PROJECT AXSHYA

A Civil Society Initiative to Strengthen TB Care and Control in India

The Global Fund Round 9 TB Project

Activity Report 2010-11
Project Axshya aims to improve access to quality TB care and control through a partnership between government and civil society. It will support India’s national TB control programme to expand its reach, visibility and effectiveness, and engage community-based providers to improve TB services, especially for women, children, marginalized, vulnerable and TB-HIV co-infected populations.

Guiding principles
- Universal access to quality TB services
- Community participation
- Sustainable interventions
- Equitable distribution with social and gender sensitivity

Project Axshya will reach about 750 million people, including some 174 million women, 199 million children, 250 million people in poor and backward districts, 50 million people in tribal districts and 40 million people in urban slums. It will cover 374 districts across 23 states of India, with 300 districts managed by The Union and 74 districts by World Vision India. 16 states will be managed by The Union, two by WVI and five jointly, through their partners.

Project Axshya builds a new dimension to TB control in India – community ‘ownership’ through civil society led public health programming. This activity report tries to capture activities, success stories and progress of the Union led Project Axshya, in the first year of its launch and implementation in 90 districts in the country. Behind this report are a number of processes, human effort, passion, commitment, dedication as well as the challenges of the patient with tuberculosis in India – no report can fully capture all of this. As this project enters its second year and expands to another 150 districts in the country, this report helps us to pause, to say ‘thank you’ and to encourage each other – patients, the communities they live in, the national programme (RNTCP), implementing partner NGOs, consultants and staff, the Global Fund and many other stakeholders. There is much to do, and not enough time or resources, but Project Axshya has clearly begun well.

- Dr Nevin C Wilson, Regional Director
  The Union South-East Asia Office

Project Axshya, through its innovative interventions focusing on Advocacy, Communication and Social Mobilisation, is strengthening the Revised National TB Control Programme to achieve its objective of Universal Access to TB services.

Dr Ashok Kumar Gupta
Deputy Director General (TB)
Directorate General of Health Services
Ministry of Health and Family Welfare
Government of India

The cover photo is of Kamla. This young tribal woman is on DOTS treatment. Her DOT provider is a community volunteer, Geeta. Kamla was deserted by her husband due to her disease and she had to come to her parent’s house for treatment. After taking DOTS for two months, her condition has improved remarkably. Her husband now wants her to return back.
Message

It is with a sense of great satisfaction and gratitude that we, at The Union and our partner organisations, close the first year of Project Axshya… and it is with a sense of great enthusiasm and commitment that we begin the next…

We feel satisfied as the project has been successfully initiated and mainstreamed, on course towards its objectives, principles and activities; and we feel grateful towards all those who made this possible. We feel grateful to the many organisations and individuals involved, and to the people whose lives the project means to save and whose suffering it means to alleviate – who truly showed us the value and potential of ‘working together’, across sectors and linkages. For this is the underlying ethos on which Project Axshya rests. It is an accepted fact, and our firm belief, that a resilient disease like tuberculosis – with its tentacles in poverty, in ignorance, in isolation, and in its links with other afflictions, going back to over a century despite a cure for it – can only be fought together. It is only when doctors and researchers and programmes work together with advocates and communities and organisations – combining medical and public health initiatives with awareness and community-building initiatives – that we can begin to hope for a headway. That is why Project Axshya was strategized around advocacy, communication and social mobilisation… to consolidate the achievements of India’s national tuberculosis control programme and to take them further… in ways and to places that only working together can… in ways that involve communities as much as all other stakeholders, and to the most diverse, remote, and vulnerable stretches of a country that still reels under the highest burden of TB and faces among the gravest of threats from drug-resistant TB and TB-HIV co-infection globally.

The first year has been a period of immense learning for us and as we move to the next with our partners, we look back with pride at having worked very hard. The achievements of this year, as well as challenges for the next, have both been motivating. There were some good practices that were clearly established, whose value was evident – such as the value of training health personnel in soft skills, which will go a long way to improve client-provider interactions and will neither be limited to TB-specific outcomes nor to the project term. Similarly, increasing local ownership of TB care and control, or coordinating efforts across sectors and levels – based on the premise that this will visibly enhance the quality and reach of the national programme – has already begun to show a change in the awareness of communities and community-based care providers, across project districts nationally. At the same time, managing the intensity and complexity of community-level interventions under Project Axshya, involving stakeholders across sectors – government, civil society, private doctors, technical agencies, affected communities, and the media – has been overwhelming and testing.

As we present the Activity Report for 2010-11, we take this opportunity to thank our donor, The Global Fund, who shared our belief in the immense value of this project and went ahead. And we thank our implementing partners, our colleagues at The Union, the Government of India, stakeholders spread across the country and, above all, the communities and the people who have been a part of this challenging and demanding, but truly enriching and fulfilling, journey.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACSM</td>
<td>Advocacy, Communication and Social Mobilisation</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune-Deficiency Syndrome</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<tr>
<td>APM</td>
<td>Assistant Programme Manager</td>
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<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
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<tr>
<td>CBCI-CARD</td>
<td>Catholic Bishops Conference of India - Coalition for AIDS and Related Diseases</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention (USA)</td>
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<tr>
<td>CHAI</td>
<td>Catholic Health Association of India</td>
</tr>
<tr>
<td>CMAI</td>
<td>Christian Medical Association of India</td>
</tr>
<tr>
<td>CNA</td>
<td>Communication Needs Assessment</td>
</tr>
<tr>
<td>CTD</td>
<td>Central TB Division (India)</td>
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<tr>
<td>DDG (TB)</td>
<td>Deputy Director General (TB) / National TB Programme Manager</td>
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<tr>
<td>DLN</td>
<td>District-Level Network</td>
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<tr>
<td>DMC</td>
<td>Designated Microscopy Centre</td>
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<tr>
<td>DOT</td>
<td>Directly Observed Treatment</td>
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<tr>
<td>DOTS</td>
<td>Directly-Observed Therapy-Short Course</td>
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<tr>
<td>DTC</td>
<td>District TB Cell</td>
</tr>
<tr>
<td>DTO</td>
<td>District TB Officer</td>
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<tr>
<td>EHA</td>
<td>Emmanuel Hospital Association (India)</td>
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<tr>
<td>GKS</td>
<td>Gaon Kalyan Samiti (Village Health and Sanitation Committee)</td>
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<tr>
<td>GoI</td>
<td>Government of India</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICTC</td>
<td>Integrated Counseling and Testing Centre</td>
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<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<tr>
<td>IMPF</td>
<td>Indian Medical Parliamentarians Forum</td>
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<td>IPC</td>
<td>Interpersonal Communication</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitudes and Practices</td>
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<tr>
<td>LHV</td>
<td>Lady Health Visitor</td>
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<tr>
<td>LRS Institute</td>
<td>Lala Ram Sarup Institute for TB and Respiratory Diseases</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td>MAMTA</td>
<td>Mamta Health Institute for Mother and Child (India)</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MDR-TB</td>
<td>Multidrug-Resistant Tuberculosis</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health &amp; Family Welfare, Government of India</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>MPW</td>
<td>Multi-Purpose Worker</td>
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<tr>
<td>MSS</td>
<td>Mamta Samajik Sanstha (India)</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NRHM</td>
<td>National Rural Health Mission (India)</td>
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<td>NTI</td>
<td>National Tuberculosis Institute (Bangalore)</td>
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<td>NTP</td>
<td>National Tuberculosis Programme</td>
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<td>OR</td>
<td>Operations Research</td>
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<td>PHC</td>
<td>Primary Health Centre</td>
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<tr>
<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
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<tr>
<td>PM</td>
<td>Programme Manager</td>
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<tr>
<td>PMU</td>
<td>Project Management Unit (Project Axshya)</td>
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<tr>
<td>PP</td>
<td>Private Practitioner</td>
</tr>
<tr>
<td>PPM</td>
<td>Public Private Mix</td>
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<tr>
<td>PR</td>
<td>Principal Recipient (Project Axshya)</td>
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<tr>
<td>PRI</td>
<td>Panchayati Raj Institution</td>
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<tr>
<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>REACH</td>
<td>Resource Group for Education and Advocacy for Community Health (India)</td>
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<tr>
<td>RHCP</td>
<td>Rural Health Care Provider</td>
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<tr>
<td>RMP</td>
<td>Registered Medical Practitioner</td>
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<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Programme (India)</td>
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<tr>
<td>SHG</td>
<td>Self-Help Group</td>
</tr>
<tr>
<td>SR</td>
<td>Sub-Recipient (Project Axshya)</td>
</tr>
<tr>
<td>STAG</td>
<td>Strategic and Technical Advisory Group</td>
</tr>
<tr>
<td>STC</td>
<td>State TB Cell</td>
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<tr>
<td>STO</td>
<td>State TB Officer</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>The Global Fund</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>The Union</td>
<td>International Union Against Tuberculosis and Lung Disease</td>
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<tr>
<td>TOT</td>
<td>Training-of-Trainers</td>
</tr>
<tr>
<td>TRC</td>
<td>Tuberculosis Research Centre (Chennai)</td>
</tr>
<tr>
<td>TU</td>
<td>Tuberculosis Unit</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>USEA</td>
<td>The Union South-East Asia Office</td>
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<tr>
<td>VHAi</td>
<td>Voluntary Health Association of India</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WVI</td>
<td>World Vision India</td>
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<tr>
<td>XDR-TB</td>
<td>Extensively Drug Resistant Tuberculosis</td>
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</table>
India bears the highest burden of tuberculosis (TB) globally. In addition to addressing the emerging challenges of drug-resistant TB and TB-HIV co-infection, a lot depends on how well awareness on TB, the reach of India’s Revised National TB Control Programme (RNTCP), and access to services, is spread nationally. The Round 9 TB grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) to India is among the largest and envisages a concerted response from government and civil society. The three principal recipients to the grant are the Government of India, The International Union Against Tuberculosis and Lung Disease (The Union) and World Vision India (WVI). While the government focus is on drug-resistant TB, the other two seek to enhance RNTCP’s reach and effectiveness, and strengthen the much-needed engagement of civil society in TB control, through a landmark project that aims to reach some 750 million people in 374 districts across 23 states of India by 2015 – 16 states managed by The Union, two by WVI and five jointly. Project Axshya (meaning ‘TB-Free’) got underway last year, and focuses on advocacy, communication and social mobilisation activities through a national network of partner organisations who will implement them in their respective states and districts through their own sub-networks of non-governmental organisations (NGOs) and community-based organisations (CBOs).

The Union, a global pathfinder in TB control that works closely with international, regional and local partners, lung associations, TB programmes and individuals, is implementing the project in 300 districts through nine sub-recipient partners. These are reputed public health organisations of India with considerable experience in TB care and control and trust in the communities they work with. In line with its vision of ‘health solutions for the poor’, The Union is especially focusing on those who have the greatest difficulty in accessing TB services – women, children, marginalised, vulnerable and TB-HIV co-infected populations. Of the 300 project districts that it will manage, over 200 comprise underperforming (with case notification rates of 50/100,000 or less), poor and backward, geographically difficult, and predominantly tribal districts. The Union South-East Asia Office (USEA) is managing Project Axshya for The Union. It is working closely with its partners in 90 districts in year one; will expand to 240 districts in year two, and to 300 in year three of the five-year project, with Phase 1 running from April 2010 to March 2012. The project is complementing programme efforts, engaging private providers in RNTCP schemes, improving access to diagnostics, committing to fight drug-resistant TB and TB-HIV at all levels, and enhancing civil society involvement in TB care and control.

