Central unit - does not organise the wide consultative meetings as PUB did
- does not liaise adequately to the states / the field to motivate field staff
21/8/97
= does not press for integr. / financial integr. - state officers do not even follow the budget
= no mechanism of live contact c̄ street level bureaucrats

NTI Library
23/2/96

IMPORTANT CIRCULARS FROM GOVT OF INDIA REG NTP

1. Sub: Various aspects of launching + revitalising Nat. TB Progr.

Dr B N M Barua, Adviser in TB for DGHS, 26/4/77, DGHS UO No 20-11/75-TB

In contn. of UO dted 20/4/77 copies of

a) Lesson plan for Trg MPW's for NTP, and

b) Role of PHC's in NTP and guidelines of the NTP lesson plan for the Block Level Medical officers — forwarded + to be passed to Dept of F.W. for incorpn. to trg manuals + job specifications + to all States/UT's + H+FW Trg Centres + other MPW Trg Institutes So that services expected esp. from these field workers in respect of TB control Progr. is highlighted.

Role of MPW in NTP integr. c̄ their gen. work. entails a minimal work load

i) Ask all pts for presence of chest symptoms

(This was later removed from job resp. when positivity rates went down)

ii) Collect spot sputum specimen from each symptomatic, prepare smear fix it + send to PHC along c̄ malaria slides

iii) Advise all persons c̄ chest symptoms to go to PHC for exn. / Rx

(not done)

iv) Help TB pts on Rx to complete Rx satisfactorily c̄ help of their families

v) Vaccinate newborns + other unprotected children c̄ BCG

(not done)

vi) Include TB info. in routine HE.

(Symp - cough 2 wks, fever/chest pain 4 wks + haemoptysis

2 lessons < 1 hr 40 min c̄ practicals

content, time in mts, method of presen., media covered

(detailed specifics)

(Intro. - chr. infectious dis, curable, preventable, case finding symptomatics, DSM, advise, prepn. of sp. smear, sputum, disposal of sputum cups, Rx - regimens, regularity, dosage, durn, uninterrupted Rx, SE, Motivation, Defaulter-action, BCG, 4 principles of NTP, How DSM Rx + vaccine are done from a PHC. Recap + dis., Role of MPW's + PHC's)

PTO

b) Guidelines – NTP lesson plans – Block level MO's. – based on 4 factors
TB an accepted activity of PHC's, NTP integ. c GHS as a routine not specialised activity, minimal workload for MPW's, PHC MO's are trainers + supervisors of MPW's hardly occurs – to check
MPW duties a) as earlier "This would be specifically relevant for MCH/FP work + fit in c minor ailment Rx responsibilities"; (b) encourage pts + family members to complete Rx – pos'g advisory rel. of MPW's c families. (c) BCG to newborns/unprotected children d) HE free Dx, Rx + prev at PHC level
only 2-3 pts / average village
Control – public hlth problem – clin of tiredness – CF – sp. 1/2 repeated if once – ve + if still -ve → ref to DTC for xray, dom. Rx – 5 regimens 12-18 mths,
danger of res, no need for isol., hosp., diet, bed rest.
Prior. notif. – PHC MO, subseq. notify by drug defaulters.
Motiv. – MPW's tracing TB pts – BCG – newborns + unprotected under 20 yr olds – introduced as early in life, no revacc.
does not occur NTP – free services as close to pts home. Organis. – DTC – PHI's managed by DTC team, HE by MPW's
Role of PHC's – major public health prob next to malaria
Prev – 16/1000 xray, 4/1000 sp +, urban-rural, sp + / av. dist 5000
Per PHC – 300 – Physical, psychol., social + ec. suffering caused
NTP – aims to control TB + alleviate suffering.
DTP – basic unit of NTP – basic admin unit of country – DTC + SD PHI's as function – plan, implement + maintain DTP in entire Dist – not done
Team – DTO, LT, TO, XT, SA, BCG team leader (NMTL).
CF – MO need not physically examine pt before sp ex.
PHC microscopist or any of the PHC staff who does not leave the PHC is trained by DTO/LT, besides providing supplies – sputum cups/stains – MO daily supervision LT mthly
Rx

R1 - INH 300 + T 150 mg simple/2 doses   Self-admn. after meals
INH preferably single dose   mthly.

