

REPORT ON WESTERN REGION TRAINING OF TRAINERS

Advocating for Equitable Access to Molecular Point-of-Care Diagnostics for HIV, TB and related infections - 6th and 7th October 2025 Mumbai

Organized by: Sankalp Rehabilitation Trust

Supported by: Global Coalition of TB Activists (GCTA) / Molbio Diagnostics

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Location: Mumbai, Maharashtra

Report Prepared by: Sankalp Rehabilitation Trust

Participant Demographics and Community Representation

A diverse cohort of participants, consisting primarily of community activists, treatment advocates and leaders from Non-Governmental Organisations (NGOs) across the Western Region, attended the Training of Trainers (ToT) workshop. The attendees were strategically selected for their direct engagement with marginalised and key populations, including people living with HIV (PLHIV), people affected by Tuberculosis (TB), high-risk groups and residents of rural and semi-urban areas where access to healthcare is limited. Their participation ensured that the workshop discussions were grounded in genuine on-the-ground challenges faced by the most vulnerable communities in accessing TB and HIV diagnostics.

Workshop Background and Objectives

The Regional Training of Trainers (TOT) Workshop for the Western Region was proposed by Sankalp Rehabilitation Trust as a crucial follow-up to the National TOT held in New Delhi on July 3rd–4th, 2025. The national workshop had set the stage by focusing on enhancing community leadership in advocating for equitable access to advanced molecular Point of Care (POC) diagnostics for TB, HIV, HCV and related infections. This regional initiative was designed to localize that national agenda for the Western states (Maharashtra, Gujarat, Madhya Pradesh and Goa).

The rationale for the regional workshop stems from the barriers to timely diagnosis and treatment faced by communities in this region. Specifically, marginalized and high-risk groups, including People Who Inject Drugs (PWIDs), Female Sex Workers and Transgenders, often lack accessible and reliable diagnostic tools. These barriers result in delayed diagnosis and poorer treatment outcomes, particularly concerning TB, HIV and their co-infections. Therefore, the workshop was necessary to strengthen the capacity and voices of community leaders from these affected groups to effectively advocate for improved diagnostic access and hold the public health system accountable for the scale-up and inclusion of POC diagnostics within primary health systems.

Objectives of the Workshop:

1. To build the capacity of regional community leaders and PLHIV/TB networks to understand and advocate for the inclusion and scale-up of POC diagnostics within public health systems.
2. To strengthen knowledge on the intersection of TB, HIV, HCV and related infections, particularly in high risk and marginalised communities.
3. To develop a regional action plan and set of priorities aligned with the national advocacy agenda for submission to NACO and NTEP.
4. To facilitate peer exchange, knowledge sharing and a combined strategic advocacy across networks.

Workshop Day 1 (6th October 2025)

Inaugural Session and Setting the Context

The workshop was inaugurated with welcome and opening remarks by Mr. Eldred Tellis, Ms. Blessina Kumar and Dr. Darivianca E. Laloo. Mr. Tellis set the context by detailing Sankalp's three decades of activism, highlighting that one of their major area of work is access to medicines. He stressed the organisation's philosophy of directly challenging pharmaceutical patents to ensure affordability, using the landmark case of Sofosbuvir for Hepatitis C as an example. He stated that through advocacy and activism, Sankalp brought the price of Sofosbuvir down from approximately ₹70 Lakhs per person to below ₹7,000 and subsequently pressured the government to offer it free of cost across India to people who need it the most.

Icebreaker and Introductions, Pre-test and Expectations

The session kicked off with a unique and fun icebreaker designed to get participants acquainted. Each person chose a printout showing half of an animal. Their task was to move around the room, find their "missing half," and pair up with the person holding the corresponding printout. Once paired, the participants were given three minutes for a quick one-on-one chat to get to know each other. Following this, each pair introduced their partner to the entire group.

This lively activity was followed by participants taking a pre-test questionnaire. Participants were then given post-its where they had to note down their expectations for the workshop and then stick it on a wall so that the facilitators could review them, address key themes throughout the workshop and ensure the content was aligned with everyone's goals.

TB 101 and HIV 101

The section on "TB 101 and HIV -101" was conducted through an interactive and engaging digital quiz format using the Kahoot platform, which was noted as a modern, paperless method. This session was split into two distinct quizzes, one for HIV and one for TB, designed to reinforce key facts and concepts.

1. HIV Quiz: Questions focused on foundational knowledge, including:

- The full form of HIV (Human Immunodeficiency Virus).
- Modes of transmission (Blood was the correct answer for transmission and Hugging/Touching was a key answer for non-transmission).
- Which part of the immune system HIV attacks (CD4 Cells).
- Treatment goals (What ART stands for and the goal of taking it regularly: Suppress the Virus).
- Advocacy concepts like U=U (Undetectable equals Un-transmittable) and prevention methods like PrEP (Pre-Exposure Prophylaxis).

2. TB Quiz: Questions tested specific knowledge essential for diagnosis and treatment advocacy, including:

- The cause of tuberculosis (Mycobacterium tuberculosis).
- Modes of spread (Through air).
- High-risk groups (People with low immunity).
- Diagnostic methods (mentioning sputum test and the role of Point-of-Care tests).
- Treatment and disease classification (such as what DS-TB and DR-TB stand for).

