
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
	Targeted Interventions for Vulnerable Population										
1	National Launching Workshop	NACO/MOTA	*								
2	State Launching Workshop	SACS/DTA	*								
3	AEP in residential schools/hostels										
	Sensitization Workshop & Advocacy	DTA	*								
	Selection/Training of NGO partner	Tribal Affairs Directorate		*							
	Implementation of AEP	NGOs			*	*	*	*	*	*	
4	AEP in Vocational Courses										
	Profiling of Students & adaptation of module	TRI	*								
	Sensitization Workshop & Advocacy	DTA		*							

	Selection/Training of NGO partner	Tribal Affairs Directorate			*						
	Implementation of AEP	NGOs				*	*	*	*	*	
5	Reimbursement of Traveling expenses	ICTC/ART etc.									
	Approval/Dissemination	NACO/SACS	*								
	Orientation of Incharges & accounts personnel			*							
	Release of funds			*							
	Reimbursement			*	*	*	*	*	*	*	
6	Waiver of CD4 test charges										
	Approval/Dissemination	NACO/SACS	*								
	Selection/contracting of agencies	DAPCU	*								
	Delivery of Services	Private Agencies		*	*	*	*	*	*	*	
	Communication Activities										
1	TRI support to IEC Agency										
	Inventorization & Model Plan for a ITDP	TRI	*								
	Development of prototype IEC Materials	TRI	*								
	Module Development for orientation of Tribal Leaders	TRI/TSU	*								
	Assistance to ITDPs	TRI		*	*	*	*	*	*	*	

2	IEC Activities by ITDP										
	Development of IEC Plan	ITDP		*							
i	Orientation of tribal Community Leaders	ITDP/TRI		*	*	*	*				
ii	Field/Outdoor Publicity in ITDP institutions	ITDP		*	*	*	*	*	*	*	
iii	Inclusion of HIV/AIDS IEC in non-health ITDP activities	ITDP		*	*	*	*	*	*	*	
	Prevention Services										
1	Services through Fairs/Hats										
	Selection of fairs/hats & inventory of mobile vans	DAPCU/ITDP	*								
	Selection of Agency	DAPCU	*								
	Operationalization Workshop & finalisation of working arrangements		*								
	Delivery of services	DAPCU/NGOs		*	*	*	*	*	*	*	
2	Improving access to counseling & testing through Mobile ICTC										
	Mapping of hard to reach areas & selection of sites for service	DAPCU	*								
	Selection of Agency	DAPCU	*								
	Operationalization Workshop & finalisation of working arrangements		*								
	Delivery of services	DAPCU/NGOs		*	*	*	*	*	*	*	
3	Social Marketing of Condoms										

	Mapping of tribal marketing & distribution channels	ITDP/SMO	*								
	Finalization of expansion of SMO channel & follow-up	SMO	*								
	Distribution of Condoms	SMO		*	*	*	*	*	*	*	
4	Mobile Dispensaries										
	Direction by MoTA to NGO	MoTA	*								
	Workshop with NGO & finalisation of linkages / training of staff	DAPCU	*								
	Delivery of Services	NGO		*	*	*	*	*	*	*	
5	NACP Services through XBH										
	Direction by MoTA to NGO	MoTA	*								
	Workshop with NGO & finalisation of linkages / proposal	DAPCU	*								
	Recruitment & training	NGO/DAPCU		*							
	Service Delivery	NGO			*	*	*	*	*	*	
	Public-Private Partnerships										
1	Engaging PPs/Hospital for STD/other NACP services										
	Identification & Recruitment	DAPCU	*								
	Training & other preparatory activities	DAPCU	*								
	Delivery of services	PPs/Hospitals		*	*	*	*	*	*	*	
2	Engaging Traditional Healers	ITDP/DTWO/NGO									

