Working Paper on the Current Challenges in the Service Delivery Components of the RNTCP Program

Based on the collective deliberations of the working group of the Steering Committee of the National Partnership for TB Care and Control in India.

1. Background

A. **Scope of the paper**

B. **Historical context of TB Service Delivery**

2. Challenges in the Service Delivery of TB Care and Control

A. **RNTCP services:**

1. Basic DOTS

Observations

Case Detection
Passive Case detection to more active case detection.

a. Currently under the RNTCP programme case detection is passive. However one of the success's that some NGO's have had in increasing is that the DOTs providers are actively involved in identifying potential TB patients in their community and getting them tested for TB. Their incentive is that the number of TB patients they are able to enlist for DOT's increases the incentive money that they receive.

b. Another way of increasing the case detection rates would be to introduce contact tracing of both adults and children diagnosed to have TB. This is currently be done in HIV programmes and could be used as a method for improving case detetction.

2. Need for **prevalence studies** in different parts of India to be determining the actual burden of the disease. Again district level data is preferable. It is possible to engage NGO's with the necessary expertise or private agency to do this so as to be able to get revised district level estimates of TB. Many NGO's feel that this information is more effective planning of RNTCP services.

Supervision and regular meetings of DOT's providers

Were NGO's have been successful one of the components has been the on going and intense supervision of DOT's providers. In the absence of supervision

2. NGO schemes

3. Lab strengthening

Observations

- Sputum transportation in hard to reach populations has been a

major constraints. The current incentive provided for

- Inadequate number of microscopic centers has put the burden on existing microscopic centre's As a result the timeliness of reporting

4. Counseling:

   A number of NGO's functioning as TU's have introduced an additional cadre of staff referred to counselors. The role of the councilors has been

5. Incentive program

B. **TB/HIV:**

Involvement of the affected community: It has been observed that the PLHIV networks, in general, have low level of TB awareness and education. In many districts they are not even part of the District TB/HIV Coordination Committees. Intensified TB screening among the PLHIV takes place in the healthcare facilities like ART and ICTC but not at community level. So the PLHIV who are not attending the facilities, can't be diagnosed TB early. The Round 9 GFATM TB project, which is about to be launched soon, is responsible to build the capacities of the state level PLHIV networks on TB and TB control.

Involvement of NGOs and CBOs: The TB services for the HIV high risk groups are still grossly inadequate. Many of the NGOs and CBOs implementing the TI projects with the HIV high-risk groups are not connected with the TB programs of the district. The RNTCP-NGO schemes are not yet attractive to the NGOs. On the other hand, offering HIV counseling and testing to the TB affected people is still a big challenge (especially in areas like North-East). Management and follow-up of the HIV co-infected TB cases imposes major challenge as well. The NGOs and CBO partners of RNTCP are not oriented and sensitized on HIV & AIDS, HIV services and HIV high risk groups including the PLHIV networks. So they find it very challenging to develop key linkages with HIV program, especially at the community level.

IEC and BCC activities: IEC and BCC activities are mainly confined at the healthcare facility level, but not effectively implemented at the community level. It looks like the general community awareness level on TB/HIV is poor.

Key general observation

1) The coordination between the outreach activities of the two programs is grossly inadequate. There are no common volunteers/workers/peer educators for performing integrated TB/HIV activities at the community level.

2) The number of NGOs and CBOs which have been able to develop effective coordination between RNTCP and NACP so far is very limited.
3) ACSM operational guideline or training module exclusively for TB/HIV collaboration is not available that can provide proper guidance and direction the NGOs and CBOs to roll out comprehensive TB care to the PLHIV and HIV high risk groups and comprehensive HIV services to the TB affected population.

Important case studies

TI-TB collaboration 1: The Avahan-HIV prevention program which is working with 290,000 HIV high risk groups (mostly sex workers, MSM,) in 6 high prevalence states had screened 254,709 members of the target linked them with RNTCP for treatment. (**Reference**: Power point presentation of Dr Bitra George, Country Director, FHI India presented in National Consultative Meeting of Partners in 2009)

TI-TB collaboration 2: A TI project implementing NGO (partner of Gujarat SACS) has developed effective linkages with the community DOTS providers and helping them refer their TB cases to the ICTCs for offering HIV counseling and testing. The project has private doctors in their panel who treat the referred STI cases from the project and all of them are also registered DOTS providers. They are providing TB education and counseling to the STI cases and HIV education to the TB cases under the same roof.

