



"Documentation and Dissemination  
of Best Practice"

Government of Tamil Nadu  
Tamil Nadu Health Systems Project

Reaching Healthcare to the Tribal Population of Tamil Nadu

Documentation Supports by :  
**Department of Administrative Reforms & Public Grievances**  
**Ministry of Personnel, Public Grievances and Pensions**  
**Government of India.**





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# CHAPTER - 1

## Situation before TNHSP Intervention

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### The background

The Ministry of Family Health and Welfare, Tamil Nadu, provides focused health management programs especially for the economically and socially backward communities of the state. One of the most backward people in this aspect is the tribal population, which has not made use of the healthcare facilities in the state due to its cultural background and inaccessibility.

The Tamil Nadu Health System Project, implemented by the Health and Family Welfare Department with World Bank funding, in 2005, has developed new approaches to address various health issues such as non-communicable diseases, reaching healthcare to the tribal people in the state and partnering with NGOs to achieve its goals.



The project identified the health issues among the tribal and the difficulties they face in accessing the healthcare facilities. Based on its analysis on the problems on the ground, it developed a wide range of interventions to address them.

### Distribution of tribal population in Tamil Nadu

In Tamil Nadu, tribal people account for 1.03 percent of the total population, at 6.5 lakhs (census 2001). There are 36 different tribes, present in almost all the districts, across 2860 villages located in 63 blocks of the state. They are predominantly in rural areas, and of these, around 5 lakh live in 13 districts, namely: Krishnagiri, Dharmapuri, Vellore, Tiruvannamalai,



Salem, Villupuram, Erode, Namakkal, Coimbatore, The Nilgiris, Dindigul, Trichy and Kanniyakumari. The remaining 1.5 lakh (20%) population live in urban areas. A total of 173 PHCs and 611 health centres serve this population.

The first step of TNHSP was to understand the reasons for the tribal not utilising the healthcare services in their district. The most common reasons were:

- Inadequate financial resources
- Poor or incorrect knowledge dictating inadequate health seeking behaviour
- Manpower at health facilities either not available (or) available only for a very brief period
- Inadequate database on the tribal population. Poor information base for disease burden / health care utilization of the tribal population
- Special problems such as sickle cell anaemia, tuberculosis, etc.
- Remoteness of many tribal villages from the nearest Primary Health Centre / Government Hospital
- Need for appropriate, timely medical assistance due to inaccessibility of health facilities
- Malnutrition
- Inadequate accountability and monitoring of health care delivery to tribal population
- Lack of special attention to tribal people in health care institutions in view of their beliefs and inhibitions

In the 13 tribal districts that housed the most number of tribal people, a mapping exercise was undertaken in all 62 blocks to understand first whether the number of healthcare centres were adequate. It was found that there are 173 primary health centres and 611 health sub centres to provide primary health care for tribal and other population. The tribals had to travel a distance of 82 kilometres at the most to reach a health sub centre.



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## CHAPTER - 2

### Identifying the Common Problems

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In April 2009, TNHSP had undertaken a morbidity analysis under its Tribal Health Initiative. The major diseases reported among tribal as per this study include:

Sl.No.	Diseases	%
1	Duodenal ulcer	21.3
2	Upper respiratory tract infections	20.2
3	Anaemia	13.9
4	Worm infestation	8.3
5	Peptic ulcer	6.5
6	Neurological Diseases	5.3
7	Acute diarrhoeal diseases	2.5
8	Scabies	2.2
9	Diabetes mellitus	1.6
10	Other causes	18.2
	<b>Total</b>	<b>100.0</b>

Institutional deliveries were also very low among the tribals. Being far away from the health centre, many a times the deliveries happened in the huts, without even basic hygiene and sanitation. This posed a risk to the health and life of the mother and the child.



### Sickle Cell Anaemia Prevalence

The All India Institute of Medical Sciences in collaboration with ICMR (Indian Council for Medical Research) conducted a study of the prevalence of sickle cell anaemia amongst tribals and published a report. The reports showed alarming prevalence of sickle cell disease in certain tribes in Tamil Nadu, ranging from 0.6% to 5.1%.



Sickle cell disease is characterized by a mutation in the shape of the red blood cell from a smooth, donut-shape to a crescent or half moon shape. The cells lack plasticity and can block small blood vessels, impairing blood flow. This condition leads to shortened red blood cell survival, and subsequent anaemia, often called sickle cell anaemia. Poor blood oxygen levels and blood vessel blockages in people with sickle cell disease can lead to chronic acute pain syndromes, severe bacterial infections, and necrosis (tissue death). In Tamil Nadu, sickle cell anaemia is prevalent mostly among tribal communities in the Gudalur and Pandalur taluks of the Nilgiris district. According to the studies done by ICMR and NAWA in this area, there is an estimated 500 patients with sickle cell disease, considering the current population of 25,000.

