Engaging CSOs through the National TB Programme

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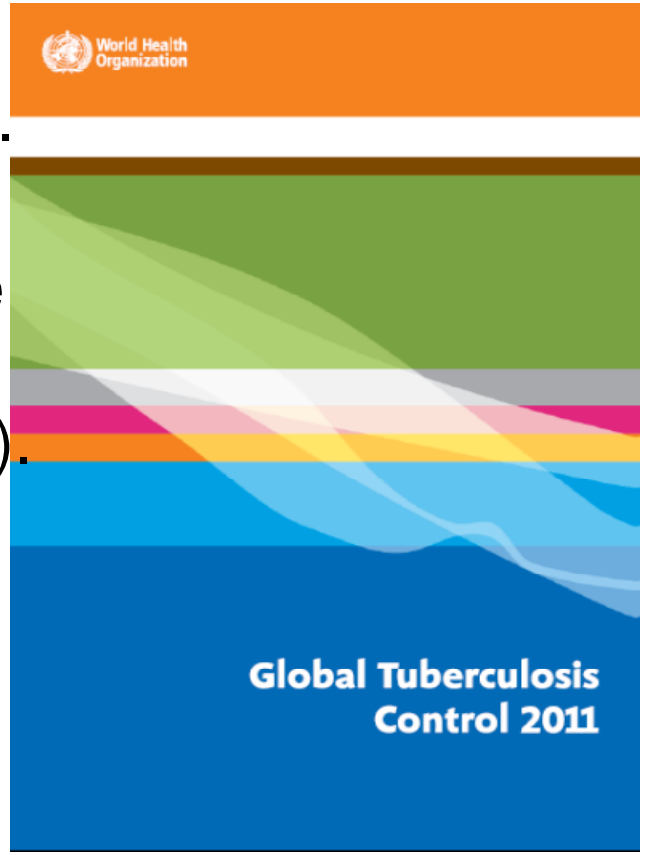
Global Tuberculosis Burden

- 2 billion infected i.e. 1 in 3 of global population
- 8.8 million (8.5-9.2) new cases in 2010.
- 12 m prevalent cases (11-14m)
- Global incidence rate is falling at a rate of 1.3%
- 1.1 m (0.9-1.2) deaths in 2009 (HIV-ve). Addl 0.35 m (0.32-0.39) TB deaths among HIV+ve. 98% in low-income countries.
- MDR-TB universal, 440,000 cases in 2009, prevalence in new cases around 3%, confirmed XDR-TB in 58 countries
- Prevalence HIV in new cases is 11%

