Attracting and retaining staff for TB work - role of governments:

Experiences from India

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Presentation covers…

- Basic inputs required for implementing DOTS strategy
- Current challenges related to Human resource
- Role of governments in addressing the challenges
- Lessons learnt in implementing TB control programme in India

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Human resource inputs for implementing DOTS

Key areas requiring Human resource inputs:

- Quality assured laboratory services with trained lab technician for diagnosis
- Trained medical manpower for treatment categorization
- Trained, accessible, acceptable and accountable DOT providers for treatment under direct observation
- Trained supervisory staff at various levels to ensure systematic monitoring and accountability
- Manpower for effective Health Management Information Systems
- Effective drugs and logistics management for ensuring uninterrupted supply of anti-TB drugs

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DOTS delivery

To deliver DOTS services

- A functional Public health system is essential
- Effective Collaboration between Public and Private Sector - to improve reach and access to TB Care for all patients
- Community awareness and participation – to seek early treatment, improve treatment adherence and reduce stigma

Thus, TB control activities are human resource intensive and is primarily a programmatic and managerial challenge

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Challenges in attracting and retaining staff for TB work

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Challenges (1)

- Inadequate long term strategic planning for infrastructure & human resource - commensurate to the demands of the health sector

- Managerial capacity of programme officers
  - Programme officers primarily clinicians
  - No specific managerial and financial training
  - Authority not commensurate to responsibility
  - Multiple lines of reporting

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Challenges in the Public health system (2)

- Varied capacity of states in terms of infrastructure, human resource and finances
- Human resource gap
  - Limited availability of qualified personnel
  - Skewed HR distribution– urban/rural; economically developed/underdeveloped areas
  - Improper implementation of HR policies – salary, transfers, postings, promotions etc leading to
    - Low commitment and morale of personnel in general health system
    - Brain drain – geographical and across programmes
- Supervision and monitoring given low priority
- All health programmes delivered by a single health worker at grass roots level

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Inter-sectoral Challenges (3)

- Diverse health care providers
- No single forum for inter-sectoral dialogue
- Low participation of private sector in national programmes
  - Large proportion of TB patients seek health care in private sector
  - Unless they are reached, the programme would not have desired impact
  - Standardised TB management essential for TB control and prevention of MDR-TB

By addressing above challenges the governments can attract manpower, boost their morale and thus retain them in TB work.

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Strategies adopted by RNTCP (1)

- Redefining Organizational structure within the existing public health system
  - Streamlining decentralized programme management through formation of state and district societies (RNTCP Structure)
- Seeking political and administrative commitment from states
  - Advocacy with state authorities to provide full time TB programme officers at the state and district level
  - Ensuring minimum tenure of 2-3 years for these officers
  - Ensuring all key staff in place