	Training Module Design	TRI/Training Research Institutions	*								
	Survey & Recruitment	ITDP/DTWO/ Counterpart Organisation	*								
	Training	ITDP/DTWO		*	*	*					
	Delivery of Services			*	*	*	*	*	*	*	
3	Unqualified Practitioners	DAPCU/CMHO									
	Survey & recruitment	ITDP/CMHO	*								
	Training Module Design	Training Research Institutions / SACS drawing upon NACO modules	*								
	Training of Practitioners	Training Agency		*							
	Selection/Training of supervisors			*							
	Delivery of Services				*	*	*	*	*	*	
	HRD: Building Capacity										
1	National Workshop	NACO/MoTA	*								
2	Capacity Building of TRIs										
i.	Trg of TRI Personnel	NARI & others	*								
ii.	Placement of Resource Person In TRIs	SACS	*								
	Orientation of Resource Person	NARI & others	*								
3	Training Need Assessment & Module Development										
	State Workshop	TRI	*								

	National Consultation	NARI/NACO		*								
	Training Module Finalization	TRI/TSU		*								Review by NARI led team
4	Training of Health & Tribal Officers	TRI		*	*	*	*	*	*	*		
5	Assessment of Training Resources for TAP	TRI	*									
	Programme Management											
1	Constitution of Tribal Cell	NACO	*									
2	Jt TRG on Tribals	NACO & MoTA	*									
3	Implementation Machinery MoTA											
	HIV/AIDS Cell	MoTA	*									
	Steering Group	MoTA	*									
4	MoTA in NACB	NACO	*									
5	Implementation Machinery DTA											
	Task Force	DTA	*									
	HIV/AIDS Cell	DTA	*									
6	Linkages	MoTA/MoHFW	*									
7	Engaging ITDP/DTA officials in NACP planning & monitoring.- instructions	NACO/MoTA	*									
	Monitoring & Evaluation, Surveillance and Research											
1	Modify surveys & surveillance systems to indicate ST status	NACO	*									

2	Modify recording, reporting & monitoring of interventions to include ST attribute for ITDP areas & tribal majority states	NACO	*								
3	Assessment of Risk Factors										
	Finalization of Tools	NACO TSU	*								
	Selection of Assessing Agencies & Dissemination of Tools	TRI		*							
	Risk Assessment	TRI/Assessing Agency			*	*					
	Dissemination	TRI									
4	Review of research needs	NACO		*							In order to get inputs of TRIs too after their capacity dev.
	Inclusion in TRI research Agenda	MOTA			*						
	Conduct of Research	TRI			*	*	*	*	*	*	After TRI Capacity development
	Mainstreaming HIV/AIDS in Tribal Sector										
1	Admission of AIDS orphans in Residential School	Residential School/ DTWO									
	Meeting of Secretaries	MoTA	*								
	Survey of Children	DAPCU + DTWO/ITDP	*								
	Revision of norms of support / Scholarship	MoTA/DTA	*								

	Sensitization of School/ hostel authorities & supervisory officials	DTA	*									
	Implementation	Residential School/ DTWO		*	*	*	*	*	*	*		
2	Admission of AIDS Orphans in Vocational Education											
	Issue Guidelines	DTA	*									
	Implementation	Training Institutions		*	*	*	*	*	*	*		
3	Inclusion of HIV/AIDS in the mandate of tribal sector institutions & Guidelines to Governor re TAC/Governor's Report	MoTA	*									
4	Circulate Guideline for inclusion of HIV/AIDS in Annual Report	MoTA/DTA		*								
5	Revision of SCA Guidelines	MoTA	*									
6	Approval in scope of scheme of support to TRIs	MoTA	*									
7	Migrant Education	NGO										
	Assess areas with large migration	TRI			*	*						Assessed in study of risk factors
	Selection of NGOs	ITDP/DTWOs				*						
	Implementation	NGO					*	*	*	*		

Annexure - 4

Outline of Action Plans

Outline of Tribal Action Plan for DTA/ITDP

State Tribal Profile

Demographic

- Total Population
- Tribal Population
- Tribal Population as % of Total Population
- District wise tribal population & % of total population
- Total number of tribes & tribe wise population
- General Male-Female Ratio
- Tribal Male-Female Ratio
- Tribal Male Literacy rate
- Tribal Female Literacy Rate
- Principal Tribal Languages spoken

