T-11014/01/2013-NACO/BSD (HIV-TB)
Government of India
Ministry of Health and Family Welfare

Minutes of Meeting of 6th National TB/HIV Co-ordination Committee (NTCC) held under the chairmanship of Secretary (H&FW), MOHFW /GoI at Nirman Bhawan, New Delhi, on 27th March 2018.

The 6th TB HIV NTCC meeting was convened under the chairmanship of Additional Secretary & Director General (NACO & RNTCP), MoHFW /GoI on 27th March 2018 at Nirman Bhawan, New Delhi. The agenda of the meeting and the list of participants are placed as Annexure 1 & 2.

At the outset, DDG (BSD), NACO welcomed all the NTCC members and outlined the objectives of the meeting. AS & DG (NACO & RNTCP) highlighted the scope of convergence between the two programs through TB active case finding among NACO high risk groups, active screening for HIV and TB in closed settings, single nodal officer for both programs in all districts, utilizing spare capacity of CBNAAT for HIV viral load and HIV VL machines for TB testing and utilization of TB survivors for retrieving loss to follow up cases similar to link worker scheme model in NACO. Director General of Health Services elaborated on the successful collaboration between the two programmes being implemented from 2001 and the need to address the dual burden of TB and HIV through effective coordination, mandatory notification of TB from private sector and implementation of coordination across all levels upto district level. DDG (BSD), NACO presented the action taken based on the recommendations of the previous NTCC meeting held on 31st July 2017.

1. The communication for nomination of DTO as DACO had been circulated to all states from Secretary (Health). Nearly 21/36 states have adopted the policy. In Uttar Pradesh, nomination has been done and trainings have been completed.
   - *The functionality of operationalization of the policy of DTO nomination as DACO at the district level to be followed up with the states.*

2. Though the co-location of DMC and HIV testing facilities have improved to 85%, nearly 2100 facilities are not co-located due to non-availability of cold storage mechanism. Issue of utilization of cold storage equipment's of immunization program for storage of HIV kits was discussed.
   - *The states with sub-optimal co-location status need to be followed up to improve co-location.*
   - *To utilize the cold storage facilities of immunization program, scope of an end-to-end protocol for sharing resources to be assessed.*
   - *Scope of provision of cold storage mechanism through CSR funds to be explored.*

3. Only 3% of the TB patients notified from private sector in 2017 knew their HIV status. Partners of both the programs would be working for private sector engagement under the present Global Fund Grant. Meeting held with partners on 19th March 2018 for development of Standard operating procedure for expansion of TB-HIV collaborative activities in private sector. The issue of confidentiality of details of HIV status of patients was raised, for which it was clarified that only aggregate data would be collected.
   - *To improve HIV testing among private sector, the incentive approved for TB notification needs to be linked to HIV testing.*

- *The Indicator for HIV testing among presumptive TB cases and TB patients in private sector to be included in the monitoring of private sector engagement activities under Project JEET.*
- *The feasibility of HIV testing of presumptive TB cases in private sector to be assessed.*

4. The Targeted Intervention program of NACO captures the status of TB screening, referral and TB treatment initiation of high risk group population in the SIMS reporting format.
   - *Feasibility of HIV testing to be done in the community along with the TB active case finding campaign to be explored.*
   - *The TB indicators of High risk group population of NACO for TB to be reviewed on a regular basis.*

5. Joint TB-HIV review meetings to be held in a systematic manner to review progress in implementation of TB-HIV collaborative activities.
   - *Regional Review meeting to be held once in a year to cover all the states, with the dates being finalized after mutual consultation with both programs.*
   - *Review meetings at the State and District level to be strengthened, with participation of representatives of HIV and TB programs in view of the convergence between both the programs.*

6. Merging of the management structure at state level with a single officer looking after both the programs would further strengthen program implementation with the resources being efficiently utilized. It was mentioned that the Project Director SACS and State TB Officer are the same in Tamil Nadu. The issue of different modes of funding of the two programs was highlighted and suggested that NACO funding would have to be shifted to NHM in order for the convergence to be successful.
   - *Feasibility of merging of State TB officer and Additional Project Director, SACS to look after the technical aspect of both the programs to be explored.*