Early 2010 saw the finalisation of grant agreements with partners and large-scale staff recruitment at the Project Management Unit (PMU) in USEA, at the sub-recipient partner level, and in project districts. By the last quarter of 2010, Project Axshya had been launched in all project states by the respective partners, project management and monitoring systems had been set in place, initial trainings to orient partners and key stakeholders had been completed and all major activities had been initiated with great enthusiasm and dynamism. In the first year, the overarching focus has been on beginning a successful process to engage communities in TB care and control across the 90 districts, while simultaneously building capacity of healthcare professionals, providing technical support, conducting research, and managing the challenging task of implementing the project through an array of partners and sub-partners. Key activity highlights of The Union and its nine partners are summarised in the subsequent pages.

All project targets were achieved for the first year of the project. Some collective achievements of the Union and its partners are given under the overall Union activities.

While involving partners across sectors – government, NGOs, private doctors, technical agencies, affected communities and the media – is a key stated strategy of Project Axshya, the past year also saw an effort at The Union to address links that continue to sustain TB as a major challenge, such as the links with poverty and malnutrition, with diseases like diabetes and HIV, and with the use of tobacco. The Secretariat of the World Health Organization’s sub-group on TB & Poverty that now functions from USEA, the Secretariat of the Partnership for TB Care and Control in India, and The Union’s focus on non-communicable diseases and tobacco control all fed into Project Axshya in various ways, in addition to the core activities of The Union and its partners under the project.
Background

The Problem: India bears the highest burden of tuberculosis (TB) globally with an annual incidence of 1.9 million new cases. About 2.6 million people live with HIV and 1.2 million are TB-HIV co-infected. India has one of the highest multidrug-resistant TB (MDR-TB) burdens globally with ~99,000 cases annually. In India, MDR-TB in new TB cases is estimated at ~3% and in previously treated cases at 12-17%.

(The Source: TB India 2011 - Annual Status Report, Central TB Division, Directorate General of Health Services, Ministry of Health and Family Welfare)

The Need: In addition to the urgent need to address drug resistant TB and the growing problem of TB-HIV co-infection, much depends on how successfully awareness on TB, increased case detection, and access to full treatment, is spread nationally. It is in this context that a civil society partnership becomes useful and a major initiative on 'Providing Universal Access to Drug-Resistant TB Control Services and Strengthening Civil Society Involvement in TB Care and Control' was envisaged, where civil society will synergise efforts against TB with the government, private sector and communities.

The Grant: The International Union Against Tuberculosis and Lung Disease (The Union) is among the three principal recipients of a Round 9 grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) to India for a major TB control project that envisages a key role for civil society. The other two are the Government of India’s Central TB Division and World Vision India (WVI). The total grant for five years is US$ 199.54 million, with the Union share at US$ 57.5 million. As per Global Fund policy, funding is first for two years (Phase-I) and then extended to three more years (Phase II).

The Project: The project’s civil society component, Project Axshya (meaning “TB-Free”), for which the principal recipients are The Union and WVI, is ‘A Civil Society Initiative to Strengthen TB Care and Control in India’. The project is a landmark. It combines the forces of The Union, which has played a pivotal role since 1920 in the fight against TB globally; World Vision, a major international NGO; and the Government of India, which has set in place one of the most successful TB programmes in the world and consistently achieves global targets at a national level for new smear-positive case detection (70%) and treatment success (85%) – in a country that nevertheless continues to struggle with the world’s highest burden of TB. Project Axshya will be implemented by The Union and WVI through their partners, sub-recipients to the grant, who will carry out project activities in their respective states and districts.

The Objective: The project aims to improve access to quality TB care and control through a partnership between government and civil society. It will support India’s Revised National TB Control Programme (RNTCP) to expand its reach, visibility and effectiveness, and engage community-based providers to improve TB services, especially for women, children, marginalised, vulnerable and TB-HIV co-infected populations. Advocacy, Communication and Social Mobilisation (ACSM) is a major focus.

The Principles: The guiding principles for Project Axshya are universal access to quality TB services, community participation in TB care and control, sustainable interventions, and equitable distribution of project benefits with social and gender sensitivity. Project Axshya also aligns with the World Health Organization (WHO) Stop TB Strategy and supports India’s national TB control programme to achieve the Millennium Development Goals (MDGs).

The Coverage: The project covers 374 districts across 23 states of India, with 300 districts managed by The Union and 74 by WVI. 16 states will be managed by The Union, two by WVI and five jointly, through their partners. Of the Union’s 300 selected districts, some 200 comprise underperforming (with case notification rates of 50/100,000 or less), poor and backward, difficult (like the north-east and Jammu & Kashmir), and predominantly tribal districts. Project Axshya seeks to reach an ambitious target of 750 million people, including some 174 million women, 199 million children, 250 million people in poor and backward districts, 50 million people in predominantly tribal districts and 40 million people living in urban slums.

The Union: The Union began in 1920 as a global response to TB and has played a pivotal role since, pioneering some of the most important measures for TB control. Its mission is to bring innovation, expertise, solutions and support to address health challenges in low- and middle-income populations. It has nearly 10,000 members and subscribers from 152 countries, and a host of partners globally. Its scientific departments focus on TB, HIV, lung health and non-communicable diseases, tobacco control and research, and each department provides technical assistance, engages in research, and offers training and other capacity-building activities towards health solutions for the poor. Headquartered in Paris, it has offices serving the Africa, Asia.
Pacific, Europe, Latin America, Middle East, North America and South-East Asia regions. The Union South-East Asia Office is the Union's first and largest region office.

**The Partners:** Other than local, national and international stakeholders that The Union is working with, its nine core sub-recipient partners in Project Axshya are reputed non-governmental organisations (NGOs) with extensive expertise and experience in TB services, and widespread networks and trust in the communities they work with. They are implementing the project through their own sub-networks of NGOs and community-based organisations to reach the farthest corners. They are the Catholic Bishops Conference of India – Coalition for AIDS and Related Diseases (CBCI-CARD), Catholic Health Association of India (CHAI), Christian Medical Association of India (CMAI) Emmanuel Hospital Association (EHA) Mamta Health Institute for Mother and Child (MAMTA) Mamta Samajik Sanstha (MSS) Population Services International (PSI) Resource Group for Education and Advocacy for Community Health (REACH) Voluntary Health Association of India (VHAI).

**The Activities:** Project Axshya focuses on strengthening India’s national TB control programme and TB services through Advocacy, Communication and Social Mobilisation (ACSM). Activities include high-level advocacy for political and administrative support, implementation of the RNTCP ACSM strategy at the state and district levels, and social mobilisation to garner community demand for TB services. This is expected to strengthen the engagement of non-programme providers in RNTCP schemes, complement programme efforts, improve access to diagnostics, increase commitment to fighting DR-TB and TB-HIV at all levels, trigger some exemplary awareness-raising efforts, and broaden the scope of civil society involvement through an enduring national partnership to link the national TB programme to other stakeholders through national and state coordination committees.

**The Implementation:** The Union South-East Asia Office (USEA) is managing Project Axshya for The Union through a dedicated Project Management Unit (PMU) housed in its New Delhi office, and supported by other USEA units. The team is coordinating with RNTCP to implement and sustain activities across districts and states, and increase access to quality TB services for all. The Union is working closely with its partners in 90 districts in the first year; will expand to 240 districts in the second, and to 300 in the third year. Implementation is for five years, 2010-15, with Phase 1 for two years from April 2010 to March 2012.

**The Report:** This report summarises the activities of The Union and its core partners under Project Axshya during the first year.

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**Key Project Activities**

- Empower communities to enhance their participation in TB services
- Conduct need-based and gender-sensitive media campaigns
- Advocate with policy-makers and parliamentarians
- Facilitate involvement of all health care providers to increase the reach of TB services and ensure rational use of diagnostics and drugs
- Synergise civil society’s TB care and control services through partnerships
- Conduct research/training on ACSM, Public-Private Mix, MDR-TB, TB epidemiology, Programme Management and Operations Research
- Support and complement RNTCP diagnostic and treatment services to increase access, especially in difficult and hard-to-reach areas
- Strengthen the state and district level ACSM capacity of programme personnel
- Strengthen the linkages between TB and HIV services
- Empower affected and vulnerable communities by facilitating platforms for TB care

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Meeting with a Women's Self-Help Group
Project Axshya
Geographical Coverage
The Union

Overall Activities: 2010-11

The core achievement of The Union and its sub-recipient partners in 2010-11, the first year of Project Axshya, was to successfully initiate the implementation of Advocacy, Communication and Social Mobilisation (ACSM) activities targeted at bringing civil societies, RNTCP staff, private health care providers, and government authorities at the national, state, district and local levels together in the fight against TB. Getting the much-needed support and acceptance of stakeholders across sectors to work together for TB control in India was the biggest challenge that we began with. The fact that we are beginning to make a real headway in meeting this challenge was evident this year in varied ways – in the new community awareness on TB and its care and control, in the changing public attitudes to TB and those affected by it, in the enthusiasm and commitment that was seen across stakeholders, in the ripple effect that advocacy and capacity building efforts have begun to create, and in the increasingly collective ownership of the national TB control programme. All of these are portents to the significant potential of Project Axshya in the coming years. The project should not only achieve its stated objectives of improving the reach and effectiveness of RNTCP and of engaging communities in TB care and control in the target districts by 2015, but also of changing the outlook on TB control in India by bringing the necessary focus on marginalised and vulnerable populations, on the removal of ignorance and stigma, and on the value of working together.

The collective achievements of The Union and its sub-recipient (SR) partners against project targets are summarised in the table and selected activities of partners detailed later. All project targets have been achieved for the first year of the project. The Global Fund has accorded an A2 rating to the grant for the period April-September 2010.

Activities undertaken by The Union are summarised below under the primary areas of its work internationally, viz. technical assistance, education and research, as also its project management responsibilities.

**Technical Assistance**

Activities here mainly involved advocacy and communication initiatives from The Union at the national, state and district level to supplement the activities of the programme and partners.

- **The project was launched** by partners with assistance from The Union in mid-2010 in the project states. These included Tamil Nadu, Karnataka, Kerala, Punjab, Uttarakhand, Manipur, Nagaland, Meghalaya, Uttar Pradesh, Maharashtra, Haryana, Rajasthan, Delhi, Jammu & Kashmir, and Goa. Events were widely covered in the media and attended by Health Ministers, Health Secretaries, National Rural Health Mission (NRHM) Directors, Directors of Health Services, State TB Officers (STOs) and District TB Officers (DTOs), indicating a high level of commitment and enthusiasm for the project.

<table>
<thead>
<tr>
<th>Indicators - Achievements (1 April 2010–31 March 2011)</th>
<th>Target</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>New partners signing up with the Partnership for TB Care and Control, India</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>People trained at the state-level Training-of-Trainers for NGOs/CBOs/PPs</td>
<td>60</td>
<td>67</td>
</tr>
<tr>
<td>District-Level Networks of people living with HIV sensitised</td>
<td>60</td>
<td>58</td>
</tr>
<tr>
<td>NGOs sensitised at state-level to register under RNTCP schemes</td>
<td>144</td>
<td>159</td>
</tr>
<tr>
<td>Rural healthcare providers sensitised on referral, DOT provision and other RNTCP schemes</td>
<td>2700</td>
<td>3154</td>
</tr>
</tbody>
</table>

![Images of events in various locations: Tamil Nadu, Maharashtra, Karnataka, Nagaland, Meghalaya]
A meeting with the Indian Medical Parliamentarian Forum (IMPF) was held on 23 March 2011. Dr Mysura Reddy, Member of Parliament (MP), Rajya Sabha (upper house), Mr Thomas Sangma, MP, Rajya Sabha, and Dr Anup Saha, MP, Lok Sabha (lower house) and Member of the Standing Committee on Health, participated. Two important issues on banning serological tests for TB and promoting the rational use of anti-TB drugs were discussed, and a policy brief for parliamentarians was released by Dr Anup Saha.