The disease is prevalent also because of consanguineous marriages common among tribals. As a result, when both parents suffer from sickle cell anemia disease, the possibility of the child born in such a marriage also suffering from this disease increases. Thus, the tribal population also faces the threat of possible extinction since very few survive to old age.

### Thalassemia Management:

ICMR had conducted another study among the tribal population, which showed the high prevalence of Thalassemia among the tribal population living in Jawadhu hills in Vellore district. This is another genetic blood disorder, passed on to next generation, causing a disruption in the production of haemoglobin, the protein that enables red blood cells to carry oxygen and carbon dioxide. This too results in several severe symptoms in the patient.

These studies revealed that in addition to reaching healthcare services and providing treatment, counselling was also necessary to save the tribal population from self-destructing.



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## CHAPTER - 3

### Strategic Initiatives Adopted for Tribal Health

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A tribal health initiative was designed based on these findings and implemented during 2010. Mainly three main strategies were introduced. These include:

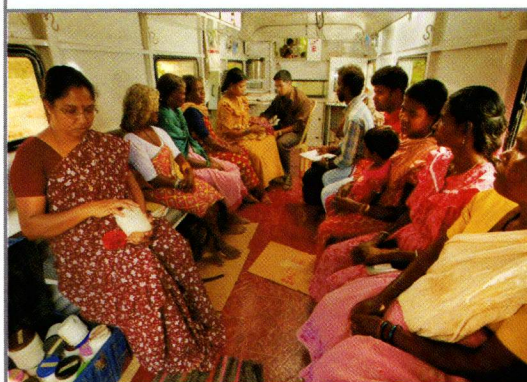
- (i) Implementing a 'Package of Services' in each tribal district, including two new districts that were not covered earlier
- (ii) Initiating new interventions based on the morbidity factor and
- (iii) Extending some interventions that did not receive adequate inputs earlier

Based on the above findings, the initiative was designed to address the dual issues of specific healthcare needs of the tribals as well as encouraging them to avail the services of the healthcare centres and the benefits of modern medicine.

The tribal development plan was initiated based on inputs from the members of tribal communities, non-governmental organizations working with tribals and tribal development consultants. The plan was also influenced by studies done on burden of diseases involving the tribal communities, and health seeking behaviour of tribal communities.

#### Stakeholders

There have been various tribal welfare programmes and initiatives such as Directorate of Tribal Welfare, TDP, the Integrated Tribal Development Programme (ITDP) etc. functioning in the state particularly among the Primitive Tribal Groups for their socio-economic development, integration and welfare.



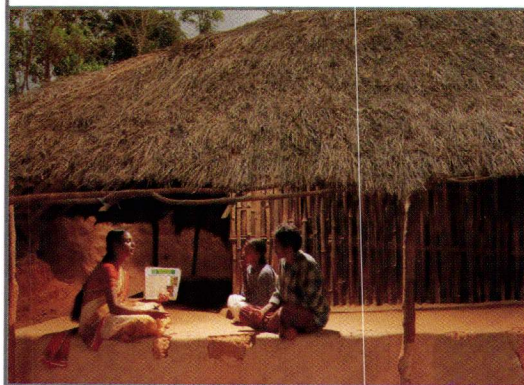


Even though the health indicators for Tamil Nadu are comparatively better than the rest of India, the health outcomes for the tribal population is considerably poorer than the non-tribal population in the state.

To improve substantially the utilization of health services by the tribals, TNHSP has planned to provide additional resources to improve health outcomes.

Understanding the poor health outcomes and morbidity dynamics of the tribal community, a holistic plan was developed in consultation with different stakeholders like the tribal department, Directorate of Public Health, Directorate of Medical Services National Rural Health Mission, Department of Forest, Department of School Education, Department of Social Welfare, District Administration, etc. and the tribal leaders from all the tribal districts. This consultation meeting has led to the establishment of line departments for specific areas that need to be addressed, with clear delegation of work to the respective line department.

One of the first things to be done was to ensure that the resources from the other programs of the health department were also mobilized, especially from the National Rural Health Mission (NRHM) and clear transition plans were developed in consultation with the NRHM. Some of the activities executed by the TNHSP have been mainstreamed in collaboration with the NRHM.