R2 - INH 6-700 mg SM 0.75 - 1g.   BDT direct supervised biweekly
Pyridoxine 10 mg if prescribed
R3 - INH 300 mg + PAS 10g.   2 div doses orally (H-one) Self-admn. after meals
R4 - INH 300 mg   single dose orally
R5 - Two phase chemotherapy
for seriously ill pts - initial intensive chemotherapy for SM/INH/PAS or T
for 8 wks foll by 2 drugs for remaining period
Sp -ve, Xray +ve. - R1 if extensive/cavitary dis
- R4 for others sufficient (more like chemoprophylaxis)

Defaulter Action - postcard / home visit by MPW.
Mthly visit by PO (This entire supervisory system scarcely exists)
BCG - direct, freeze dried, intradermal
Role of PHC MO - 1. Select symptomatics from PHC OPD for sp ex.
2. Prescribe Rx + intimate pt Aced as TB
3. Train & guide MPW's - rep symptomatics, Rx compl., BCG
4. Supervise day to day work of microscopist, drug distributor & MPW.
Role of Supervisors of MPW's - (1) That MPW's understand TB & NTP
(2) That they examine abt symptomatics, make smears, refer pts to PHC
(3) Hand over names of defaulting pts to them (from PHC) for home visits, re[illegible] (4) ensure that MPW's cover newborns + those below 20 yrs c BCG.
Role of MPW's under NTP 1. Abt 3% of pop - likely abc, these symptomatics
2. 2-3 pts/village c TB - develop close rapport bet. them
3. 50% pop. below 20 yrs. some need BCG + annual birth rate of abt 4% to be covered.

(2) DGHS (EPI Section) --> All DHS State/UT's, All STO's, All State EPI Officers

13th April 81 — BCG vaccn of children

Conse to dtd 19/2/81, under MPW Scheme, HF(F) Recommended BCG vaccn in intensive area of 5000 pop. Remaining area HW(M) BCG Technicians & exclusive BCG Teams to have MPW's. While theoretical & pen tp is part of regular MPW tp as per guidelines of Rural Health Div of M/O H+FW, practical tp to be given on the jobs (urban PHC's) by BCG Technicians intermittent (intended) ing.

It would be appreciated if steps are taken for coverage of childre below 1yr of age by BCG.

R N Bose, ADG (EPI)

(3) Letter No. 2200.9/4/82 dt 26/4/1982 from Sri C U S Mani, Addl Sec Health Min of H+FW, N. Delhi to all Health Secretaries.

Subj: Twenty Point Progr - NTCP 1982-83 Target

In consultn Dr S P Gupta, TB Adviser, DGHS, it has been decided that 1982-83 target in respect of NTP should be expressed in terms of no. of new TB pts to be detected in States/UT's, so far as your State/UT is concerned this has been determined at 60,000 new TB pts to be detected during the year

In consultn your State TB adviser you may kindly work out a month wise distribution of this target for maintaining purposes & let me have a copy of the same. You may also make a district wise distn of this target.

To achieve the target it would be expedient that

a) every PH+HI and PHC's in the Dist (where lab/outlets have been provided) undertake at least 2 sputum exn/working day of new pts (chest symptomatic aged 20yr or more, suffering chr cough & expectn of ≥ 2 wks dur or sputum of blood)

mechanism

b) in Distt where MPW scheme is implemented, each MPW identified at least 2 chest symptomatics every week (during field visit) collect their sputum on the spot, make smear, fix it & send it to the nearest health unit: where lab. facilities are available for microscopy

c) Pts (chest symptomatics) found to be repeatedly sputum be ref. to DTC/HI for x-ray / other investi.

In regard to Rx activities, you may kindly issue instructions that will ensure that a) all pts found to be suffering from TB are put on dom. Rx + (b) at least 80% of pts put on Rx take ATT regularly for the prescribed period of time.

