Minutes of meeting of National Technical Working Group on HIV/TB Collaborative Activities at National AIDS Control Organization, New Delhi, on 21/04/2011

The first meeting of re-constituted National Technical Working Group (NTWG) was convened at NACO on 21st of April 2011. Dr.Mohammed Shaukat, ADG Basic Services Division NACO and member secretary of NTWG welcomed all NTWG members. Dr.Ashok Kumar, DDG (TB) chaired the meeting. He briefed the group members about constitution of the group and urged for regular meetings of the group in future and participation of all members. ADG/NACO further elaborated on terms of reference for the NTWG.

The list of participants is annexed at Annexure-1

The agenda for the meeting was as follows:

1. Review of intensified TB case finding (ICF) activities at HIV care settings
2. Review of Intensified TB/HIV Package implementation
3. Decisions on the issue of IPT roll-out in ART Centers
4. Decision on revision of TB-HIV documents in view of revision of RNTCP and NACO Programme guidelines
5. Decision on amending the RNTCP TB/HIV PPM Scheme (CTD)
6. Any other issues with the permission of chair

Following issues were discussed by NTWG and decisions taken are as below:

1. **Measures for improvement of Intensified TB Case Finding (ICF) activities at ICTC and ART centres:**

   The NTWG noted that ICF is being implemented at ICTC and ART centres in majority of states and UT. In ICF at ICTC apart from states like Maharashtra, Andhra Pradesh, Karnataka, Gujarat, Nagaland and Mizoram, referral of TB suspects is less than 5%. Similarly problems are noted with quality of reporting on NACO CMIS in several states. In ICF at ART centres TB/HIV reports from about 160 out of 291 centres are received consistently in 2010. Therefore NTWG recommended a need to strengthen implementation of ICF activity and to improve quality of reporting through following measures:

   1.1 DDG TB stressed importance of **strengthening TB/HIV collaborative mechanisms** at state (State Coordination committee –SCC and State Working group meetings –SWG) and district level (District coordination committee –DCC and monthly HIV/TB meetings) and urged NACO and CTD to take measures to strengthen reporting and monitoring of these activities at state and national level. A consolidated status report for the previous quarter may be

discussed in quarterly NTWG meeting. This information would be prepared by CTD, from RNTCP quarterly reports. Also a communication regarding the same to be sent to SACS and STC (State TB Cell) from NACO and CTD respectively

- It was recommended to ensure participation of members of PLHIV network and civil society organizations in the SCC and DCC

1.2 To **strengthen supervision, monitoring and review** of TB/HIV collaborative activities, it was decided that joint field visits of NACO and CTD officials would be conducted regularly to atleast 2 states every quarter. At state level SACS and STC officials to conduct joint TB/HIV visits to atleast 2 districts per quarter and submit report to NACO and CTD. Although recommended in national TB/HIV framework, this activity is not implemented at state level. NACO and CTD to monitor conduct of these visits and a status report on the same be shared in next NTWG

- Civil society member suggested inclusion of training / sensitization of members of PLHIV network to improve ICF activities which was agreed

1.3 **Data management:** it is noted that many SACS do not submit monthly ICF reports (ICTC/ART) to NACO and CTD. Also the quality of data reported is questionable.

- The group recommended measures to strengthen overall TB/HIV data management on ICF from both ICTC and ARTC like
- Training for M&E officers (MEO) at SACS in these issues to be conducted by facilitators from NACO and CTD within 3 months. These MEOs would in-turn sensitize all the district ICTC supervisors and the RNTCP district DP&TB/HIV supervisors in data collection, compilation and reporting over next 3 months.
- Sensitization of CST consultants and Regional co-ordinators to be done by nodal officer in NACO during review meeting to help streamline ICF reporting from ART centres to SACS.

1.4 **Reporting:**

1. Due to continued issues with data extraction from current NACO CMIS, the ICTC wise reporting from SACS to NACO should be continued using "**Standard reporting format**" (Excel Based) and further strengthened to ensure reporting from all SACS
2. The NTWG was informed about the upcoming NACO Strategic Information System (SIMS), a web based application for capturing client wise information at all ICTCs and ARTCs with automated generation of registers and reports.

TB/HIV nodal officer at NACO may coordinate with the SIMS technical team to incorporate feedback provided on TB/HIV reporting by CTD into software design.