Administrative- Political

- Administrative framework & hierarchy for tribal activities at state, regional, district & field level.
- Have ITDP(s) been constituted for the state? Are ITDP(s) organized on area basis or targeted at certain tribes? Enumerate all ITDPs and district(s) they are located in as well as the ST population covered thereby. Structure and functions of ITDP.
- Similar details for Autonomous Council
- Is there a Tribal Research Institute for the state? What is its mandate & structure? Its competencies in the field of tribal health research & assessment, tribal languages, development &

adaptation of communication material. What are other resources in this area in the state?

- Tribal Advisory Council- availability, structure and functions
- Educational institutions for tribal students- number, type, students admitted and structure of their administration and supervision
- Hostels for the tribal students- number, type, students admitted, scholarships admissible, health, educational & other facilities available therein
- Health facilities for tribals
 - Structure, organization of health services in ITDP or Council areas
 - Their linkage with the ITDP/Council
 - Number & type of health institutions run by the project or tribal development department
 - Ten bedded hospitals or mobile hospitals run by the NGOs with MoTA support
 - Hospitals or health institutions run by NGOs with State/Project support – nature & type of services
 - Community level field workers in health if different from the above
- Brief description of marketing, supply or public distribution network for tribal areas including their access, commodities handled etc.

Situation Analysis

Based on the sentinel surveillance, BSS, NFHS – III / any other survey carried out by the state tabulate following for the districts in which ITDP or Autonomous Council located

District→	X	Y	Z		
% tribal population					
% ANC clinic tested +ve in last 3 years (HSS)					
% STD clinic attendee's tested + ve in last 3 years (HSS)					

% tested +ve in PPTCT(CMIS)					
% tested +ve in ICTC (CMIS)					
STI cases treated in last year to total pop (%)					
% of population reporting STD in last 12 months					

- % of ST men & women who have heard of AIDS
- % of ST men & women who know 2 methods of prevention of HIV/AIDS
- % of ST men & women who have comprehensive knowledge of routes of HIV transmission
- % of ST men & women engaging in last 12 months in high risk intercourse / using condoms

Mapping: A detailed pictorial map of the ITDPs/Autonomous Councils would be drawn, depicting the high risk sites for high risk groups, areas of large in & out migration, sex workers, highways, *Hats*, fairs, district categorization etc. and the functional status of ICTCs , PPTCTs, Blood Storage Units, STD Clinics, TIs, Hospitals or mobile dispensaries run through MoTA/STA. This mapping will give a clear idea of the presence of affected and high risk population groups, the areas of concentration of bridge populations, the network of TIs and other care givers and the need for further up-scaling of services.

Status of AEP Program in schools& hostels run by the tribal development department & inclusion of HIV/AIDS as a component therein

Policies regarding preference in admission to residential schools/ hostels to wards of dead or destitute AIDS parents

TRI Activities

- a. Assessment of risks – Describe following
 - Area where risk to be assessed
 - Implementation mode- self or through hired agency
 - Supervision
 - Training & orientation of assessment groups
 - Dissemination & application of findings
 - Development & dissemination of tools for summary risk assessment
 - Timeline

Costing

- Recruitment of agency for assessment
- Dissemination workshops
- Cost of adaptation, translation and printing of tools
- Assessment expenses
- Dissemination of findings – workshops, reports etc.
- Technical assistance in application of findings for programming & upgradation

b.. Capacity building

Faculty Development (for HIV/AIDS related training, consultancy and communication)

Assessment of need

Identification of own experts

Requirement of outsourced resources

Timeline & responsibility

Costing

- Salary & overheads for outsourced resources/support staff
- Books & Periodicals
- Traveling Expenses
- Purchase of Computers & other equipments
- Telephone & communication expenses
- Stationary & other overheads
- Institutional charges

c. Training of health & tribal development personnel

- Training Need Assessment
- Training recipients – description & numbers
- Training Goals- competencies & numerical targets
- Supervision, support & mentorship arrangements
- Timeline & responsibility
- Costing