(4) 16th March 1983, from CVS Mani, Addl Sec. To All Health Secrs.
Sub - 20 Point Progr. NTP 1983-84 targets MH+fw,
I am to DHS to send up to DGHS AIT. Dr SP. Gupta to ADG TB, ADG TB,

1. Ref. Director by name, Director NTI.
Vide this ministry's letter of 28/4/1st May 1982 target for detection of new TB patients in your State during 1982-83 was communicated. Detailed guidelines were also stipulated in the aforesaid letter eg. involvement of PHC & HI's incl. PHC's & MPW's in diagnosis & Rx activities under the progr.
2. For 1983-84 it has been decided that the targets of detection of new TB pts pertaining to your State/UT has been indicated in Annexure I, top-down
3. You may please be advised that the no. of new TB cases to be detected includes both sputum +ve cases as well as x-ray +ve but sputum -ve cases & the info has to be collected & compiled accordingly & only the consolidated figures has to be furnished by you to this Ministry
(On this basis was this made)

(5)

3. In accordance to the decision taken in the Health Secretary's meeting on 21-22 Jan 1983 it has also been decided that targets for conducting sputum exⁿ of new chest symptomatics at PHC's may also be fixed in 1983-84. It was agreed to that every PHC may conduct 50 sp ex's of new pts suffering from chronic chest symptomatics (!) + attending the OPD of PHC's (aged 20 yrs or more c chr cough c expectoⁿ of > 2 wks durⁿ or spitting of blood) per month! Targets for sp. ex at PHC's of your State/UT indicated in Annexure II during 83-84

4. Above target fixed exclusively for PHC's. Work done at TB Centres, Gen Hosps / dispensaries / other peripheral medical institutions is outside this target. ∴ Monthly report on achievement against this target is to be in respect of the PHC's

5. You may also please make District-wise distribution of the above targets keeping the existing facilities available in each of the dist.

6. It is requested that the mthly progress of the achievement of the above mentioned targets may please be sent regularly by the 15th of each mth. c foll info.

a — No of TB cases detected during mth under report

b — No. of sp ex cond. of new chest symp's at PHC's .. .. ;

c — No of sp +ve cases (new pts) detected at PHC's out of no. of sp. ex's conducted.

(Strong sense of power, of Govt functioning, centralised top down functioning
This lot out of touch c probs of focussing only on numbers in BCG campaign. ∴ Shd lth be made a public affair — look after peoples basic needs

Target for new TB case Detection 83-84 — 12,50,000 All India
75,000 Karnataka | Cld achieve

No of PHC's as of 1/4/82 — 5,739. Kar 305

IMMEDIATE

(5) From Dr SP Gupta for DGHS -> All MO's i/c State run DTC's, State run TB clinics receiving anti TB drugs / miniature x-ray films from DGHS under 'Plan Scheme' 11th April 1983.

Sub Revision of procedure of supplies ref. - A TB drugs & min Xray films

Minor procedural change

proposed / not implemented

Apathy & wastage & lack of info

Above released by DGHS directly to centre/clinic on a 6 monthly basis on receipt of drug consump^n report for period ending 30th June & 31st Dec each year - prescribed proforma. ∵ of long time delays before drugs reach the TB Centres from the Govt. Medical Store Depots + considerable work involved in the Directorate in processing individual requests & subsequent despatch of drugs to hundreds of medical centres throughout the country, it is decided that anti TB drugs would now be supplied directly to State DHS once a year for further distri to TB centres under his control.

Procedure - Proforma A in Sept-83 c̄ stock of drugs as of 31st Aug 82, consumption of drugs during the period, balance, also for 83-84. Send them to him by 15 Sept every yr & he will send a consolidated list to DGHS by 1st week of Oct.

Sanatoria & hospitals to get drugs supply by States

Meant only for domiciliary Rx. On receipt make arrangements for distr to PHI's participating in DTP

Recommended regimens same as earlier

R3 - INH 300mg + Ethambutol (dose 20mg/kg) daily

* SM (sulfate) in 0.75 gm is just as effective and less toxic than 1 gm esp in pts >40 yrs in whom vestibular toxicity - more frequent.
Ensure that facilities for proper admin of inj's are available & they are willing to come to the Centre for free inj's.

* Regimens of INH 200mg - 300mg daily & SM 0.75/1gm twice or thrice wkly are not sufficiently effective & are not recommended.

