RNTCP INDIA: JOURNEY FROM 1996-2002*

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Accessibility to the entire TB family in the country for 24 hours for all 365 days of each year from 1996-2002, hands-on monitoring meetings with all level of workers, random visits to peripheral centres and patients in their houses, balance between expressing displeasure and appreciation and lending shoulder to fellow workers were some of the pillars of success. At the same time initial slow expansion, delayed formulation of national IEC strategy, temporary suspension of disbursement by World Bank were some of the weak areas.

I am grateful to all, particularly to Dr. R.K. Srivastava, Chairman, TB Association of India, for having chosen me for Lupin TAI Oration award delivered at the 60th National Conference on Tuberculosis & Chest Diseases organized by TB Association of India — an institution with a global name and fame.

While talking of the journey from 1996-2002, this long period of 6 years retrospectively appears to be too short and it appears that 1996 was only a few months back.

At the onset, I would like to appreciate the excellent work done by National TB Programme (NTP) for more than 3 decades starting from 1962 by establishing basic infrastructure. Joint review of NTP undertaken by Govt. of India in partnership with WHO and SIDA in 1992 was an important landmark in the preparation for journey. This review revealed a treatment completion rate of about 30% and death rate of around 29%. Review also revealed managerial weakness, inadequate funding, over-reliance on x-ray, use of non-standard treatment regimens and lack of systematic information on treatment outcome. Addressing these deficiencies, Revised National TB Control Programme (RNTCP) incorporating DOTS strategy was conceived and successfully pilot-tested for technical aspects from 2nd October, 1993 in a population of 2.35 million at 5 sites in the States of Delhi, Kerala, West Bengal, Maharashtra and Gujarat. Thereafter, RNTCP was expanded to cover 13.5 million to test its administrative feasibility. I will be failing in my duty if I don’t mention significant contributions made by my predecessors for these successful pilot projects and particularly support given by Dr. Rohit Sareen, who worked full time at Central TB Division (CTD) in formative years of the revised programme.

In June, 1996 when I took over the programme, the first task that we faced was naming the programme. Since earlier programme was termed NTP, the revised programme was termed as RNTP. Tuning it with our goal of controlling TB, we renamed it as Revised National TB Control Programme (RNTCP). Before starting the journey we publicly addressed two most important issues of why & how RNTCP? DOTS strategy being successfully implemented by a large number of countries was also successful in all pilot projects in India. Since RNTCP fully addressed identified deficiencies in NTP
and had been demonstrated to be administratively and technically feasible in Indian context, it was considered appropriate to adopt it as national programme. For implementation of RNTCP at national level, we identified possible challenges and addressed each one of them step by step.

First challenge of bringing TB control high on political/administrative agenda was addressed by focused advocacy on gravity of TB problem by quantifying its affliction of morbidity, mortality and socio economic impact both on individual patients and society at large. RNTCP was projected as the most cost effective poverty alleviation intervention and developed a feasible implementation plan with well defined targets. All this was possible because of tremendous support from technical experts, WHO and other apex technical bodies including NTI Bangalore and TRC Chennai and veterans like late Dr. S.P. Pamra, Dr. D.R. Nagpaul, Dr. R.C. Jain and Dr. M.M. Singh who are sitting here. Dy. Director General (DDG - TB) was made a full time post in compliance to pre-conditions stipulated by World Bank for commencement of negotiations for soft loan.