ASHA workers supported by the NRHM were deployed in the tribal hamlets. They were provided with mobile phones to enable communication with the Emergency Medical Services van (108). Stay facility for antenatal mothers has been taken over by the NRHM and also been extended to all the primary care centres across the state in tribal areas.

TNHSP has implemented 12 mobile outreach vans and had proposed to introduce eight additional vans in the extension phase of the project. The Project Director motivated the Mission Director, NRHM, to fund the programme that would be monitored by both HSP and NRHM.



Six interventions were undertaken, including:

- Mobile outreach services to improve accessibility
- Diagnosis and treatment of sickle cell anaemia
- Providing peer counsellors
- Promotion of institutional deliveries
- Provision of bed grants and
- Activities to Inform, Educate and Communicate (IEC)

In addition to these, workshops were also conducted in the following categories:

- Consultative workshop for NGOs working in tribal areas
- Sensitisation workshop for local leaders
- State level workshop on tribal health

### Mobile outreach services to improve accessibility

As has been seen, historically, only 1-2 percent of the tribal communities have access to hospital facilities. The reasons are varied, and include inaccessibility of the hospital, non-availability of doctors in health facilities and the cultural practices followed by the tribal community.

Since one of the main reasons for tribals not availing the free government healthcare services is inaccessibility, it was decided to reach healthcare to the remote tribal locations through mobile outreach services in partnership with non-governmental organizations in the districts of Nilgiris, Coimbatore, Dharmapuri, Krishnagiri, Vellore, Salem, Namakkal, Dindigul, Kanyakumari and Villupuram. The services were monitored by the district administration. Vehicles equipped with a doctor, nurse, lab technician, and a pharmacist visit difficult-to-access areas once in 15 days. In Nilgiris district, three vans were provided as it has a higher concentration of tribal population. Twelve mobile outreach vans with the medical and paramedical teams were operated by NGOs using a PPP model to deliver the services for the tribal community. Additionally, two private hospitals were identified to provide inpatient care services. These inpatient costs were reimbursed by the project.





Initially these services were taken to the difficult-to access areas inhabited by the tribal communities. But the uptake was very low, primarily due to the beliefs and practices prevalent in the community. Therefore interpersonal communication tools were developed in consultation with the community to increase the acceptance of the healthcare services.

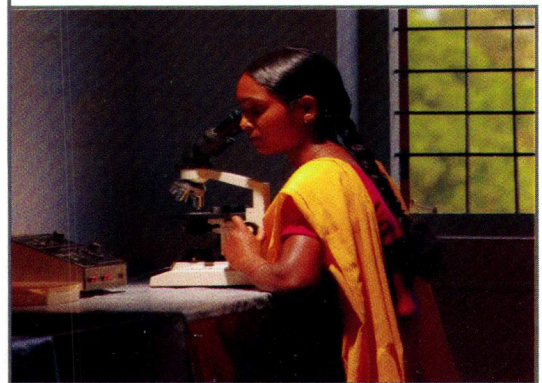
The scope of the tribal health plan was increased to include components like bed grants, stay of antenatal mothers from remote and inaccessible areas in selected Primary Health Centres (PHCs) etc. This ensured quality uptake in government health care services. As the project progressed, the tribal communities started accessing the health care centres available in the plains. In such hospitals, a tribal counsellor was appointed to help increase the confidence level in the services provided and consequently improve the uptake of Government health care services.

Apart from out-patient services, the mobile outreach services also provide ante-natal and post-natal checkup. Newborns are vaccinated. Laboratory services and IEC services are also provided. The programme is funded by the National Rural Health Mission.

### Diagnosis and treatment of sickle cell anaemia

In order to prevent and treat this disease, various interventions were undertaken. The approach was to combine screening and identification of sickle cell patients, along with counseling and treatment. Two NGOs, Ashwini Hospital, Gudalur, and Nawa Hospital, Kotagiri, run these sickle cell anaemia centers. A standard management protocol in diagnosis and treatment was developed and is followed in these hospitals. This consists of the following:

1. A survey was done to find how many people had sickle cell anemia, and how many were likely to get the disease, so that interventions could be provided accordingly. Treatment cards were issued to positive patients.
2. Premarital counseling was provided to discourage two people with sickle cell anemia from marrying each other to ensure that any offspring they may have would not contract the disease.





3. Out-patient services such as vaccination are provided against pneumococci and treatment for minor ailments.
4. During emergency, which occurs during a sickle cell crisis, blood transfusions are provided.
5. Hydroxy urea tablets are provided throughout the lifetime of a sickle cell anemia patient.

The average per annum cost for implementing the program in one district is Rs. 20 lakhs.

