Minutes of National joint review meeting of States/UTs on HIV/TB collaborative activities 1st group of South & West States held at NTI Bangalore during 16th to 17th July 2014

The National joint review meeting of States/UTs on HIV/TB collaborative activities 1st group of South & West States was held at NTI Bangalore during 16th to 17th July 2014. The inaugural session of the meeting on 16th July 2014 was chaired by Dr. Ashok Kumar, Dy.DG (BSD)/ NACO / MOFW/GOI. Dr Prahlad Kumar, Director NTI delivered the opening address and welcomed all the participants to the First National Joint review meeting. Dr K.S.Sachdeva, Addl.DDG-TB, in his address greeted everyone and highlighted the objectives of the meeting. Dr Sreenivas, NPO TB, WHO India in his address appreciated the initiative of National Joint HIV/TB review and congratulated both CTD & NACO for taking steps towards the universal access of TB and HIV care. Dr Malik Parmar ,NPO DR-TB reiterated the need of Joint reviews to strengthen the strong HIV/TB Coordination in India.

The first half of the meeting on 16th July 2014 comprised of an introductory presentation on Status & Update on TB-HIV Collaborative activities in India by Dr.Amar Shah(National Consultant TB-HIV/ CTD) ; followed by presentation on Overview of NACP IV &Infection control in HIV/TB Care settings in India by Dr Rajesh Deshmukh (National Consultant & PO HIV-TB /NACO);Presentation on TB –HIV Pilot Project including 3 I’s to reduce mortality among PLHIVs by Dr Sreenivas A.N (NPO-TB ,WHO India).

This was followed by individual State presentations. Highlights of the individual state presentations made on day one & two and the actions points identified therein for each state are as follows:

**Karnataka**

- State to proactively plan the trainings of staff of both programmes as and when new medical and paramedical personnel join.
- In ART centres located in medical college, Prof/ Assoc Prof/ Asst Prof should be attending ARTC and support in patient management.
- Vacant LT posts of Bangalore city to be filled using the LT scheme. Process to be completed by 31st July 2014.
- WBT to be planned for centres where standalone facilities are not available and for non-DMC PHIs.
- STWG meeting to be conducted quarterly. The next meeting to be done in July 2014 and quarterly thereafter.
• Do not club District Coordination Committee meeting with District Health Society meeting. Standalone DCC is preferred. DCC to be conducted regularly.
• In continuation with the recommendation given during DTOs 1q14 QRM, the state to arrange a meeting of members from all the medical colleges. Talk to STF. To be done in Aug 2014.
• Bangalore Urban data, to include Bangalore City data as well.
• STO and PD to meet Commissioner BBMP to sort out the issue of co-location of DMCs, HIV testing facilities and HR related issue of Bangalore city.
• Data on HIV infected presumptive TB cases tested on CBNAAT to be shared by the state with CTD on priority.
• ARTC wise referrals to be reviewed and corrective actions to be taken.
• KMC Mangalore has zero referrals to RNTCP in 1q 2014. Issue to be streamlined. STF Chairman to visit KMC Mangalore and sort the issue. Report to be submitted to CTD-NACO
• Staff nurse/ care coordinator should do the symptom screen every month to patients coming every month to ARTC
• Four symptom screen at the first point of contact also is an opportunity to fast-track and help in AIC
• ART-MOs to be jointly reviewed/ updated at state level to streamline the issues biannually.
• CPT of 6 months to be tracked by the programme staff
• CD-4 analysis to be used. Make strategies to reduce deaths among HIV infected TB patients. Pilot in few districts to improve outcomes
• AIC committee should be formed at the institution level and nodal officer to be identified. Periodic meetings and follow-up to be done
• AIC measures to be implemented as per the communication from NACO and CTD
• Optimization of CBNAAT usage to be done in Karnataka. (Responsibility: Karnataka SACS &STC)