* Sp-ve x-ray + ple — H300 + T. C rptd examn for confirm of Dx.
· Highest priority for proper & effective Rx of confirmed cases of PT
d Durn. — Min. durn 1 yr, if interrupted for 3 mths or more during 1st year — shd continue for atleast 1 yr when Rx is restarted. Optimum period of uninterrupted chemoth is 18 mth — 2 yrs. Beyond 2 yrs chemoth. confers no extra benefit.

Response to Rx — assessed by Sp. smear ex. at regular intervals
+ve smear at 6th / subsequent mth during course of chemoth indicates either that the pt has not been taking adequate chemoth. or the bacilli has devd drug res. Rptd x rays for follow up / assessn of progress / response to Rx are not so reliable as properly conducted sp ex. at regular intervals. ESR of little value in either estab. Dx or in assessing progress.

Supply of Miniature X ray film rolls: — to the extent received out of SIDA Assistance and as per budgetary provisions made from year to year are also supplied at present from the Directorate to your centre under the Plan Scheme on a 6 mthly basis on receipt of the prescribed proforma. This proc. to continue forms to come by 15th July / 15th Jan.
This revised scheme already communicated to your DHS.
The receipt of this letter may pl. be acknowledged.

gradual, careful introduction, because of awareness of improper use & dev't of drug res.

Registered (9)

(7) 1st May 1986 From Dr SP Gupta To DHS Maharashtra, Guj, TN

Reg: Intro of SCC. Drug Regimens on a wider scale under NTP in the 3 States in a phased manner.

MoH+FW, GoI, vide telegram 6th Mar 1986 addressed to Health Sec of your State had informed that a meeting would be held at N Delhi on 14/3/86 to discuss the intro of SCC on a wider scale under NTP. This was held under the chairmanship of Sri PK Umashankar, Addl. Sec. Health, GoI.

After reviewing the progress of pilot studies in your State & detailed discn - reg various aspects of SCC, the unanimous view was that the stage has come when SCC regimens containing Rifampicin & Pyrazinamide may be intro under NTP in more no. of Dists of some States. The salient decisions were

(* Gujarat State Govt could not attend the meeting)

1. SCC may be intro as present in 3 States of TN, Guj + Mah, & States experience in the use of these regimens, more no. of dists in these 3 States may be considered for incl. in subsequent years & the possibility of introducing these regimens in some other States/UTs of the country may also be considered.
2. All Sp + cases in chosen dists may be offered SCC irrespective of HIV R & anti TB drugs in earlier mthe.
3. Pts living v. close to TB Centres/PHC's & who are prepared & give an undertaking to come to the Medical Institutions shd be offered biweekly intermittent supervised chemotherapy. Those who are unable to come or rightly fail to come may be offered a Short R. 2 mths of R+Z+H+E foll by HT / HE (if intolerant to T) for 6 mths.
4. Biweekly intermittent supervised regimen pts may be offered RZHE x 2 mths foll by RH biweekly for 4 mths.

SPG - manpower & skills

* decided that SCC be introduced presently in 7 districts in Gujarat, 12 districts of Mah & 7 dist. of TN.
* Kindly intimate the names of the districts of your State where you wish to introduce SCC during 1986-87 - restricted to nos. indicated above.
* Ensure that DTC's of concerned dists are functioning satisfactorily - i.e. full team of NTI trained staff whose performance has been considered v. satisfactory by you & essential X-ray, lab. equipment, vehicles etc in functioning order & sufficient amount of POL available to such DTC's to organise the activity properly on a div. wide basis.
* Requested to take immediate action. Requisite quantities of drugs like R + Z would be released to the chosen dists on receipt of info & after a final decision is arrived at in the matter in this Directorate. The value of drugs supplied to the chosen districts of your State would be adjusted against the 50% share of Central Assistance under Plan Scheme (Centrally Sponsored Sector) for TB Programme during 1986-87 & in subsequent years. It may also kindly be noted that there would be no other financial liability to the GOI on the intron of SCC in the dists finally chosen in your State & the assistance would be limited only to supply of INH ATT drugs & R + Z keeping in view the workload involved in each of the chosen dists & taking into account also the overall budgetary provisions made for your State under Plan Schemes during the year.