### Providing peer counsellors

Counsellors from tribal communities were appointed at 30 healthcare centres (25 hospitals, 5 primary healthcare centres) to increase the comfort-levels of the members of tribal communities accessing the hospitals. As these counsellors are from tribal communities, they instil confidence and help in removing fears and apprehensions the tribals faced over the years. These counsellors will assist patients from the tribal communities visiting hospitals and also maintain detailed records of their visits.



The counsellors were given training in HMDI Salem in November 2008 and reorientation training in March 2009. This intervention has helped increase attendance of members of tribal communities in hospitals.

### Promotion of institutional deliveries

Women in tribal communities shy away from institutional deliveries because of inhibitions and other cultural factors, which leads to a higher preventable maternal and neonatal mortality and morbidity. Myths and misconceptions prevalent in the tribal population deterred a number of antenatal mothers from utilizing the PHCs for delivery. Their stay at the health care facility also affected the family income. As a result, it was always preferred to conduct the deliveries at home by elderly women or dais. This often resulted in maternal and neonatal mortality and morbidity which could have been prevented with proper care.



To address this and encourage mothers to use the facility for safe deliveries, a pilot programme - 'Antenatal mothers stay plan (AMS) in PHCs' - was implemented by TNHSP in four primary health centres where expectant mothers are brought in from their place of residence to a PHC three days before their expected delivery date. The cost of shelter, medical attention, and food is taken care of by the State for the mother and an attender. Soon, this will be expanded to all tribal districts through the National Rural Health Mission.

This was implemented with the following objectives:

1. To bring all tribal antenatal mothers in advance from remote and inaccessible areas to Primary Health Centers for safe delivery.
2. To promote institutional deliveries.
3. To reduce maternal and neonatal mortality and morbidity among the tribal population.
4. To educate the tribal community, health workers and health professionals about the importance of safe and institutional delivery.
5. To detect complications at an early stage and to refer the cases to higher institution for timely interventions.

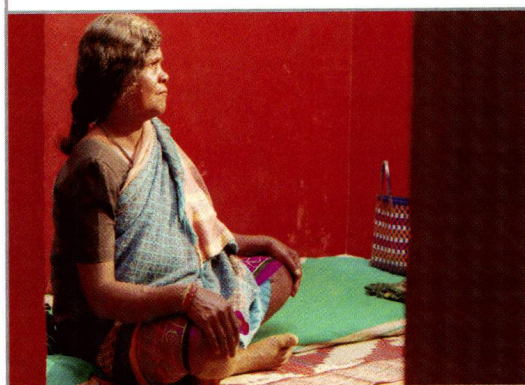


The pilot initiative to provide lodging facilities for 10 days with food for the mother and an attendant was set up. The transportation cost from and to the place of residence was also borne by the project. This resulted in increase in institutional deliveries in the catchment area of the PHCs where the project was implemented. Based on the positive outcomes of the initiative, the programme was extended to all the PHCs in tribal areas across the state to cater to all antenatal mothers.



### Provision of bed grants

In two hospitals as a pilot program all the costs associated with inpatient care for tribals are reimbursed. This is administered through NGO partnerships. These hospitals are Aswini Hospital in Gudalur, Nilgiris, and NGO Hospital of Nilgiris Wayanad Tribal Welfare Society.



### Activities to Inform, Educate and Communicate (IEC)

Sensitisation workshops were conducted for leaders of the tribal communities on healthcare services provided, in CMC Vellore in May 2009 at Chennai. Apart from tribal leaders from 10 districts, this workshop was attended by NGO partners and other officials. Apart from healthcare issues, education and economic concerns were discussed.

The recommendations from this workshop, and another consultative workshop conducted at Ooty in April 2009, have been shared with the World Bank. It was decided that TNHSP along with other departments such as NRHM, DMS, and DPH will take care of the tribal healthcare issues. A committee with officials from various departments has been planned to tackle other issues.

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## CHAPTER - 4

### Outcome of the Programme

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#### Transparency and stakeholder participation

One of the reasons for tribals not accessing the health facilities even if it was within reach was because of myths and misconception. Therefore one of the first steps the TNHSP undertook to develop the tribal health initiatives after analysing the gaps in access / non availability of health care services was to consult with several stakeholders in the tribal districts. The consultative meetings were conducted with the district level health administrators, representatives from the National Rural Health Mission, Department of Health and Family Welfare, tribal welfare department, district administration, NGOs working with the tribal population, and tribal leaders from all the tribal districts. This enabled the development of an action framework by all the departments concerned.