7. The internal working group chaired by JS of both the programs had been constituted and met in November 2017 and January 2018.
   - *It was suggested that the internal working group meeting every 2 months to discuss on the issues and streamline implementation of activities.*

8. The scope of the symptom screening may be extended to cover the extra-pulmonary symptoms also.
   - *An expert committee would be constituted to discuss on the scope of extension of TB symptom screening to include extra-pulmonary symptoms, requirement of Pyridoxine supplementation for Isoniazid Preventive therapy and its dosage.*
   - *The committee would consist of Dr K S Sachdeva, Dr S D Khaparde, Dr Samiran Panda, Dr Rajasekaran, Dr Neeraj Nischal, Dr S K Sharma, Dr Behera and Dr Ranjani Ramachandran and the meeting would be convened within 2 weeks by NACO.*

9. The issue of transportation of sputum samples from ART centres to CBNAAT site and poor uptake of partnership scheme for sputum collection and transportation was highlighted.
   - *A communication to be sent from NACO to all states to engage community based organizations, targeted intervention sites associated with the HIV program in transportation of samples from non-*

collocated ART centres, Link-ART centres and ICTCs to CBNAAT sites using the partnership options under RNTCP.

- *Status of co-location of the ART centres and CBNAAT site to be updated in view of the installation of the 507 additional machines installed under RNTCP in the past few months.*

10. It had been decided that spare capacity of CBNAAT machines established under RNTCP may be utilized to perform HIV viral load test and 2 sites had been identified. It was mentioned that the quotation had been obtained from the supplier and IFD approval is being obtained for procurement
    - *AS & DG (NACO & RNTCP) instructed that the CBNAAT HIV VL cartridges may be purchased at the earliest and the activity implemented on priority.*

11. Communication had been sent from NACO to all states to provide nutritional support linkages to all TB-HIV co-infected patients and 22 States/UTs had linked patients to one or more social support schemes. It was mentioned that state-specific schemes exist for provision of social support to PLHIV and moreover the TB program would be providing INR 500 for every TB patient for nutritional support.
    - *AS & DG (NACO & RNTCP) suggested that a proposal may be put up for provision of additional incentive to TB-HIV co-infected patients over and above the INR 500 to be provided under the TB program.*

12. The TB and HIV convergence meeting recommended that Inter-operability of the IT systems of both the programs would be ensured and development of API would be supported by CHAI as a part of Project SOCH. JS (TB) emphasized the importance of integration of the IT systems for effective monitoring of both programs by the District TB Officer, who have also been nominated as District AIDS Control Officer.
    - *AS & DG (NACO & RNTCP) recommended that a meeting may be held with both the programs and CHAI to obtain an update on the Inter-operability of the IT systems of both the programs with specific reference to the TB-HIV collaborative activities and the activity may be carried out on a priority basis.*
    - *Mapping of the variables and requirements of data of either programs to be worked up prior to the meeting.*
    - *Validation of the TB-HIV data being submitted to be ensured by the District TB officer, with staff of both programs reconciling the data at the District level.*

13. Joint IEC meeting held between both the program to discuss on existing materials and identify support from partners for development of new materials. Posters and audio-visual materials were finalized and have been included in the national level IEC campaign of RNTCP. The issue of sub-optimal visibility of the existing campaign was highlighted.

DADG (TB), CTD presented on the progress in TB/HIV collaborative activities in 2017 to reduce burden of HIV among TB patients.

