ACCESSING MEDICINES IN AFRICA AND SOUTH ASIA (AMASA)

The Foundation for Research in Community Health

Policy Brief

Access to medicines under India's National Disease Control Programmes: local study of TB, HIV and malaria medicines.

Medicines for treating three of India's key public health threats – malaria, tuberculosis and AIDS – are differently available within the national disease control programmes. Progress in controlling these diseases is heavily constrained by poor coverage in the case of AIDS and treatment for P. Falciparum malaria. There is a need to consider innovative solutions to reduce travel costs and improve drug availability.

Three National Disease Control Programmes – TB, malaria and AIDS – have been prioritized by the Government of India and implemented nationwide. These programmes seek to provide free drugs, based on a standardized regimen approved by national and WHO guidelines. Implementation of these programmes has called for strong political commitment and public financing.

A survey in four districts of Maharashtra conducted by the Foundation for Research in Community Health (FRCH) under the framework of the AMASA project (Access to Medicines in Africa and South Asia) during January to June 2012, investigated the outreach of the drug treatment provided by the Revised National Tuberculosis Control Programme (RNTCP); the National Vector Borne Disease Control Programme (NVBDCP)(but only focusing on *P. Falciparum (PF)* cases); and the National AIDS Control Programme (NACP). The survey found that a patient's access to treatment continues to be inhibited by the long distances and transportation difficulties in reaching a health centre.

The feature most influencing access to treatment in India is easier reach of the private sector services, which is currently utilized by 70 per cent of the Indian population. Barely 30 per cent go to the public sector. While the promise of free medicines makes the public sector more attractive today, many poor patients are unaware of this opportunity. The public sector has inherited a legacy of low patient confidence, as well as a history of interrupted supplies of medicines. Both the public sector and the unregulated private sector have a long record of irrational drug prescriptions by doctors, especially in TB control. The study found that with money, infrastructure and a highly motivated and trained cadre of TB workers, the RNTCP has percolated rural communities and access is fairly good compared with Malaria and HIV. However recent reports warn of a major looming shortage in the availability of first line TB drugs as the government has failed to procure TB drugs since 2012. The initial

Table: Distance (km) between residence and the health facilityfrom where medicine was accessed by patients.

	DOTS (Tuberculosis)		ACT (*P. Falciparum*, Malaria)		ARV (HIVAIDS)	
	Mean	SD	Mean	SD	Mean	SD
Mumbai City						
District	1.2	0.4	3.2	2.3	18.2	19.7
Dhule	1.6	1.1	4.9	4.4	24.0	23.6
Urban	1.3	0.6	3.0	1.6	12.9	17.9
Rural	1.9	1.4	6.6	5.5	35.7	23.6
Nagpur	2.5	2.8	6.2	4.5	34.7	34.9
Urban	2.9	3.8	--#	--	11.9	13.6
Rural	2.3	1.9	6.5	4.6	58.7	34.6
Sangli	2.1	1.8	4.4	4.1	27.7	27.4
Urban	2.0	2.0	3.2	1.9	5.3	5.5
Rural	2.3	1.7	5.1	4.8	47.0	23.6
Total	1.9	1.9	4.8	4.1	26.2	27.4
Urban	1.7	1.9	3.1	1.9	13.4	16.7
Rural	2.2	1.7	6.2	4.9	47.1	28.7

(DOTS – Direct Observation Treatment Scheme for TB; ACT – Artemisinin Combination Therapy; ARV – Antiretroviral therapy for HIV/AIDS; SD – Standard Deviation), # - sample size inadequate.

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impact of the programme however reveals the sharp drop in mortality rates from 28 percent before 1993 when the new programme began, to the current rate of 4 percent. (# The Hindu, 18th, 21st and 27th June 2013)

In contrast to the TB programme, the malaria programme (PF cases) is limited by the longer distances involved in travel to a public health facility. While malaria has a home diagnostic service, along with delivery of a standardized three drugs combination treatment by a special cadre of designated workers, their percolation at the community level appears to be less than that of TB. This gap is particularly evident in the diagnosis and treatment of PF cases, especially cerebral malaria cases.

To access the AIDS programme, patients have to travel the longest distance -- up to 58kms in rural Sangli. Antiretroviral (ARV) therapy is available at a centre situated in a medical college at the district headquarters far away, often requiring an entire day's travel time. The programme has not been decentralized because of the technical limitations of the treatment, which require supervision of the therapy by a qualified doctor and regular conduct of laboratory tests to monitor the presence of the virus in the patient's blood.

Access is defined as having drugs continuously available and affordable at public or private health facilities or drug outlets that are within one hour's walk of the population.* While the TB control programme has largely achieved that goal, it is not so in the case of PF malaria and even less so for individuals living with HIV/AIDS.

The study results show the need for improving public transportation links between the community and the health centre and reducing costs. This would facilitate access to all three national programmes. In order to reduce the gap in the achievements of the TB and malaria programme, further investigation is required in the financial and structural aspects of the programme. In the case of HIV/AIDS, patients should be provided free transportation while their incidental costs of travel (food; expenses covering the person accompanying the patient; loss of daily wages) need to be supported by the national programme.

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