Meeting with the Medical Parliamentarians

Advocacy meetings with eight medical colleges and secondary/tertiary level non-government hospitals were held in the states of Maharashtra and Bihar, to promote WHO/STAG recommendations and RNTCP DOTS Plus guidelines.

The illustrated version of the Patient Charter for TB Care was developed by the Project Management Unit (PMU) at The Union with inputs from all partners. This is available in 19 languages spoken across the country and is being disseminated through TB forums and community meetings. It will be prominently displayed in health care facilities across the project districts.

Quarterly state RNTCP review meetings for Bihar, Madhya Pradesh, Maharashtra, Tamil Nadu and Uttarakhand were supported.
Other than this, technical support was also provided for the following:

- **A comprehensive annual maintenance contract (AMC)** was finalised for over 2000 binocular microscopes for the states of Bihar and Uttar Pradesh and taken up with the support of the State TB Cells. These states were facing a challenge in ensuring the AMCs, which was leading to a delay in the repair of microscopes and affecting the programme performance.

- **Union consultants are providing expert support to the national TB programme** in the areas of Monitoring and Evaluation, Operational Research, ACSM and Public–Private Mix. Over the last year, these experts assisted in undertaking a review of programme activities, capacity building of states and districts, and reviewing the RNTCP component of the state NRHM Project Implementation Plans. They also contributed to the pre-production meeting of the partner media agency of the Central TB Division (CTD), human resource assessment meetings, and the RNTCP Phase III (2012-17) planning meeting.

**Education**

The project’s significant focus on capacity building at the grassroots through the community, local, district and state-level activities of Union partners, were complemented and supported by Union trainings at the national-level.

- **Two clinical management courses on MDR-TB** were conducted by The Union in collaboration with RNTCP and the Lala Ram Sarup Institute for TB and Respiratory Diseases (LRS), New Delhi, in October 2010. 42 participants, including clinicians from DOTS plus sites, faculty from medical colleges and district programme managers from states implementing MDR-TB control, were trained on various aspects of managing drug-resistant TB.

- **An orientation and project planning workshop for partner staff** was conducted by The Union for Programme Managers (PMs), Assistant Programme Managers (APMs) and District Coordinators (DCs) of all SR partners implementing the project. The five-day workshop was conducted in three batches for 73 participants in all. DTOs of implementing districts were invited on the last day to develop micro-plans with project staff to undertake project activities in their districts. Participants were oriented on basic knowledge of TB, case detection, case holding, standard operating procedures for the project, monitoring and evaluation (M&E) systems, and planning. Soft skill development sessions were incorporated on interpersonal communication, team/partnership building, presentation, etc.
The 41st World Union Conference on Lung Health held at Berlin, Germany, in November 2010 was used as a forum to learn, network and tap international experience towards Project Axshya, as also to give international visibility to the project through sessions coordinated by the Union South-East Asia Office (USEA). A project brochure produced and disseminated for the occasion. USEA also facilitated the participation of RNTCP personnel in the conference, including a Chief Medical Officer from CTD, the STO of Madhya Pradesh, and a RNTCP consultant.

Research

The Union provided operations research support to Project Axshya through studies, trainings and manpower.

- An operations research (OR) training was organised by The Union in coordination with CTD, the National TB Institute (NTI), Bangalore, WHO-India and Centers for Disease Control (CDC) Atlanta. The training was based on the Union model and comprised three workshops to mentor trainees in developing quality protocols on priority topics, supporting them on studies and publications, and assisting translation into policy. The first workshop in September 2010 has resulted in the finalisation of 17 research protocols of national priority. These proposals are being supported through limited funding under Project Axshya.

- A baseline Knowledge, Attitudes and Practices (KAP) survey on TB, covering communities, healthcare providers, patients and opinion leaders, across a sample of 30 project districts was initiated through an identified agency in October 2010. The report of the study will be available by July 2011.

Project Management

As principal recipient to the Global Fund grant for Project Axshya, The Union was involved in a host of project management activities in the first year that involved executing grant agreements, setting in place a Project Management Unit (PMU), training partner staff on project management systems, developing project-related software and communications material, and implementing all project management functions related to planning, coordinating, supervising, monitoring, evaluating and reporting.

- A Project Management Unit was set up at the USEA office in the first part of the year, and agreements implemented with all sub-recipient partners. The PMU closely coordinated with other units at USEA to kick-start activities.

Organisational Structure

- A Monitoring and Evaluation (M&E) plan was developed in consultation with WVI and CTD to have a robust reference document to monitor project implementation and effectiveness of reaching pre-determined targets, and for all SR partners to monitor their own activities. Specific indicators to measure project performance and tools for uniform recording and reporting, including a system for quality assurance that emphasises the delivery of accurate and reliable project data, are inbuilt in the plan. A management information system to process, store and analyse data, including measures to ensure data integrity, is a critical component of it. Project-specific indicators selected to monitor and evaluate activities are drawn from the National M&E Plan linked to RNTCP outcome indicators. Activities undertaken at the community-level are collated and consolidated at the district and state-levels by partners and reported to the PMU. Reports are analysed and feedback given to the SRs and DCs.
- **The First National Coordination Committee Meeting** was organised by The Union on 19 October 2010 at the LRS Institute. The Committee, constituted under the Chairmanship of the Deputy Director General (TB), provides oversight to the Global Fund Round 9 Project. The meeting was attended by donors and technical partners including World Bank, DFID, USAID, Gates Foundation, WHO, etc. who were apprised of the project activities and the progress so far.

- **Regular meetings with the Central TB Division and World Vision India** were held to discuss coordination issues at the national and state levels to ensure that all partners functioned inclusively and collectively towards common objectives.

- **AxReal, an innovative electronic real-time monitoring software** for Project Axshya, was developed at USEA to capture real-time field data. Quarterly action plans are entered by DCs for districts and SRs for states in this web-based software. Activities are entered in the activity reporting section as and when completed. This software has a real-time dashboard feature to help PMs at all levels monitor activities at various levels. AxReal was pilot tested for PMs, APMs and DCs of all SRs.

- **Project and partner staff was trained** in the M&E strategy and AxReal software. A system for regular supervision by the PMU and by SRs has been developed with necessary tools to ensure adequate supportive supervision at the field-level. A grant-monitoring mechanism is also in place, which has both technical and financial monitoring components.

- **Quarterly reporting by SR partners** on financial and programme indicators was completed. A review meeting with SRs was held from 22 to 24 February 2011, in Delhi. PMs, APMs and Finance Officers of all the nine SRs participated.

- **Nine grant monitoring** (technical and financial) of all SR partners were undertaken by the PMU.

- **Ten supervisory visits** were undertaken by the PMU to the project states to review project activities and provide technical support to improve the quality of implementation.
The Partnership for Tuberculosis Care and Control, India (the Partnership) brings together civil society across the country on a common platform to support and strengthen India’s TB control efforts. It seeks to harness the strengths and expertise of partners in various technical and implementation areas, and to empower communities. It has technical agencies, NGOs, CBOs, affected communities, the private sector, professional bodies and academia as partners. Its Steering Committee comprises members from various partner organisations. Standing invitees include the Deputy Director General (TB), a WHO India representative, and the Regional Director of the Union South-East Asia Office.

In January 2009, a Secretariat was appointed and hosted at the Union South-East Asia Office. It provides technical and administrative support to the Partnership, works transparently as a coordinating mechanism, and is accountable to the Steering Committee. It regularly interacts with stakeholders and the government to help achieve common goals, adds value to the work of the Stop TB Partnership, publishes newsletters, maintains a website, disseminates TB information, and coordinates partner activities for events like the World TB Day. The Union, while hosting the Secretariat, also provides technical guidance and administrative assistance.

Expanding the partner and stakeholder base in India’s fight against TB is crucial to the Partnership’s strategy. Besides uniting for a common cause, partners benefit by featuring their activities in the Partnership newsletter and website; getting invited to working group meetings; using a common logo and directory to share ideas, best practices and resources; and accessing relevant databases. In a short time, the Partnership has become a hub to disseminate information, create visibility for India’s RNTCP, respond to TB-related challenges and provide support to various stakeholders.

To help achieve the targets of universal access, the Steering Committee advised civil society to identify challenges and suggest recommendations for the RNTCP Phase III planning. Data was collected from all partners, compiled, a consolidated paper of recommendations written, voted upon, action by civil society added, and a consensus reached at the National Consultative Meeting in January 2011. This is being submitted as a final paper to the Central TB Division for consideration and inclusion in the RNTCP III plan.

While the challenge of TB care and control is multi-dimensional, it is important to strengthen the community response and make its voice heard against the threat of TB through meaningful and effective participation of civil society organisations. With the shift to universal access of TB care, the role of civil society will become more critical in terms of consolidating and scaling up key community linkages with essential services, especially in underserved and difficult-to-reach areas, and with marginalized, vulnerable and migrated populations across the country. There is also a huge task to link up non-formal and private healthcare providers effectively to RNTCP.

At the end of March 2011, the Partnership had 65 partners.

For more information please visit www.tbpartnershipindia.org
The Union’s Core Partners in Project Axshya

The Union’s partners in the project are some of the most reputed, trusted and experienced public health organisations of India. Through their own deep networks and sub-networks of NGOs, CBOs, SHGs and grassroots workers in the regions they work in, they reach communities in the furthest corners of a huge and diverse country. And enable people, especially the disadvantaged, to access TB services in a way that may otherwise not have been possible.

- Catholic Bishops Conference of India–Coalition for AIDS and Related Diseases (CBCI-CARD)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Emmanuel Hospital Association (EHA)
- Mamta Health Institute for Mother and Child (MAMTA)
- Mamta Samajik Sanstha (MSS)
- Population Services International (PSI)
- Resource Group for Education and Advocacy for Community Health (REACH)
- Voluntary Health Association of India (VHAI)
The Catholic Bishops Conference of India – Coalition for AIDS and Related Diseases

CBCI-CARD is a registered, non-profit society of leading Catholic National Organisations working in health and development in India. With a specific focus on TB, HIV/AIDS, Malaria and related diseases, the organisation attempts to better coordinate and network the activities of the Catholic Church in India in the field of health through an overarching vision and mission. The health policy of the Catholic Church in India (‘sharing the fullness of life’) envisages a healthy society where people, especially the poor and the marginalised, attain and maintain holistic well being. Consequently, CBCI-CARD looks upon its vision in health as the fulfillment of a divine call, not just a profession, through a commitment to protect life, and transform it through genuine compassion, participation of people, sustainable development, and a holistic approach. Its mission is to provide humanising care, ensure preventive, curative and rehabilitative health, and engage in social mobilisation of the community. Its strategic priorities include greater partnership and involvement of stakeholders at every level, better outreach, especially to the under-served areas, and challenging fields; improved quality of service and efficient management. The Catholic Church network has a total of 5937 healthcare facilities in India. CBCI CARD has also been working in the Global Fund RCC TB Project 2008 onwards, covering 19 states. Under Project Axshya, CBCI CARD is covering 24 districts across four states in a phased manner. In year one, there are seven districts, another 12 in year two, and five more in year three.

