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Tuberculosis control in India: growing complexities for management

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In India, tuberculosis (TB) remains a major public health problem despite the creation of the Revised National Tuberculosis Control Programme (RNTCP) in 1997. India has 30 States and 6 Union Territories (UT), with 637 districts.¹ The Ministry of Health and Family Welfare (MoHFW) provides technical guidance and extends financial support to the RNTCP in the states and districts. For implementation, there are 697 programme management units (PMU) managed by District TB control officers. The onus of implementation remains with the general health system along with a few additional RNTCP contractual staff, and is supported by technical assistance provided by the World Health Organization (WHO).

As health is a subject of national importance, the focus on RNTCP implementation issues risks being sidelined, and its challenges remain unaddressed as the issues become diluted along with various national health programmes. We discuss some of challenges that we believe, if addressed appropriately, could strengthen the RNTCP.

First, as it is a centrally driven programme, the RNTCP is accorded varying levels of priority by the individual States/UTs, resulting in a lack of appropriate ownership. Sub-optimal administrative commitment to providing exclusive, full-time programme managers continues to plague the system. To meet the higher standards of programme implementation, such as 'composite indicators',² there is a need for dedicated full-time RNTCP managers at all levels.

Second, there is a fragile professional relationship between the contractual RNTCP staff and permanent general health system staff working in the field. The former are responsible for supervision and monitoring activities

and are considered as dedicated staff of a vertical programme by the permanent general health staff. These misplaced notions trigger hierarchical issues that lead to disharmony and disfunctionality. Discontent also prevails among contractual RNTCP staff as regards job security, salaries, lack of opportunities for promotion and lack of health insurance or other facilities. Technical assistance and support strategies also remain unclear.

Third, despite the robust guidelines in place for drugs and logistics management, the absence of real-time monitoring mechanisms has hindered the delivery of quality services.

Fourth, failure to devise strategies and leadership that can appositely and effectively engage the private and non-governmental sector has become a complex managerial problem.

Fifth, the health system is slower to adapt newer diagnostic technologies and treatment regimens than other high-burden TB countries.

Lastly, the complex imbroglio of fund flow and fiscal management within the programme precludes the effective and timely utilisation of money, thereby creating a vicious cycle of less expenditure and less disbursement, leading to compromised activities.

Feasible solutions to these complex managerial issues urgently need to be found for TB control to be effective in India.

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