As per norms of NACO for need assessment & training proper

d. Orientation of traditional healers

- Module development
- Orientation of key personnel of implementing agency
- Conduct of orientation of the traditional healers, if DRP or NGO unable to handle
 - Timeline and responsibility
 - Costing as per norms of NACO

e. Development of model IEC plan for ITDP and prototype IEC material

- Identification of ITDP
- Requirement of consultancy & other resources
- Timeline
- Support required of SACS/its IEC agency
- Costing

As per NACO norms

3. Admission of wards of dead/destitute children in residential schools/hostels

- Estimation of such children & support required
- Implementation approach & responsibility
- Additional number of seats/units required
- Policy decisions on scholarship/allowances, preference in admissions
- Additional funds needed
- Orientation of educational authorities, headmasters, wardens & teachers
- Inspection by experts and resource persons
- Periodic refresher –cum-review meetings

4. Study of migrational patterns & risk mitigation interventions

- Identification of intervention areas with substantial migration
- Implementation methodology
- Timeline & responsibility
- Linkages & policy decisions required
- Assessment of requirement of funds & source
 - Recruitment of NGOs/agency
 - Orientation of NGO personnel by TRIs
 - Survey of migrant families
 - Advocacy meetings
 - Sensitization of grassroots/community workers
 - Expenses of migrant identification card
 - Support for development of migrant education & counseling center
 - NGO's administrative & counseling personnel & office maintenance Expenses

5. Sensitization of tribal youth in HIV/AIDS

a. AEP in residential schools / hostels

- Need Assessment-describe number of schools/hostels & students to be covered – class-wise
- Implementation steps & agency

- Policy decisions needed
 - Linkages & support needed
 - Timeline
 - Costing
 - Selection & orientation of NGOs
 - Sensitization workshop for educational authorities, headmasters, wardens
 - Advocacy with the decision-makers & parents
 - Conduct of AEP activities
 - Supervision & review meetings
- b. AEP in vocational training programs
- Situational Analysis – number of training courses, students, profile
 - Adaptation of module for vocational programs by DTA/SACS
 - Implementation agency & timeline
 - Linkages
 - Costing
 - Module development
 - Orientation of heads of vocational institutions
 - Payment for resource persons, materials and allied items
 - External supervision expenses

6. **IEC activities by ITDPs**

- a. Orientation of Community Heads
- Situational Analysis – numbers, role in communities, socio-economic profile
 - Training Module- duration, topics
 - Implementation modality – agency, linkages, support
 - Timeline
 - Costing
 - Module development
 - Training of trainers
 - Implementation of training program
 - Supervision & oversight
- b. Field/Outdoor publicity in institutions controlled by ITDPs/Councils
- Assessment of number & type of ITDP institutions
 - Criterion for selection of institution and type/size of outdoor items
 - Costing
 - As per NACP –III norms
- c. Incorporation of HIV/AIDS in non-health sector activities by ITDPs
 Situation analysis – SWOT analysis of existing IEC activities in ITDPs

Identification of activities for implementation by ITDPs viz. advocacy meetings with tribal elders & leaders, panchayat functionaries, church & religious leaders, forest committees workers, SHGs etc.; integration of HIV/AIDS in IEC activities of other departments under ITDPs; booths in fairs & hats; community radio etc. These would supplement the IEC activities by DAPCU and would be focused on tribal communities being designed in their language, idioms and symbols

Implementation arrangements
Costing as per norms of NACP – III.

7. Unit in the Tribal Directorate/Commissionerate for HIV/AIDS

2 experts & 1 support staff to be provided for Madhya Pradesh, Maharashtra, Orissa, Gujarat, Chhatishgarh, Rajasthan, Jharkhand, Andhra Pradesh, West Bengal. For other states, 1 expert & 1 support staff will be supported.