1. The gap in notification of TB/HIV co-infected cases (54%) as compared to the estimated numbers was highlighted.
    - *Reporting of HIV testing among TB patients notified from private sector to be improved.*

2. The HIV testing among TB patients in public sector was 75%, with the decrease in comparison to the previous year on account of the revision in the recording and reporting system of RNTCP. Overall 60% of

the TB patients knew their HIV status in public and private sector, with the number being less on account of only 3% of the TB patients in private sector knowing their HIV status. The state-wise Known HIV status among TB patients in public and private sector is provided in Table 1

Table 1: State-wise proportion of known HIV status among public, private and total notified TB patients (2017)

State	Total TB patients notified from public sector (2017)	No. & % of TB patients notified from public sector with known HIV status	Total TB patients notified from private sector (2017)	No. & % of TB patients notified from private sector with known HIV status	Total TB patients notified (public +private sector) (2017) (2017)	No. & % of TB patients notified (public +private sector) with known HIV status
A & N Islands	597	483 (81%)	26	1 (4%)	623	484 (78%)
Andhra Pradesh	67228	64962 (97%)	17580	377 (2%)	84808	65339 (77%)
Arunachal Pradesh	3136	1877 (60%)	15	0 (0%)	3151	1877 (60%)
Assam	36621	16618 (45%)	3521	107 (3%)	40142	16725 (42%)
Bihar	54762	37750 (69%)	41415	74 (0%)	96177	37824 (39%)
Chandigarh	5649	2631 (47%)	270	1 (0%)	5919	2632 (44%)
Chhattisgarh	30282	28828 (95%)	10797	393 (4%)	41079	29221 (71%)
Dadar & Nagar Haveli	893	521 (58%)	70	0 (0%)	963	521 (54%)
Daman & Diu	381	323 (85%)	76	0 (0%)	457	323 (71%)
Delhi	60585	39592 (65%)	5761	9 (0%)	66346	39601 (60%)
Goa	1563	1121 (72%)	369	0 (0%)	1932	1121 (58%)
Gujarat	111490	94589 (85%)	39680	1397 (4%)	151170	95986 (63%)
Haryana	33826	27225 (80%)	6642	327 (5%)	40468	27552 (68%)
Himachal Pradesh	16670	10233 (61%)	801	162 (20%)	17471	10395 (59%)
Jammu & Kashmir	9372	5258 (56%)	1031	372 (36%)	10403	5630 (54%)
Jharkhand	36751	26811 (73%)	7601	235 (3%)	44352	27046 (61%)
Karnataka	69543	53326 (77%)	12290	774 (6%)	81833	54100 (66%)
Kerala	14294	10261 (72%)	8667	1076 (12%)	22961	11337 (49%)
Lakshadweep	27	10 (37%)	0	#DIV/0!	27	10 (37%)
Madhya Pradesh	117974	84086 (71%)	17110	133 (1%)	135084	84219 (62%)

State	Total TB patients notified from public sector (2017)	No. & % of TB patients notified from public sector with known HIV status	Total TB patients notified from private sector (2017)	No. & % of TB patients notified from private sector with known HIV status	Total TB patients notified (public + private sector) (2017) (2017)	No. & % of TB patients notified (public +private sector) with known HIV status
Maharashtra	**129013**	**105509 (82%)**	**69422**	**1007 (1%)**	**198435**	**106516 (54%)**
Manipur	**1688**	**1116 (66%)**	**1114**	**160 (14%)**	**2802**	**1276 (46%)**
Meghalaya	**3366**	**1692 (50%)**	**601**	**20 (3%)**	**3967**	**1712 (43%)**
Mizoram	**2200**	**1768 (80%)**	**44**	**0 (0%)**	**2244**	**1768 (79%)**
Nagaland	**2284**	**1806 (79%)**	**713**	**87 (12%)**	**2997**	**1893 (63%)**
Odisha	**66860**	**48374 (72%)**	**3975**	**564 (14%)**	**70835**	**48938 (69%)**
Puducherry	**1591**	**1552 (98%)**	**3**	**0 (0%)**	**1594**	**1552 (97%)**
Punjab	**38942**	**27656 (71%)**	**6329**	**59 (1%)**	**45271**	**27715 (61%)**
Rajasthan	**83555**	**66094 (79%)**	**22238**	**572 (3%)**	**105793**	**66666 (63%)**
Sikkim	**1231**	**616 (50%)**	**39**	**2 (5%)**	**1270**	**618 (49%)**
Tamil Nadu	**74394**	**63293 (85%)**	**19890**	**453 (2%)**	**94284**	**63746 (68%)**
Telangana	**40699**	**35289 (87%)**	**7698**	**316 (4%)**	**48397**	**35605 (74%)**
Tripura	**1671**	**1088 (65%)**	**8**	**0 (0%)**	**1679**	**1088 (65%)**
Uttar Pradesh	**244892**	**167548 (68%)**	**67652**	**1297 (2%)**	**312544**	**168845 (54%)**
Uttarakhand	**12902**	**7237 (56%)**	**3807**	**11 (0%)**	**16709**	**7248 (43%)**
West Bengal	**82610**	**60048 (73%)**	**14991**	**694 (5%)**	**97601**	**60742 (62%)**
INDIA	**1459542**	**1097191 (75%)**	**392246**	**10680 (3%)**	**1851788**	**1107871 (60%)**