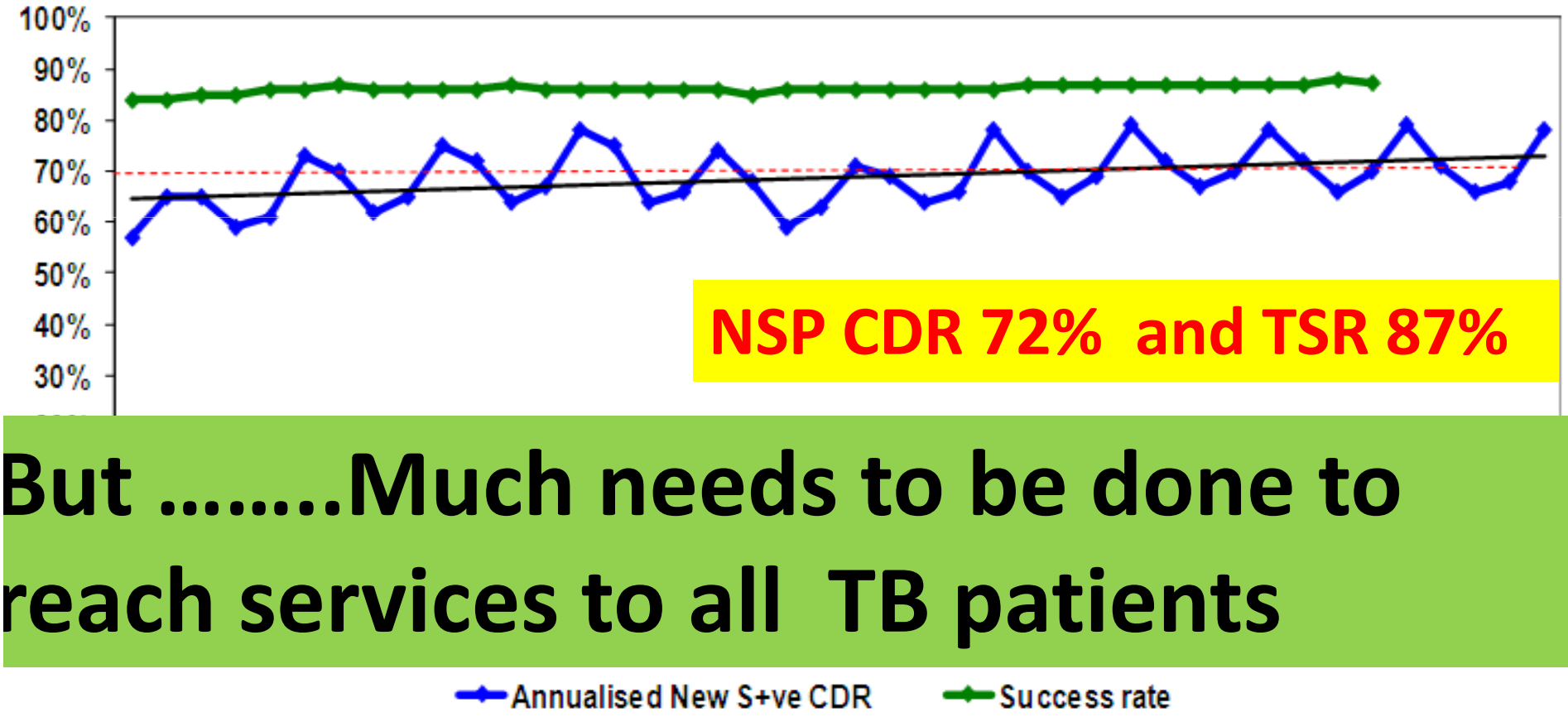


TB Burden in India

- Incidence: 2 million new TB case annually (2009)
- Prevalence: 3.8 million bacteriologically positive cases (2000)
- Deaths: About 280,000 deaths due to TB each year (2009)
- MDR-TB (Multidrug resistant-TB) in new cases is ~3% and in previously treated cases is 14%-17%
- ~4.85% of TB patients estimated to be HIV positive

RNTCP has successfully achieved & sustained twin objectives – averting >2.4 million deaths

Annualized New Smear-Positive Case Detection Rate and Treatment Success Rate in DOTS areas, 2001 – 2011



But ……..Much needs to be done to reach services to all TB patients

- Population projected from 2001 census
- Estimated no. of NSP cases - 75/100,000 population per year (based on recent ARTI report)

Vision

Universal Access-reaching the unreached

The vision of the Government of India is a "TB-free India - through achieving Universal Access by provision of quality diagnosis and treatment for all TB patients in the community".

Strategic vision of GoI for TB

Objectives

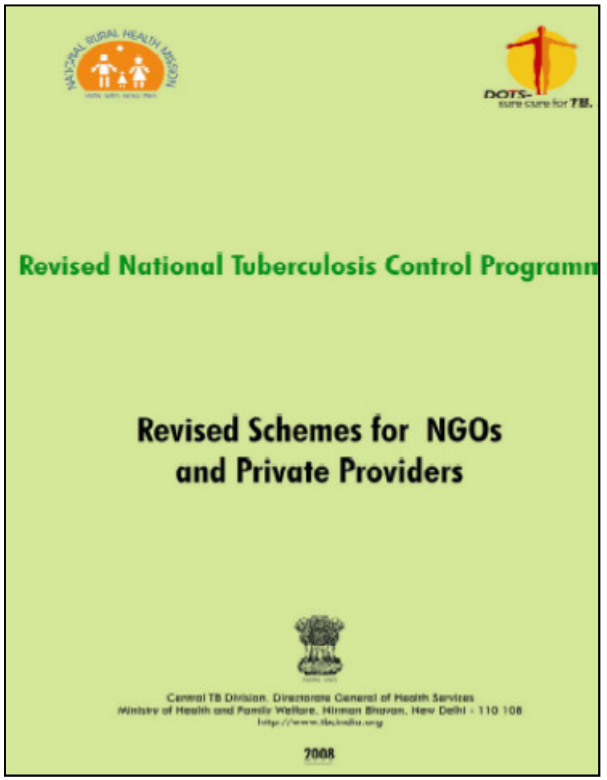
- To achieve 90% notification rate for all cases
- To achieve 90% success rate for all new and 85% for re-treatment cases
- To significantly improve the successful outcomes of treatment of Drug Resistant TB Cases
- To achieve decreased morbidity and mortality of HIV associated TB
- To improve outcomes of TB care in the private sector