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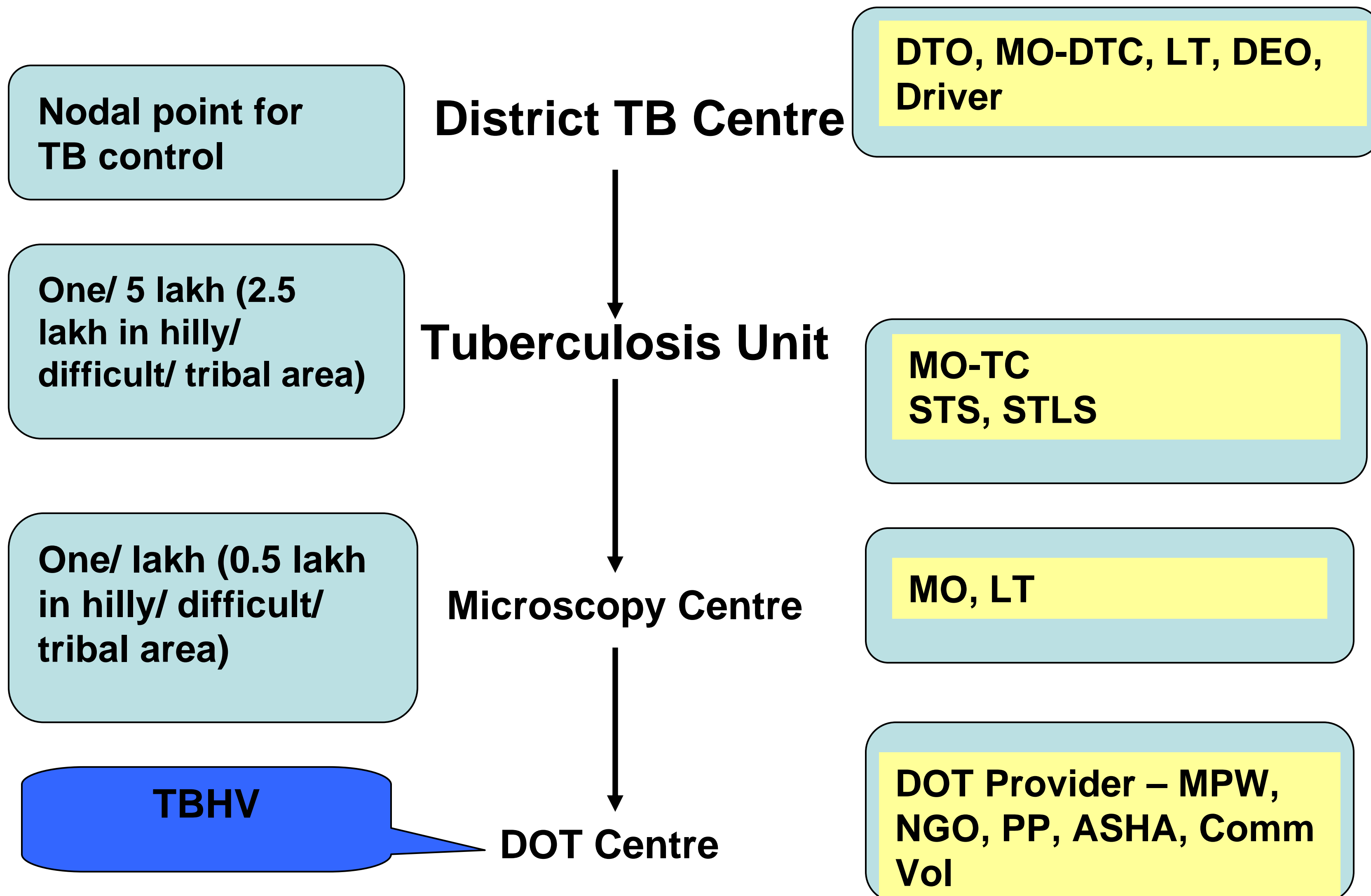
Structure of RNTCP at State level



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Strategies adopted by RNTCP (2)

- National Action for HRD
  - HRD Unit at national level supported by 3 National Institutes
    - to monitor vacancy, training & retraining, salary/financial incentives etc. (Review & Monitoring)
  - Defining roles and responsibilities for each level of health staff - ensuring clarity of purpose and accountability
  - Training Plan based on needs assessment
    - Training – induction, update and additional need based retraining
    - Use of standardized modular training
  - Supportive supervision to ensure increased commitment, enhancement of quality of work and morale (Tools for S&M)
  - Recognition of efforts at national and state level for programme managers

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Regular programme review and monitoring

- Quarterly review of staffing position & vacancy/ training/ supervisory activities through regular quarterly reporting system
  - Quarterly feedback sent in from states to districts and from centre to states – identifying the gaps
- Monitoring of
  - Financial management – regularity of payment of dues to contractual staff (Salary and POL allowance)
  - Performance of staff – TU/DMC wise analysis/ supervisory visits
- These issues are regularly reviewed and monitored at the highest administrative levels during quarterly and biannual review meetings

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Supportive supervision

- Detailed Supervision and Monitoring Strategy
  - Pre-defined supervisory protocols for all programme staff
  - Supervisory registers developed and placed at all PHIs
  - Supervisory and Monitoring checklist
  - On the job sensitization and training
  - Performance appraisal of key staff
  - Systems for regular central and state level evaluations

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Strategies adopted by RNTCP (3)

- Capacity building of programme managers
  - Training on Programme Management; Financial and logistic management; Leadership; and Communication (IPC)
  - Administrative empowerment to guide programme activities at the state and district level (Member secretary of STCS/DTCS)
- Recognition and documentation
  - Publication of success stories in Annual Report, recognizing good performance
  - Awards to dedicated workers on World TB day
  - Opportunities for representing state/country at national and international meets

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Strategies adopted by RNTCP (4)

- Contractual staff for filling up essential/key human resource gap
  - Special cadre of staff for supervision & monitoring (STS/STLS)
  - Additional manpower to support state and district programme management units – Medical Officer, Accountant; Data Entry Operator;
  - Clearly defined qualification requirements, induction training and Terms of Reference
  - Renewable annual contracts – linked to performance appraisal
- Budgetary provisions made for:
  - Competitive pay scales
  - Annual pay raise linked to performance
  - Paid casual leave
  - Ensuring mobility for supervision - by providing vehicles/ funds for vehicle hiring / POL

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Addressing HR gap through Partnerships

- Programmatic need for main streaming health care providers in other sectors
  - In-spite of a vast network of public health institutions, there is a gap in terms of provision of equitable services to the population – especially in tribal, hard to reach areas and amongst the marginalized population groups
  - Private/NGO sector have a wide reach as well as acceptability in the community where public sector has limited penetration (infrastructure/ human resource/ popularity)
- Health care providers from other sectors (NGO/PP) involved in the planning process as members of the district and state TB control/health societies

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Partnerships (Contd.)