Tamil Nadu
• To utilize CBNAAT machine at NIRT to screen PLHIV presumptive TB cases along with machines in Coimbatore and Madurai.
• Vacancies in TNSACS to be filled in three months.
• All non-co located DMCS to be established with ICTC/FICTC testing facilities within next three months
• A team from Karnataka to visit the state in the second week of August 2014 to evaluate the TBHIV activities of TN. Team to make visits to underperforming districts (Karur, Kanyakumari, Cuddalore, Vellore, Theni, Sivaganga, Erode, Tambaram) and submit a detailed report to Secretary health, MD NRHM and CTD.
• Conduct of District co-ordination committee meetings to be supervised and monitored by STO. Minutes of DCC meeting to be shared with STC and TNSACS.
• All mails from STO office to be communicated to PD TNSACCS with a copy to JD BSD, JD CSD and Regional Coordinator.
• District wise analysis of reasons for sub optimal initiation of CPT and ART to be evaluated.
• State TB office and TNSACCS to conduct regional TBHIV reviews alternately every quarter with DTOs, DNOs, TBHIV Coordinators.
• All the DTO quarterly reviews to be attended by TNSACCS representatives and all DNO reviews to be attended by State TB Office representatives.
• Delay in initiation of CPT and ART to be tracked district wise by comparing the data of conversion and RT reports vis-a-vis the treatment outcomes of patients. All process indicators involved in quality of referral from ICTCs and ART centers, patients reaching DMCs, issues in TB diagnosis at DMCs, Recording and reporting to be analyzed district wise. (Responsibility: TN SACS & STC)

Kerala

• State should take proactive steps to fill the vacancy. Epidemiologist post is vacant nearly one year. STO-Kerala agreed to appoint all the vacant post in August.
• 23% of the DMC were not having HIV testing (ICTC/FICTC) facilities. HIV testing facilities (ICTC/FICTC) have to implement in all medical colleges and all Govt DMCs in top priority. FICTC has to be made functional in needed private DMCs as per the workload. KSACS should take proactive steps for establishing the FICTC in private sectors
• State HIV-TB coordination committee meeting happened more than year (18.2.2013) back. HIV-TB Coordination meeting should be conducted periodically and this will solve the majority of administrative problems in the both programs.
• House appreciated for the combined IEC materials developed by the STC and KSACS.
• PPM activities to be strengthen in the state through the partners working in the TB-HIV field.
• District Coordination Committee (DCC) meeting should be conducted by DTO and Nodal person of KSACS with chaired by the District Collector.
• Apart from nodal person in the district, KSACS state program officers from BSD and CST, Epidemiology, STI should participate in the State Internal evaluation and District coordination committee.
• All the ART Medical officers and KSACS program officers must be trained in RNTCP and RNTCP program officers must be trained for HIV conducted by DAC.
• ICTC referral should be improved and 10 point counselling has to adopted and keeps proper documentation.
• ART centres should follow the Intensive Case finding (ICF), Infection Control (IC) and INH Prophylaxis Treatment (IPT) and all the staffs should be trained for the same.
• In Kerala over the past four years decreasing trend of HIV positivity among TB patients (from 3.1% in 2010 to 1.3% in 1q2014) with increasing trend of registered TB patients with known HIV status (from 27% in 2010 to 94% in 1q2014) and operational research has to be implemented in this area.
• Palakkad district has very low % (70% and state average 94%) registered TB patients with known HIV status. STC-KSACS has to prepare intensive action plan and work together to improve the performance with coordination of partners.
• State to develop plan to initiate 100% of CPT and ART for all the HIV-TB Co-Infected patients.
• Even though the increasing trend of proportion received ART (from 80% in 2010 to 90% in 1q2013) in HIV-TB patients there is no significant improvement in the treatment outcome ART (from 65% in 2010 to 72% in 1q2013) for the past four years and operational research has to be implemented in this area.
• Kerala should prepare the concept note for analyse the treatment outcome of HIV-TB patients with Diabetes mellitus.
• PITC among presumptive TB cases should be initiated in Category B districts –Ernakulum and Calicut.
• KSACS should take initiative and implement airborne infection control measures at HIV Care settings in Kerala.
• Data should be shared each other by TB and HIV/AID at state and district level for the validation and analysis the program performance and Operational research with technical support of WHO RNTCP Consultants for the same.
• DDG-BSD and ADDG-TB agreed to provide viral load testing in Kerala to minimize the delay in service delivery for diagnosis as well as second line treatment. State should try to initiate ART centre in private sector.
  (Responsibility: Kerala STC & SACS )