Public Private Mix

Initiatives by RNTCP

Revised NGO/PP schemes for involvement of NGOs and PPs (2008)

- Scheme for ACSM
- Scheme for Sputum Collection
- Scheme for Sputum Transport
- Scheme for Microscopy center
- LT Scheme
- Culture and DST Scheme
- Scheme for Treatment Adherence
- Scheme for Urban Slums
- Scheme for the Tuberculosis Unit
- Scheme for TB/HIV



PPM DOTS
Systematic process in involvement

- **Sensitization** of administrators and opinion leaders
- **Orientation** of RNTCP staff on PPM DOTS
- **Listing** of PPM health care providers
- **Identification**/verification of PPM facility
- **Sensitisation** of PPM providers
- **Training** of PPM providers
- **Signing** of RNTCP schemes (Memorandum of Understanding-MoU)
- **Start** of service delivery

PPM -- Achievements

- IMA involved in 16 states (167 districts) – Sensitizing and training IMA members
  - 170 CME sessions organized across 13 states
  - 6887 Private medical practitioners sensitized
  - 2788 private practitioners trained in DOTS
  - 1072 IMA members have signed MOU under RNTCP PPP scheme
  - 513 DOTS provider created from IMA members

Partnership with CBCI

- Under its partnership with The Catholic Bishops' Conference of India- Coalition for AIDS & Related Diseases (CBCI CARD), RNTCP brought into its ambit the network of Catholic Healthcare Facilities (CHFs) and associations such as Nurses' Guild of India, Sister Doctors' Forum of India (SDFI) in 19 states of India

PPM-Involvement of Pharmacists

- MOU signed between the Central TB Division, Directorate General of Health Services and Indian Pharmaceutical Associations (IPA), All India Organisation of Chemist and Druggists (AIOCD), Pharmacy Council of India (PCI) and SEARPharm Forum. This agreement is made for engaging retail pharmacies (community pharmacies) in Revised National Tuberculoses Control Programme

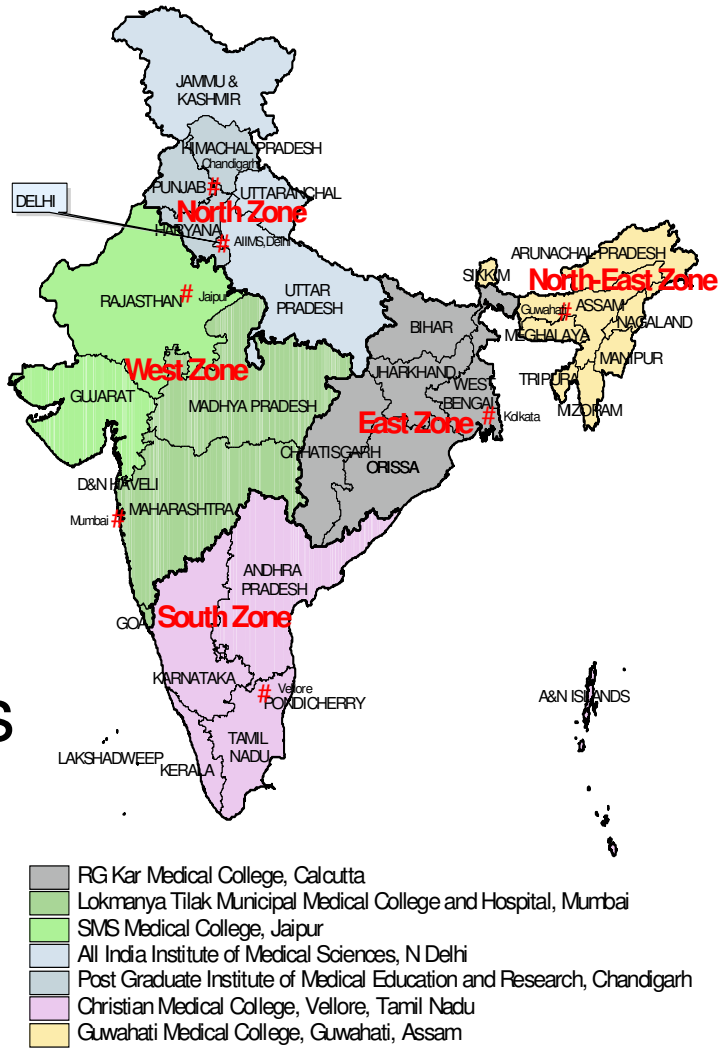
PPM-Involvement of Corporates

- National task Force formed for involvement of Corporate hospitals and private sector institutions offering DNB under RNTCP
- National Technical Working Group formed for providing policy guidance and strategy direction for starting new PPP initiatives and scaling them up