- Special schemes for involvement of NGOs and PPS developed in consultation with representatives from these sectors
- Specific areas for partnerships identified
  - Advocacy and awareness generation
  - Provision of diagnostic and treatment services
  - Manage TUs or DMCs
  - Act as DOT providers
- Grant in aid and commodity assistance
- Capacity building through training, seminars and Workshops
- Recognition of efforts by process of Certifications/ rewards etc.
- Results of Pro-active advocacy
  - Over 12,000 PPs, 2000 NGOs, and 120 corporate houses involved
  - Health facilities in other ministries viz. ESI, Railways, Coal & Mines, Ports, etc., involved.

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Encouraging Community Participation

- RNTCP encourages community participation for social mobilization, advocacy, and to address the public health gap for decentralized DOT provision
- Community volunteers – VHG/ASHA (Health) / AWW (ICDS) as well as general public involved as DOT Providers.
  - Training and supportive supervision to build capacity
  - Financial incentive for community volunteers for working as DOT providers on successful completion of treatment by the patients
- Recognition of efforts
  - By the patient and family members
  - By the community
  - By the programme – honorarium/ awards

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Achievements of RNTCP

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Population covered under DOTS and total TB patients put on treatment in each quarter

Total patients treated
Population coverage(in millions)

Over 6 million TB patients initiated on DOTS

>100,000 patients put on treatment every month

≈1.3 million patients put on treatment in 2005

364799

Population covered (millions): 0, 200, 400, 600, 800, 1000, 1200

Total patients treated: 0, 50000, 100000, 150000, 200000, 250000, 300000, 350000

Quarter/Year: Qtr1-94, Qtr3-94, Qtr1-95, Qtr3-95, Qtr1-96, Qtr3-96, Qtr1-97, Qtr3-97, Qtr1-98, Qtr3-98, Qtr1-99, Qtr3-99, Qtr1-00, Qtr3-00, Qtr1-01, Qtr3-01, Qtr1-02, Qtr3-02, Qtr1-03, Qtr3-03, Qtr1-04, Qtr3-04, Qtr1-05, Qtr3-05, Qtr1-06

Annualized new smear-positive case detection rate and treatment success rate in DOTS areas, 1999-2006 *

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Qtr1-99 Qtr2-99 Qtr3-99 Qtr4-99 Qtr1-00 Qtr2-00 Qtr3-00 Qtr4-00 Qtr1-01 Qtr2-01 Qtr3-01 Qtr4-01 Qtr1-02 Qtr2-02 Qtr3-02 Qtr4-02 Qtr1-03 Qtr2-03 Qtr3-03 Qtr4-03 Qtr1-04 Qtr2-04 Qtr3-04 Qtr4-04 Qtr1-05 Qtr2-05 Qtr3-05 Qtr4-05 Qtr1-06 Qtr2-06

Annualised New S+ve CDR   Success rate

- Population projected from 2001 census
- Estimated no. of NSP cases - 75/100,000 population per year (based on recent ARTI report)

Summary and future challenges

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Summary

- Human resource is a constraint in TB control
- RNTCP has made efforts to address this constraint
  - Capacity building through standardized training
  - Strengthening of public system through additional contractual manpower
  - Public private collaborations
  - Involvement of community volunteers
  - System for supportive supervision, monitoring, evaluation and
  - System for recognition of good performance

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Future Challenges

- Cross hiring of staff across programmes – Brain drain
  - Higher pay scales in HIV/AIDS programme
- Rapid turn over of staff
  - With in the public health system – due to transfer policies
- Mal-distribution in rural areas
  - weak general health infrastructure and system
  - Lack of incentives (increments/promotion - within the government system)
  - Poor quality of life – fail to attract manpower
- Poor attitude of section of workforce – including physicians – emphasis on clinical work/ inadequate supervision
- Failure to address HRD as a management issue – work distribution/ satisfaction/ growth/ pay scale etc

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Thank You