**Maharashtra**

• STO did not participate in meeting. No representation from MSACs, one person who is actually not the staff of MSACs was asked to participate in meeting.
• Key posts at MSACS are vacant and Training status of Staff in HIV/TB not satisfactory.
• 15 % DMC in State does not have collocated with HIV testing facility- Action plan to be developed to improve the co-location status. Plan to have a 100% DMCs with collocated HIV testing facility. Presently 224 DMCs are not having collocated HIV testing facility, especially in Mumbai & other corporations.
• State TB HIV Coordination Committee meeting did not happen though it is mentioned in the presentation.
• State Technical Working Group meeting did not happen after Dec 2013
• Joint HIV TB review are not happening at State and District level
• What are the monitoring results of DTO/CTOs visit to ART centre?
• Joint reviews to be planned with SACS. These reviews may planned without PD. JD BST & CST to be involved in these review meeting. These review meetings may be planned once by SACS & next time by STO.
• Plan the joint review meeting and inform it to CTD & NACO. We will send representative.
• Optimal utilisation of CBNAAT for the diagnosis of TB amongst PLHIVs.
• Referral from ART centre to RNTCP to be improved. Analyse the data of centres who are having less referral.
• The districts in Mumbai having less HIV testing & ART linkages needs to be monitored closely.
• Coordination between SACS & STC to be improved.
• Joint supervisory visits to be made separately, only visits during SIE are done which not Satisfactory.
• Include TB/HIV component in Mumbai action plan.
• CTD & NACO will jointly visit to Maharashtra and Mumbai for joint HIV /TB review.
• SACS to explore the possibility of establishing ART centre on PPP mode at Bel air hospital at Panchgani, Satara. Patients from outside state/district may be initiated on ART. (Responsibility: Maharashtra STC & SACS)

**Andhra Pradesh & Telangana**

• Frequent change of SMOs in ART Centres is a concern for the state.
• Not able to conduct regular district level coordination committee meetings for HIV-TB Coordination is a major concern for the state. It was observed that the meeting happened last time in year 2012 in some of the districts.
• Not able to conduct the state level coordination committee meeting was a major concern for the state.
• Programmatically, though, both the programs are faring well in the state, the referrals from ART centres to RNTCP need to be strengthened. CBNAAT machines can be utilized for effective strengthening of the referrals and fast tracking of linkages to be done.
• Implementation of AIC guidelines in ART Centres to be implemented ASAP. Towards this it was suggested to form a committee including JD-CST, JD-BSD, JD-TB, RC, WHO-RNTCP Consultant, TB HIV Coordinator so that the committee will oversee the status of survey and implementation of the AIC guidelines.
Support from CTD: Facilitation of completion of State Bifurcation processes and initiate fund flow which is effecting conducting of any training, meeting of review at this moment in both the states
   1. Establishing STDC, IRL, SDS in Andhra Pradesh
   2. Setting up STC in Telangana
Support from DAC: An exclusive point person as TB-HIV Coordinator was requested for the APSACS. DDG-DAC clarified that there won’t be any such position and JD-BSD would be taking care of HIV-TB Coordination also. Instructions from DAC will be sent to JD-BSD to do take responsibilities of HIV-TB Coordination issues including organizing coordination meetings.
Communication for utilizing the services of DTCOs in conducting the monthly TB-HIV meetings where DAPCU nodal officer positions are vacant.
Allocation of exclusive committed whole blood test kits and co-trimoxazole for the HIV-TB component (Responsibility: APIncl Telangana STC & SACS)

Goa

HR in GSACS – Vacant post of M & E officer, district supervisor (2), ICTC LT(1) & one ART MO to be filled.
All issues to be discussed in detail during SWG & SCC meetings and corrective actions to be done timely.
Regular joint supervisory visits to be conducted & report to be submitted to NACO & CTD.
GSACS representative to participate in RNTCP Internal evaluations.
GSACS to ensure uninterrupted supply of CPT stock at ART & Link ART centres.
There is a decline in ICTC to RNTCP referral, needs to be improved.
Referral of TB suspects from ART centre to RNTCP is very low( 1q14-1%). Four symptom complex screening tool to identify TB suspects to be used strictly in ART & Link ART centres.
Ensure early linkages of co-infected patients to ART. 100% of co-infected patients to be linked to ART, irrespective of their non-availability of permanent address.
Death (17%) & default rate(10%) is very high for the cohort of Yr 2012 , among co-infected patients. Efforts to be made to bring it down by timely initiation of ART & prompt default retrieval.
Monthly exchange of data between SACS & RNTCP to be done regularly.
Recording & reporting of TB/HIV data at ART centres to be improved.
Strengthen the PITC & improve the reporting & recording.
Asses the high risk health facilities (ART centres, LAC, medical college, TB hospital, district hospital) for Airborne infection control (AIC) measures as per the national airborne infection control guidelines and implement the AIC measures.
• Formulate the state level Airborne Infection control committee.
• Plan for roll out of INH Preventive Therapy in the State.
  (Responsibility: Goa STC & SACS )

