Minutes of the Third meeting of the National Airborne Infection Control Committee

LRS Institute, New Delhi
24th December, 2009

The third meeting of the National Airborne Infection Control Committee (NAICC) was held at LRS Institute, New Delhi on 24th December, 2009 under the chairmanship of Prof S K Jindal. The list of members and other participants is enclosed in Annexure I.

Prof Jindal welcomed all the members and participants. The committee members deliberated on the following objectives during the meeting:

1. *To review and endorse the Final draft of the National Guidelines on Airborne Infection Control (AIC) in Healthcare and Other Settings in India.*
2. *To discuss the Operational Research Protocol for pilot testing the operational feasibility and effectiveness of implementation of the National AIC Guidelines in selected facilities in 2 states.*
3. *To discuss and endorse the plan of action for pilot implementation of the National AIC Guidelines in West Bengal and Gujarat.*
4. *To discuss adaptation of Respiratory Infection Prevention and Control (RIPC) package of training materials for health care workers with support from NCDC.*
5. *To work out the modalities of engaging PATH in the pilot implementation of National AIC Guidelines.*

Dr Puneet Dewan made a presentation on **"Finalization of National Guidelines on Airborne Infection Control – Unresolved Issues"** highlighting the areas that need to be considered for a decision by the committee and their appropriate reflection in the national guidelines. He stressed that the area of infection control is growing in evidence, and that future revisions in the guidelines would be expected as the experience is gained. The decisions on the unresolved issues are as follows:

Unanswered Questions / Critical Issues:

1. ***Surveillance of TB or other infectious respiratory disease among health care workers***
   - The section on surveillance needs to be included in the National Guidelines restricting it to routine reporting of instances of TB by health care workers.
   - The guidelines should include a general recommendation for the activity, but not specify operational guidelines. Operational guidance would be issued in the future, after implementation experiences could be gathered and evaluated.
   - The selection of sites where surveillance would be included in the pilot should be restricted to the setting.
   - The guidelines would be restricted to surveillance for TB alone, and would include only passive case reporting and not active screening. It was acknowledged that the episodes of acute respiratory infections reported by health care workers would be another option to monitor the effectiveness of the entire package of Airborne Infection Control, and that should be considered in the pilot project development.

2. ***Reporting on airborne infection control activities***
   - The NAICC requested MoHFW to consider integrating AIC reports into existing IDSP or NRHM reports.
   - If MoHFW agrees to this integration, then IDSP / NRHM should be included in the title of all the reporting formats.
   - State and District health societies under NRHM should be responsible for analysis and periodic review of the progress made by various health care facilities in implementation of airborne infection control guidelines.

- The timelines for reporting needs to be synchronized with existing reports
- The mechanism of compilation, analysis and review of these reports needs to be clarified further in the guidelines.

3. Patient Counseling:

- Specific recommendations for sputum collection/disposal at home
  - The range of minimal possible options may be given in the guidelines for sputum collection and disposal at home. Eg.
    - Collect sputum in paper (tissue or any other paper) and burn it in the evening
    - Collect sputum in ash pot or lime container in rural areas and burry it in the evening

4. Training:

- The training of SAICC members, District SC-BMW/IC committee members, programme officers, infection control focal persons and health care facility administrators at the state level would be in the National AIC Guidelines using the workshop methodology similar to the one used in the National Capacity Building workshop on AIC conducted in October 2009. The course can be reduced to a minimum of 4 days for the state level workshops.
- The NIHFW/NCDC and states may be requested by CTD to take the onus of training the general health workers in general principles of airborne infection control. The training of trainers from SIHFW and master trainers identified by the states would be conducted at the national level by NCDC with support from NAICC. Normative guidelines and training materials inspired from the WHO-published "Respiratory Infection Prevention and Control" health care worker training package would be developed by NCDC with support from NAICC for this training.
- The committee requested NCDC to take up this responsibility of aligning the WHO-published "Respiratory Infection Prevention and Control" health care worker training package to the national AIC guidelines. A formal letter requesting the same need to be sent to the Director, NCDC from CTD on behalf of NAICC to take up this task.
- The training of health care workers should be prioritized based on level of risk of acquiring infection. Wherever possible this training needs to be preferably integrated with trainings on H1N1 Influenza.
- A letter also needs to be sent from CTD to Director Emergency Medical Relief to support in integrating the RIPC training with the training on Guidelines for H1N1 Influenza in coordination with NCDC.
- Small section of infection control activities also needs to be integrated with the revised RNTCP modules, so that medical officers nationwide have exposure to good infection control principles and recommended best practices.
- In the draft guidelines, Section B under the training section on RIPC training needs to be further clarified.