Initiatives to Involve Medical Colleges

- Consensus conference held 1997
- Workshop of professors 2001
- Workshops in States / Medical
- Colleges from 2002 onwards
- National/Zonal/State Task MC
- Forces created
- Core Committees in MCs
- Microscopy centers ,and RNTCP single window established in Medical colleges
- MO, LT and TB HV provided
- Logistics for lab supplied by RNTCP

Medical Colleges as RNTCP Nodal centres



Medical College Contribution

	2009-10	2010-11
Total Number of Medical Colleges involved	282/307	291/321
TB suspects examined for diagnosis	611683	689342
Smear positive TB cases were diagnosed	92071	95272
Sputum Smear+ ve TB cases (put on Rx, refereed)	84015	87271
Initial Defaulters	8056 (9%)	8001 (8%)
Sputum Smear -ve TB cases (put on Rx or refereed)	49788	49031
Extra-pulmonary (put on Rx or refereed)	81615	83824

Limitation

- Data indicate that the actual contribution made by the private sector other than medical college to national case detection remains about 5%
- Various small pilot projects to engage private providers. PPM activities are a very minor part of the RNTCP II budget. The implementation of schemes is highly uneven occurring almost exclusively in Gujarat and Maharashtra

Challenges

- Public sector-concern with quality of TB care provided in private sector
- Apprehensions of private sector
- Limited capacity of the state to engage with large numbers of independent private providers
- Lack of demonstrated financial viability of working with the public sector
- Lack of an approach, which faces the existing market forces operating in the private sector
- Weak regulatory enforcement mechanisms
- Concerns about the supervision mechanisms employed by the public sector

WAY FORWARD

Improving partnerships between public and private is crucial to expanding treatment services

Requirements

To extend the umbrella of quality TB care and control to include those provided by the private sector

- Increased flexibility for acceptable protocols
- Appropriate level of incentives to motivate private providers
- Decreased reliance on schemes