3. NPO ART pointed out that there is error in the denominator reported in ICF report from ART centres (Number of HIV positive patients attending ART centres during the month- pre-ART and ART) as this is not captured in ART centre records. He informed the group that an OPD register shall now be instituted at all ART centres to capture this information accurately in future.

4. NPO ART pointed out that the terms "Intensified TB HIV package" and "Intensified TB case findings (ICF)" confuse field staff and are used interchangeably. It was clarified that "Intensified TB HIV package" indicates a set of activities (routine offer of HIV test to TB patients and linking HIV infected TB patients to "decentralized CPT" and ART) to reduce impact of HIV among TB patients. This term was primarily used to monitor scale-up of activities and after national coverage is achieved, it would be discontinued. However ICF would remain to indicate TB screening activities at HIV care settings.

1.5 Visit by nodal officers from NACO and CTD to states with major problems in quality of reporting to examine ICF reports with their line-list and suggest state specific actions

2. **Review of Tb/HHIV package implementation**:

2.1- Expansion of intensified TB/HIV package:

It was informed that intensified TB/HIV package has been expanded to whole of the country except states of Bihar and Jammu & Kashmir and 4 union territories. In states where the package was launched in year 2010, national level trainings of trainers are completed, jointly facilitated by NACO and RNTCP. The states are at various stages of implementation of services. NTWG recommended NACO to issue official memorandum for launch of intensified TB/HIV package in remaining states and UT (Bihar, Jammu & Kashmir and the union territories of Daman and Diu, Dadra & Nagar Haveli, Andaman & Nicobar and Lakshadweep) in 2011-12. Following the same CTD may also communicate to respective State TB cells (STC) to facilitate early completion of necessary preparatory activities.

2.2 Linkage of HIV infected TB patient to ART care and support:

It was noted that only about 50% HIV infected TB patients registered under RNTCP in 2009 were initiated on ART. Further findings of an operational study shared by CMO TB/HIV from CTD reiterated the gap in diagnosis and linkage to ART care and support. The NTWG

recommended urgent measures to ensure early linkage to ART care and support to minimize mortality, through following discussion points

a) Operational research conducted in the state of Karnataka has demonstrated that about 88% of HIV infected TB patients are eligible for ART as per current NACO ART guidelines. Another study (submitted for publication) from National TB Institute also shows a similar finding and indicates a very high incidence of adverse treatment outcomes (about 20%), even among HIV infected TB patients with CD4 counts more than 350/$mm^{3.}$ This makes a strong case for providing ART to all HIV infected TB patients irrespective of CD4 count. DDGTB therefore indicated the need to revise ART eligibility criteria in line with WHO guidelines to avoid delay in ART initiation.
    - NPO ART informed the group that NACO TRG has taken decision in this regard and it will be operationalized as soon as the drugs and other logistics are in place.

b) NPO ART pointed that the current format of the referral form used to refer HIV infected TB patients to ART centre was not adequate to capture the processes at ART centre. Information for patients who are not started immediately on ART but after a lead-in period of 2 weeks would not be captured appropriately in the feedback section of the referral form and hence possible under-reporting in RNTCP reports. It was decided that **referral form would be modified accordingly** and incorporated into the training modules in the next revision.
    - The nodal officer from CTD however pointed out that the information on ART initiation in RNTCP records is captured from multiple sources including the feedback forms. The “TB/HIV register” at ART centre and “patients ART booklet” are also reviewed to capture his ART status, hence this may not be the sole reason for low proportion on ART.

c) The issue of limited access to ART centres in low and medium prevalent state too was pointed as an important hurdle. It was suggested that travel support be provided to all HIV infected TB patients and an attendant to ensure that all patients reach ART centre. The mechanism for the provision of same needs to be explored and existing ones in NACP strengthened.

d) NPO ART also pointed out that patients initiated on ATT but not immediately initiated on ART are not “referred back” to ART centres for ART initiation by concerned MO PHI. The group recognized that ART initiation status should be tracked throughout TB treatment and not just once initially.

- A communication to strengthen this activity may be issued to all State TB officers and SACS, for onward communication to district level officers and MO-PHI.

e) Importance of timely updating of ART centre TB/HIV register, extraction of district wise information and communication of the same to the concerned DTO was stressed. The ART centre nurse, STS of concerned TU and the district ICTC supervisor and RNTCP TB/HIV supervisors are responsible for compilation and communication of this information to DTO and thus to MO-PHI.