Selection Process: They would be selected and placed by SACS.

Costing

- Salaries & overheads for personnel
- Books & Periodicals
- Traveling Expenses
- Purchase of Computers & other equipments

Outline of Tribal Action Plan for SACS/DAPCU

State Tribal Profile

1 Demographic

- Total Population
- Tribal Population
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- Total number of tribes & tribe wise population
- General Male-Female Ratio
- Tribal Male-Female Ratio
- Tribal Male Literacy rate
- Tribal Female Literacy Rate
- Principal Tribal Languages spoken

2 Administrative- Political

Administrative framework & hierarchy for tribal activities at state, regional, district & field level.

Have ITDP(s) been constituted for the state? Are ITDP(s) organized on area basis or targeted at certain tribes? Enumerate all ITDPs and district(s) they are located in as well as the ST population covered thereby. Structure and functions of ITDP.

Similar details for Autonomous Council

Is there a Tribal Research Institute for the state? What is its mandate & structure? Its competencies in the field of tribal health research & assessment, tribal languages, development & adaptation of communication material. What are other resources in this area in the state?

Tribal Advisory Council- availability, structure and functions

3. Health facilities for tribals

- Structure, organization of health services in ITDP or Council areas
- Their linkage with the ITDP/Council
- Number & type of health institutions run by the project or tribal development department
- Ten bedded hospitals or mobile hospitals run by the NGOs with MoTA support
- Hospitals or health institutions run by NGOs with State/Project support – nature & type of services

- Community level field workers in health if different from the above

Brief description of marketing, supply or public distribution network for tribal areas including their access, commodities handled etc.

4. Situation Analysis

Based on the sentinel surveillance, BSS, NFHS – III / any other survey carried out by the state tabulate following for the districts in which ITDP or Autonomous Council located

District→	X	Y	Z		
% tribal population					
District Category					
% ANC clinic tested +ve in last 3 years (HSS)					
% STD clinic attendee's tested +ve in last 3 years (HSS)					
% tested +ve in PPTCT(CMIS)					
% tested +ve in ICTC (CMIS)					
STI cases treated in last year to total pop (%)					
% of population reporting STD in last 12 months					

% of ST men & women who have heard of AIDS

% of ST men & women who know 2 methods of prevention of HIV/AIDS

% of ST men & women who have comprehensive knowledge of routes of HIV transmission

% of ST men & women engaging in last 12 months in high risk intercourse / using condoms

5. Availability of NACP – III services/facilities

- ITDP/Council wise ICTC, PPTCT, Blood Storage Units, STD Clinics
- ITDP/Council wise TI Projects for HRGs & Bridge Populations
- IEC/Advocacy activities in above areas including RRC, AEPs etc.
- Orientation activities for community workers viz. anganwari workers, ASHA, Dais, ANMs ; opinion leaders viz. Panchayat

Presidents, Cooperative secretaries, religious leaders, teachers, transport associations, labour unions & officers of converging departments viz. social welfare, jail, police, SHGs, labour etc.

- Convergence with NRHM
- Linkages with private sector to provide aforesaid services
- Existing gaps in service delivery and plans for addressing them
- Constraints arising out of norms, guidelines, circulars etc. & relaxation sought

6. **Mapping:** A detailed pictorial map of the ITDPs/Autonomous Councils would be drawn, depicting the high risk sites for high risk groups, areas of large in & out migration, sex workers, highways, *Hats*, fairs, district categorization etc. and the functional status of ICTCs , PPTCTs, Blood Storage Units, STD Clinics, TIs, Hospitals or mobile dispensaries run through MoTA/STA. This mapping will give a clear idea of the presence of affected and high risk population groups, the areas of concentration of bridge populations, the network of TIs and other care givers and the need for further up-scaling of services.