Further detailed guidelines esp. regimens & technical & procedural details will be sent to DTO's after learning from you.

Sense of urgency - probably d/o funding agency presume - deadlines

(8) S&C under DTP scheme - ? report from SCC (11)

(9) July 1987 Guidelines for intron of SCC in DTP

(10) 21/1/88 - ext'n of SCC drug regimens in phased manner during 1987-88
To DHS - from Dr AK Sen for DGHS cc - STO, JD (TB) DP/AD (TB), DTO concerned

1986-87 — Dists under SCC

Gujarat - 1. Ahmedabad 2. Bharuch 3. Jamnagar 4. Mehsana
5. Panchmahals (Godhra) 6. Surat 7. Surendranagar (contd.

Mah - 1. Ahmednagar 2. Akola. 3. Amravati 4 Beed 5. Buldana.
6 Dhule 7 Jalgaon 8 Kolhapur 9. Nasik
10 Parbhani 11. Sangli 12. Solapur

TN - 1. Chengalpat (Kancheepuram) 2. Dharmapuri
3. Periyar (Erode) 4. Salem 5. S. Arcot (Cuddalore)
6 Thanjavur 7. Tiruchirapalli

→ Ref. to Dy. Sec. ate letter dtd 3/9/87 - The full DTC's from your State have been selected for intro of SCC for RP + TB Case Detailed guidelines, DTP report + return form for SCC are being issued to concerned DTO's for furnishing periodic reports in prescribed format to NTI regularly for monitoring SCC.

Also requested that NTI trained MO, LT + TO (HV) be made available. Other DTC's of your State x-ray + lab equip in functioning order + vehicle in adequate pool so that more DTC's can be selected for intro of SCC in the ensuing years.

Matter may be RTed as most Immediate

(12) 75 DTC's for entry of SCC. during 87-88

AP - 7 - Anantapur, Cuddappa, Kakinada (E Godavari) Guntur, Krishna, Vishakhapatnam, Warangal

Assam - 3 - Dibrugarh, Kamrup, Jorhat

Tripura - 1 - Chest clinic Agartala

Bihar - 2 - Monghyr, Dhanbad

Gujarat - 4 - Amreli, Bhavnagar, Junagarh, Nadiad

Haryana - 1 Faridabad

HP - 2 - Mandi, Una

J+K 2 → Srinagar, Udhampur

* Karnataka - 5 - Chitradurga, Gulbarga, Chikmagalur, Hassan, Shimoga

Kerala - 3 - Coimbatore, Ernakulam (Cochin) Trivandrum

MP - 8 - Bilaspur, Chhatarpur, Chindwara, Durg, Guna, Hoshangabad, Indore, Shahdol

Manipur - 1 Lamphelpat

Meghalaya - 1 - Shillong

Nagaland - 1 - Mokokchung

Orissa - 4 - Baripada (Mayurbhanj), Dhenkanal, Keonjhar, Cuttack

Punjab - 2 - Ludhiana, Amritsar

Rajasthan 3 - Bharatpur, Dungarpur, Tonk

TN - 3 - Kanyakumari, Ramanathapuram, Tuticorin (Tuticorin)

WB - 3 - Malda, Jalpaiguri, Calcutta

UP - 14 14 Aligarh, Almora, Pratapgarh, Ballia, Gonda, Basti Banki, Mathura, Bulandshahr

No.T-18019/1/83-TB (D) REGISTERED

DIRECTORATE GENERAL OF HEALTH SERVICES

*****

Nirman Bhavan,
New Delhi-110011.

Dated the 27 December, 1985

To

The Director of Health Services of States/UTs.,

Subject:- Supply of Anti-TB-Drugs under 'Plan Scheme' to States/Union Territories run TB Centres for domiciliary treatment of TB patients - Revision of procedure of supplies - Regarding.