- Instruction regarding the same may be issued to SACS and all state TB officers by NACO and CTD respectively

f) NPO ART indicated need to capture LFU/death etc. in TB/HIV register at ART centre. RNTCP nodal officer clarified that the present column of treatment outcome captures any outcome including default and death. Hence it was agreed to retain the existing format

g) NPO ART informed that ART centres have reported lack of supply of prolongation pouches (PP) from RNTCP. CMO CTD suggested that there is no shortage of PP, but since most ART centres are situated in tertiary care settings, which invariably have a DOT centre, hence it may not be necessary to stock PP in ART centre. It was decided that while the ART MO can prescribe treatment (categorize) to all TB patients diagnosed at ART centre, as per existing guidelines, they will be referred to local DOT centre for initiating treatment and ensuring appropriate referral to concerned PHI. For patients admitted in the wards, DOT centre will arrange for supply of PP on information from ART centre/hospital. This currently recommended practice may be reinforced by a communication to all ART centres and district TB officers.

h) NPO ART raised the issue of lack of supply of Rifabutin for HIV infected TB patients on second line ART at NACO Centres of Excellence (COE) by RNTCP. It was agreed that

- CTD to issue communication to all State TB cells reiterating importance of Rifabutin procurement and uninterrupted availability at COE.
- NACO to share regular information on number of patients initiated on second line ART at COE and the number of TB cases among these patients, to assist CTD and STC make realistic assessment of requirement of Rifabutin.

2.3 Issue of scaling up HIV testing facilities to achieve universal testing of TB patient:

CMO CTD in his presentation pointed that HIV testing of TB patients has been an exceptional source of HIV case finding for NACO; HIV prevalence among TB patients has been consistently higher than HIV prevalence among ICTC clients (7 to 8% compared to 3% among ICTC clients at national level) and in some states as much as 15% of HIV cases detected were via referrals of TB patients for HIV testing. Operational research study has supported this finding, with atleast 50% of HIV infections detected among TB patients with no known prior HIV positive result i.e. being newly detected as HIV positive. It was noted that although proportion of TB patients with known HIV status in high and medium HIV prevalence states reached more than 80%, it is less than 50% in remaining states. Universal HIV testing of TB patients is a challenge primarily due to limited availability of HIV testing facilities *vis a vis* number of RNTCP Designated Microscopy Centres (DMC). This gap is more pronounced in low and medium HIV prevalent states. The NTWG deliberated on this issue and following action points were recommended:

1. NACO to reiterate to all SACS to prioritize HIV testing of TB patients in situations of shortage of test kits along with the high risk groups (HRG), STI patients and ANC clients
2. NACO to communicate to all SACS to prioritize RNTCP TB unit (TU) headquarter town or the 24*7 PHI having a DMC for establishment of the facility integrated ICTC, while establishing Facility integrated-ICTC (F-ICTC) as decided in annual action plans for 2011-12
3. The shared vision with both programmes is to have co-located HIV testing/Screening centre in every DMC. This vision will be incorporated into the planning process for the next national strategic plans (NSP) for both programmes, NACP IV and RNTCP National Strategic Plan (2012-2017).
4. CTD informed that it is in process of collecting and compiling the list of TB units and DMC without ICTC, state wise and the same would be shared with NACO. NACO was requested to communicate the same to SACS for the prioritization exercise to establish F-ICTC.
5. The NTWG suggested NACO to consider establishing HIV screening centres with Whole Blood Test (WBT) at all DMC without an ICTC (neither stand alone ICTC nor F-ICTC). These centres may be developed as comprehensive setups offering services to Antenatal women, TB patients, HRG and STI patients.
6. NACO to immediately initiate work on development of the WBT operational guidelines and planning for logistics, supply chain, reporting and training material for staff at the PHI (MO/paramedical staff) and the laboratory technician. It was also agreed that DMC laboratory technician (LT) will be among those trained to perform WBT, and staff nurse or

ANM to provide limited pre-test information after referral by the PHI MO. Opt-out method may be used for HIV screening at these centres. A simple 5 to 10 point "**pre-test information tool**" may also be developed for use by the nurse/ANM before offer of this test.