3. Almost 459 districts in 31 states had started testing presumptive TB cases for HIV in 2017
   - *The implementation of HIV testing among presumptive TB cases to be scaled up in all states across the country ensuring availability of adequate HIV testing kits.*
4. The coverage of ART among TB-HIV co-infected patients was 87% in 2016. The mortality of TB-HIV co-infected patients has remained constant at 14% over the years with wide variation across States and districts. It was emphasized to detect HIV and TB early in order to have better outcomes. The low mortality

among co-infected patients in Bihar needs to be assessed. It was clarified that DRTB-HIV co-infection was low in India with 1% co-infection rate among notified cases.

DDG (BSD), NACO presented on the progress in TB/HIV collaborative activities in 2017 to reduce burden of TB among HIV patients.

1. The intensified case finding activities for TB among PLHIV in ART centre was presented, with the gap in each step of the cascade highlighted. It was mentioned that the loss was in part due to patients presenting with extra-pulmonary symptoms, patients not visiting the CBNAAT site in spite of referral by the ART medical officer.
   - *The list of ART centres with poor TB screening of PLHIV (<80%) to be identified.*
   - *The trainings of ART centre with poor performance in TB-HIV collaborative activities need to be carried out.*

2. The issue of shortage of Isoniazid and Pyridoxine for Isoniazid Preventive therapy was raised. It was mentioned that provision of pyridoxine resulted in better outcomes for the patients initiated on IPT. The following states have been able to successfully procure Tab. Pyridoxine: Chandigarh, Delhi, Mumbai, Mizoram and Tamil Nadu. There are also various Central Public Sector Enterprises like Karnataka Antibiotics & Pharmaceuticals Limited (KAPL) Bangalore, Rajasthan Drugs & Pharmaceuticals Limited (RDPL) Jaipur, Hindustan Antibiotics Limited (HAL) Pune, Bengal Chemicals & Pharmaceuticals limited (BCPL) Kolkata and Indian Drugs & Pharmaceuticals Limited (IDPL), Gurgaon which are involved in supply of Antibiotics to the National Health programs and may be roped in to manufacture Isoniazid and Pyridoxine.
   - *AS & DG (NACO & RNTCP) recommended that the supplies of Isoniazid to the states be completed by CTD by the end of April.*
   - *The states may be guided to procure Pyridoxine from states which have been successful in procuring the drug.*
   - *Public Sector undertakings like HLL may be roped in to manufacture required amount of Isoniazid and Pyridoxine. Involvement of Janaushadi pharmacy in stocking and supplying the drug also to be explored.*

The meeting was concluded by summarizing the following action points, before thanking all the member of NTCC. The action points are listed below:

1) The functionality of operationalization of the policy of DTO nomination as DACO at the district level to be followed up with the states. Feasibility of merging of State TB officer and Additional Project Director, SACS to look after the technical aspect of both the programs to be explored **(BSD Division – NACO & CTD - MoHFW)**.

2) The states with sub-optimal co-location status need to be followed up to improve co-location **(CTD - MoHFW & BSD Division – NACO)**.

3) To utilize the cold storage facilities of immunization program, scope of an end-to-end protocol for sharing resources to be assessed **(Immunization Division, CTD - MoHFW & BSD Division – NACO)**.

4) Scope of provision of cold storage mechanism through CSR funds to be explored.