5. Infection control related to autopsies:

- This section needs to be retained in the guidelines.

6. Next Steps:

- Further editing and incorporation of suggestions by the committee members need to be completed by the first week of February 2010.
- Publication on RNTCP website should be done as soon as possible after obtaining necessary approval from the MoHFW, including NRHM.
- States to proceed with pilot based on the current draft
- Guidelines would be revised as and when experiences available from planned pilot activities or other settings to inform improvements.

This was followed by an open discussion where members made suggestions for further minor editing, corrections and modifications required in the draft guidelines.

Dr Malik Parmar then made a presentation on the Operational Research Protocol on Airborne Infection Control Pilot titled **"A pilot project to assess the feasibility and effectiveness of implementation of National Airborne Infection Control Guidelines in selected health care facilities in three states of India."** The presentation was followed by further deliberations on the protocol and following decisions arrived at pertaining to the OR Proposal:

1. The pilot would not be dependent on procurement of Vanometer, UV meters etc.
2. A variety of health care facilities need to be included in each of the districts to enable assessment of the district coordination mechanism
3. The indicator on TB surveillance may not be feasible and difficult to measure. Hence, the number of acute respiratory tract infection episodes reported by health care workers of the selected facilities should also be assessed.
4. The guidelines would not be restricted only to the pilot states but would be open for any interested state or facility for adoption and implementation. However, the pilot related activities would be restricted only to the selected pilot states.
5. The timelines for pilot should be extended from December 2010 to March 201
6. The responsibilities of the programme manager in the pilot implementation need to be spelt out more clearly.
7. The committee endorsed the proposal for implementation with simplifications suggested.
8. Considering the interest and commitment expressed by STO Andhra Pradesh in his email to DDG TB, NAICC agreed upon inclusion of AP as the 3rd pilot state. CTD may formally communicate the same to AP state, share the guidelines and call for their action plan.

This was followed by presentation of the **state infection control plan by Dr RN Solanki, Gujarat and Dr Kar, DHS, West Bengal.** Each of the state plans was discussed further to arrive at the following decisions:

Gujarat State Action Plan:

1. The committee suggested that surveillance needs to be passive. There needs to be an element of testing the feasibility of surveillance system during the pilot.
2. The element of educating the staff to report occurrence of ARTI episodes needs to be added in the plan.

West Bengal State Action Plan:

1. It was suggested that for funding of the pilot activities, there needs to be a formal communication from the Ministry of Health and Family Welfare, GoI to Mission Director at National level to agree on extending support for implementation of infection control guidelines and in turn directives need to be sent out by MD NRHM to State MD NRHM of the pilot states.
2. Focal points need to be defined for each of the major activities in the plan. It was decided in the first meeting that Public Health Programme managers would be responsible for the implementation of infection control activities with support from TB Programme managers.
3. It was informed that funding support for infection control activities is being proposed in the project implementation plan under NRHM additionality component. It was requested that this NRHM additionality component may be approved from Central level.
4. While preparing the comments on NRHM additionalities, CTD may justify and support the infection control activities related budget proposed by the pilot states. Sensitization of NRHM reviewer at National level about this aspect may be undertaken by CTD.

Dr Sheena George, Lab Consultant, PATH then presented the **USAID supported PATH work plan for infection control**. The following decisions were arrived at after discussion by the NAICC members:

1. It was decided that the technical human resources and experts need to be spelt out more clearly especially people to be hired with what expertise and timelines for the same

2. The role of states & PATH needs to be clarified further.
3. ACSM activities on Infection Control and development of new training material and dissemination can be taken up by PATH.
4. Sites tentatively proposed for AP state are more high risk settings. AP needs to take general health institutes in the plan. DOTS-plus sites in particular are not a priority, as these have TA for infection control already through other mechanisms, and are very limited in size and scope.
5. International resources and expertise need to be utilized more for capacity building of engineers and architects.
6. CTD may request partners PATH / WHO for such consultants who would support the following activities
    a. Trainings / Capacity Building, particularly of architects and engineers
    b. Assistance in assessments
    c. Monitor pilot

This was followed by a presentation by Dr Sunil Gupta, Joint Director, NCDC on **Proposed Changes in RIPC package of training material for Haws for alignment with National AIC Guidelines**. The following decisions were arrived at after discussion by the NAICC members:

1. It was informed to the NAICC that a WHO CDC workshop on RIPC was held on 4th – 7th November '09 at NCDC where NCDC had co-facilitated.
2. It was highlighted that laboratory workers infection control practices are not covered in RIPC. Similarly, infection control practices in household and community settings and waste disposal practices are also not covered in RIPC. The committee may consider adding a section on this.
3. Specific IEC materials would require to be developed on airborne infection control.
4. RIPC training curriculum is based on assumption that participants are qualified service providers and are trained in basic infection control guidelines.
5. Specific slight modifications for various cadres of staff need to be considered in curriculum
6. Presentations in the RIPC package may be condensed, clubbed and minimized to avoid unnecessary repetition of the same facts
7. It was decided that a sub-committee needs to be formed as a composite group of experts to work on adaptation on RIPC package to the NAIC guidelines. Dr Sunil Gupta from NCDC to Chair the sub-committee and complete the adaptation within the next 3 months.
8. Standard reference material published by WHO is available for use by this sub-committee on adaptation of RICP package to the NAIC guidelines.
9. CTD may be requested to send formal communication to Director, NCDC, NIHFW, and NRHM Mission Director for directives to SIHFW, NRHM Directors in the state on taking up the task training of health care work force in RIPC package with funding support from NRHM.

Dr Puneet Dewan informed the NAICC members that there is a training course of Architects and Engineers in TB Infection Control at Harvard Institute from Public Health in the later half of 2010.
- The NAICC recommended that Indian participants, particularly medical architects from MoHFW and States, Hospital services Consultancy Corporation HSCC or PWD should be nominated for this training course. A request should be sent from CTD to WHO to facilitate the application and support for travel of such candidates.
- The NAICC recommended that a course for capacity building of architects and engineers in airborne infection control considerations be arranged in India, perhaps with international facilitation. A request should be sent from CTD to WHO to identify support for and facilitate this workshop in 2nd or 3rd quarter 2010, subject to the availability of appropriate facilitators. Participants would include State PWD officials, engineering faculty who may be involved in future trainings, and infection control focal points.

It was decided that the State level Capacity Building Workshop on Airborne infection control for SAICC members, SC-BMW/IC members of selected districts and administrators/in charge officials of the identified sites for pilot implementation would be held from February - March '10 at

Ahmedabad, Gujarat and Kolkata, West Bengal. Funding support for the activity would be sought from States

Dr Jindal then presented the final summary of the decisions taken on behalf of the NAICC as follows:

1. The NAICC approved the National Guidelines on Airborne Infection Control in Health Care and Other settings. The guidelines may be submitted to the MoHFW, GoI and NRHM Director for endorsement and necessary support after minor edits as discussed during the meeting. The guidelines may then be disseminated to the states and hosted on the programme website TBCINDIA.ORG
2. The NAICC approved the Operation Research protocol on pilot implementation of the guidelines in the pilot states with minor suggestions that may be incorporated in the protocol.
3. The states of Gujarat and West Bengal may go ahead with their state infection control action plan.
4. Andhra Pradesh with support of PATH may be sent the sample plans of Gujarat and West Bengal to facilitate them prepare their state infection control action plan
5. A Sub-committee under Chairmanship of Dr Sunil Gupta, Joint Director, NCDC may be formed for adaptation of the RIPC package with the NAIC guidelines.
6. In-country and out-of-country capacity-building for engineers and architects on airborne infection control issues should be pursued.

Annexure 1

List of Participants:

1. Prof Dr S K Jindal, Head, Dept. of Pulmonary Medicine, PGIMER, Chandigarh – Chairman
2. Dr D Behara, Director, LRS Institute, New Delhi
3. Dr Devesh Gupta, CMO-TB, CTD, New Delhi
4. Dr Aniruddha Kar, Director Health Services, West Bengal
5. Prof. R K Solanki, Dept. of Pulmonary Medicine, BJMC, Ahmedabad, Gujarat
6. Dr S Rajasekharan, NACO Consultant & Ex-Director, GHTM, Tambaram, Chennai
7. Dr Sunil Gupta, Joint Director, NCDC, New Delhi
8. Dr Rohit Sarin, AMS & Head, Dept of TB Control & Training, LRS Institute, New Delhi
9. Dr Rupak Singla, Head, Dept of TB and Respiratory Diseases, LRS Institute, New Delhi
10. Dr Anand Sridhar, Microbiologist, NTI, Bangalore
11. Dr Puneet Dewan, MO-TB, WHO SEARO, New Delhi
12. Dr Ranjani Ramachandran, Laboratory Consultant, WHO SEARO, New Delhi
13. Dr Malik Parmar, WHO Consultant - RNTCP, CTD, New Delhi
14. Dr A Sreenivas, WHO Consultant - Epidemiologist, CTD, New Delhi
15. Dr Sheena George, Laboratory Consultant, PATH International, New Delhi
16. Dr Kiran Rade, Medical Consultant – WHO RNTCP (Technical Assistance Project), Gujarat
17. Dr Silajit Sarkar, Medical Consultant – WHO RNTCP (Technical Assistance Project), West Bengal