Activities

- 330 Gaon Kalyan Samiti meetings, seven NGO sensitisations with a total of 66 participating, seven CBO trainings with a total of 64 participating, and seven soft skills trainings with 660 participants, were conducted for the seven districts.
- Community-level activities were completed in five districts, special activities in seven, and TB forums constituted in six districts.
- CBCI-CARD trained 223 RHCPs in the seven districts. Follow-up referral by RHCPs is being done on regular basis. As a result, referrals have increased in all seven districts. For instance, in Muzaffarpur, RHCPs referred 37 suspects to the Marval PHC TB Unit and 30 to the Kati PHC TB Unit.

Highlights

- World TB Day activities spanned a month with several innovative initiatives to spread public awareness on TB:
  - Auto-hoods with TB messages were pasted on auto rickshaws.
  - Stickers were pasted on cars, autos, bikes, shops, clinics, medical shops, pan-shops, barber shops, etc.
  - Banners were made and signature campaigns undertaken to mobilise the community on the World TB Day.

The first year’s journey in Project Axshya has been very enriching. We managed to reach the nooks and corners of our project areas, and reached the masses through painstakingly conducted awareness campaigns. There is a definite shift in public attitude. But there is still a long way to go. We are confident that the experience gained in the past one year will enable us to work better in the coming years.

Fr Mathew Abraham
Officiating Executive Director, CBCI-CARD
Caps and t-shirts with TB messages were distributed to all DOTS providers, RNTCP staff, auto-drivers, and participants. Campaigns were conducted by distributing pamphlets with TB information to people on the highway to Raipur. A documentary film on TB was shown in intervals during the screening of a Hindi movie. Wall paintings with TB messages were done in consultation with the DTO. Street plays were conducted in the railway station, court campus and prominent crossroads. A candle march on the eve of World TB Day was held with RNTCP staff, youth clubs, NGOs, CBOs, etc, where all took an oath to stop TB. IEC material was distributed and a puppet show on TB held in many places using a TB rath (chariot).

Lab registers mention CBCI-CARD referrals – as acknowledged in a letter from the STO of Bihar, the New Smear Positive (NSP) rate of Bihar’s Buxar district, a very low performing area, was only 17% in 2010 but has now increased to 29%.

Grassroots efforts are showing results – communities are becoming more aware of TB, RNTCP and Project Axshya, and a visible change was there in people’s attitude towards TB patients. Volunteers, who refer TB suspects, are increasing.

In Sidhi district, three sputum collection centres run by a partner NGO referred 16 suspects – seven tested positive and were put on DOTS.

In Jabalpur district too, suspects were sent by community volunteers for sputum examination to the DMC.

Tourists are being reached by putting TB messages on boats at Gauri Ghat on Narmada river. Over 2000 people from the entire district, as well as surrounding districts, visit this river bank daily to worship and enjoy sailing.

Slogans by volunteers

DOTS ko apnana hai, TB ko door bhagana hai” (We have to adopt DOTS, we have to chase TB away)

Project Axshya hai achcha, DOTS hai sachcha ” (Project Axshya is good, DOTS is true)
A family saved

Khamaria

Mr Shivdas Tiwari and his two daughters, Mausmi on the left and Neha on his right, make up a TB-infected family of village Khamaria in Jabalpur, MP – his wife and son died of TB years back. Mr Shivdas (55 years) and Mausmi (22 years) too are TB patients and their treatments are on. One of CBCI-CARD’s NGO partners, Norbetine Social Society, met them during Project Axshya activities. Mausmi was the first victim of TB and the family was searching for treatment here and there but, they say, they could not get good treatment and guidance even at the government hospitals. Finally, CBCI-CARD helped her in reaching a RNTCP microscopy centre where she was diagnosed as a TB patient and treatment was started. Before treatment, she lacked appetite, had loss of eyesight, and was so feeble that she could not move from one place to another. Now she can do all her activities on her own. She has been taking paediatric anti TB drugs as per her bodyweight. Her weight has now increased and she is responding to the treatment. Meanwhile, Mr Shivdas too developed a cough and was also diagnosed as a TB patient after sputum examination. He was advised to take treatment and was also started on DOTS. They are now very hopeful they will be cured – and we are very happy that we could save a family.

Help from a TB forum member

Khandwa

Mr Rajendra Kapoor, who lives in Khandwa, is a vendor of sweets by profession and the only bread winner of his family. Economically, he is very weak. He had a lot of cough and went to a private hospital in Khandwa, MP, where he tested positive for TB. He started TB medicines on his own, but left the treatment as he could not afford the medicines. After some time, one of TB forum members – Mr Tasleem Shabbir, a press reporter in Khandwa – met him and made him aware of DOTS and its benefits and that the treatment was available free of cost. Mr Shabbir sent him for sputum examination and Mr Kapoor was started on DOTS. His condition is now improving and he is much happier.
The Catholic Health Association of India

CHAI, established in 1943, is now among the world’s largest healthcare NGOs with a national presence in India. A membership-based organisation, it has over 3,300 member institutions (MIs) including large, medium and small hospitals, health centres, and diocesan social service societies. Large MIs provide predominantly curative care. Health centers, which account for over 80% of its membership, deliver curative and preventive health services. MIs operate throughout India in urban, semi-urban, rural, and remote areas, to serve the needs of the poor and the marginalised. For close to 70 years, CHAI has been dedicated to the complete physical, mental, social, and spiritual well-being of all. In 1993, it underwent a strategic shift from a hospital-based to a community-based approach. Policy and grassroots advocacy are now built into most CHAI programmes. With a central office in Secunderabad (Andhra Pradesh), 11 regional units covering all states and union territories, diocesan units, and a zone office in New Delhi, its major operations focus on programme intervention and meeting the continued medical education needs of MIs through The Post-Graduate Diploma in Hospital Administration and The Nurse Practitioner Programme in HIV/AIDS. In addition to MIs, CHAI also collaborates with organisations, civil societies, government bodies and bilateral agencies. It has designed and implemented structured interventions in communicable diseases, community health, advocacy, and
disasters. Its TB-related interventions include work as an India partner of Advocacy to Control Tuberculosis Internationally (ACTION), an international partnership of advocates mobilising resources to treat and prevent the spread of TB in high TB-burden countries; and work under the First IMPACT TB Control Programme, where CHAI facilitates the enrolment of its rural-based MIs into various RNTCP schemes and forges collaboration between mission hospitals and the government in seven states. In December 2010, CHAI was approved by the Indira Gandhi National Open University to work as a community college and, beginning 2011, it will offer several courses for medical and social work professionals. In Project Axshya, CHAI is a partner in a large number of districts. It will cover 96 districts across 10 states in a phased manner, with 29 districts in year-one, extending to 76 districts in year-two, and reaching all 96 by the end of year-three.

The Union is committed to tackle tuberculosis head-on and the mission has been translated into an effective project called Axshya. CHAI being a sub-recipient of Project Axshya has been closely associated with The Union.

Rev. Dr. Tomi Thomas, Director General, CHAI
Activities

- **Community focus group meetings** were held as per a plan of ten meetings per month per operational district to cover influencers in a target community so that the community gets better knowledge and awareness of TB, RNTCP and Project Axshaya. The community is motivated to utilise RNTCP services in the vicinity and work in partnership to eliminate TB. 2159 community meetings with Gaon Kalyan Samitis, Self Help Groups, Panchayati Raj Institutions, CBOs and others were organised and 58860 participated in these.

- **Mid-media activities and special/IEC events** were designed to raise community awareness in focussed areas on TB and RNTCP through different campaigns. Street plays, puppet shows, slide shows, wall paintings and other entertainment-cum-education events are used to enhance awareness and knowledge on TB symptoms, referrals and treatment. They also help locate defaulters and put them back on treatment by identifying the nearest TB centres. One such activity is planned per month per operational district.

- **Sensitisations of NGOs on RNTCP Schemes** were conducted for South Karnataka and North Karnataka, which saw civil society and government on a common platform. RNTCP teams were involved in these and participants agreed to take up schemes as per their eligibility. DTO presentations were very found to be very useful and significantly enhanced the knowledge of NGOs on TB and RNTCP schemes. The South Karnataka sensitisation took place on 24-25 September 2010 with 27 participants and the North Karnataka one on 20-21 December with 24 participants from six districts.

- **A state-level training-of-trainers (TOT)** for NGOs in Karnataka was held 25-27 November 2010 to develop a pool of district-level trainers from civil societies in each of the CHAI’s 18 implementing districts in the state of Karnataka. The trained district-level trainers would be resource persons for carrying out trainings within the district for NGOs/CBOs on Project Axshya.

- **Capacity building and allied activities** included selecting and training 29 local NGO networks, one state-level TOT for health staff, 29 trainings for health staff on soft skills covering 3000 health staff, 29 trainings for over 10 CBOs each and 29 trainings for rural health care providers. In addition, 24 quarterly meetings of CBOs with District TB Officers were held, 29 TB forums were developed and oriented and 58 joint meetings of ICTCs and DMCs were held.

- **Advocacy activities** have also been conducted. The TB forum and community groups advocated for pension for TB Patients on DOTS with Wayanad district authorities and were successful in getting government approval. Short radio jingles were also developed on TB in Kannada and aired on FM radio in the districts of Mangalore and Chikmagalure.

Awareness helps
Perambalur, Tamil Nadu

Mrs Panchamirtham is 50 years old and works as a farmer. Her husband, Mr Ramasamy, is 60 years old and they have two daughters and a son, all of whom are married. They live in the rural Ediyar village of Perambalur distinct in Tamil Nadu. Earlier, they were not aware of TB at all. Through a community meeting, they got the chance to attend a TB awareness programme organised by CHAI and STAR Organization. After this, Mrs Panchamirtham realised that she had the symptoms of TB as she had been coughing for several months. She approached CHAI and STAR staff, and was referred to the DMC for sputum testing and she tested positive. After counseling her, she was registered with RNTCP and put on DOTS. Now, she thanks Project Axshya, CHAI and STAR staff for all this help.
The Christian Medical Association of India

CMAI has a history that dates back to 1905 when a group of missionaries serving in India set up the Medical Missionary Association, a forum to support each other professionally and spiritually. In 1926, it was renamed the Christian Medical Association of India, and has grown in strength by keeping pace with the changing healthcare needs in the country. CMAI has done pioneering work in several areas, including leprosy, tuberculosis, malaria and HIV/AIDS. Its focus has largely been on underdeveloped areas like the BIMAROU belt (the states of Bihar, MP, Rajasthan, Orissa, and UP) and more recently Chota Nagpur in MP, Chhattisgarh, and the North-Eastern states. Its objectives are:

- Prevention and relief of human suffering irrespective of caste, creed, community, religion and economic status.
- Promotion of knowledge of the factors governing health.

CMAI's other activities include:

- Coordination of activities for training doctors, nurses, allied health professionals and others involved in the ministry of healing.
- Implementation of schemes for comprehensive health care, family planning and community welfare.
- Rendering health in calamities and disasters of all kinds.

Under Project Axshya, CMAI is covering 15 districts in the North Eastern states of Meghalaya and Mizoram. In year one, five districts of Meghalaya have been covered and will be expanded to another seven districts of Meghalaya and Mizoram in year two and additional three districts of Mizoram in year three.