**Gujarat**

• State has initiated PITC from 01 July 2014 and taken into note.
• GeneXpert is not being used for diagnosis of TB among HIV reactive presumptive TB patients in the state. This is because, all existing GX equipment are saturated at full capacity for diagnosis of DR-TB. When more GeneXpert labs established in the future, the state need to consider linking ART centres with GeneXpert lab for diagnosis of TB among PLHIV.
• Joint supervisory visit was conducted in June14. This is to be sustained on regular basis. Districts below state average in treatment success rate of HIV-TB patients should be prioritized for supportive supervision.
• State AIDS Control Society need to conduct baseline assessment for AIC in all ART centres and implement guidelines of AIC in all ART Centres.
  (Responsibility: Gujarat STC & SACS )

**Daman and Diu**

• Posts of one ICTC LT, Epidemiologist, MO-STC and State TB-HIV coordinator to filled up. And ICTC counsellors to be trained by October 14 end.
• UT had conducted STWG meeting in July 2014. This should be continued and to be conducted regularly.
• UT of Daman and Diu need to initiate PITC for all presumptive TB patients.
• UT of Daman and Diu can roll out IPT
  (Responsibility: Daman &Diu STC & SACS )

**Dadra & Nagar Haveli**

• Dadra & Nagar Haveli has 6 DMCs without co-located HIV testing facilities. All DMCs need to have a co-located HIV testing facility.
• UT need to conduct STWG meeting regularly.
• UT of Dadra & Nagar Haveli needs to initiate PITC for all presumptive TB patients.
• UT of Dadra & Nagar Haveli can roll out IPT
  (Responsibility: DNH STC & SACS )
**Odisha**

- Whole Blood finger prick test to be implemented at the earliest.
- LT vacancies to be sorted out.
- DCC meetings not happening at Cuttack district – ATD&TC to take up the issue
- SACS to participate in State Internal evaluations conducted by RNTCP.
- Screening of TB suspects at ART centres to increase to more than 10%.
- Co-location of ICTC/DMC to be increased in Kalahandi district and Deogarh district.
- CPT provision to improve in Ganjam district.
- AIC measures to be implemented across the state.
- IPT provisioning to be expedited and INH to be procured locally.

(Responsibility: Odisha STC & SACS)

In addition to State specific action Points following important points emerged during the meeting which needed action at

1. Airborne infection control guidelines should be simplified for different level of Staff working at HIV/TB care settings e.g. Nursing staff at ART centre and counsellors.

**Action:** A team constituting of DAC and CTD members as follows will be constituted as writing group for simplifying the Infection control guidelines w.r.t HIV/TB through email-consultations:

i) Dr Mayank Ghedia (National Consultant Labs/CTD)
ii) Dr Rajesh Deshmukh (Program officer HIV/TB/DAC)
iii) Dr Amar Shah (National Consultant HIV/TB/CTD)
iv) Dr Sudhir Chawala (JD CST, GSACS)
v) Dr Emmanuel (RC Andhra Pradesh)
vi) Dr B.K Swain (JD BSD Odisha)
vi) Dr Jayashree (JD BSD Kerala)
viii) Dr Murugesan (STO Tamil Nadu)

Team will be coordinated by Dr Mayan K Ghedia (NC labs /CTD) and submit the draft to DDG (TB) & DDGBSD within 2 weeks. (Responsibility : CTD/DAC)

2. To intensify the supervision and building capacity of States through cross learning’s, it is suggested that State teams of 5 members comprising of SACS officials, State TB cell officials, RNTCP Consultant,
coordinator & Member of National Institute of TB /National Institute of HIV in the zone.

Taminadu team will proceed with the scheduled plan of visits to Maharashtra and Karnataka team(Dr Kaurur, Dr Balaji, Dr Anil, Dr Chetna, Dr Shastri & Member of NTI Bangalore/NIRT Chennai to visit Tamil Nadu(2 Districts including Cuddalore, Vellore). TA/DA of the visits (except for WHO/DAC representatives will be drawn from respective State/UT TB Cell/State AIDS Control Society.