*****

Sir,

Kindly refer to this Directorate Circular letter No.T.18019/1/83-TB dated the 9th March, 1983, on the subject cited above. It may kindly be recalled that in the aforecited circular letter it was inter alia intimated that -

1.1 Anti-TB-Drugs would be supplied by this Directorate once a year after receipt of the consolidated indent from your office in the month of October each year alongwith a copy of the prescribed proforma duly completed in respect of the individual TB Centres of your State.

1.2 That, the entire stock of drugs meant for your TB Centres would be supplied in bulk to your State Directorate for further distribution to the individual TB Centres of your State in accordance to their work-load and requirements etc.

1.3 You were accordingly requested to take needful advance action for the receipt, storage and further distribution of the Anti-TB-Drugs to the individual TB Centres under your control.

1.4 During the last few months, a number of States have been representing to the Ministry of Health and Family Welfare/this Directorate, that they have no facilities available in their Directorates for the receipt, storage and further distribution of the drugs, if received from this end and that it will entail considerable expenditure to the State Governments for undertaking this work and additional staff and accommodation would be required and there would be considerable delay in the supply of Anti-TB-Drugs to the individual TB Centres. This matter was raised by some of the States in the Regional Health Ministers' Meeting also when it was requested that the earlier practice of supplying Anti-TB-Drugs to the individual TB Centres of your State/Union Territory by this Directorate directly may be continued in the interest of the smooth working of the scheme.

2. The matter has been considered in detail in consultation with the Ministry of Health and Family Welfare who have now decided to slightly modify the procedure, keeping in view the requests and view points of a large number of State Governments in the matter, and would be, as under:-

2.1 Anti-TB-Drugs would continue to be supplied only once a year to the TB Centres of your State by this Directorate.

Contd...2/-

2.2. The District TB Officer/Medical Officer Incharge, TB Centres of your State would furnish in the prescribed proforma (a copy of which was sent to you along with this Directorate Circular letter dated 9th March, 1983) in duplicate directly to you by the 15th of September each year duly completed in all respects.

2.3. One copy of the Proforma of each of the TB Centre of your State may then be sent by you under registered cover to the TB Section of this Directorate as early as possible in the month of October each year with your recommendations. It may, however, please be noted that Proforma of all the TB Centres of your State should be sent by you in one lot and not in piecemeal to this Directorate. Further it is not necessary now for you to prepare consolidated Indent for the State and send it to this Directorate. You are required to send only a copy of the proforma duly completed by each of the TB Centres under cover of your recommendatary letter.

2.4. The Proforma of the individual TB Centres of your State would then be analysed by the Office of the Directorate General of Health Services and Anti TB Drugs in accordance with the consumption, balances, workload and of course, keeping the total budgetary provisions made for your State from year to year, would then be released directly by this Directorate to the individual TB Centres of your State through our Medical Store Depots as per the practice followed in the earlier years. A copy of the release indent would, however, continued to be sent to you as before.

2.5. As already pointed put, the above modification in the proceddure of supplies has been made keeping in view the view points and requests made by a large number of State Governments in the matter. You would kindly appreciate that this would again considerably increase the work in the Office of the DGHS as supply to nearly 400 TB Centres would have to be arranged directly. You are, therefore, requested to extend your cooperation for the smooth implementation of the scheme by sending the proforme of all the TB Centres of your State in one lot(to whom you wish that anti TB Drugs may be supplied by this Directorate under 'Plan Scheme') and also to ensure that the proformae are correctly filled in all respects before they are forwarded by you to this Directorate so that unnecessary correspondence i is avoided. It has been our experience this year that though it was stipulated by us in our circular letter dated 9.3.83 that the proformae may be sent by you in the early part of October, a number of States had to be reminded repeatedly to obtain the requisite information and copies of the Proformae.

3. The proceddure regarding direct supply of miniature X-ray films to the TB Centres twice a year on receipt of their direct returns and the other guidelines as contained in this Directorate Circular letter dated 9th March 1983 referred to above remain unchanged.

Receipt of the letter may please be acknowledged.

Yours faithfully,

(DR.S.P.GUPTA)
for Director General of Health Services.

REGISTERED
No.T.18019/1/83-TB(D) dated the

Copy to _____ State TB Officer C/o Director of Health Services _____ for information and necessary action.

(DR.S.P.GUPTA)
for Director General of Health Services.