#### Innovativeness of the initiative and its replicability

Sickle Cell Anaemia : Based on a study report by the AIMS and ICMR, the Sickle Cell Anaemia program was initiated to cover the endemic tribal areas. A standard management protocol for diagnosis and treatment of the sickle cell anemia was evolved. A total of 32067 persons were covered. Primary screening was done for 14296 patients and secondary confirmation test for 3860 patients. A total of 228 positive cases was identified. In the absence of this screening, these high-

risk patients would not have been identified till they suffered a crisis. The program covered all the at-risk population in the endemic area.





Active counselling in core areas like genetic counselling, premarital counselling, antenatal counselling etc is also given to ensure long-lasting health-seeking behaviour.

The average per annum cost for implementing the program in one district is Rs. 12 lakhs. The program at the field level is being implemented by NGOs that are working with the tribal population in the district. It is a very cost effective method that can be replicated in areas that have been found to be endemic for sickle cell anaemia.

#### Mobile Outreach Services:

The introduction of the mobile outreach services has considerably reduced the distance to be travelled to access medical services. This has improved the uptake of health care services by the tribal communities. Developing interpersonal communication tools also encouraged the use of mobile outreach services by the tribals. Information Boards announcing the day and time of availability of the services were put up in places where the mobile outreach services were made available. The average running cost per unit per annum is Rs. 21.96 lakhs for providing outpatient services for about 20,000 persons per year (per unit cost works out to approximately Rs. 109). This initiative can be replicated in tribal districts where the tribal hamlets are located in remote areas.

S.No.	Activities	Periods					
		2007-08 (Apr. 07- Mar.08)	2008-09 (Apr. 08- Mar.09)	2009-10 (Apr. 09- Mar.10)	2010-11 (Apr. 10- Mar.11)	2011-12 (Apr. 11- Mar.12)	2012-13 (Apr.12- June12)
1	No. of Vehicles	12	12	12	12	12	20
2	No.of OP Treated	137543	266040	274791	240347	280905	89712
3	No.of persons referred	4177	19306	7414	3491	3161	1623
4	No.of AN Check up	2057	4233	4165	3822	4291	1519
5	No.of PN Check up	1410	4905	4008	3387	2245	1029
6	Lab. Investigation	29167	33262	45860	45150	56890	22318



### Stay facility for Antenatal women at the Health care facility:

Following the implementation of the initiative for institutional deliveries, started in four PHCs, a total of 1037 mothers benefited. Based on the positive outcomes of the pilot project, the scheme was extended to all the PHCs across the state in tribal areas to provide stay with diet support for antenatal mothers and their attenders. This initiative led to an increase in the institutional delivery across the state and decrease in the maternal and neonatal morbidity and mortality.



### Bed grants in tribal areas through PPP initiative:

Though the public health care facilities in the tribal areas have adequate infrastructure and manpower, the utilization in term of bed occupancy and OP utilization is very low. The tribal population is attracted by the services that are provided by the committed NGOs as they are nearer to them. Therefore to support / encourage the services provided by the NGOs the “Bed grant” was established as a pilot programme to reimburse all costs associated with inpatient care for tribal in two NGO operated tribal hospitals.

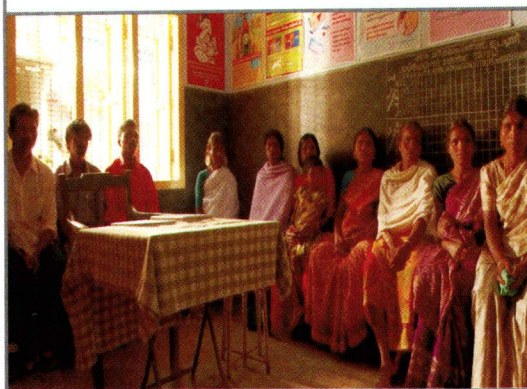
More than half of the sampled patients have visited the hospital from a distance of 25 kms or more than that. This suggests that the bed grant facilities available in the hospital are in significantly high demand and that patients have availed these facilities in spite of large distances. Around 17 percent of the selected patients were in the age group of 14 years or less than that, another 25 percent patients were reported in the age group of 15 – 25 years, around 55 percent patients were reported in the age group of 26 to 60 years. As per the assessment, 95 percent of the tribal population who access the hospital had a monthly income of less than Rs. 3000.

The initiative can be replicated in tribal areas where there are private providers by bearing the inpatient treatment cost. This will lead to an increase in uptake of in-patient service and decrease in morbidity and mortality. More so importantly it would help to reduce the out of pocket expenses of the poor tribal population.