3 **Isoniazid Preventive Therapy (IPT) roll-out in ART Centers:** NPO ART presented the evidence pertaining to IPT use among PLHIV and the concerns of NACP in adoptions of this strategy

- The NTWG accepted the evidence available globally and in India regarding efficacy of Isoniazid in preventing TB among HIV infected individuals
- The group also recognized need for generating evidence to answer questions on operational feasibility of adoption of IPT strategy in NACP settings. Since NACO is in process of revising ART guidelines and changing its threshold for ART initiation from CD4 count of 250/$mm^3$to 350/mm^3 for all HIV infected individuals and given the well established potential of ART in preventing TB, information on additional effectiveness of IPT would also need to be captured as part of the activity.
- As recommended in previous meeting, NTWG requested NACO to expedite the operational study in association with an ICMR institute at select ART centres in the country to answer questions of both operational feasibility and effectiveness of IPT.

4 **Revision of TB/HIV documents:** It was brought to notice of NTWG that considering the fact that ICF and intensified TB/HIV package are implemented uniformly across the country now, separate training material are no longer required. Also national policy framework needs to be revised to accommodate recent policy changes in NACP and RNTCP. It was decided that nodal officers in NACO and CTD may initiate work on consolidation of training module.

5 **RNTCP PPM guideline for TB/HIV scheme:** Since the eligibility criteria in RNTCP TB/HIV scheme for NGO/PP currently restricts the involvement of Community Care Centres with atleast 20 beds, uptake of this scheme is found to be poor as majority of CCC working with NACP are 10 bedded. This issue was discussed in the last national TB/HIV review. NTWG agreed that the criterion needs to be revised to accommodate even 10 bedded CCC and requested CTD for necessary administrative approval and communication to states. However it was reiterated that TB/HIV activities should be a mandate for all CCC and NACO was requested to revise the TORs for NGO running CCC.

6 **Other issues**

6.1 NPO ART raised the issue of need to implement **TB/HIV activities in high risk groups** for HIV specially IDU. It was informed that though it was decided in the past meetings of NTWG to consider inclusion of TB/HIV activities as integral part of TOR for NGO implementing NACO TI projects, there was no further follow up on this recommendation. Since the experience of implementing TB/HIV activities in TI settings already exists from the RNTCP-AVAHAN project the same may be used to formulate strategy at national level.

- NTWG asked NACO to discuss the matter internally with TI division and in agreement draw a plan for adoption of TB/HIV activities among HRG through modification of TOR for NGO working in the TI projects.

6.2 **Infection control at HIV care settings**: NPO ART agreed that although infection control at ART centres is highly recommended activity, majority of the centres have infrastructural constraints. However instructions are issued to all centres to fast track patients with cough through various sections in ART centres and place facemasks at entrance of ART centres. The NTWG recommended strengthening of such administrative measures further to help infection control in HIV care settings. Detailed airborne infection control sensitization would be included at the session of CST regional coordinators.

DDG (TB) in his closing remarks mentioned the need for regular conduct of these meetings and it was decided to schedule the next meeting in 3rd week of July. The meeting concluded with a vote of thanks by ADG/CST

Annexure:1. List of participants in NTWG on 21/04/2011

1. Dr. Ashok Kumar, Deputy Director General, Central TB Division, Ministry of Health & Family Welfare
2. Dr.Mohammed Shaukat, Asst. Director General, National AIDS Control Organization, Department of AIDS Control, Ministry of Health & Family Welfare
3. Dr. B.B. Rewari NPO(ART), NACO
4. Dr. Devesh Gupta, CMO, CTD, Ministry of Health & Family Welfare
5. Dr. Po Lin Chan, WHO Country Officer for HIV
6. Dr. Puneet Dewan, MO(TB), WHO-SEARO
7. Dr. Ajay Kumar, WHO National Consultant, TB/HIV Co-ordination, Central TB Division
8. Dr.Soumya Swaminathan, HOD HIV division, TB Research Centre Chennai
9. Ms Janhabi Goswami, President, Indian Network of positive People, Delhi
10. Ms.Mamta Jacobs, Advocacy coordinator, Global Health Advocates (Advocacy in TB Control Internationally)
11. Dr.Raghuram Rao, Programme Officer (ICTC), NACO
12. Dr.Avinash Kanchar, Programme Officer (HIV/TB), NACO
13. Dr.Reshu Agarwal, Programme Officer (ART), NACO