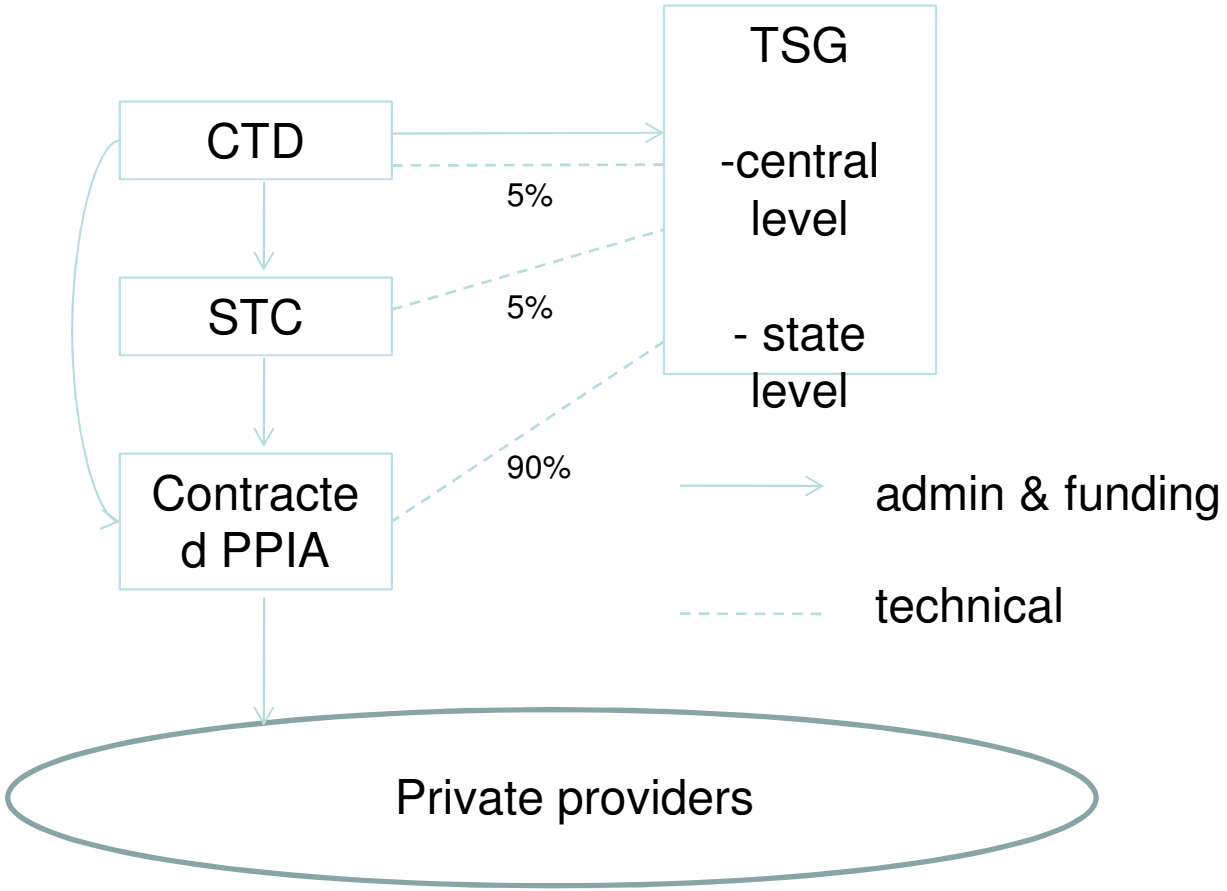
Engagement of Private Sector

- Private sector engagement essential for universal access and early detection
- RNTCP needs to set norms and conduct surveillance while maintaining some flexibility
- Move from sensitization model today to output-based contracting of services
- States need to experiment with innovation and scale-up of those models that are successful
- MUST include labs and pharmacists to detect patients at earliest points of care

National Strategic Plan (NSP)

- **National Technical Working Group (NTWG).**
- **PPM Technical Support Group (PPM-TSG)**
- **Private Provider Interface Agency (PPIA)**

Overall strategy



Private Provider Interface Agency

Functions

- Improve case-finding, appropriate treatment and notification of cases in the private sector
- Ensure notification of cases diagnosed & treated cases in the private sector
- Ensure minimum quality standards as per the ISTC
- Provide or reimburse drugs for privately-treated patients for regimens that meet the ISTC standards and government quality requirements

Technical Support Group

- A group to operational ideas put forward by NTWG, with the requisite skills and mandate to systematically improve and scale-up contracting of intermediaries to engage the private sector.
- TSG will operate much as the NACO TSG for social marketing and may be outsourced

TSG

- TSG will be established to support the Central TB Division (CTD) in designing and implementing this strategy, notably through the use of contracted state-level Public-Private Interface Agencies (PPIA).
- The PPIAs will engage private health service providers with strategies adapted to specific contexts, based on a menu of developed by the TSG.

Private Provider Interface Agency

Functions

- Voucher/conditional cash transfer to patients (to use to purchase drugs that meet govt quality standards)
- Social marketing of anti-TB drugs following agreed procedures and quality standards
- Innovate and adapt to meet these objectives
- Design and deploy financing mechanisms to meet objectives

PPIA

- Relationship with private providers:
  - Training
  - Access to resources (drugs, consumables, financial)
  - Access to diagnostic services, including govt and private sector labs
  - Quality assurance to ensure adherence to the protocol (clinical & price)
  - Ensure reporting, notification, ICT
  - Ensure communication to consumers / providing patients with information
  - Adherence support (i.e. defaulter tracing)
  - Building a “value proposition” for the provider
  - Branding (RNTCP) (not essential)

Urban TB

- The public-private engagement strategy will be closely coordinated with initiatives to improve urban TB control, and will indeed focus on urban and peri-urban areas that have the highest density of private sector health care providers. It will also be closely coordinated with the program's diagnostics and information and communication technology (ICT) strategies.

Urban TB

- City-specific strategies, plans and budgets will be developed for each selected urban area. Cities which are currently poorly-aligned with RNTCP population-based norms for human resources will be encouraged to decentralize management of TB services, making greater resources available.

Indian Standards of TB Care (ISTC)

- ISTC that incorporate treatment options for private providers, reporting and monitoring cases diagnosed and treated in the private sector according to those standards, and subsidizing those diagnosis and treatment services will be developed
- The objectives are to increase notifications of patients diagnosed with TB in the private sector, improve the quality of diagnosis and care that they receive, and reduce the financial barriers and burden that they face

ROLE OF CSOs

- Primary role is to supplement the efforts of RNTCP with particular focus on new initiatives. The focus areas are:

a) Notification

b) Ban on serology

c) Involvement of Private practitioners

d) Involvement of community pharmacists

e) Capacity building of NGOs

ROLE OF CSOs

f) Innovation for Urban TB Control

g) Community Engagement

h) Pilot projects for TB control

e) Research on RNTCP priorities

THANKS