## Outcome

The impact of the tribal Mobile Outreach Services was assessed by a study that enquired about the distance travelled by the beneficiaries to avail this service. It was reported that the majority (83 %) of the beneficiaries who had participated in beneficiary exit interview had traveled less than a kilometer to avail the services. The findings from the qualitative study



revealed that the Mobile Outreach Services van was taken in to the tribal villages. This shows that the location of the Mobile Outreach Services provided right in the tribal village was optimal. Only in some places where there was no possibility of driving the vehicle the MOS van was parked at the end of the road and the tribal people were mobilized to avail the services from there. Detailed outreach plans were developed based on the catchment area of the MOS vans. The tour was planned such that a village was visited either once in a fortnight or week. Thirty nine percent of the study respondents reported that the MOS team had visited their village once in a week or more in last 3 months.

A base line study on the distance the tribal had to travel to access health care services was assessed as minimum of 3 to a maximum of 37 Kms with an average distance of 12.9 Kms. After the introduction of the mobile outreach services, the distance traveled to access the mobile health unit was assessed and the impact study revealed that 83 percent of the respondents had to travel less than 1 km to access the service while 12 percent of the respondents had to travel for 1-5 Kms and only 5 percent of the population had to travel more than 5 Kms to access the services.

The analysis of the data revealed 58 percent of the study respondents were female and the remaining 42 percent were male. Classically, it is health of the females which is often neglected. They rarely avail the health services. The data analysis presented above, shows beyond question that the Mobile Outreach Services has ensured that basic health services are provided free of cost to the women as well.

The study enquired about the key factor responsible for making respondents utilize Mobile Outreach Services for treatment. 'Services were available at the door step' was the important factor pointed out by the majority (about 75%) of the respondents. Medicines



provided along with the treatment attracted about 64 percent of the beneficiaries to the services, and about 62 percent of the beneficiaries reportedly approached the Mobile Outreach Services since their ailment was minor. More than half the respondents expressed that reliable treatment and courteous approach of mobile outreach services team (health care providers) had attracted them to the Mobile Outreach Services.



The respondents were asked to rate their satisfaction level towards the TNHSP's mobile outreach services in a five point scale where 1 stands for highly dissatisfied and 5 stands for highly satisfied. Almost 27 percent of the respondent reported that they were highly satisfied with the overall services provided by the mobile outreach services team while 58 percent said that they were satisfied. Almost all the respondents expressed that they would avail the mobile outreach services if at all they require it in the future and they would also refer the service to their friends and relatives. This confirms their satisfaction towards the programme

The baseline studies show that the percentage of tribal population availing any health care services was very low. The 52nd round of the NSSO survey shows that only 20 percent availed the government health services. The ICMR study shows that only 11. percent of the tribals with morbidity availed government services. The performance of the mobile outreach services shows that 46 percent of the tribal population have availed the government implemented mobile outreach services.

Tribal Counselling was established to provide counselling services to the tribal visiting the hospitals. The counselling services were provided by counsellors who were trained and appointed by the local NGOs. The impact assessment study reveals that 60 percent of the respondents appreciated the counselling service as be very useful and helpful in utilizing the services of the hospital. About 99.7 percent of the respondents said that they would recommend their friends and relatives to avail of these services. During the Financial Year 2011-12 about 11.32 lakhs tribals had availed the counselling services, showing a sharp increase from 2.50 lakhs that availed the services during 20011-2012. During 2008-09 only 2215 tribals were counselled.



S.No.	Activities	Periods					
		2007-08 (Apr. 07- Mar.08)	2008-09 (Apr. 08- Mar.09)	2009-10 (Apr. 09- Mar.10)	2010-11 (Apr. 10- Mar.11)	2011-12 (Apr. 11- Mar.12)	2012-13 (Apr. 12- June.12)
1	No. of NGOs	2	2	2	4	4	4
2	No.of Inpatients Treated	503	1141	1355	906	2125	591

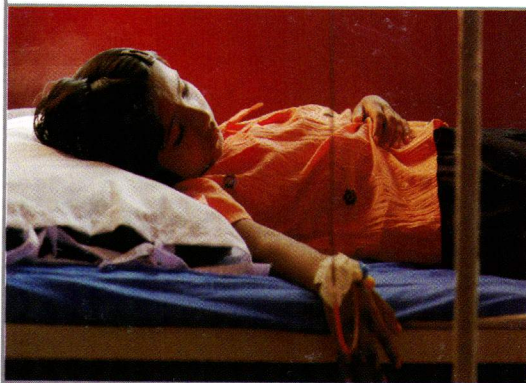
### Sickle Cell Anaemia

An impact assessment study of the impact of the program for Sickle Cell Anaemia has showed that about 32 percent of the respondents were children. The awareness of the respondents regarding SCA was judged during the study and it was found that about 63 percent of the respondents were unaware about SCA.

