RNTCP:

Over the years, India has made great strides in improving access to Tuberculosis detection and treatment across the country. India's Revised National Tuberculosis Control Programme (RNTCP), based on DOTS strategy, is being implemented through general health system of the states under the umbrella of National Rural Health mission (NRHM). The Programme is implementing all components of WHO Stop TB Strategy 2006 and has made great strides in achieving global targets for new smear positive case detection (NSP CDR) (70%) and treatment success (85%), as per the Millennium Development Goals (MDGs) and the related Stop TB Partnership's Global Plan (2006-2015).

The RNTCP has been one of the successful Public health Programs in India with a highly successful detection and cure rate. Recently, the program has shifted focus to provide universal access for Total TB care. In such a scenario of universal access, the non program service providers, both formal and informal become important stakeholders in the scheme of things. Effective involvement of these service providers would enable the program to go through the last mile in universal access.

Problem Statement

However, India still bears 21% of the global burden of incident TB cases and has the highest estimated incidence of Multi Drug Resistant-TB cases (MDR-TB) (131,000 out of global incidence of about 500,000 in 2007). Extensively Drug Resistant TB (XDR-TB) has also been reported from India. HIV prevalence among TB patients is reported to be 4.85%. With 70% of health care in India being provided by the private sector, it is of great importance that this sector is effectively engaged and included in the treatment of Tuberculosis. Private health care is rapidly expanding in India. Data from the National sample survey shows that the public health sector, to a large extent fails to provide the necessary outpatient services, even to the poorer sections of society[i]. The private sector on the contrary is popular and accessible. Private physicians are seen in India as the first point of contact for a majority of illnesses.

The private sector mentioned includes, allopathic, other systems of non allopathic medicine (Ayurveda, Hoemopathy, Siddha etc), traditional healers and pharmacists. Their involvement has been limited so far.

With large scale migration in India from rural to urban settings for economic reasons, it is the urban poor who access seek treatment for TB through private pharmacies and non –allopathic practitioners. With unregulated treatment practices, the MDR and XDR TB cases have emerged as a threat to successful TB treatment programs. These coupled with the stigma to HIV-TB cases (which make these patients seek treatment in the comfort and anonymity of these private sector providers) has made it ever so necessary to effectively include the preferred providers of the urban poor in the scheme of things for strengthening the TB program in India and improving coverage and utilization of services. The unhealthy and cramped living conditions in urban slums leads to transmission of TB within the migrant communities much faster. It is these groups of communities which have resisted seeking treatment in formal government settings in spite of concerted efforts by various programs for various reasons.

The Private Sector Service providers

Often, the private sector providers are seen as one entity. The 'easier-to-reach' allopathic physicians are taken as a major player in the formal sector. Most studies on prescription

patterns and practices provide information on the allopathic provider. There is very limited information available on the nature of services being provided by the other groups such as the formal non – allopathic physicians (AYUSH), the pharmacies and the other traditional healers, which often are the preferred and only service provider for a majority. Even in the allopathic sector, limited information is available about the large corporate hospitals providing TB care.

PPM

Various schemes being available for the Private physician through the national program, the uptake of these schemes have been sub-optimal. The reasons for the low uptake have not been properly understood with limited information and research findings. No straight-forward conclusion can be drawn. Expansion of PPM has been suggested as the answer to improve case detection and treatment. Studies have shown that lag time between first contact and referral to DOTS has impacted the outcome of successful treatment. Reasons for this delay are varied for different communities. Quite a few implementation projects including GFATM have included training as one of their activities in the involvement of the private provider. However, past experience and evidence suggest that training without any tangible output and deliverables for the private service provider would remain an incomplete exercise and achieve nothing in the long run. Training may have to be tied up with a two pronged outcome – i) referral to national DOTS program or ii) delivery of quality services as per nation national guidelines. In order to achieve both these outcomes the programs and schemes would require to have attractive incentives (financial and professional) and a compliant monitoring mechanism.

Steps forward

Further inputs are necessary for guiding the national strategy on expansion of the existing PPM schemes. The reasons for low uptake require further information gathering which might suggest the revision of the schemes. It is very necessary to differentiate the cadres of private service providers into formal (allopathic, non-allopathic, pharmacies) and the non-formal (other traditional healers and quacks).

While additional information is required on the following points before arriving at any conclusion in strengthening existing PPM programs, piloting of some PPM on a limited scale is recommended.

Studies

1. Treatment seeking behavior of the urban poor
2. Reasons for the successful implementation of PPM schemes in some areas and low uptake in others.
3. Understanding practice patterns of the non-formal service provider
4. Prescription audit in certain areas for prioritizing PPM

Pilot programs

5. Strengthening of training programs with innovations (incentives such as vouchers reimbursements, CME credits etc)
6. Branding of Good Private service provider
7. Involvement of the non-formal preferred provider