Dr Vijay Aruldas Kumar, General Secretary, CMAI

"Project Axshya’s special contribution is in stimulating a large-scale community-based mobilisation to build awareness and strengthen access to government TB services, especially in underserved areas."

Soft skill training of health workers
Activities

- 300 community meetings held
- Five trainings for Rural Health Care Providers conducted
- Five trainings for Health Care Providers were conducted in soft skills.
- Five TB forums were formed during the year
- CMAI is in the process of streamlining the referral system and default finding that could not be initiated and integrated in full swing. Despite more time than expected to sign Memorandum of Understanding (MoUs) with some implementing partner NGOs, work has already begun.

Highlights

Help from a neighbouring state: Ri Bhoi district in Meghalaya share borders with the state of Assam. Nongpoh is one area under the district where the population has a huge proportion of migrants from neighbouring states and countries. As it is quite a mixed community, GKS meeting are usually difficult. CMAI made an effort to address this situation and contacted the state IEC officer, RNTCP, Assam. With the help of neighbouring states, CMAI, will conduct GKS meetings to cater to all the populations.

Sensitising drivers: Around 168 tourist drivers were sensitised on RNTCP at the Polo ground of East Khasi Hills during their meeting with CMAI as part of the CBO meeting on 8 March 2011. Not only did they request for more meetings, a few drivers even called CMAI District Coordinator, to inquire about the nearest DMC available. This activity has accelerated action on early diagnosis and treatment of TB.

Jwela Khongthah is a Rural Health Care Provider (RHCP) from Pynursla and, like Kriston Thabah, mostly practices traditional medicine with local herbs. But in some cases she uses a mixture of local herbs and allopathic balms. Though she learned the art of medicine herself, she was a part of the RHCP training conducted at Pynursla in East Khasi Hills District on 17 December 2010. She mostly sees patients on market day and there are people with cough each time. She administers local herbs for some and if that does not help, she advises them to go to the hospital for a check-up. She continues to practice her medicine but, ever since the training, she has been referring patients with cough to the nearest DMC. In her understanding, smokers are highly prone to this disease but anybody can get it through the air in the public transport. According to her she has referred about 10–15 patients to the DMC. Most of these had cough for a long time, usually 3-4 months. Among the patients she referred, four tested positive. She knows that the duration of medication is long but has never seen the medicine herself. She is now willing to become a DOT provider.

CMAI is really helping RNTCP, especially through the training that was conducted for different sectors.

Dr LM Pdah, DTO, Ribhoi District

Soft skill training of health workers

Since CMAI is working with the Church, it really helps in spreading the message to the community and this will bring benefit not only to the community but also to the government.

Mantha Warjri Senior Treatment Supervisor, Mawphlang Tuberculosis Unit, East Khasi Hill District
Training rural health care providers pays

Pynursla, Meghalaya

There is medicine even in this stone.
You need to have the eyes to see it.

These are the words of Mr Kriston Thabhah, a traditional healer catering to the primary health care needs of tribal people in his native village, Siatbakon, in Pynursla in Meghalaya state. He is among the many such healers in India who people in remote tribal areas rely on to treat minor, and sometimes major, illnesses. Thabhah, now 69 years, has been practicing indigenous medicine for over 50 years. He learned the art of healing from his father, also a traditional healer. Now his wife and daughter assist him in preparing and dispensing medicine and he is grooming his daughter to succeed him.

Thabhah is one of the many who attended the ‘Rural Health Care Provider training’ under Project Axshya, as part of the project’s very essential focus on rural practitioners, including informal and traditional healers. Here he was sensitised on the most common TB symptoms (“the cough”), the need to refer TB suspects to a designated microscopy centre (DMC), how to do this, and how to provide DOT to TB patients. Now, Thabhah immediately refers all his patients with cough of two weeks or more to the Pynursla Public Health Centre, the nearest DMC.

We met him as part of a supervisory visit to a remote village in the East Khasi Hills district of Meghalaya – being managed by CMAI, the Union partner for Project Axshya in Meghalaya. Thabhah sees some 10-15 patients with cough on ‘market day’ – the day each week when villagers assemble for the local market. People use this opportunity to seek health care for their ailments. For cough, Thabhah has some herbal powders (churnas). He is also a specialist in skin ailments, including ulcers and swellings. What is unique to his practice is that he uses his mobile to photograph lesions and tumours, before and after treatment, to demonstrate the efficacy of his treatment to his patients. When asked why he keeps the photos, he said “For Documentation”. An important lesson for all of us!

In the first year of Project Axshya, over 2500 such traditional healers were trained in 90 implementing districts. Over 10,000 will be trained in the second year in 240 districts. Training this large pool of traditional healers could contribute significantly to the much needed early diagnosis of TB.

Recounted by A. Sreenivas,
The Union Project Axshya team
Emmanuel Hospital Association

EHA is a large, non-profit provider of health care in India, with a network of 20 hospitals and 30 community-based projects across 14 states of India. EHA’s comprehensive health services integrate essential clinical services with primary healthcare and community-level engagement to address the health priorities of the poor and the marginalised. EHA serves communities in the rural and semi-urban areas of Jharkhand, Bihar, Chhattisgarh, Madhya Pradesh, Uttar Pradesh, Uttarakhand, Delhi, Jammu & Kashmir, Maharashtra, Manipur, Mizoram, Nagaland, Assam, and Andaman Islands. Established in 1969, EHA has a forty-year history of holistic work focusing on the health and well-being of the poor through health, development, HIV/AIDS and disaster relief and rehabilitation programmes. EHA works in partnership with communities, governments, CBOs and NGOs, at the district, state and national levels. Its major focus areas are:

- Provision of appropriate health care through 20 hospitals
- Empowering communities through 30 health and development projects
- HIV/AIDS care and prevention through HIV/AIDS projects
- Humanitarian assistance in natural calamities through relief and development projects

The common infectious diseases that EHA hospitals come across continue to be TB and Malaria, and some seasonal and area-specific diseases. EHA hospitals have been involved in TB control for many years, and continue to support RNTCP. 15 of the hospitals provide various levels of RNTCP services: five DOTS Centres, nine Designated Microscopy Centres, and one TB Unit. EHA works to improve access to quality TB care in target areas through various projects and hospitals, focusing specifically on marginalised and vulnerable groups, affected communities and hard-to-reach populations. EHA is a steering committee member and a partner of the Partnership for TB care and Control in India.

Under Project Axshya EHA is implementing project activities in 25 districts across 8 states. EHA is covering seven districts in year one, 13 in year two and five in year three.

Activities

- **Trainings:** In Chandel district of Manipur, rural healthcare providers were trained who, post-training, collectively decided to refer patients with TB symptoms to DOTS centers rather than treating themselves. A training programme for District Level Network (DLN) in Nagaland resulted in the DLN becoming more pro-active on TB and reaching out to more people, especially PLHIVs.

- **Sensitisation:** In Sahibganj district of Jharkhand, regular sensitisation meetings are having an impact. Partner NGOs conduct an average of 75 such meetings a month. Prior to Project Axshya, the community was unaware of free TB treatment and DOTS centers but now they are more aware of these services. Sputum collection and transport have increased after year one activities of the project - an average of 21 sputum collections are now done and transported every month.

District AIDS Control Officer taking a session of DLN in Nagaland
- **Soft skills:** In the same district, soft skill training to health staff had an impact on improving their interpersonal skills. After the training, there is better coordination between service providers and receivers. More people have started going to public health centres when they are sick due to this.

- **World TB Day:** In Chazuba Block of Phek district in Nagaland, the programme on 24 March 2011 was unique in that 500 people attended – something not seen previously. People from different walks of life were present, including church leaders, students and health professionals. Mass awareness on TB was done through this programme. In the Palamu and Sahibgunj districts of Jharkand, World TB day was organised with collaboration from the Health Department. Rallies were taken out with placards carrying TB-related messages. The DTO, CMO and others from the Health Department were part of the occasion where some 150 people gathered.

*Look at me, I am a TB patient. Don’t ignore your cough, get treated, it is free. I’m cured after eight months of medicines. Listen to these people.*

In Sahibganj, a patient during a sensitisation meeting
In Nagaland’s Chandel district, the training for NGOs has had visible success. The “Rachael Care Centre” (RCC), an NGO serving the poor, has started to sensitise the community on TB and its control. RCC is in Machi block that covers 60 villages with some 30,000 mainly tribal people. It has very good rapport with the DTO and the other health department staff in the block, which has helped collaboration on TB services. RCC is known by the community for its dedicated staff of seven persons and their work. The people of Machi block earlier ignored prolonged coughs and did not know of TB or its treatment. But Project Axshya, through RCC, has sensitised them to a large extent using mass awareness interventions like skits, dramas and sensitisation of youth and women groups. Now, if there are any TB suspects or a prolonged cough is detected in the community, people either refer the cases to RCC or the suspects come forward themselves. The RCC now does an average of 15-20 sputum collections and transportations per month. Its dedication – and collaboration with local government staff – has paid.
Mamta Health Institute for Mother and Child

MAMTA, established in 1990, is a national-level NGO working on issues related to Sexual and Reproductive Health (SRH), HIV/AIDS, with a special focus on women, children, young people and marginalized groups. MAMTA’s programme approaches include networking, capacity building, direct intervention, advocacy and research. Its direct interventions spread across seven states of the country, while it implements programmes in partnership with NGOs in about fifteen states. Its capacity building work spreads across India and in about ten countries of South-East Asia. In 2008, MAMTA partnered with NGOs in Nepal and Bangladesh to implement programmes on SRH issues. MAMTA has a team of some 212 personnel that include medical professionals, social scientists, researchers, development and management professionals, web developers and financial experts.

Project Axshya is being implemented by MAMTA in 19 districts of Bihar, Haryana and Uttar Pradesh. In the first year, it created good rapport with local NGOs in these districts. It is involving them to strengthen community engagement and is closely working with the State and District TB programme to strengthen RNTCP at state and district-level.

“I honestly believe that you are doing a great job for the district to achieve the RNTCP objectives.”

DTO of Sonipat district, Haryana, to Dr P K Goswami of MAMTA
Activities

Training of Rural Health Care Providers (RHCPs)

- 408 Rural Health Care Providers were trained in the first year of our intervention.
- RHCP training was found to be very meaningful to the project objectives. Most RHCPs have nominal formal education and are a relatively young group located in the community and hence, accessible and affordable to the local community and knowledgeable about their local socio-economic conditions.
- During training it was observed that RHCPs knew relatively little about RNTCP; Hence, inputs were found to be very useful.
- RHCPs expressed desire to not only help in case detection and referral but also become community DOT providers.
- The health care workers wanted this type of orientation on communications skill on a periodic basis so that field problems on communication with TB patients could be shared with the facilitators and resolved.

Soft skills training for Health Care Workers

- The first batch of soft skills trainings for 1370 health care workers (ANMs, LHVs and ASHAs) were conducted in the districts of Bihar, UP and Haryana and have been found to be extremely useful and relevant to the health functionaries.
- Attendance in all trainings was overwhelming and active participation helped to achieve the training objectives.
- In the post-training assessment, the utility of the training was felt not only for enhancing communication and counseling skills but also for day-to-day work as DOT providers.
- The health care workers wanted this type of orientation on communications skill on a periodic basis so that field problems on communication with TB patients could be shared with the facilitators and resolved.