**Action:** Letter from Central TB Division /Department of AIDS Control to the concerned states will be sent after finalisation of the visit plan. State TB Cell & SACS to visits the poor performing districts in the states with checklist and recommendations to be debrief to the Health Secretary of the State along with Project Directors of SACS.(Responsibility:CTD/DAC/STC/SACS)

3. Linkage of CBNAAT services to PLHIV attending ART centres needs to be strengthened. The information related to number of PLHIV screened for TB using CBNAAT should be reported to the CTD & DAC in prescribed format.

**Action:** CTD to develop a format and circulate to State for reporting to CTD and DAC on monthly basis.(Responsibility:CTD)

4. As a part of Joint Supervisory visit from DAC and CTD to States /UTs visit to be scheduled to Ernakulum District (Kerala) including other districts to Document best practices in the District and State. Similarly State TB Cell/SACS to share success stories/best practices to CTD/DAC for documentation.

**Action:** Nodal officers HIV/TB at DAC and CTD to visit Kerala(include district Ernakulum ) & submit best practices in the District /State to DAC/CTD. (Responsibility:CTD/DAC)

5. States to share TB/HIV Information, Education & Communication (IEC) material developed by State TB Cell/SACS/District to DAC/CTD at earliest for compilation at National level.

**Action:** STCs/SACS to share TB/HIV Information ,Education & Communication (IEC) material developed by State TB Cell/SACS/District to DAC/CTD. (Responsibility : CTD/DAC)
6. Sizable proportion (23%) of TB HIV co-infected patients are leading to poor outcomes. It was suggested that a protocol should be developed jointly by CTD and DAC to study the associated factors such as (prevalence of Diabetes among this TB HIV Co-infected patients.) SACS/State TB Cell, TB-HIV Coordinators & Regional coordinators from states to help in the data collection. RNTCP Consultants will be technically supporting the EPI Data entry by respective states DEOs after validation.

**Action:** SACS/State TB Cell, TB HIV Coordinators & Regional coordinators from states to help in the data collection related to the TB HIV co-infected patients. RNTCP Consultants will be technically supporting the EPI Data entry by respective states DEOs after validation. (Responsibility: CTD/DAC)

7. To improve the intensified case finding at ART Centres, It was recommended that Care Coordinators who are the first point of contact can conduct symptom screening for early diagnosis of TB among PLHIVs and record the symptom screening details in the green card. ICF at all CSCs should be strengthened to increase screening of presumptive TB cases amongst PLHIV registered at CSCs and their family members through community-based ICF approach using Outreach workers of CSCs.

**Action:** Guidance tool regarding active case finding by care coordinators and outreach workers of CSCs will be sent by CST division, DAC to all concerned. (Responsibility: CST/DAC)

8. It was noticed that State TB/HIV coordination committees, State Technical review meeting are not held regularly in States/UTs. Joint HIV/TB technical review are also suggested at state level to be called alternatively by State TB officer and JD(BSD) SACS.JD(CST) should also be invited in this meeting. Technical review should be conducted monthly alternatively at State TB cell and SACS.

**Action:** State TB/HIV coordination committees, State Technical review meeting should be held regularly. In addition Joint HIV/TB technical review should be held monthly at state level to be called alternatively by State TB officer and JD(BSD) SACS.JD(CST) should also be invited in this meeting. (Responsibility: CTD)
9. During the review of the Maharashtra state it was noticed that the mortality among TB HIV co-infected cases is high in Mumbai and also the ART, CPT coverage in Parel, Grant Road are low.

It was suggested that a Joint visit of team comprising of 5 members including nodal officers HIV/TB from DAC and CTD to plan visit to Mumbai (Maharashtra) on priority and report to be submitted to CTD/DAC. It was also suggested that Mumbai Action plan to incorporate HIV/TB activities on priority.

**Action:** Joint visit of team comprising of 5 members including nodal officers HIV/TB from DAC and CTD to plan visit to Mumbai (Maharashtra) on priority and report to be submitted to CTD/DAC. Nodal officers from CTD & DAC to finalise dates immediately in coordination with STC Maharashtra/MDACS/MSACS.

(Responsibility: CTD/DAC/STO MH/MSACS/MDACS/)

10. It was noticed that TB/HIV coordinators are need update on HIV & TB. Two days training at National level to be conducted by CTD.