B. **Migrant populations:**

- Presently, there is no national level strategy and guideline for tuberculosis care and control for the migrants in India

- Millions of migrants are currently working in unorganized job sectors with no health facilities, insurance facilities and work place policy for disease care and control like TB, HIV etc. Such workers are solely dependent on the relatively expensive private health sectors (including quacks and unqualified medical practitioners) for their healthcare.

- Extreme apathy of the employers of the migrant workers for their well being and health services

- Accessing those migrants at their residences (source) and working places (destination) with the key messages of TB, DOTS and RNTCP is extremely challenging because of the geographically scattered areas and huge number of the migrants

- Women engaged in unorganized job sectors are particularly prone to tuberculosis due to continuous exploitation by the employers (lowest

wage rates, lack of nutrition, strenuous work for non-fixed hours, no policy for female workers).

C. **MDR/ XDR TB**

3. Recommendations

Basic Dots

- Strengthen the supervision of DOT's providers. There needs to be more regular training and on field supervision. Clear guidelines need to be developed and the involvement of NGO's at the block level.
- Enhancing Case detection by evolving a more active case detection strategies including volunteers and existing DOT's provider and their networks and by introducing contact tracing.
- The need for counseling TB patients is critical to their completion of the course of treatment and so it recommended that councilors be included both at the TU but also at the field level.
- There is a need for more robust monitoring and to redresses problems both at the block and the district level. The involvement of NGO's and civil society in this has been limited. It is recommended that NGO's be involved in this.
- The creation of state level and eventually a national level electronic data base of TB patients.
- Involvement of NGO's by the District TB Societies especially in the planning and the design of the District TB plans.
- NGO schemes: The main issues faced by NGO have been difficulty with released of funds on a timely manner resulting in cash flow problems. Many of the smaller regional NGO's have tended to drop out. We suggest that clearer and more precise operational guidelines be developed for the NGO schemes s

TB/HIV

- ACSM operational guideline and training module for the CSOs to support TB/HIV collaboration at community level
- HIV sensitization and training of the implementing partners of the TB partnership forum of the CSOs
- Coordination with NACO and SACS to facilitate TB training of the TI implementing CSOs, HIV outreach workers and private healthcare providers across the country
- Coordination with national, state and district level PLHIV networks for imparting TB training and education and enhancing their participation in the TB/HIV collaboration (already an activity of Round 9 GFATM TB Project)
- HIV training of the community DOTS providers to enhance HIV testing and counseling of the TB cases and providing necessary support to the TB cases who are co-infected by HIV

- Developing flip charts, tools targeting BCC of the affected and vulnerable communities
- Popularizing RNTCP-NGO schemes (how?)

Migrant Workers

- The ACSM program of RNTCP should work with the existing migrant workers' unions[1] in the urban set ups and sensitize them on TB, RNTCP and DOTS.

- The migrant workers should be mapped in the urban and peri-urban areas (construction sites, street dwellers, illegal residents along the railway tracts, brick kilns, sabji mandi etc.) and provided RNTCP services (like sensitization on TB, identification of suspected TB cases, referral and tracking) through community-based programs as part of the ACSM plan and activities.

- The TB component should be introduced into the existing HIV programs for migrant workers after collaboration with National AIDS Control Program.

- It is important to initiate advocacy and develop collaboration with Ministry of Labor for restoration of rights and entitlements of the poor migrant workers with special focus to women that can be also useful for communicable disease control and care like TB, HIV etc. The TB partnership members should do the important monitoring targeting especially the unorganized job sectors

- The ACSM program should provide support to the local level small and medium factories to develop their work place policy for TB control and care and help them to implement the policy

[1] Porters' union, Ricksaw pullers' union, Truckers' union, Auto-drivers' union, House-maids' union, Factory workers' union, Vendors' union, Hawkers' union, Barbers' union etc