Other project activities

- 10896 Gaon Kalyan Samiti meetings were held in villages across three states.
- 17 TB forums were established in 17 districts.
- 807 members from NGOs and CBOs were trained. These members in turn will educate and sensitize the local community. This strategy will promote the community system strengthening and sustainability in the long run.
- 50 mid-media activities in villages/blocks were held on the occasion of International Women's Day, World TB Day and Mother' Day. The messages are reaching quickly and effectively to the poor and illiterate community through Nukkad Natak and Mobile Mike demonstrations.
Overcoming stigma
Sonipat, Haryana

A sixteen year old suffering from severe cough and fever, and taking medicines now and then, was unaware that her parents were under immense pressure and were not ready to accept the reality of her suffering; it was not ignorance it was apprehension of being discriminated. This is a common practice when it comes to adolescent girls and TB, especially in rural areas where a major stigma is associated with a girl getting TB – no one will marry her and she will not conceive in the future. This tends to prevent family members from accessing appropriate treatment for their sisters and daughters. This is what happened in Naina’s case. An NGO worker identified her during a community visit in Sonipat and tried to intervene but Naina’s mother just denied her suffering and was not ready to listen to anything on TB. The disappointed worker informed the district coordinator, Deepika, an active Project Axshya staff member, and asked her to intervene while strongly recommending a sputum test for the girl. When Deepika went to visit the family the next day, she realized their attitude towards TB. Keeping in mind the feelings of the family members and the sensitivity of the matter, she began building a rapport with them by asking about their daughter’s prolonged illness. She probed gender issues and indirectly started clarifying doubts on misconceptions about TB. She also shared success stories of adolescent girls who suffered from TB, took proper treatment and were now happily married and running healthy families. After listening to her, the parents started opening up and said that they were apprehensive about their neighbours’ reaction. But Deepika clarified doubts, and persisted. The parents eventually realised the importance of TB treatment. The next day they took Naina to the nearest DMC and got her sputum tested. She tested positive and is under treatment. The parents now actively motivate other community members. The credit goes not only to NGO worker & Deepika but also to the health system in Sonipat for the quick support.

Employing locally
Jhajha, Bihar

During a field supervisory visit to Jhajha block in Jamui district, a field staff member Ms Priti was identified, who had done a commendable job in the ACSM project. She showed keen interest in the TB care and control programme and working for the community. She also discussed the tobacco link with the Mamta-Axshya team in the context of bidi workers in Jhajha.

Based on this, MAMTA gave her the opportunity to become the DC for Jamui. Within two months of her association with the project, referrals improved and the Jamui DTC recently provided a support letter to open a Sputum Collection Centre in Jhajha block. She enjoys a good rapport with the local community. The strategy of appointing a dedicated local candidate at Jamui both decreased the cost of employment as well as reaped the benefit in the form of referrals, linkages, community participation and engagement in the RNTCP programme as a local person was clearly more acceptable to the community for bringing about change.
Mamta Samajik Sanstha

MSS is a non-profit registered organisation that aims to reach the unreached with the right message and right service at the right time. This voluntary organisation was formed with the vision of improving the lives of children and women in the foothills of Himalayas, ensnared in adverse circumstances due to their financial and social constraints. The organisation started in 1992 with a handful of committed workers who wanted to serve society without any personal gain to alleviate the poor socio-economic and health status of the region. Other than the core area of health, MSS has launched and completed several development projects. It strives for sustainable development through primary health care, adult literacy including legal literacy, diversified agriculture, gender empowerment and community participation. Presently, MSS works in close collaboration with state and central governments, related departments, local panchayats, 40 grassroots organizations and over 350 community leaders and volunteers in more than 600 villages and slums of Uttarakhand and UP. For over five years, it has partnered 17 NGOs in six districts of Uttarakhand and one district of UP. The organisation has a motivated team of experts and some 250 dedicated village volunteers and its partners have included several international agencies. Since its establishment, MSS has completed several TB projects as the twin epidemics of TB and HIV are among a core focus for it. MSS is an active partner with RNTCP, The Union, USAID and The Stop TB partnership. Recent TB control activities, other than the ongoing Project Axshya, have included a project for TB awareness and DOTS expansion at Nagthaat-Kalsi, Dehradun and an ACSM Project in Hardwar and Almora in partnership with USAID. MSS has also conducted sensitisation programmes on TB and HIV/AIDS in over 600 villages of Uttarakhand and western UP, trainings in the past 16 years for middle and grassroots functionaries, baseline surveys and activities in the field of adolescent health. Project Axshya will be implemented by MSS in 13 districts of Uttarakhand and five districts of Uttar Pradesh. These include five districts in year one, 10 in year two, and three in year three of the project.

“Project Axshya is a boon for those who could not access TB services due to various reasons. We seek to reach the unreached and provide them services at their door step through our CBO partners. We will knock at each door to knock out TB.

Mr J M Singh,
Chief Functionary, MSS
Training of NGO Network on RNTCP

Signature Campaign on World TB Day
**TB forums help**  
**Meerut and Haridwar**

- In Meerut, the TB Forum was initiated with 12 representatives from slums, communities, women’s groups, youth and religious bodies. TB champions and DOT providers joined the forum. Members regularly visit out-patient departments and interact with TB patients to find out the challenges they undergo during treatment, which they later take up in review meetings with the DTO. Forum members have divided their areas of work and sought volunteers to identify existing TB cases in their respective areas, so that patient concerns are addressed at the right time. Forum members also identify DOT providers for patients who have a problem in taking medicines from the DOTS center.

- Members of the TB forum in Haridwar, with support from MSS, conducted an industrial awareness programme at Relaxo Shoe Company. Sensitisation was done through thematic magic shows and street plays performed by community health workers. In the programme, 80 factory workers and management participated. In the end, the management requested the project team to conduct such programmes and sputum checkup camps on a periodic basis and assured referral of suspected cases to the nearest DMC.

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**Activities**

Launched in October 2010 in Dehradun, in the first year Project Axshya focused on empowering civil societies and enhancing community awareness in Almora and Haridwar districts of Uttarakhand, and Moradabad, Meerut, and JP Nagar districts of Uttar Pradesh.

- Five members each from the four NGO partners per district were identified and trained in RNTCP, making a total of 100 members for the five districts. These NGOs in turn organised Gaon Kalyan Samiti and community meetings in different villages – till date the project has conducted 507 meetings.

- The project also sensitised 100 CBO members on RNTCP to build leadership capacity in them.

- NGO partners referred 520 suspects out of which 30 were diagnosed as affected with TB.

- To strengthen the referral system at village-level, 148 rural health providers were trained in the five districts on RNTCP and DOTS.

- The project facilitated soft skills training for Senior Treatment Supervisors, TB health volunteers and counselors.

- TB Forums have been constituted in all five districts with volunteers from different community groups to support advocacy issues for TB patients.
Population Services International

PSI is a non-profit organisation founded in 1970, with health programmes in over 65 countries across Africa, Asia, Latin America and Eastern Europe. Its mission is to measurably improve the health of poor and vulnerable people in the developing world, principally through the targeted distribution of health products/services and evidence-based communications.

PSI in India seeks to empower people to lead healthy lives by addressing priority public health challenges in India using social marketing, social franchising and behaviour change communication. PSI began operations in India in 1988 and now has over 1200 staff members, enabling it to improve consumer access to health products and services in 22 states. Programmes have evolved substantially over the years to include targeted marketing in reproductive and child health, and the prevention of HIV/AIDS, TB and malaria. PSI is also involved in the prevention of lifestyle diseases through its work in tobacco control. Since 1988, it has been part of the MoH’s Contraceptive Social Marketing programme and is increasingly involved in health service delivery through the management of reproductive health clinics and franchised networks of private sector health clinics. Over the past 20 years, PSI has worked in most states of India and its key strengths and technical expertise lie in:

- Social marketing to increase access to health products in urban and peri-urban areas
- Behaviour Change Communication to improve health care seeking behaviour, and research
- Monitoring & Evaluation: PSI uses Disability Adjusted Life Years (DALYs) to measure impact and compare cost effectiveness across health areas. PSI is implementing activities in 30 districts across six states.

PSI is proud to be part of Project Axshya under the leadership of The Union. We are happy that our expertise in communication and experience of working with private sector healthcare providers can play a role in helping the Government of India attain its objectives for TB care and control. PSI teams are looking for ways to improve collaboration with the private sector. We are also generating demand for TB testing, through multi-media communication campaigns, to increase the case detection rate.

Dana Ward, Managing Director, PSI
Activities

A Communication Needs Assessment (CNA) Study, entailing a thorough review and situational analysis, was conducted to understand target populations, design behaviour change communication and social marketing strategies, and understand RNTCP processes, achievements, challenges and gaps. Data was collected from stakeholders and the community on TB to understand:

- The TB situation (s) specific to project districts across six states in India.
- Vulnerability of special/high-risk groups to TB, based on gender, geography, faith, etc, through community/population profiling in six states.
- Barriers and motivators in critical stages that were identified as problem areas for the TB programme.
- Challenges for future ACSM.
- Archetypes implying the socio-demographics of the target population.

Workshops were conducted for key stakeholders like STOs, DTOs, WHO-RNTCP consultants, NGO partners and others in Jaipur (Rajasthan), Pune (Maharashtra) and Patna (Bihar). Community group discussions were also organised to triangulate findings with those from stakeholders. Key problems in achieving success on TB in the regions were identified and triggers/barriers for community behaviour listed. Analysis showed that the stages prioritised were interestingly similar to the two RNTCP priority indicators:
Early detection: reporting the problem to a qualified provider if a person has had cough for two or more weeks.

Completion of treatment: completing the full course of treatment as prescribed by the provider.

The first stage was targeted by PSI for ground communication further as secondary data also shows it to be a graver problem than the second. Statements by the groups on early detection were categorised under various themes like awareness and correct knowledge, delay in seeking care, risk perception, reasons for discontinuing treatment, myths and beliefs, and stigma. Analysis was completed in a one-day workshop by PSI with participants from various programmes, communication team members from the six states and The Union. Final determinants prioritised were:

- Knowledge that "cough for two or more weeks is a symptom of TB"
- Misconception that simple cough cannot be TB
- Misconception that a person cannot get TB if no one in his/her family has it

PSI has developed the first round of IPC tools based on the findings. These are now being produced and, after pre-testing, will be made available by The Union for use.

Project Axshya was launched in Rajasthan on 28 February 2011. It was inaugurated by Dr O P Gupta, Director Public Health. The State TB officer, Dr K N Gupta, presented an overview of the implementation of RNTCP in the state and focused on the need to improve performance in PSI priority districts (Barmer, Bharatpur, Nagaur, Jhunjhunu, Jodhpur). Dr Geetanjali Sharma from The Union introduced the implementing partners of the project in the state of Rajasthan viz. PSI, MAMTA and VHAI. The Rajasthan STO extended full support to PSI and other partners for the project.

In Project Axshya PSI will collaboratively create an evidence based mass media campaign that will help to improve knowledge, positive social norms and risk perception among vulnerable populations. In addition, PSI will support capacity building of frontline government health workers (ASHAs) to integrate TB messages in outreach.