Second challenge of mobilization of resources was addressed by motivating Government of India in making TB control a 100% centrally sponsored programme. This was very essential as 50/50 sharing basis between Centre and State was not successfully working. TB fraternity would remain indebted to Prof. J.S. Bajaj who, as a member of Planning Commission, played a pivotal role in making TB Control a 100% centrally sponsored project. We successfully negotiated a World Bank credit of 144 million dollars amounting to about Rs. 604 crores supplemented with counter funding of Rs. 144 crores and this historic agreement was signed at Washington on 9th December, 1996. Medical fraternity in India was honoured as this agreement of soft loan was probably the first agreement which was signed by a Doctor on behalf of the Union Health Ministry. I was simply thrilled at the formal credit agreement signing ceremony! Support from DFID & DANIDA in various manners in early stages was invaluable. At occasions they performed the role of “a stitch in time saves nine”. Subsequently GFATM and GDF also supported. All through these years, without WHO support the programme would never have reached this level. In the WHO Regional Office, the commitment and faith shown by Dr. JP Narain and also Stop TB Secretariat at Geneva had been exemplary. I must confess that without contributions from Dr. Tom Frieden and Mr. J.L. Castro it would not have been possible to undertake this successful journey. Tom was the trail blazer.

In ensuring adequate and effective utilization of resources and reducing administrative bottle necks, State and District TB Control Societies were constituted and funds from Centre were directly transferred to them. Financial norms for expenses under all identified cost centres for different levels were developed and funds released/monitored accordingly. Clear and comprehensive operational and technical guidelines were developed, some what field tested, printed and disseminated to all levels in sufficient numbers. I own short comings which hampered in efficient utilization of resources. With lack of experience in budgeting TB control programme based on new strategy for a country like India and a normal attitude of over budgeting, negotiated amount was over budgeted in almost every head. This was further compounded by initial slow expansion, delayed formulation of guidelines for NGO’s, PP’s and national IEC strategy. For non-compliance of some of the World Bank requirements, credit also got suspended and there was less spending by State and District staff who had no experience of spending as per World Bank guidelines.

Next challenge was adoption of DOTS by health providers. Before expanding we formulated technical guidelines covering all categories of staff working directly for the programme. To minimize the element of subjectivity, modular training material including role plays was developed. Specifications for quality binocular microscopes were developed by a team of experts and the same procured and provided at all microscopy centres.
which were established at least for every 100,000 population. However, this population norm was relaxed for difficult areas/hard to access population. With support from WHO, rapid sample assessment was undertaken to assess average expenditure required for upgrading existing laboratory services to undertake quality sputum microscopy. Due amount assessed on this scale was released to the District at the preparatory stage itself. Any support beyond this would call for detailed justification. DOTS adoption was further facilitated by removing bottle necks at regional and peripheral levels and by establishing effective problem solving channels. Problem solving monitoring visits were invariably made up to the most peripheral levels and solutions developed in consultation with peripheral and district level staff. DDG (TB) often became the spokesperson of the State, District & Peripheral level staff to their concerned authorities including District Magistrates, State Director and Health Secretaries. All channels of communication including telephone were always kept open irrespective of the official status of the person and all communications were properly responded. Decisions to be implemented by various partners were always taken in consultation with them. Guidelines for involvement of NGO’s, private practitioners were formulated only with consensus of respective bodies. Visit by Sir John Crofton in 1997 and addressing the concerns of mammoth gathering of medical college teachers initiated successful involvement of India’s medical colleges in RNTCP. Taking critics of the programme to the field including first independent programme review and transparency and universal accessibility to the data gave a lot of credibility to the programme.

However, all couldn’t be accomplished in this area also. Little focus could be placed on involvement of private sector. Consensus on developing technical guidelines for paediatric diagnosis and treatment could not be evolved. Inspite of the fact that urban health care lacks primary health care infrastructure, no interventions were incorporated at the project formulation stage. It was only when the programme in urban areas of Delhi, Mumbai, Ahmedabad and Calcutta didn’t perform well, we realized this weakness and then facilitated a policy decision of appropriate staff supplementation in such areas. Problems of HIV-TB and MDR-TB were also not adequately addressed.