Status of AEP Program in schools& hostels run by the tribal development department & inclusion of HIV/AIDS as a component therein

7. Activities

1. PPP for STI services

Situation Analysis – Prevalence of STDs, attitude towards seeking care, other constraints to access, availability of STD services & need

- a. Non- Government Hospitals for comprehensive NACP – III services
On the basis of gaps identified in situation analysis made earlier and availability of private/non-govt. hospitals, institutions will be identified.

They will be engaged in accordance with the framework developed by the NACP –III in this regard.

- b. Private Practitioners

Gaps in access of services after engaging private hospitals are assessed. The private practitioners will be engaged to fill those gaps. Implementation arrangements including for supervision

Timeline

- Costing
 - Survey & recruitment
 - Training & orientation including for supervisors
 - Supervision expenses
- Supplies
 - STD drugs & consummables
 - Stationary & formats
 - IEC materials

c. Unqualified practitioners

They shall be used more as a screening mechanism for the STDs rather than a source of treatment. The selection of such providers will be made from among those who are fairly popular & ready to undertake such a role. About 1 such provider per 5000 population should be selected.

Implementation arrangements including for supervision

- Costing
 - Survey & recruitment
 - Training & orientation including for supervisors
 - Payment of incentives
 - Supervision expenses
- Supplies
 - STD drugs & consumables
 - Stationary & formats
 - IEC materials

2. Delivery of services in fairs & hats

Situation Analysis – Listing of *hats/fairs*, prioritization according to their remoteness, area/population it serves, nature of transactions etc. (a cattle hat or fair would be less preferred compared to one in which grocery/miscellaneous transactions takes place)

Identification of *hats* for starting service & among them those that can be served by existing vans of Health/Family Welfare Deptt. or MoTA NGO or by PHCs

Assess additional inputs required for delivery of desired services

Based on the above, determine number of new mobile units to be set up. One such unit may be proposed for about 20 days of work per month.

Implementation Agency – DAPCU/NGO

Implementation Arrangements including for supervision

Linkages with NRHM, RNTCP etc.

Timeline

- Costing
 - Survey & recruitment of Agency
 - Additional inputs for using existing channels(POL, manpower, tents, contingency, repair, agency charges etc.)
 - new vans & equipments
 - Related expenses viz. manpower, POL, contingency, agency charges
- Supplies

- Drugs & consumables
- Stationary & formats
- IEC materials

3. Mobile ICTCs

Situation Analysis – Mapping of high risk areas/hot spots to be done. From among those, areas more than 30 kms away from the static ICTCs will be chosen and prioritized according to size of the affected population and the intensity of high risk activity.

According to the nature of such place, the frequency of provision of mobile ICTC service will be determined.

Thereafter, the possibility of servicing these places with the existing mobile units or those planned for servicing hats and fairs will be explored and the additional inputs for this purpose.

If the above is found insufficient, new mobile ICTC unit would be approved. It shall be ensured that a C category district has at least one mobile ICTC.

Implementation Agency – DAPCU/NGO

Implementation Arrangements including for supervision

Linkages with NRHM, RNTCP etc.

- Costing

- Survey & recruitment of Agency
- Additional inputs for using existing mobile units(equipments, manpower, contingency, agency charges etc.)
- New vans & equipments
- Related expenses viz. manpower, POL, contingency, agency charges for new units

- Supplies

- Drugs & consumables
- Stationary & formats
- IEC materials

4. Social marketing through tribal marketing & distribution channels

Situation Analysis – Tribal marketing & distribution channels will be located. Their potential for distribution of condoms and awareness generation activities will be analyzed in discussion with ITDP, marketing & distribution agency. On the basis of analysis, plans for expansion of social marketing network will be prepared.

Implementing Agency – SMO, Tribal marketing & distribution agency

Implementation arrangements & linkages

Timeline

Costing

Training of personnel of marketing/district Agencies

Cost of additional storage /handling of supplies

Additional supervision charges

5. Ten Bedded Hospitals

Situation Analysis – Number of units functional in the area. If these are located at locations other than district headquarters, they may be supported.

Additional support required – manpower, equipments, drug & consumables, test kits, condoms, contingency, stationary & forms etc.