Shankar Narayanan, Chief of Party, PSI
The role of counselling
Satara District, Maharashtra

Mr Santosh Wankhede (IPC, Satara) and Mr Pramod Borakhede (IPCC, Satara) had gone to village Atit, a sub-centre under Naghtane DMC in Satara, to assess the work strategy of MPW for RNTCP work. During their visit they noticed that a MPW went from door to door to get information on TB suspects along with other diseases. He would ask if anyone in the family had cough for two or more weeks. If so, he would give them a container to collect sputum and ask them to go to the DMC for the morning sample. After scrutinising the TB suspects list from the village, they zoomed in on Mr Hanumant Tatyaba Karavale, aged 60 years, who had cough for over 25 days. They talked to him but he refused to give a sputum sample to the MPW. PSI district staff counselled him and finally convinced him to give a sample, which he did. PSI staff also found that his wife Mrs Mangal, 52 years old, too was coughing. So they also counselled her. She was initially reluctant to undergo sputum examination, saying that she was alright and went to work daily, but finally agreed and gave a spot sample. Both then agreed to go to Nagthane for a morning sample. During counselling sessions, ASHAs from the village, Mrs Pallavi Mohan Bhakare, Mrs Rekha Santosh Kale and Mrs Nisha Sampat Mane were also called in and trained on counselling skills. These ASHAs were already DOT providers and they agreed to counsel all TB suspects and patients on DOTS. The PSI team felt that counselling skills as well as personal follow up of every TB suspect is a must and there are MPW, ANM, ASHA and AWW in villages who can play a very important role in improving case detection and successful completion of treatment.

World TB Day: Awareness campaigns were held at various locations by PSI district staff (IPCs/IPCCs), IEC materials distributed and their queries answered. Topics included symptoms, testing centres and medicines for TB – when and where to go, free treatment facilities, checkups at specified locations, and myths on TB. Leaflets were distributed and motivating pictures displayed. Street plays, candle light processions and rallies were organised in the states of Karnataka, Rajasthan, Punjab and Haryana by involving district health staff and mobilising community volunteers and school children and information on TB was provided through the same.
Resource Group for Education and Advocacy for Community Health

REACH was formed as a registered society, with its main office in Chennai, to raise awareness on issues critical to community health, a major one being TB control. It has been working in slums, schools and communities, and caters to patients from the lower socio-economic strata by supporting them through treatment; counselling, removing stigma; offering support for food, conveyance and tests that the patient may need; and helping patients to stay motivated to complete treatment. Its key activities are:

- Providing social support to TB patients through patient provider meetings and counselling to family members.
- Provision of supervision to TB patients taking anti-TB drugs at the Public Private Mix (PPM) Centres
- Supporting a helpline +91-9962063000 to help patients with their TB related queries
- Engaging and training community volunteers in both urban and rural areas to supervise treatment of TB patients
- Engaging community volunteers and support groups to facilitate referral of symptomatic patients
- Setting up peri-urban and semi-rural PPM centres to cater to growing numbers here
- Providing nutritional support to TB patients as the economic impact of the disease is high despite free treatment

Its current projects and programmes include:

- Project Axshya, which has been initiated in four districts and increase in a phased manner to cover 14 districts in Tamil Nadu.
- The REACH/Lily MDR-TB Partnership Media Project which initiated a fellowship programme to encourage local language journalists nationally to report on TB. A second round of awards for excellence in TB reporting was held and student workshops are planned. The project also focuses on using the wide reach of Community Radio Stations to broadcast information on TB.
- A study, funded by the Eli Lily MDR TB Partnership, on the reasons for treatment default in registered patients is underway to see if they can be encouraged to restart and complete treatment by providing additional social support.
- Engaging ordinary people from the community who volunteer to provide DOT for neighbouring patients. DOT providers can be vegetable vendors, friends, housewives, community leaders, teachers and students, from all strata with a common aim of helping TB patients.
- A sustained advocacy campaign was carried out for three years in Chennai with funding from The Global Fund. IEC activities were targeted at slum and non-slum populations, schools and colleges. REACH employed electronic and print media, and local personalised tools like talks, slide shows, school programmes, street plays, etc. for mass communication, with messages on TB, its symptoms, treatment, advocacy, stigma and care. This had a positive impact.
- Engaging private health care providers by sensitising them to participate in RNTCP has been a priority at REACH. Advocacy and training of PPs was carried out and PPM set up as an informal non-profit collaboration initiated by REACH and Chennai Corporation.
- REACH in association with Lilly MDR TB partnership launched the “Speak up to stop TB” campaign, to increase awareness on TB in the media, and launched the site www.media4tb.org for information on TB, frequently asked questions, information on stakeholders, communication materials, etc.
Activities

Under Project Axshya the following activities have been performed:

- State-level training-of-trainers for health staff trained 25 master trainers as resource persons for district-level activities
- Local NGO networks were selected and four trainings conducted for them
- Eight training programmes in soft skills were conducted at the district-level for health staff
- Four capacity building meetings were conducted for ten CBOs in each district
- Four TB forums were developed and eight orientations held with cured patients, marginalized people, old people, slum-dwellers and the homeless
- Rural health providers were selected and four trainings held for them
- 240 sensitisation meetings with Gaon Kalyan Samitis and community groups were held in four districts
- Special referral slips to document the referrals from RHPs, NGOs and CBOs has been developed by REACH.
- REACH also initiated a Community Radio Initiative by involving community radio stations (CRS) to create awareness on TB in the community and link symptomatic members to appropriate diagnostic and treatment facilities. Activities have included:
  - 26 pre-recorded messages were prepared in Tamil and 260 episodes aired through five radio stations in Tamil Nadu (half hour episodes with 15 minutes pre-recorded information and 15 minutes of live show)
  - A two-day workshop was organised for Radio Jockeys and key functionaries of seven community radio station in Chennai of which MoU was signed with five CRS. A one-day orientation was conducted in the Union office in Delhi for CRS willing to work in Year two.
The most significant achievement of the past year has been getting the support and acceptance of civil society as partners in TB control from state, district and local health authorities, NTP managers and programme staff. Our interaction with local NGOs has brought about a change in their attitude towards TB control, resulting in renewed enthusiasm and commitment among NGO partners as well as the community. There is now a clear internal understanding at REACH that this project will change the outlook for TB Control in India dramatically and we have committed ourselves to do all it takes to push for successful outcomes. The past year has successfully shown that there is a feeling of collective ownership of the programme from all stakeholders ranging from the PMU in Delhi to the village Panchayat leader.

Dr Nalini Krishnan, Director, REACH
Rural access

Tiruvallur

“I am proud to be associated with REACH and Project Axshya – the focus of the project on rural vulnerable populations has helped establish good linkages with government health departments to refer TB patients,” says Dr Sankaramoorthy, a DOTS Promoter among Registered Indian Medical Practitioners (RIMPs). Aged 51 years, he is the secretary for RIMPs Association in Tiruvallur district and a point person for taking TB information from REACH to the community of 35 field-level RIMPs. He has been trained to facilitate the DOTS programme by REACH under Project Axshya since 2010. He has gained rich experience through the trainings under the project and feels it is a well-designed programme. Involvement of RHCPs is a good concept to improve access for TB services. As a doctor catering to the needs of the rural poor and running a small hospital in the Peria Palayam area of Tiruvallur, Dr Sankaramoorthy is able to refer patients to nearest DMC. So far, he has referred 20 symptomatic persons to the hospital and is happy to be rebranded as a DOTS Promoter among the RIMPs.

Combating TB-HIV co-infection

Tiruvallur

Mr Kumaravel, aged 42, has been facilitating the TB programme in Tiruvallur district under Project Axshya since its inception. He is president of the state-level Positive Friends Welfare Association. He and his wife are HIV-infected, although their daughter is healthy and is pursuing her studies. At the district level, over 2000 HIV-positive people have been enrolled of which over 1000 are availing antiretroviral therapy (ART). Each month, 20-25 new HIV-positive people are counselled on TB by his association, as Mr Kumaravel personally feels that majority of HIV patients die due to TB. He himself suffered from TB in 2001 and was administered various treatments and therapies before being diagnosed as a case of tuberculosis. He was eventually put on treatment for which he had to travel a long distance every alternate day along with his wife. He completed his anti TB treatment, after which he was on ART as well. By 2003, he recovered completely. But this ordeal had left him with a good understanding of the problems faced by TB-HIV coinfected people. He resigned from his regular job and started the HIV positive people’s association in 2003. To this group, he provides information on TB and refers them for TB screening. A few have become DOT providers as well. Under the guidance of REACH, the association shares the information of nearby DMCs with the members of the association for getting the sputum smear examinations. These people have also gained knowledge through the strategic intervention of Gaon Kalyan Samitis and the community programmes of NGOs. Mr Kumaravel is a role model in having benefitted from the RNTCP-DOTS scheme who now shares TB information in different forums. “My journey will continue …” he says.

Awareness helps

Kancheepuram

Mrs Arulmozhi is a home maker, a TB forum member from Sithalapakkam and leader of a SHG. She testifies to the benefits of Project Axshya. Her husband is a tailor and her daughter a tenth standard student. By her own admission, “first I used to think that people needed only money but then I realised that they also needed awareness on communicable diseases.” She participated in a REACH TB awareness programme and learnt about TB: how it spreads, its symptoms, diagnosis, and availability of free treatment. With this knowledge, she herself started spreading TB awareness to the general public, SHG groups and schools. Her daughter too created awareness on TB in her school by talking to over 500 students. Arulmozhi felt fulfilled with this service. She joined as a member of a TB forum but, during the service, she had symptoms of cough, evening fever and weight loss. She suspected TB. She consulted a private doctor and had sputum examination, which tested negative in Medavakkam and also had an x-ray done. The result showed no symptoms of TB and the doctor gave her antibiotics for 2-3 weeks, suspecting pneumonia. When this did not work, her husband took her to Chettinad hospital where she was put on anti TB treatment. Within a week, her symptoms subsided. Since she was aware of availability of free TB treatment under DOTS during her meeting with REACH workers, she approached them. Now she is under DOTS treatment and feels confident of being cured. There are many like her who require such information and awareness on TB. She, on her part, is somotivated that she has decided to dedicate her life to fight TB and her overriding message to people is to know about DOTS, get tested on time and if diagnosed as TB, complete the treatment.
Voluntary Health Association of India

VHAI is a leading NGO working in public health since 1970. It is a federation of 27 State Voluntary Health Associations (VHAs) in the country, which are further linked to over 4500 member institutions across the country. VHAI also works closely with a large number of associates and partner organisations in India and abroad. These make VHAI one of the largest health and development networks in the world. The Government of India recognises VHAI as an institution of national importance. VHAI advocates for policy change and effective health planning and programme management through active participation of the people. It also leads the Independent Commission on Development and Health in India set up by the Prime Minister in 1995 and is a partner in the India Coalition Against Tuberculosis (ICAT). The key activity areas of VHAI include:

- Policy Intervention, Knowledge Development and Advocacy at the international and national levels
- Community Level Action, such as KHOJ Projects, Parivartan Projects, work on HIV/AIDS, Indian System of Medicine, Development projects in Orissa Disaster Response and Management
- Capacity Building through the strengthening of State VHAs
- Activities as a resource centre
- Health Promotion
- Development Communication, including VHAI publications, sales and distribution.

In the first year, VHAI is implementing the activities in eight districts of Madhya Pradesh and six districts of Punjab. In year two the project will be expanded to another 23 districts and to additional nine districts in year three.
Activities

- Despite some delay initially, the project has gained momentum in almost all districts of Punjab and Madhya Pradesh. The key factor in achieving most targets and going beyond has been the hard work and positive attitude of the DCs with regular support from the Programme Managers.

- NGO trainings, RHCP trainings, CBO trainings, and soft skill trainings were done in all project districts. In January-March 2011, 402 GKS and 79 community events in MP and 89 GKS and 32 community events in Punjab were conducted.

