

PROFILE OF DOT PROVIDERS IN PRIVATE SECTOR

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Summary - The essential feature of the DOTS (Directly Observed Treatment Short Course) strategy of the Revised National Tuberculosis Control Programme is provision for DOT providers who can ensure that treatment is taken by each patient under direct observation. Normally, this is made possible by requiring patients to attend the DOT Centre, as and where required, to receive treatment in person. However, a considerable proportion of patients prefer to receive treatment in the private sector, for which it has become crucial to organise a system for appointing DOT providers who can follow the RNTCP guidelines and observe drug consumption by privately treated patients. In Chennai, a non-government organization, ACT, has organized a group of 20 private practitioners who after simple training have set up a system of quality microscopy for diagnosis of tuberculosis and volunteer DOT providers selected by patient/practitioners for delivering drugs to patients under direct observation, mostly in their homes. ACT also provides a trained Supervisor to monitor all the aspects including DOT providers.

The preliminary findings of this study suggest that it is feasible to identify medical practitioners and DOT providers in the private sector who can be simply trained and whose services can be integrated with the governmental DOT centres under the RNTCP.

Key Words: private sector participation, RNTCP, DOT providers, NGOs in TB Control

INTRODUCTION

DOTS (Directly Observed Treatment Short Course) is the management package for effective delivery of health care services aiming at tuberculosis control. The burden of tuberculosis in our country necessitates the integration of anti-tuberculosis services in the private sector, for both case-finding and treatment, with the services under the Revised National Tuberculosis Control Programme (RNTCP), even though implementation of DOTS in the private sector poses a challenging task. The Advocacy for Control of Tuberculosis (ACT), a private registered society in Chennai, working in collaboration with the Tuberculosis Research Centre (TRC) is making efforts to meet this challenge, since its inception in March, 1998. Accordingly, ACT has launched a pilot project in collaboration with Chennai based private practitioners and has utilized the services of private DOT providers (DP) for implementing DOTS.

The functioning of the ACT Model for participation of private sector in RNTCP was planned as follows :-

1) ACT identified qualified independent, allopathic medical practitioners willing to participate in RNTCP through their medical association, and

by advertising in a prominent local newspaper. The practitioners were then trained by the TRC on RNTCP concepts and procedures.

- 2) Private laboratory technicians associated with those practitioners were trained in sputum microscopy for RNTCP including quality control. The practitioners referred their suspected pulmonary tuberculosis patients to these private laboratories for sputum examination. For histopathology and radiology examinations, the choice of laboratory was left to the practitioners.
- 3) When diagnosis of pulmonary tuberculosis was confirmed, the practitioner would reveal the diagnosis to the patient, instruct that treatment would be supervised and that the patient had to identify a reliable person, preferably a non-family member to administer the drugs (DP).
- 4) Thus, when a patient chose his DP and the DP was approved by the medical practitioner, all the three met the ACT social worker to arrange for drug supply.
- 5) Drugs were supplied to ACT by the Chennai Corporation and ACT channelised the same to the DPs.

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- 6) DPs were given hands-on-training by ACT social worker; they were told what DOTS stood for and the responsibilities of DPs in respect of DOT i.e. maintenance of records and carrying out follow up reviews. After getting a written declaration from each trained DP, the ACT social worker would hand over the drugs to the trained DPs for their respective patients.
- 7) The DPs maintained their patients' treatment attendance dates, days, and appointments for clinical and bacteriological follow up reviews. The Patient's Treatment Card was suitably modified for use by DP, as the practitioners gave the entire treatment responsibility to DPs.
- 8) Monitoring services were handed over to the ACT social worker, specially commissioned for this purpose. Monitoring included drug-checks, patient-monitoring for clinical and bacteriological follow up and DP monitoring as well as checking of their records.

Following the implementation of the Model, 20 trained private practitioners have treated 130 tuberculosis patients in one year i.e. from December, 1998 to November, 1999, entirely in the private sector but according to RNTCP guidelines. The TRC's study of the ACT Model is the subject of the present report.

OBJECTIVE

To study the profile and perceptions of privately chosen DPs, independently.

STUDY DESIGN

A list of all the DPs who had supervised treatment of their patients from December, 1998 to November, 1999 was obtained. They were interviewed by an independent TRC medical officer using a semi-structured questionnaire; Information relating to demography, awareness of disease, performance, perception and views on patient benefit, etc. was elicited during the interview. The responses were recorded as reported by the DPs and verified from ACT records, wherever necessary. The responses were coded and analyzed with SPSS package. This is an ongoing study and the interim findings are being reported now.

RESULTS

In all, 97 DPs were interviewed.