S.No.	Activities	Periods				
		2008-09 (Apr. 08- Mar.09)	2009-10 (Apr. 09- Mar.10)	2010-11 (Apr. 10- Mar.11)	2011-12 (Apr. 11- Mar.12)	2012-13 (Apr.12 - June.12)
1	No. of NGOs	2	2	2	2	2
2	Primary screening (No. of persons screened).	4225	3224	3249	2857	741
3	Secondary confirmative test.	1939	671	583	517	150
4	Number positive for secondary confirmative test.	78	43	61	33	13

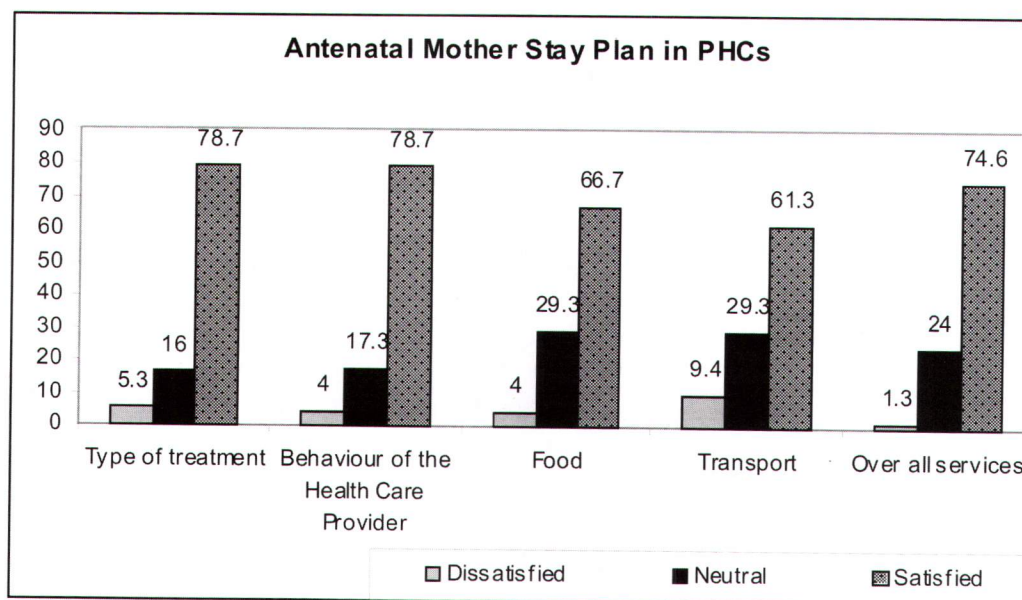
The study enquired with the SCA patients if they regularly visited the hospital for treatment. Of the total of 31 respondents, it was found that only 67.7 percent of them visited the hospital for regular treatment. This shows that not all of the SCA patients visit the hospital regularly. The study enquired with the 10 respondents who did not regularly visit the hospital for treatment about the reason for not doing so. Nine of the ten respondents said that they did not visit the hospital regularly as the NGO workers visited them in the village itself and provided the necessary care.

The respondents were asked if anybody from the NGO visited them to discuss about SCA and related dos and don'ts. It was found that about 92 percent of the respondents said that NGO staff visited them to discuss about SCA. A majority of the respondents (75%) also said that the NGO staff visited them once in a month.



The study enquired about the perception of the respondents about the services and treatment that they were being offered. The perception on type of treatment and services and the behavior of doctor and nurses was assessed. Further the perception on overall services was also assessed. It was found that about 85 percent of them were highly satisfied with the services offered to them.

**Antenatal mothers stay plan in PHCs** Data related to the age of the beneficiaries at the time of interview was collected in the study. The analysis revealed that the majority (68%)





of the beneficiaries belonged to the young age group of 19 yrs to 25 yrs, while 29 percent belong to 26yrs to 30 yrs. The youngest mother who had availed the services was 19 yrs old and the oldest was about 35yrs old. The mean age of the mothers who has availed the AMS services was about 25 yrs. This shows an increase in awareness to go for institutional deliveries among the younger age group.

**Bed Grant Programme** To assess the implementation of bed grant programme an impact assessment study was conducted. More than 50 percent of the sampled patients reported that they have visited the hospital from a distance of 25 kms or more. This clearly indicates a high level of acceptance for this initiative. The average monthly household income from all sources put together was less than or equal to Rs.3500/ in about 95 percent of the cases.

