Open Discussion:

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- **Discussion closed by 21st January 2011.**

Group discussion on Service delivery: 6th January 2011

The group discussed a set of challenges that had been identified by a working group prior to the meeting and added a few challenges to the list. All challenges were discussed along with their possible solutions which were listed as recommendations. Specific activities contributing towards the recommendations that could be undertaken by civil society partners were listed separately. The challenges and recommendations are based on current situation as well as the future vision of RNTCP for the strategic plan period of 2012 to 2017. The group supported the RNTCP vision of universal access and a number of the recommendations were based on the need to change current practices in order to achieve universal access.

Challenge	Recommendation	Action by Civil Society
1. Reaching vulnerable populations and underserved areas in order to achieve Universal Access	▪ Periodic Mapping at district and block (TU area) level ▪ Identify underserved areas and populations ▪ Allocate special incentives for difficult and underserved areas to patients and care providers, including CSOs ▪ Incentives to be released in time to all volunteers and CSOs ▪ Special interventions and models to be devised for special groups	▪ Civil Society can assist in identification of the underserved areas and mapping at each level ▪ CSOs can provide outreach and implement incentive based innovative models of care delivery (e.g. conditional cash transfers based on the experiences of NRHM JSY)
2. Increasing Access	▪ Align the TUs to the NRHM block system and revise the TU scheme in order that CSOs can get more TUs to manage and assist in addressing human resource inadequacies for TUs. ▪ TB problem to be included in village health plan ▪ Convergence with other health programmes and non Health programmes ▪ Use of appropriate technology(e.g. mobile phones)	▪ Sensitize CSO's to take up TUs ▪ Sensitisation of the VHSC ▪ Pilot projects to improve access by the use of innovative technology (e.g. Mobile phone, etc) ▪ Build the capacity of the local civil society and PRIs to function as watch dogs with formal facilitation from RNTCP. ▪ Dissemination and Sensitisation of PCTC ▪ Partnership/Consortium to manage NGO schemes for CTD,

	▪ Improve internal communication systems (Feedback) between TUs and DTCO ▪ Patient charter to be used as an elementary tool for improving Service delivery ▪ Implementing RNTCP NGO Schemes through Intermediary partnership Civil Society/Civil Society consortium, etc	including disbursement of funds, monitoring of results, etc. This can start as a model in one selected state and expanded based on the experience gained.
3. Care delivery to Migrants and Homeless	▪ Focus to be on Default prevention by treatment adherence ▪ Incentivising homeless patients and CSOs to ensure diagnosis, treatment and care ▪ Not to exclude patients from treatment just because they are Migrants/Homeless ▪ Migrants : Identify migrants as a separate group and incorporate a special chapter in the plan	▪ Develop different models of service delivery to the Migrants and Homeless, using innovations to promote adherence to diagnostic and treatment advice, prevention of default, continuity of treatment while migrating across state, district and international borders. ▪
4. Sputum Collection Centres	▪ NGO scheme need to be revised with higher allocation of budgets particularly covering transport and speedy delivery of samples Lessons to be learnt from the	▪ CSOs to run sputum collection centres in remote areas, difficult terrain, urban slums and other settings where access is sub-optimal to microscopy centres or

	success of private sector laboratories which collect specimen, transport to labs across the country, track specimen and results and disseminate results to patients rapidly.	molecular diagnostic sites (including for diagnosis of drug resistant TB) ▪ CSOs can provide adequate information in the revision and operationalization of the NGO Schemes by providing inputs from their ground level experience.
5. Active Case Finding	▪ House hold contact investigation to be included with higher incentives in 'Adherence' scheme ▪ Active case finding for high risk groups by incentivising DOTS providers scheme ▪ Implement active case finding strategies in other vulnerable population groups (e.g. congregate settings, prisons, urban slums, etc.), and amongst clients of other relevant public health and social programmes. ▪ Systematically implement intensified TB case finding activities in all HIV care and support facilities. ▪ Actively screen health care seekers	▪ CSOs can assist in conducting contact investigation ▪ CSOs to implement active case finding strategies in vulnerable population groups. ▪ Implement intensified TB case finding activities in HIV care settings. ▪ Implement active screening of all health care seekers at their respective health facilities.

	at all health facilities for symptoms suggestive of TB.	
6. Low awareness on TB among PLHIV networks	▪ Directly work with PLHIV networks with suitable schemes ▪ Work through Intermediary NGOs for capacity building and mentoring of the PLHIV networks	▪ CSOs can assist in sensitisation and capacity building of the PLHIV networks to adopt the schemes. ▪ As Intermediary NGOs - capacity building and mentoring of the PLHIV networks
7. Lack of involvement of Existing HIV-TI in TB control	▪ To include TB control as a component in HIV-TIs by advocating with NACO ▪ Review and revise the existing NGO scheme (based on the AVAHAN experience) with enhanced budget lines	▪ Advocacy with HIV-TI NGOs for the implementation of TB activities and adoption of the RNTCP scheme
8. Counselling in TB programme	▪ Counselling to be made mandatory using patient charter at DMC /PHC level with specific budget and deliverables through CSO	▪ Undertake counselling of patients
9. Unregistered cases with private sector	▪ Identify a process to institutionalise 'Notification' by private practitioners	▪ Develop and implement market based models for notification of all TB cases by medical practitioners. Use mobile phone technology, conditional cash/credit/loyalty-points transfers, vouchers, etc.
10. Ensuring greater flexibility in	▪ Ensuring flexibility in RNTCP in the	▪ Participate in the process of

RNTCP guidelines	area of changing diagnosis, treatment and care methods, and providing and enabling environment for inclusion of a range of practices that are consistent with the international standards of TB care. This will greatly facilitate engagement with all care providers and moving towards universal access.	revision and evolution of RNTCP technical and operational guidelines. Bring the perspective of the affected community, patients and a diverse range of front-line care providers to the revision process.
11. Health Insurance Schemes covering TB	▪ Engage with public and private sector health insurance entities and initiatives to establish norms and standards for insurance coverage of TB diagnosis and management, based on the principles of early detection, notification, quality of diagnosis and treatment, etc.	▪ Advocacy with insurance authorities and initiatives
12. Space for innovation and operational research in Service delivery	▪ Identifying a budget and institutionalising opportunities for innovation in service delivery and research for developing new models (Innovation fund) ▪ Budget for new diagnostics, new regimens, including for children	▪ Advocacy at national level for budgetary provision and at local level for timely and effective use of the funds.

13. Sustaining technical expertise and motivation among health care staff	▪ Orientation and refresher trainings for Health care staff – bottom up through CSOs	▪ Conduct training on soft skill development of key RNTCP staff ▪ Motivation of staff by recognition and awards

Additional discussion points and recommendations from the group on "Service Delivery"

- How will all the recommendations be converted into action points?
- Roles of CTD and Civil Society need to be specified and agreed upon in taking the recommendations forward.
- All the NGO schemes under RNTCP to be revised and designed by civil societies (Users)
- Civil Society organisations (CSO) to be part of policy formulation, programme planning, implementation, monitoring and evaluation
- Delegation of decision making on allotment of NGO schemes to District health administration (for all schemes)
- Identify and institutionalise intermediary NGO (Mother NGO) to manage CSO participation with specific budget line and deliverables – National/state/district level
- To ensure effectiveness and efficiency and accountability – joint MIS (with NRHM) to be developed with better set of tools