- Two quarterly meetings of CBOs with the District TB Officer (DTO) were conducted in Bhopal and Neemuch districts. The DTOs appreciated the support provided by the CBOs in creating awareness about TB and strengthening TB services.

- Five Rural Health Care Provider (RHCP) meetings with DTOs took place in Bhopal, Morena, Panna, Satna and Neemuch.

“This is a first of its kind meeting in my block for the staff and it would certainly improve their functioning.”

Dr Meena Hardeep, Senior Medical Officer, Mohali District, Punjab, on VHAI’s soft skill workshop for health staff.
The RHCPs during these meetings reassured their commitment to TB control by referring TB suspects for sputum microscopy and providing DOT services to TB patients.

- On World Women’s Day, discussions on women empowerment, TB and HIV/AIDS were held – a rally and signature campaign was organised in Satna district to increase awareness on these issues.

- On World TB Day, sensitisation workshops and rallies with various groups were held, such as religious leaders, politicians, media persons, school children, jawans, cadets, nursing students, etc.

- The project team is working in close coordination with the state and district TB programme RHCPs, CBOs and NGOs.

**Going Beyond**

- In all districts of MP, training of the CBOs was taken up with the result that the CBOs have now taken ownership of conducting activities at the community level.

- TB forums have been constituted in all the 14 districts and are taking active interest in supporting the cause of the affected community.

- NGOs in Bhopal and Indore have been motivated to form folk groups to create community awareness and mid-media programmes.

- In Neemuch district, in Jan-March 2011, 78 TB suspects were referred for sputum examination by the efforts of local NGOs & Project team. Out of the 78 referred suspects six were found positive. In addition one Sputum Collection & Transportation Centre was sanctioned by the DTO in Kukdeshwar panchayat under the NGO RNTCP Scheme.

- After NGO sensitisation, the DTO agreed on the establishment of a DMC in Ratangadh Public Health Centre in Neemuch district.

- Extensive support of Chief Medical Officer, District Programme Manager National Rural Health Mission (NRHM) & media to the programme. Community volunteers are coming out as sputum transporters.

- RHCPs have been doing a good job in all districts of Punjab. Many are already referring patients to Government Health Facilities.

- Motivated by a series of awareness workshops on TB in various colleges of Mohali in Punjab, students developed a documentary on TB.

- The sensitisation of the of the GKS has initiated the process of strengthening the TB services. The GKS informs the key RNTCP staff (Senior Treatment Supervisor and Senior TB Lab Supervisor) and other field staff about treatment interrupters and defaulters and supports them in retrieving these patients back on treatment. The GKS also informs the RNTCP staff about DOT providers demanding money from patients or if the provider is not getting the honorarium.

- In MP, the State ACSM Task Force was initiated by VHAI where other sub-recipient partners and civil societies who have been contributing to RNTCP at the state-level became members to conduct activities and work to increase RNTCP’s visibility.

A rapport has been established with most state and district officials to successfully implement project activities. Currently, all DCs are making activity plans in close coordination with DTOs while incorporating their suggestions and ensuring their involvement in the actual execution of a wide range of activities.
Training helps
Berasiya, Bhopal, MP

Panther Sports Club is a CBO in North Berasiya, in Bhopal district, MP. Mr Pradeep Kumar Sharma, a member of the CBO, attended the TB sensitisation and soft skills training conducted by VHAI under Project Axshya, after which he referred nine people from the community and ensured that all were tested. One of them was found positive and was put on DOTS. Mr Pradeep also motivated other members, as a result of which members of Panther Sports Club have now been identified as DOTS providers by the District TB Officer. This CBO has further taken the responsibility of collecting and transporting sputum to Berasiya TB Unit from North Berasiya.

Local involvement
Naya Gaon, Mohali, Punjab

A regular treatment defaulter, Mr Rajvir from Janta Colony, Naya Gaon, in Mohali district of Punjab was counselled and motivated by the local Sarpanch, Mr Surjit Singh, following which he has restarted his treatment and promised to take it regularly. The Sarpanch, Mr Surjit Singh, is a satisfied man and has committed all possible support to the District Coordinator in combating TB.

Street plays
Neemuch District, MP

Project Axshya started in Neemuch on 22 November 2010. The District Coordinator (DC) approached various cultural groups from Bhopal and Indore to conduct street plays. Members of the local youth group expressed their interest. This group belongs to the Bachda community, who are primarily sexual workers. Male members usually idle around – playing cards, gambling and drinking – while female members earn for the family. But after meeting the group and seeing their interest in doing some good work for society, the DC suggested that they conduct street plays to generate awareness on TB. The group agreed and has been conducting such plays in the district April onwards. Initially, the group was accompanied by the DC during the plays. But now they perform independently and submit monthly plans and reports to the DC, who only monitors. The group is also in the process of conducting meetings to sensitize the community on TB-HIV co-infection. The DC has facilitated the linkage of the group with NRHM to conduct street plays under other health programmes. It now not only creates awareness on TB but also acts as an inspiration for more community involvement in TB.
Finance

The total approved budget for Phase 1 (April 2010 - March 2012) is US$ 15.53 million, which includes US$ 4.23 million for The Union and US$ 11.30 for the Union’s sub-recipient partners. The total budget for year 1 (Apr 2010-Mar 2011) was US$ 4.34 million.

**Continuous Financial Review Process**

After recruitment of sub-recipient staff, orientation meetings were held in which financial guidelines and Standard Operating Procedures (SoPs) were shared to establish robust financial systems and accounting procedures. Capacity building, from a financial perspective, focused on how to adhere to work plans and utilise budgets cost-effectively. Participatory sessions were held on documentation required to authenticate financial transactions, to bring more transparency and reduce the level of associated risks.

During the year, review visits were conducted for each partner, focusing on the review of financial procedures, systems and project accounting. During these visits, the finance and accounts personnel of partners were also oriented on good financial practices. Observations and recommendations from the visit are communicated to the partners through a management letter, which includes strict timelines for action. Partners are expected to report the action taken through a compliance letter. On receipt of the compliance report with their feedback and response, necessary action is taken and a response for further necessary action given on parts that are found unsatisfactory.

During quarterly partner review meetings, achievements and learning are shared by the partners. Both general issues in financial management, as well as practices followed during project implementation by the different partners, are shared. This platform also gives an opportunity to interact with senior management of the partner organisations on their progress and plans for the next quarter. At the principal recipient level, similar efforts are made to review the systems established and followed at various levels of transactions to make them flawless.

For the year ending 31 March 2011 cumulative budget utilisation for all partners was 75%.
Challenges

• **Coordination:** The success of the project rests largely on the coordination with the Country Coordination Mechanism (CCM), RNTCP, WVI (co-principal recipient), sub-recipient partners and other stakeholders at the national, state and district levels. The project is proactively ensuring this through regular meetings, periodic sharing of information related to the project and its achievements and consultations. However, considering the vast expanse of the project and the large number of stakeholders involved, this continues to be a challenge.

• **Expansion:** The project has been successfully initiated and implemented, as planned, in 90 districts during the first year. In the coming year, the activities will be expanded to another 150 districts. This entails recruiting human resources, identifying and training implementing NGOs, and planning and executing activities. Intensive and focused efforts will be required to support SR partners in executing project activities, over a large and often difficult geographical area, while adhering to timelines, quantum of activities, and quality.

• **Monitoring:** A key factor defining the success of the project will be effective supervision and monitoring. The project has a well-defined M&E strategy, which has facilitated technical support and evaluation of project activities to ensure effective and efficient implementation.

• **Financial Management:** To ensure appropriate financial management by SR partners, regular grant monitoring visits are conducted that not only review the financial processes but also provide technical support to build capacity in partner staff.

Our national TB control programme has done an outstanding job, but it is now recognised that TB in India cannot be successfully addressed by the government alone. Multiple stakeholders across sectors need to work together to expand access to information and services, increase accountability and truly empower communities. This is the biggest challenge and this is what Project Axshya seeks to address.

The logistics of Project Axshya sound daunting, but the idea is to extend the impact of our efforts by building new stronger networks for TB control. For The Union, we have put in place a good team and are partnering nine organisations, each with an excellent track record of working in their respective states. This is the core group, but many more will be involved. Successfully building bridges with relevant stakeholders is equally a challenge. Addressing the linkages of TB with poverty and with non-communicable diseases and expanding partnerships across sectors are not just wishful thoughts for us – we have set up concrete mechanisms that we hope will feed into Project Axshya very usefully.
India is a country with the potential to show other countries that ACSM and involving committed communities can make the difference in the fight against TB and in the prevention of MDR-TB. Project Axshya has well established the organizational structures for implementation during this first year and it is now the role of all stakeholders together - SRs, RNTCP and involved civil society groups - to assure the quality of activities, defining and fine tuning in consensus, the roles and responsibilities. To show the needed evidence in ACSM, M&E systems need to be in place and accessible for all stakeholders to show progress and impact on TB indicators - like communities' contribution to early case finding and successful treatment, - as also to measure the quality of services through the eyes of the patient and behaviour change objectives, including stigma reduction.

Dr Netty Kamp, Chair, ACSM sub-group, WHO Stop TB Partnership

Establishing and sustaining linkages between the community and the health system are vital to realize the goal of “Universal Access to TB Care”. There had been efforts to mobilize civil society in the past as well, but these had largely been isolated and uncoordinated. Project Axshya has effectively addressed this issue and has been able to bring about a major increase in community mobilization. In my field visits I could sense the momentum building. The reach of the project is immense, with partners spread across the length and breadth of the country. To USAID, Project Axshya represents the final push that will tip the scales in India’s favor…

Dr K. Hemachandran, Senior Advisor (TB Care & Control), USAID, India

The name “AXSHYA” suggests “No TB”. This project aims to improve access to quality TB care and control through a partnership between government and civil societies and will certainly help in reaching difficult-to-reach and high-risk populations with greater partnership of stakeholders. I feel this will prove an effective way forward for universal access, and to prevent the emergence of drug-resistant TB.

Dr K.N. Gupta, State TB Officer, Rajasthan

Project Axshya is contributing significantly in reaching the unreached and the underprivileged sections of the population to achieve RNTCP’s objective of universal access.

Dr Rakesh Sehl, State TB Officer, Haryana

Project Axshya is unique and especially relevant for a state like Uttarakhand.

Dr. Ajeet Gairola, State TB Officer, Uttarakhand

Universal accessibility of DOTS would be possible only through civil society partnership by social mobilisation and community ownership. Union’s Project Axshya is moving ahead on its way in the state of Karnataka.

Dr Lal, State TB Officer, Karnataka
Infectious diseases like TB spread from person to person, and eventually you have millions of people who are sick. With Project Axshya we are trying to reverse the process — spreading information on TB, telling people that it is curable, and empowering them to access services. In this way, we hope to reach millions — and save many lives.
The mission of the International Union Against Tuberculosis and Lung Disease (The Union) is to bring innovation, expertise, solutions and support to address health challenges in low- and middle-income populations. With nearly 10,000 members and subscribers from 152 countries, The Union has its headquarters in Paris and offices serving the Africa, Asia Pacific, Europe, Latin America, Middle East, North America and South-East Asia regions. Its scientific departments focus on tuberculosis, HIV, lung health and non-communicable diseases, tobacco control and research. Each department engages in research, provides technical assistance and offers training and other capacity building activities leading to health solutions for the poor.

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