Almost 100 percent patients reported that they are extremely satisfied with the bed grant facilities and around 30 percent of them also reported that without such facilities they might have had to depend on other traditional methods for healing. Almost 100 percent of the patients would like to avail the facility again in future. One of the service providers caters to 16000 Adivasi members across nearly 300 hamlets. The hospital authority felt that the bed grant programme had a positive impact on the health of the community members. The hospital authority opined that this is one the best programmes for tribal health care offered by TNHSP

**Tribal Counseling Services** This programme provides counseling services to the tribals that access the primary health centres. An impact assessment study was conducted to assess the programme. Some of the key findings of the study are that more than half of the respondents for this study (66%) were outpatients. It was found that about 64 percent of the beneficiaries interviewed were women. This shows that a higher percentage of women were actually using the patient counseling services as compared to men. More than half of the respondents (58%) travelled up to 5 kms to access the services at the hospital. About 20 percent of them travelled up to 10 km from their place of residence to access the patient counseling service.

S.No.	Activities	Periods				
		2008-09 (Apr. 08- Mar.09)	2009-10 (Apr. 09- Mar.10)	2010-11 (Apr. 10- Mar.11)	2011-12 (Apr. 11- Mar.12)	2012-13 (Apr.12 - June.12)
1	No. of counseling Centre	30	30	30	32	32
2	No.of counselors	30	30	30	32	32
3	No. of patient counseled	80512	250613	270836	487477	89567

Explanation of the prescription, detailing the administration of the medicines was one of the most popular service provided by the counselor This was followed by sessions on the availability of different type of OP services and dietary needs. It was found that about 30 percent of the respondents had availed this service once. The remaining 70 percent had availed this service for more than once.

About 60 percent of the respondents said that they would found it difficult to obtain health services in the hospital in the absence of such a service. Hence it can be concluded that tribal communities have found the counseling service very useful and helpful in utilizing the services of the hospital. About 99.7 percent of the respondents said that they would recommend their friends and relatives to avail of these services.



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## CHAPTER - 5

### Future developments

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To improve the tribal health initiative during 2010, three main strategies were introduced as mentioned below:

1. Implementing a "Package of Services" - "Package of Services" consisted of:
  - community outreach to deliver primary care through mobile vans
  - village link volunteer scheme
  - stay program for antenatal mothers (with support from NRHM);
  - patient counsellors

These initiatives would be implemented in each tribal district, including two new districts that were not covered during Phase I. In addition, the Bed grant scheme will be continued in the existing two locations and the Sickle Cell Anaemia scheme will be extended to one additional location in consultation with ICMR.

2. Initiating new interventions - The consultation meeting with key stake holders, resulted in the initiation of two new interventions:
  - i. Introduction of the ASHA worker under NRHM.
  - ii. Introduction of a multi-sectoral approach to tribal development. It was understood that TNHSP cannot take the responsibility for undertaking all the diverse activities. Instead, it could act as a catalyst for other departments to coordinate their activities as they move forward.

3. Extending activities that did not take off under Phase I: The IEC campaign which is deemed vital to changing health seeking behaviour and awareness among tribals did not do well under Phase I. It was focussed to strengthen the IEC campaign in the tribal districts. The activities were linked up with other line departments like the Tamil Nadu State AIDS Control Society to collaborate and implement the campaign.

So for the future and replication of the Phase I in other districts includes:

- Additional medical and paramedical staff for the mobile outreach services to work in the difficult hilly terrains.
- Finding alternatives to reach tribal areas that cannot be reached/reached only by walking up to a distance of 16 kilometres.
- To further improve institutional delivery in tribal populations.
- To find MOs, staff nurses and VHN in government hospitals/ PHCs and Health Sub centres situated in the tribal areas.

### Sustainability of the initiative

The stay facility for antenatal mothers in the selected PHCs initiated as a pilot project has now been taken over by the National Rural Health Mission program and has been extended across the state to cover all antenatal mothers. The pilot project has not only been scaled up to cover the entire state but has also been mainstreamed with the health department for sustainability.

The tribal mobile outreach program was implemented in two phases, the first phase of the tribal mobile outreach has been mainstreamed with NRHM, the next phase will also be transitioned to NRHM where it will become a part of the regular health delivery system that would provide mobile outreach services to the tribal population.

The other initiatives have been planned in such a way that in a phased manner the programmes will be integrated with the National Rural Health Mission.





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