5) To improve HIV testing among private sector, the incentive approved for TB notification needs to be linked to HIV testing.

6) The Indicator for HIV testing among presumptive TB cases and TB patients in private sector to be included in the monitoring of private sector engagement activities under Project JEET. Reporting of HIV testing among TB patients notified from private sector to be improved.

7) The feasibility of HIV testing of presumptive TB cases in private sector to be assessed **(BSD Division – NACO & CTD - MoHFW)**.

8) Feasibility of HIV testing to be done in the community along with the TB active case finding campaign to be explored **(BSD Division – NACO & CTD - MoHFW)**.

9) The TB indicators of High risk group population of NACO for TB to be reviewed on a regular basis **(BSD Division - NACO & CTD - MoHFW)**.

10) Regional Review meeting to be held once in a year to cover all the states, with the dates being finalized after mutual consultation with both programs.

11) Review meetings at the State and District level to be strengthened, with participation of representatives of HIV and TB programs in view of the convergence between both the programs **(CTD - MoHFW & BSD Division - NACO)**.

12) It was suggested that the internal working group meeting every 2 months to discuss on the issues and streamline implementation of activities **(BSD Division - NACO)**.

13) An expert committee would be constituted to discuss on the scope of extension of TB symptom screening to include extra-pulmonary symptoms, requirement of Pyridoxine supplementation for Isoniazid Preventive therapy and its dosage. The committee would consist of Dr K S Sachdeva, Dr S D Khaparde, Dr Samiran Panda, Dr Rajasekaran, Dr Neeraj Nischal, Dr S K Sharma, Dr Behera and Dr Ranjani Ramachandran and the meeting would be convened within 2 weeks by NACO **(BSD Division - NACO)**.

14) A communication to be sent from NACO to all states to engage community based organizations, targeted intervention sites associated with the HIV program in transportation of samples from non-collocated ART centres, Link-ART centres and ICTCs to CBNAAT sites using the partnership options under RNTCP **(BSD Division - NACO)**.

15) Status of co-location of the ART centres and CBNAAT site to be updated in view of the installation of the 507 additional machines installed under RNTCP in the past few months **(BSD Division - NACO)**.

16) AS & DG (NACO & RNTCP) instructed that the CBNAAT HIV VL cartridges may be purchased at the earliest and the activity implemented on priority **(BSD Division - NACO)**.

17) AS & DG (NACO & RNTCP) suggested that a proposal may be put up for provision of additional incentive to TB-HIV co-infected patients over and above the INR 500 to be provided under the TB program **(BSD Division – NACO & CTD - MoHFW)**.

18) AS & DG (NACO & RNTCP) recommended that a meeting may be held with both the programs and CHAI to obtain an update on the Inter-operability of the IT systems of both the programs with specific reference to the TB-HIV collaborative activities and the activity may be carried out on a priority basis. Mapping of the variables and requirements of data of either programs to be worked up prior to the meeting **(BSD – Division NACO & CTD - MoHFW)**.

19) Validation of the TB-HIV data being submitted to be ensured by the District TB officer, with staff of both programs reconciling the data at the District level **(BSD Division – NACO & CTD - MoHFW)**.

20) The implementation of HIV testing among presumptive TB cases to be scaled up in all states across the country ensuring availability of adequate HIV testing kits **(BSD Division – NACO & CTD - MoHFW)**.

21) The list of ART centres with poor TB screening of PLHIV (<80%) to be identified. The trainings of ART centres with poor performance in TB-HIV collaborative activities need to be carried out **(BSD Division – NACO & CTD - MoHFW)**.

22) AS & DG (NACO & RNTCP) recommended that the supplies of Isoniazid to the states be completed by CTD by the end of April. The states may be guided to procure Pyridoxine from states which have been successful in procuring the drug. Public Sector undertakings like HLL may be roped in to manufacture required amount of Isoniazid and Pyridoxine. Involvement of Janaushadi, Amrit pharmacy stores in stocking the drug also to be explored **(BSD Division – NACO & CTD - MoHFW)**.

