National Tuberculosis Control Programme in India

Health is a major contributor to poverty in India. Communicable diseases continue to account for nearly half of disease burden, of which Tuberculosis is among the most widespread cause of morbidity, disability and mortality. In order to address this large and costly burden of the disease, the Government of India is currently implementing the Revised National Tuberculosis Control Programme (RNTCP).

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The huge private sector in India comprises a wide range of providers from private medical practitioners in different streams of medicine, both modern and traditional including those having no formal training and para-medics. By using the experiences gained from the collaboration with NGOs and the private sector in RNTCP-I. Currently, 19,000 NGOs and 10,000 private providers are involved with the TB programme in a variety of ways. The Central TB Division published various guidelines for the participation of NGOs (in 2001) and private practitioners (in 2002).

Although TB affects all socio-economic groups in India, the disease is disproportionately borne by the poorest and marginalized sections of society. It often affects the most productive age groups, and can pull households deeper into poverty due to the long course of treatment and cost of drugs, as well as foregone productivity and wages. The World Health Organization (WHO) has estimated that annual TB incidence in India in 2005 was 209 new infections per 100,000 population. This translates to about 2.4 million new cases each year. Mortality due to TB was estimated at 36 per 100,000 population, or about 410,000 deaths annually (WHO, 2011).

The Government of India's (GOI) Eleventh Five-Year Plan (2007-12) included continued commitment to TB control and emphasized integration of RNTCP and other disease- specific programs into the National Rural Health Mission (NRHM) that was launched in 2005 (GOI Planning Commission, 2008). The World Bank's 2005-08 Country Assistance Strategy (CAS) described the planned program's contributions to the Millennium Development Goals (MDGs), and stated that because infectious diseases are of global concern, with Multi Drug Resistant-Tuberculosis (MDR-TB) presenting a particular threat, and that they disproportionately affect the poor, the World Bank would continue to support India's efforts to control TB and other diseases.

Project Development Objective

The objective was: (i) to achieve the global targets of 70% case detection and 85% cure rate in all districts of the country; and (ii) for the zones where Directed Observed Treatment Short-course (DOTS) has been under implementation for five or more years, the incidence of smear-positive TB starts to decline.

Main Beneficiaries

The main beneficiaries of the program were to be people infected with TB India, as well as their families and communities. In addition, groups who were singled out for particular attention were to be: (i) poor, tribal, and other "hard to reach" populations; (ii) HIV/AIDS patients; (iii) children suffering from TB; (iv) MDR-TB patients; and (v) TB patients who seek care from the private sector.

RNTCP services

This component aimed at consolidating and sustaining the quality of the RNTCP services that had been established across the country over the previous eight years. This included the following:
(i) Improvement in the quality of laboratory services, including establishment of intermediate reference laboratories (IRL), introducing a laboratory quality assurance (QA) system, and ensuring routine reporting of QA results in order to inform measures for improvement.
(ii) Improvement in supervision and monitoring, including field monitoring, a computerized management information system (MIS), surveys to estimate incidence, and staff increases in low- performing areas.

(iii) Strengthening of information, education and communication (IEC), including creating awareness among patients and heath care providers of the free-of- charge RNTCP services, advocating for commitment to TB control, and enhancing provider–patient communication.

(iv) Development of institutional capacity, including strengthening the Central TB Division (CTD) of the Ministry of Health and Family Welfare (MOHFW); developing managerial capacity at the state and district levels; supporting further decentralization of program management and strengthening staff in large and poorly-performing states, providing quality training, and supporting public and private medical colleges on Directed Observed Treatment Short-course (DOTS) training and implementation.

Expansion of RNTCP outreach to target special groups

This component aimed to maximize access to TB services by under-served and other vulnerable groups. This included the following:

(i) Improvement of coverage of poor, tribal and other "hard to reach" groups, including implementing activities identified by a social assessment (SA) and tribal action plan (TAP), using incentives for health staff in difficult and tribal areas, and providing additional financial and managerial support to poor performing areas.

(ii) Promotion of the involvement of private health care providers in RNTCP and DOTS provision, including continuing with ongoing public-private mix (PPM) efforts and drawing from their experience, developing a plan for further expansion of PPM, providing additional training, and undertaking operational research.