Availability of full time STO and DTO were included as essential components of a successful district appraisal. Strict adoption of appraisal criteria covering successful completion of all appropriate preparatory activities including standard of training and availability of mobile vertical staff in the form of STS/STLS at all sub district levels was ensured and only successfully appraised Districts were permitted to start DOTS. I vividly remember of a District which I appraised and found training to be of not acceptable level. Inspite of the fact that all arrangements for DOTS launching function had been widely publicised, the District had to redo the entire training before DOTS was permitted to be launched. For this repeat training, even no per diem was permitted. Expanding coverage was always accorded a back seat to the quality of preparatory activities.

Inspite of availability of funds for deputation of STO’s to State TB Societies, no State showed any interest in this. Although provisions were made for vehicle hiring for Medical Officers at sub-district level (MO-TC) but he/she remained a weak link in the programme. Other unaddressed area was mismatch between posted LT’s and those at the designated microscopy centres. STLS, as an external staff was not always welcome. Lack of Medical Officers at primary health care centres and at occasions’ low referrals even from those available lead to low case detection.

Still by and large, we could build up cohesive and cogent teams at State & District levels and adopted a concept of National RNTCP family. Motivation of staff was ensured by deeds and not by words. Lead was given by example, always patted good work and supported useful ideas irrespective of the level of their genesis. Publicly ownership of success was given to the
colleagues and failures owned. Depending upon the opportunity, exposure within/outside the country were linked with the performance. Although we did adopt a policy of carrot and stick but a shoulder to cry was always available to all the members of RNTCP family. WHO consultants were made self sufficient with all support essential for discharging their assigned job responsibilities. These consultants played commendable job and have been back bone of the programme. Other interventions supporting provision of quality services included equipping all DTOs and STOs with fax/computer/internet facilities.

Appointment of independent procurement agency on turnkey basis not only ensured quality assurance and smooth procurement but also relieved DDG (TB) from nitty gritties of procurement procedures resulting in availability of more time for technical issues and monitoring key areas of programme. Quality of laboratory services could not be monitored well due to delayed development of external quality assurance protocol. Delayed hiring of independent quality assurance agencies for drugs, sub-optimal utilization/operationalisation of State TB Training and Demonstration Centres (STDCS) and lack of District level supervisory visits immediately after start of service delivery were some of the other weak areas of quality assurance.

For ensuring convenient DOTS services, complete flexibility in choosing DOT providers including encouragement to community through payment of incentive was provided. Financial and technical norms for most interventions were relaxed for difficult/hard to reach areas and under privileged population. Social mobilization enhancing community awareness was encouraged and so was the involvement of other sectors. Beyond sticking to five principles of DOTS, local authorities were encouraged to find, assess and implement local and focal solutions. Some of the weaknesses which hampered reaching every patient resulting in low case detection included delayed formulation of Central level IEC strategy, interventions beyond relaxation of norms for hard to access areas and marginalized population. Similarly prioritizing quality services over rapid expansion resulted in initial slow expansion.

Starting from scratch, coverage of Indian RNTCP till 2002, when I took voluntary retirement from Govt. of India and thereafter is depicted in the following graph:

**Coverage of India’s RNTCP**
- starting from scratch

![Coverage Graph]

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Following could be termed as key achievements:

- Sound, modular training materials, technical/operational/financial guidelines developed, field tested and adopted
- Policy for involvement of NGOs and Private sector formulated in consultation with partners and documented.
- Expansion from ~18 million (1998) to ~500 million (2002) - the fastest expanding programme in world with quality services
- In 1999, Indian expansion of DOTS accounted for 1/3 and in 2000 & 2001 for over 1/2 of global increase in DOTS coverage
- Proportion of sputum positive cases confirmed in the laboratory doubled to that of the previous programme
- Treatment success rates tripled from 25% to 86%
- TB death rates cut 7-fold from 29% to 4%

In the end I would say that 6 years is a long period but I feel as if it happened yesterday. I am glad that DOTS is now available to a population of more than 1 billion of the country and programme continues to perform well in safe hands.

My vision on Global TB Control is eat TB, drink TB, sleep TB, do nothing but TB........to stop TB.