**Action:** The training schedule of TB/HIV coordinators to be finalised and 2 days training of TB/HIV coordinators to be held at National level by CTD in coordination with DAC. (Responsibility: CTD)

11. To strengthen the involvement of Railway Hospitals, ESIS & Prisons in HIV/TB collaborative activities it was requested that a communication from CTD & DAC should be sent to National authorities of Railways ESIS & Prisons.

**Action:** A letter from DDG (BSD) & DDG (TB) should be sent jointly to National authorities of Railways ESIS & Prisons hospitals for involvement in HIV/TB collaborative activities. (Responsibility: CTD/DAC)

**On the 2nd day (17th July 2014) Group works were conducted on:**

1. Action plan to Improve Co-location of ICTC-DMC & improve ICF at ICTC in states
2. Action plan to Improve ICF at ART in States
3. Action plan to Implement Airborne infection control in HIV/TB care settings

The meeting ended with a concluding remarks by DDG BSD/NACO & vote of thanks by Addl. DDG, Dr. K.S.Sachdeva.
### Annex I: List of participants from NACO, CTD, NTI (MOHFW/GOI), WHO India

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<th>S.No.</th>
<th>Name</th>
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<tr>
<td>1</td>
<td>Dr. Ashok Kumar</td>
<td>Dy.DG BSD, NACO</td>
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<td>2</td>
<td>Dr. Prahlad Kumar</td>
<td>Director, NTI</td>
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<td>3</td>
<td>Dr. K.S. Sachdeva</td>
<td>Addl. DDG TB, CTD</td>
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<td>4</td>
<td>Dr. Sreenivas A.N</td>
<td>NPO TB, WHO India</td>
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<td>5</td>
<td>Dr. Malik Parmar</td>
<td>NPO DR-TB, WHO India</td>
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<td>6</td>
<td>Dr. Mayank Ghedia</td>
<td>NC Labs/CTD</td>
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<td>7</td>
<td>Dr. Rajesh Deshmukh</td>
<td>NC&amp; PO (HIV/TB – NACO)</td>
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<td>8</td>
<td>Dr. Amar Shah</td>
<td>NC TB HIV/CTD</td>
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<td>1</td>
<td>Dr. Sahu S (STO Odisha)</td>
<td>14 Dr. Suryankantha (STO Karnataka)</td>
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<td>2</td>
<td>Dr B.K Swain (JD BSD Odisha)</td>
<td>15 Dr Karur (PD KSACS)</td>
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<td>3</td>
<td>Dr. Jayashree (JD BSD Kerala)</td>
<td>16 Dr Selvarajan (JDBSD) Karnataka</td>
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<td>4</td>
<td>Dr. Maximiano De Sa (STO Goa)</td>
<td>17 Dr. P M Patel (STDC Dir Gujarat)</td>
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<td>5</td>
<td>Ms. Esther Dhanwade (MDACS)</td>
<td>18 Dr Lalitha Umraskar (JD CST Goa)</td>
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<td>6</td>
<td>Dr Dixit K (STHC Gujarat)</td>
<td>19 Dr Govindarajan (STO Puducherry)</td>
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<td>7</td>
<td>Dr. Jayasankar .S (STO Kerala)</td>
<td>20 Ms Mayarani Mohanty. AD (ICTC Odhisha SACS)</td>
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<td>8</td>
<td>Dr. B. C. Das (STHC Goa)</td>
<td>21 Dr S Shastri (STC Karnataka)</td>
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<td>9</td>
<td>Dr. Prasad Sant (DD BSD D &amp; D)</td>
<td>22 Dr. Chakrapani Chatla (HQ consultant AP)</td>
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<td>10</td>
<td>Dr Sanjay S (Mah HQ Consultant)</td>
<td>23 Dr. A K Mahala (STO DNH)</td>
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<td>11</td>
<td>Dr Shazia (TN HQ Consultant)</td>
<td>24 Dr. G. Kamal Chand Naik (STHC AP)</td>
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<td>12</td>
<td>Dr Balaji N (Karnataka HQ Consultant)</td>
<td>25 Dr Kartkeyan (Kerala HQ Consultant)</td>
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<td>13</td>
<td>Dr Chetana (Epidemiologist KSAPS)</td>
<td>26 Dr Satish (KSACS)</td>
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Participants from States/UTs including Regional coordinators/CST