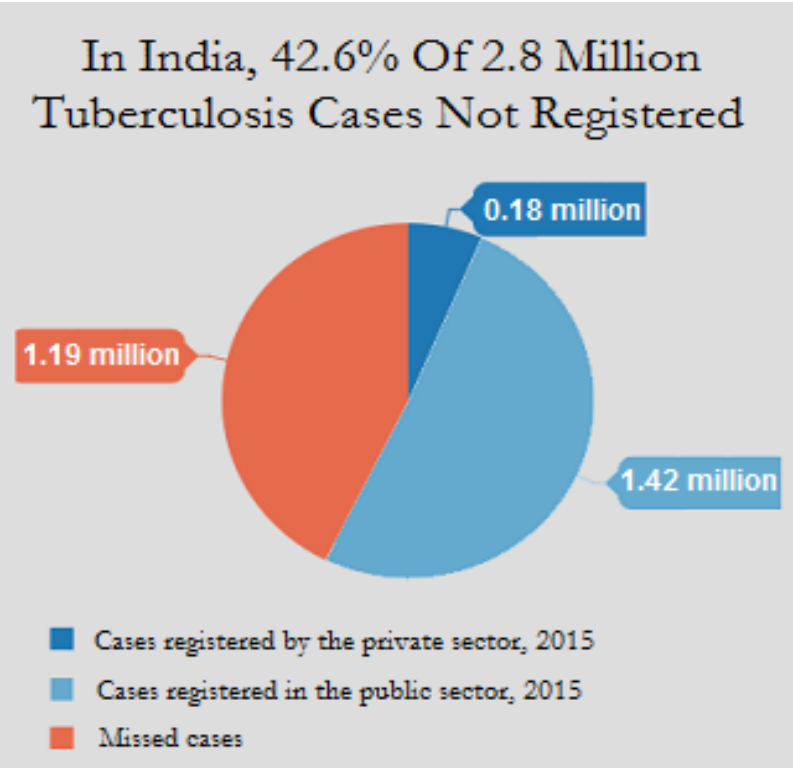
(iii) Deepening of HIV/TB coordination, including strengthening of joint planning, health communication, training, surveillance and case-finding, as well as increasing staffing.

(iv) Improvement in the care of paediatric cases, including introducing standardized drug regimens, ensuring availability of diagnostic facilities, training, and reporting.

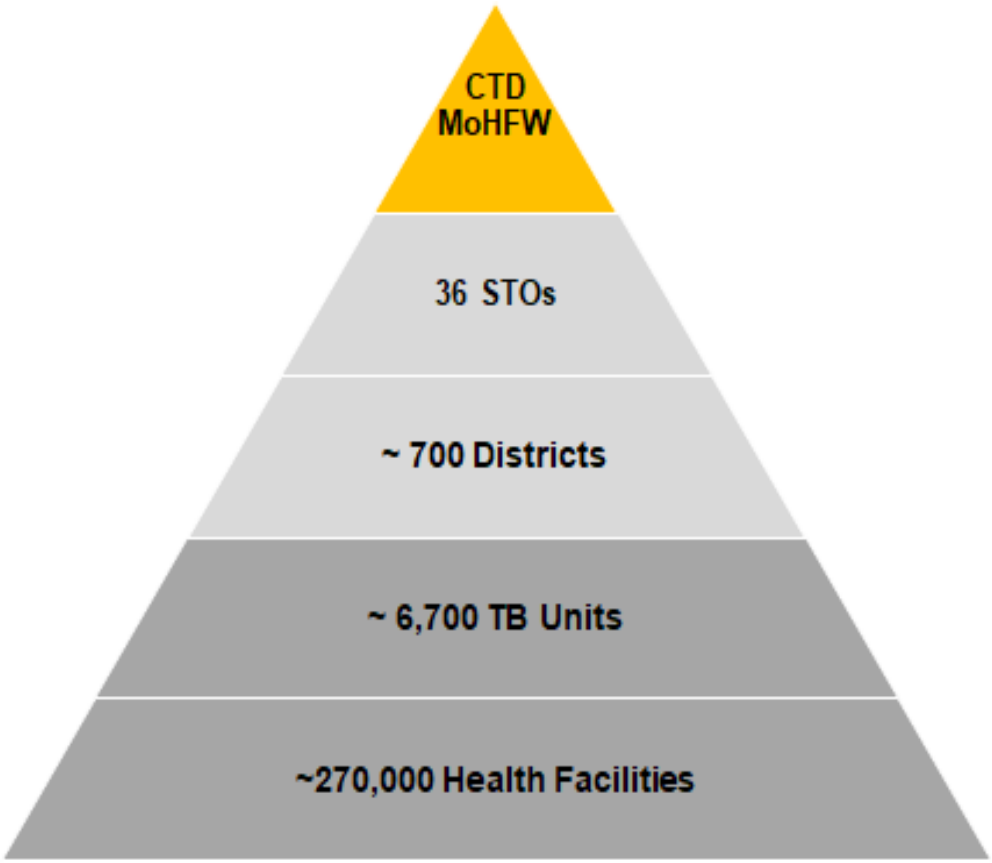
(v) Development of the program's response to MDR-TB, including establishing laboratory capacity, improving surveillance, establishment of clinical centres, and "gradual expansion" of access to drug resistance testing and MDR-TB treatment for patients who fail treatment under the RNTCP's base program.

