Public Health Action

International Union Against Tuberculosis and Lung Disease
Health solutions for the poor

VOL 7 NO 2 PUBLISHED 21 JUNE 2017

CORRESPONDENCE

How we ensured 100% TB notification: experiences from a private tertiary care hospital in India

P. Nair,[1] P. T. James,[1] A. Kunoor,[1] P. S. Rakesh[1]

http://dx.doi.org/10.5588/pha.16.0128

India's private sector treats an enormous number of patients for tuberculosis (TB), appreciably more than in the public sector.[1] Undernotification of TB by the private sector remains a major issue in India 4 years after mandatory TB notification was declared by the Government of India.[2,3]

Amrita Institute of Medical Sciences (AIMS), Kerala, is a tertiary care hospital with an annual patient turnover of 800 000 out-patients and 50 000 in-patients. TB patients were notified from 2012 onwards, at an average of 15 per quarter. We looked at reasons for incomplete notification in our hospital during February 2016 by conducting key informant interviews with doctors. Identified barriers to notification were misconceptions about notification, concerns about patient confidentiality, the workload involved in the notification procedure, fear of losing patients to the government system, lack of a notification system within the hospital and lack of coordination between the public and private sectors.

The motivation to notify all TB cases intensified when the Government of Kerala declared that patient confidentiality would be maintained for all those notified and that patients would not be contacted by the government system without the permission of the treating clinician.

All doctors working in our hospital underwent sensitisation through training and frequent communications from the hospital administration. To make the system more effective, a single window for TB notification, via a multipurpose worker and a Nodal Medical Officer, was established. Staff nurses were responsible for filling in hard copies of notifications from each department. Regular reports were requested from the microbiology laboratory, which reported all sputum-positive, culture-positive and cartridge-based nucleic acid amplification testing (CB NAAT) positive cases. The medical records department shortlisted patient details with international classification of diseases coding for TB on a monthly basis. Linkage was made with the nodal department for collecting and compiling weekly Integrated Disease Surveillance Project reports, which captures details of all probable and laboratory-confirmed communicable diseases among in-patients in the hospital.

We evaluated the completeness of TB notification on a monthly basis by comparing notifications with the list obtained from the pharmacy department containing details of patients to whom anti-tuberculosis drugs had been issued. Precautions were taken to avoid duplications by generating a line list. When in doubt, patient information was checked in the hospital information system using the patient registration number. All patient details were entered into the NIKSHAY web portal for monitoring TB patients using a password issued by the district health authority.[4]

With all these initiatives, the notification figure for the hospital increased from 14 in the first quarter of 2016 to 72 and 58 cases in the second and third quarters, of which respectively 54 and 42 cases were taking their anti-tuberculosis treatment privately. Of these, respectively 38 and 27 were extra-pulmonary cases.

Although it is possible that we might have missed some patients if they left the hospital without buying drugs or bought them from other pharmacies, we feel that this is a rare possibility as all AIMS prescriptions are electronic. Local public health authorities provided access to and training in NIKSHAY, helped conduct sensitisation sessions for doctors, ensured patient confidentiality and provided regular feedback.

This process highlighted how many cases with TB are missing from the surveillance system in India. It also gave us the opportunity to quantify the number of cases diagnosed with TB in our hospital and to take the initiative to offer them the services set out in the Standards of TB Care in India.[5]

Notification needs to be perceived as an essential tool for surveillance rather than a weapon for auditing the private sector. The vision of India's national TB control programme should be that people suffering from TB need to receive the highest standards of care and support from the health care providers of their choice. This should be possible, given that a recent study from Kerala, India, reported reasonably good TB management practices by doctors in the private sector.[6] The system needs to be made patient-centric by leaving the choices to the patients and promoting standards of TB care in both sectors.

References

1 Arinaminpathy N, Batra D, Khaparde S, et al. The number of privately treated tuberculosis cases in India: estimation from drug sales data. Lancet Infect Dis 2016; 16: 1255–1260.
2 Central TB Division. TB India, 2015. Revised National TB Control Programme: Annual status report. Central TB Division. Delhi, India: Ministry of Health and Family Welfare, Government of India, 2014. www.tbcindia.nic.in/showfile.php?lid=3166 Accessed June 2017.

AFFILIATION
1 Amrita Institute of Medical Sciences, Kerala, India

CORRESPONDENCE
P S Rakesh
Amrita Institute of Medical Sciences
Ponnekkara
P. O. Kochi
Kerala 682041
India
e-mail: rakeshrenjini@gmail.com, rakeshps@aims.amrita.edu

Conflicts of interest: none declared.

3 Nagaraja D B, Achanta S, Kumar A M V, Satyanarayana S. Extending tuberculosis notification to the private sector in India :Programmatic challenges. Int J Tuberc Lung Dis 2014; 18: 1353–1356.
4 Ministry of Health and Family Welfare. Guidance for TB notification in India, 2012. Delhi, India: Ministry of Health and Family Welfare, 2012. www.tbcindia.nic.in/showfile.php?lid=3139 Accessed June 2017.
5 World Health Organization. Standards of TB Care in India. New Delhi, India: WHO SEA Regional Office and Central TB Division, Ministry of Health and Family Welfare, 2014. http://www.searo.who. int/india/mediacentre/events/2014/stci_book.pdf Accessed June 2017.
6 Rakesh P S, Balakrishnan S, Jayasankar S, Asokan R V. TB management by private practitioners. Is it bad everywhere? Indian J Tuberc 2016; 63: 251–254.

Public Health Action (PHA) The voice for operational research.
Published by The Union (www.theunion.org), PHA provides a platform to fulfil its mission, 'Health solutions for the poor'. PHA publishes high-quality scientific research that provides new knowledge to improve the accessibility, equity, quality and efficiency of health systems and services.

e-ISSN 2220-8372
Editor-in-Chief: Dermot Maher, MD, Switzerland
Contact: pha@theunion.org
PHA website: http://www.theunion.org/what-we-do/journals/pha
Article submission: http://mc.manuscriptcentral.com/pha