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<td>27</td>
<td>Dr. T. Rani Samuktha</td>
<td>(STO Andhra Pradesh)</td>
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<td>28</td>
<td>Dr Murugesan (STO Tamil Nadu)</td>
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<td>Dr Vetal (STHC Maharashtra)</td>
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<td>Dr. A K Mahala (STO DNH)</td>
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<td>31</td>
<td>Dr Sudhir Chawla (JD CST Guj)</td>
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<td>32</td>
<td>Dr Pramod Deoraj (RC DAPCU MH)</td>
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<td>33</td>
<td>Dr Quincy Madonna (STHC TN)</td>
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<td>34</td>
<td>Dr Prabhakumari (ST HC Kerala)</td>
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<td>35</td>
<td>Dr Bhavin (Guj HQ Consultant)</td>
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<td>Dr Rajabhau (Goa HQ Consultant)</td>
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<td>37</td>
<td>Dr Kindo (Odhisha HQ Consultant)</td>
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<td>38</td>
<td>Dr. Emmanuel (RC Andhra Pradesh)</td>
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<tr>
<td>39</td>
<td>Dr. A.S. Valan (RC TN, Kerala)</td>
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Annex II: Agenda

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<thead>
<tr>
<th>National Joint review meeting on TB-HIV collaborative activities</th>
<th>Venue: National Tuberculosis Institute NTI, Bellary Road, Bangalore, Karnataka</th>
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<tr>
<td><strong>Objectives:</strong></td>
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<td>To review the performance of the TB/HIV collaborative activities at state and district level</td>
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<td>Set the roadmap for the states to implement newer policies in TB/HIV</td>
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<tr>
<td><strong>Programme</strong></td>
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<tr>
<td><strong>Day 1 16th July 2014</strong></td>
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<tr>
<td><strong>08.30am – 09.00am</strong></td>
<td>Registration</td>
</tr>
<tr>
<td><strong>09.00am - 09.45am</strong></td>
<td>Inaugural Session Welcome</td>
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<tr>
<td></td>
<td>Objectives of the review meeting</td>
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<tr>
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<td>Address</td>
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<td></td>
<td>Vote of Thanks</td>
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<tr>
<td><strong>09.45am-10.15am</strong></td>
<td>Tea Break</td>
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<tr>
<td><strong>10.15am – 11.00am</strong></td>
<td>Status &amp; Update on TB- HIV collaborative activities in India</td>
</tr>
<tr>
<td><strong>11.00am – 12.00noon</strong></td>
<td>Overview of NACP-IV &amp; TB Infection control in HIV care settings in India</td>
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<tr>
<td><strong>12.00noon – 13.00pm</strong></td>
<td>Implementation of TB-HIV pilot project including 3 I’s to reduce mortality among PLHIVs</td>
</tr>
<tr>
<td><strong>13.00pm - 14.00pm</strong></td>
<td>Lunch Break</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
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<tr>
<td>14.00-15.30</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
</tr>
<tr>
<td>15.30pm-17.00pm</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
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<tr>
<td>17.00pm-17.15pm</td>
<td>Tea Break</td>
</tr>
<tr>
<td>17.15pm-18.00pm</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
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</tbody>
</table>

**Day 2**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
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<tbody>
<tr>
<td>09.00am - 10.30am</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
<td>STO &amp;JD/DD(BSD) of SACS Andhra Pradesh &amp; Telangana</td>
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<tr>
<td>10.30am - 10.45am</td>
<td>Tea Break</td>
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<tr>
<td>10.45am - 12.15noon</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
<td>STO &amp;JD/DD(BSD) of SACS Maharashtra</td>
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<tr>
<td>12.15pm - 13.15pm</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
<td>STO &amp;JD/DD(BSD) of SACS Goa</td>
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<tr>
<td>13.15pm - 14.00pm</td>
<td>Lunch Break</td>
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<tr>
<td>14:00pm - 15:30pm</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
<td>STO &amp;JD/DD(BSD) of SACS Gujarat, Diu &amp;Daman, Dadra &amp; Nagar Haveli</td>
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<tr>
<td>15:30pm - 16:30pm</td>
<td>Template presentation by state on TB-HIV collaborative activities</td>
<td>STO &amp;JD/DD(BSD) of SACS Odisha</td>
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<tr>
<td>16.30pm - 16.45pm</td>
<td>Tea Break</td>
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<tr>
<td>16.45pm - 18.00pm</td>
<td>Action points and way ahead. Conclusion with Final Remarks</td>
<td>Dr. K S Sachdeva(Addl.DDG) DDG (BSD)</td>
</tr>
</tbody>
</table>