Implementation

Establishment of institutional arrangements - Several institutional arrangements were established. These included: (i) decentralization mechanisms and expanding the role of State TB cells and TB Units; (ii) establishment of five additional units in CTD to manage supervision, human resource management, advocacy and communication, finance, and procurement and hiring of contractual staff; (iii) establishing an Empowered Procurement Wing (EPW) within the MOHFW; (iv) development of an Information, Education & Communication (IEC) strategy for hard-to-reach groups; and (v) development of a national PPM framework.



Strong supervisory and M&E system- RNTCP II was supported by a strong reporting system that has been in place for several years. The program had dedicated supervisory staff at the TB Unit (TU), state, district and national levels, who implemented regular and structured field monitoring. This well-established



system supported the problem identification process and technical support to states and expedited the progress towards achieving the set targets.

Effective partnership arrangements - Several bilateral and multilateral partners supported the RNTCP II, with each financing different activities in different states and districts. The GOI was successful in coordinating this support and in establishing one set of systems and procedures to be used by all. Joint Monitoring Missions were led by WHO every three years, while annual joint missions were organized by the World Bank. These provided a single forum for technical supervision and support to the program by the Bank and other partners.

Contracted technical assistance - WHO played an important role in ensuring supervision and technical assistance at the state and district levels. The role of WHO consultants was critical in providing technical assistance and supervision needed for project implementation.

Focus on governance - A Detailed Implementation Review (DIR) of procurement under health sector projects financed by IDA in India contributed to a 15-month period between appraisal and Board approval of the TB project (World Bank, 2007). As a result, procurement arrangements for the project were further strengthened, including out sourcing procurement management, and adopting various other accountability measures in the GAAP.

As per the recommendations of various monitoring missions, RNTCP has conducted various studies to study the impact and aid effectiveness. The Economic Impact Study conducted in 2009 under the program has shown economic benefits and aid effectiveness. Tuberculosis control has consistently been ranked as among the most cost-effective health interventions available, second only to basic routine immunization. The expansion of RNTCP from 1997-2006 was estimated to have the following health and economic impacts:

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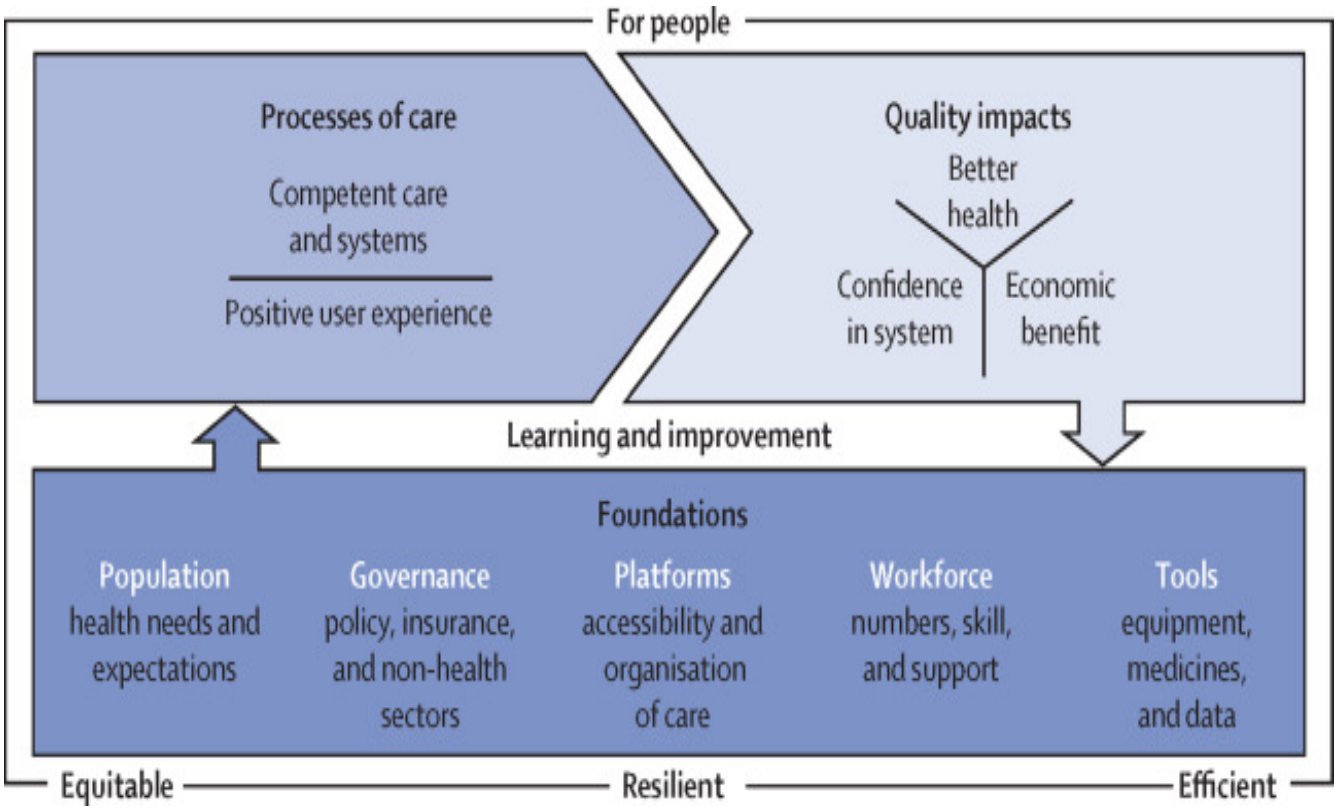

- 6.3 million TB patients diagnosed and treated, with 1.3 million deaths averted.
- Total health benefit of 29.2 million disability adjusted life years (DALYs),
- Total gain in economic well-being from TB control of US$88.1 billion
- Total public expenditure on TB control over this period amounted to US$768 million, with the RNTCP accounting for US$299 million and other health sector costs accounting for US$469 million.
- The cost of TB control average just US$ 26 per DALY gained over 1997-2006 and generate a return of US$ 115 per dollar spent.

Considering this, if the project would achieve its deliverables 2012-2017 of treating>8.2 million Tuberculosis (TB) patients with at least 88% success rate then an additional >1.3 million deaths (due to the Project) due to TB could be averted and approximately 30 million patients could be saved.

Conclusion

As per the recommendations of various monitoring missions, RNTCP with reference to the National Tuberculosis Control Programme, India has conducted various studies to study the impact and aid effectiveness. The Economic Impact Study conducted in 2009 under the program has shown economic benefits and aid effectiveness. Tuberculosis control has consistently been ranked as among the most cost-effective health interventions available, second only to basic routine immunization. The World Bank in their supervision mission of April 2011 rated the implementation progress of the project as highly satisfactory. The achievement of Project Development Objectives was also related as highly satisfactory by the World Bank. The foremost objective of the project was to shift the focus of TB control in the country to the new internationally accepted paradigm for management of TB, namely DOTS, which is highly successful.

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