Relationship of DPs to Patients

Eighty three DPs had been chosen by patients, 12 by medical practitioners and 2 had volunteered of their own accord. Of them, 34% were family members, 35% were neighbours, 11% were ex-patients (identified for the patient by medical practitioner) and 20% were friends.

Demographic Profile

Of the 97 DPs, 52 were females; 56 were in the age groups between 31 to 50 years, the youngest being 17 years and oldest 76 years old; 80 were married; 87 were literate; 66 were employed holding different jobs; 31 were unemployed housewives; 76 belonged to the lower income groups.

Awareness about Tuberculosis and RNTCP

Out of 97 DPs, 90 were aware of tuberculosis, its affect on the community as an infectious disease, and on individual patient suffering from it; just 30 were aware of RNTCP and 54 understood DOTS. When further questioned about the reason for DOT as a treatment strategy, they (94) responded that it was to ensure regular treatment.

Performance of DPs - Responsibilities & Tasks

The responsibilities assigned to the DPs were direct observation of drug intake, drugs to be administered as a single dose, maintenance of records and ensuring of follow up for clinical and bacteriological reviews. All the 97 DPs responded correctly to the former three responsibilities, while only 62 responded correctly to the last one.

When their replies were compared with the tasks actually recorded as performed by them, it was found that only 80 DPs had observed the patients' swallowing the drugs, 11 had given drugs to patients and 6 to the family members; 85 gave the drugs in a single dose; all the 97 had maintained records; only 58 had gone for follow up reviews.

Awareness of Treatment Details

In all, 82 DPs were aware of the total duration of treatment taken by patients; 80 were aware of the

two treatment phases; 72 knew the duration of each phase of treatment and the number of drugs administered in each phase and 78 knew the treatment rhythm, intermittent during phase-I and daily during phase-II.

Location & Time of DOT

Regarding the place of DOT, 77 DPs gave the drugs to patients in patients' houses, 9 in their own homes and 7 in their work place (this included 4 private practitioners' clinics). As far as timing of DOT is concerned, 43 DPs gave drugs in the morning, 11 at noon, 2 in the evening, 31 at night and 10 at no fixed time of the day (as they gave DOT to more than one patient).

Duration of DOT

Of the 97 DPs, 67 gave DOT for the entire treatment period; the remaining 30 gave DOT for partial duration because of DPs' migration or patients' migration or adverse drug reactions or change in a patient's behaviour (due to alcohol and other habits) or patients' hospitalization or family reasons (mainly cultural) or change of DP or death of the patient. Patient's default was minimal. Except for 5 patients who migrated, any patient default was promptly recorded and corrected.

Problems encountered during DOT

of the 97 DPs, 65 did not confront any problem, 17 came across adverse drug reactions, 14 met with a change in patients' behaviour and 5 came across disease complications like haemoptysis or breathlessness. When confronted with these problems, the DPs informed either ACT or the attending practitioner personally or went along with the patient.

Interactions during DOT

Eighty seven DPs had interacted with the practitioner during the initial session i.e. at the start of treatment and 56 during the follow up reviews; 87 had interacted with ACT initially and 96 during the follow up i.e. during drug checking and forgiving patient information to ACT.

Of the 52 female DPs, 32 gave DOT to female patients, 19 to male patients and one to both the sexes. Of the 45 male DPs, 32 gave DOT to female patients and 13 to male patients. Each of 88 patients had one DP; only 9 DPs gave DOT to more than one patient and all these 9 DPs were identified by the practitioners.

Perception About Patient Benefits

The benefits enumerated by the 97 DPs were : regular treatment (88) free drugs, and thus an economic gains (82), less time loss (86), cure of the disease (64), improved patient compliance (45) and no loss of job or wages (38).

All the 97 DPs held the view that DOT should be the treatment strategy for all patients; 70 stated that confidentiality in treatment was needed, 72 said that social stigma persists; 94 said that they were willing to assist RNTCP in case-finding and providing DOT in future also. None of the DPs worked for a compensation, nor did they ever expect any return, monetary or otherwise, and they provided DOT without any fear of contracting the disease.

DPs Opinion about DPs

Fifty three DPs favoured a family member to provide DOT; 9 felt that medical practitioner himself should give DOT while 7 favoured any health worker for 'doing so; 54 reacted that any trustworthy person could provide DOT.

DPs Opinion of Health Sector

Seventy two DPs preferred the private sector because of better care offered by more responsible practitioners and spending of less time by patients; 20 preferred government sector for economic reasons, while 5 felt that the choice depended on the patient's needs and preferences.

Interim Conclusions

- 1. Though the number of DPs and duration of the study were limited, their performance demonstrates that DOT can be provided in private sector.**
- 2. No specific criteria are needed for the choice of DP; One DP to one patient relationship is practicable. Informal training is adequate.**
- 3. Frequent monitoring of DPs, as done by ACT staff, is essential.**

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