Implementation arrangements & linkages

- Costing
 - Additional inputs (manpower, equipments, contingency etc.)
 - Training
- Supplies
 - Drugs & consumables
 - Test kits
 - Condoms
 - Stationary & forms

6. Engaging with Tribal Healers

Situation Analysis - existence, role, estimated number, previous engagement, if any, likelihood of their working with NACP

Implementing Agency – ITDP, where health is integrated with the Project otherwise through DHS/DAPCU. NGO could be engaged to handle the activity.

Implementation methodology, responsibilities & linkages

Supervision arrangements

- Costing
 - Survey & recruitment
 - Orientation of personnel of implementing agency (to be added by SACS)
 - Orientation of healers
 - Orientation of Supervisors
 - Refresher training-cum-review meetings (1 every quarter)
 - Agency charges (personnel, contingency, and communication exp.)

7. Reimbursement of travel expenses/waiver of CD charges

Situation analysis –

Poverty among tribal population, estimation of expense involved in seeking ICT services, estimation of slipback into poverty due to sickness, if any. Estimate number of visits made by tribals for seeking different NACP –III services.

Estimate of tribal PLHAs. % of tribals below poverty line. Likely number of CD4 tests needed by BPL tribals

Policy decisions required-Implementation methodology, responsibility and linkages

Costing

- Orientation of I/c and accountants of NACP facilities
- Information & publicity of the scheme (press advertisement, circulars, posters etc.)
- Reimbursement of TA – Initially an amount of Rs. 2 lakh/district may be provided.

8. Launching Workshop of the Tribal Action Plan in the State

Purpose

- To generate awareness of vulnerabilities of tribal communities to HIV/AIDS
- To take stock of programs and initiatives in this regard in the state
- To develop a consensus on a plan of action for addressing vulnerabilities including on advocacy, policy changes and special treatment to AIDS devastated families
- To work out implementation framework and mechanisms for the above

Participants

- State Ministers of Tribal Affairs, Health
- Chief Secretary or his development counterpart
- Secretaries i/c tribal affairs, health, family welfare, education, labour, etc.
- PD SACS/Director, Health Services/Family Welfare/Tribal Welfare/Director TRI/Labour Commissioner
- NGOs working for Tribal Health
- TSU
- Experts working in field of tribal development/health
- Training Resource Institutions

Costing – As per NACP – III norms

At **NACO**

1. National Workshops & Meetings

- a. National Workshop of State Secretaries i/c Tribal Affairs/Health & PD, SACS for launch of Tribal Action Plan

Purpose:

- To generate awareness of vulnerabilities of tribal communities to HIV/AIDS
- To take stock of programs and initiatives in this regard
- To develop a consensus on a plan of action for addressing vulnerabilities including on policy changes and special treatment to AIDS devastated families
- To work out implementation framework and mechanisms for the above

Participants

- Secretaries of the States in charge of Tribal Affairs/Health Dept.
 - Some selected PD SACS
 - MoTA & NACO officials
 - MoHFW Officer in-charge of NRHM/Tribal Health
 - Planning Commission
 - Experts
 - Development Partners
 - NGOs active in the field of tribal health (identified jointly by MoTA /MoHFW /NACO)
- b. National Workshop of Director TRIs, State Secretaries of Tribal Affairs, PD SACS on role of TRIs in implementation of Tribal Action Plan
 - c. Consultation Meeting on development of modules for training of tribal & health/HIV/AIDS related officials and traditional healers
- Participants – The participants for the above is described in the main document

2. Training of TRI experts/faculty

- a. Training to TRI faculty members/TSU resource persons
- b. Orientation to outsourced experts of TRIs

3. Tribal Cell in the NACO

This cell would consist of 2 experts and 2 support staff. They may be supported by the Development Partners. The functions etc. are described in the main document.

4. HIV/AIDS Cell in MOTA

This would consist of 1 expert and 1 support staff. Their establishment would be supported by NACO.