Annexure 1: Agenda of the TB-HIV NTCC meeting

6th National TB/HIV Coordination Committee Meeting **Date:** 27th March 2018**, Time:** 12:00 – 01:00 PM **Venue: Secretary Office, 1st Floor, Nirman Bhawan, New Delhi 110001**		
Programme		
12:00 pm -12:03 pm	Welcome address and Meeting Objectives	DDG / BSD / NACO
12:03 pm – 12:06 pm	Opening Remarks	AS (Health) & DG NACO/ MoHFW
12:06 pm – 12:09 pm	Address by DGHS	DGHS / MoHFW
12:09 pm – 12:15 pm	Action taken report on decisions of last National TB HIV Coordination Committee meeting held on 31st July 2017	DDG / BSD / NACO
12:15 pm – 12:20 pm	Update on TB and HIV convergence meeting recommendations	DDG / BSD / NACO
12:20 pm – 12:35 pm	Progress on TB/HIV collaborative activities to reduce burden of HIV among TB patients	DDG / TB / CTD
12:35 pm – 12:50 pm	Progress on TB/HIV collaborative activities to reduce burden of TB among HIV patients	DDG / CST / NACO
12:50 pm – 12:55 pm	Recommendations from WHO Inter-Ministerial conference in Moscow (Nov 2017)	DDG / BSD / NACO
12:55 pm -01:00 pm	Any other points for discussion with permission of Chair	
01:00 pm	Closing Comments by Secretary (Health) / MoHFW	

Annexure 2: List of participants for the TB-HIV NTCC meeting

Meeting on National TB HIV Coordination Committee (NTCC) on TB/HIV Collaborative Activities

Dated: 27th Mar, 2018

Time: 12:00am-1:00 PM

Venue: Secretary Office ,, First Floor, Nirman Bhawan

S.No.	Name	Organization	Designation	E-mail id	Contact no.	Signature
1.	Ms. Preeti Sudan	M/o H&FW	Secretary (HFW)			
2.	Dr. B.D. Athani	MOHFW	DGHS			
3.	Sh. Sanjeeva kumar	MOHFW	AS & DG (NAC)			
4.	Dr. K.S. Subdeva	DDG, NACO.	DDG (BSD)			

Meeting on National TB HIV Coordination Committee (NTCC) on TB/HIV Collaborative Activities

Dated: 27th Mar, 2018

Time: 12:00am-1:00 PM

Venue: Secretary Office ,, First Floor, Nirman Bhawan

S.No.	Name	Organization	Designation	E-mail id	Contact no.	Signature
1.						
2.	Vikas Sheel	MOHFW	JS - TB	sheelv@nic.in	9424200606	
3.	Sundar Mase	WHO	MO	mases@who.int	9717170688	
4.	PANKAJ KUMAR	PD, UPSACS	PD	mdupnrhm@gmail.com.	7380888884	
5.	Dr. Padmapriya	NIRT, Chennai	Sc.-E	pcorchids@gmail.com	9498022949	C.Pad
6	TEJINDER AHLUWALIA	Tuberculosis Assn of India	Secy General	tbasshindia@nic.co.in	9810550888	
7.	Dr. S.M. Goyal	Delhi TB Association	Hony. Genl. Secretary	dtba1939@Rediffmail.com	9810310546	
8.	Dr. Vinlesh Purohit	WHO	NPO (HIV + Hepatitis)	purohitv@who.int	8130340809	
9	Dr. R.R. Gangakhedkar	ICMR	Head, Div. ECD	rgangakhedkar.hq@icmr.gov.in	24220879	
10	Dr. Raghuram Rao	CTD, MoHFW	Dy Dir (TB)	rrao@rntcp.org	9555113213	
11	Dr. SUNIL D KHARADE	DDG TB CTD	DDG (TB)	DDGTB@rntcp.org	9953097012	
12	Dr. RANJANI RAMACHANDRAN	WHO	NPO (TB)	ramachandranr@who.int	8826221815	
13	Dr. Mahesh Gosla	CTD	NC (TB HIV)	goslam@rntcp.org	7799443756	
14.	A. Deepak B	NACO	NC (TB-HIV	nchivtenaco@gmail.com	7352825524	