The session was fun and competitive, with Ms. Rashmi Yenaskar from NMP+ winning the HIV quiz and Ms. Meera Yadav winning the TB quiz. The activity was successful in providing a lively, quick and engaging method of assessing individual's knowledge on these subjects.

Patient Testimony: The Human Cost of Delayed Diagnosis

To ground the technical discussion in real-world challenges, Ms. Meera Yadav a TB survivor and activist was invited to share her personal journey. Her powerful testimony highlighted the devastating consequences of misdiagnosis, stigma and lack of support:

- **Eight Years of Struggle and Failed Treatment:** Meera was diagnosed with TB in 2012. She was initially misdiagnosed with drug-sensitive TB while in a private hospital, when she actually had Multi-Drug Resistant (MDR-TB). This resulted in a year of painful daily injections and failed treatment because she was receiving the wrong drugs.
- **Progression to XDR-TB and Surgery:** Due to the misdiagnosis and treatment failure, her condition progressed from MDR-TB to Extensively Drug-Resistant (XDR-TB). A doctor eventually told her that one of her lungs was completely damaged, necessitating a major open-window surgery where her left lung was completely removed.

- **Psychosocial Crisis and Stigma:** She revealed that during her eight-year ordeal, she attempted suicide twice due to the lack of counselling and psychosocial support. She faced severe stigma, even from her own family, which led to her being removed from her home just four months after a new delivery.
- **The Advocacy Ask:** Meera emphasized that her entire suffering, the removal of her lung and eight years of failed treatment, was directly traceable to being wrongly diagnosed in 2012. Her key message was: Diagnosis is a major problem. She stressed that the availability of new, rapid regimens (like Bedaquiline/Pretomanid) and technology is useless if the initial diagnosis is incorrect or severely delayed making a strong case for the workshop's goal of improving access to accurate, Point-of-Care diagnostics.

The Call for Justice and Accountability

Following the testimony, Ms. Blessina Kumar delivered a strong message asserting that Ms. Meera Yadavs eight-year diagnostic struggle was "not acceptable" and represented a failure of public health commitments. She highlighted the mismatch between India's goal to end TB by 2030 and the tragic reality that more than 1,000 people are dying of TB every day in the country.

The core message was that the fight against TB and HIV is fundamentally a "fight for justice", not merely against a virus or bacteria, but against the social issues, stigma and broken systems that deny treatment. She emphasized that TB's burden is heavy, affecting not just the patient's body but their brain, income and family (citing Ms. Meera Yadavs loss of her child and income).

She contrasted the success of the HIV advocacy movement, which built a loud, unified voice that held programmers accountable for drug access, with the isolated voices in the TB space. She stressed that while the country possesses the diagnostic tools (many of which are made in India) and curable treatments, the system fails because these resources don't reach the people. The session concluded by framing the workshop's goal (improving diagnosis) as the essential first step in this larger fight for justice.

Overview of TB /HIV diagnostics in India

This was followed by a presentation on the "Overview of TB Diagnostics in India" session, led by Ms. Blessina Kumar, including the dramatic global and national burden statistics and the critical discussions around the challenges and new diagnostic technologies. The session began with a presentation of the global and Indian TB burden, immediately emphasizing the urgency of the issue and linking it back to Ms. Meera Yadavs earlier testimony.

TB Burden: A Global and National Crisis

Ms. Blessina Kumar highlighted that TB remains a massive public health catastrophe, with India carrying a disproportionate share of the burden:

- **Global Burden:** Annually, there are 10.8 million new TB cases (incidence), with 1.25 million people dying globally. The incidence of Drug-Resistant TB (DR-TB) is 400,000 new cases every year.
- **India's Burden:** India holds the world's "First Prize" for both the highest number of overall TB cases and the most Drug-Resistant TB. Every year, 2.8 million people contract TB and 315,000 people die from it. This death toll means that more than 1,000 people are dying of TB every day in India.
- **TB/HIV Co-infection:** TB is the biggest killer of people living with HIV. There are 42,000 new TB cases among PLHIV annually, with 8,200 PLHIV deaths due to TB.

Diagnostic Challenges and the Importance of POC

The discussion then shifted to the challenges in achieving a right diagnosis, which is the crucial first step for efficient treatment, preventing disease progression and curbing community transmission.

Challenges identified by participants included:

- **Poor Diagnostic Tools:** The traditional method of sputum microscopy was deemed useless and inaccurate, particularly for children and PLHIV and cannot detect drug resistance (a failure that directly led to Ms. Meera Yadavs misdiagnosis).
- **Systemic Barriers:** Lack of knowledge about symptoms and available services, stigma and discrimination (including self-stigma), poor accessibility to labs/doctors and issues of congested living spaces which lack sunlight known to kill TB bacteria were cited as major obstacles.
- **Extra-Pulmonary TB:** It was clarified that pulmonary TB (TB of the lungs) is the only transmissible form, which is why it receives the most focus. However, TB can affect every part of the body except nails and hair and PLHIV are more commonly affected by Extra-Pulmonary TB, making diagnosis more complex.

Embracing Rapid Molecular Diagnostics

The discussion emphasized that new diagnostic tools must be Point-of-Care (POC), meaning the test must come to the person, not the person to the test.

- **WHO Recommended Tests:** The Nucleic Acid Amplification Test (NAT) is the key WHO-recommended rapid molecular diagnostic.

- **GeneXpert (Cepheid):** While a pioneer, it was criticized for being initially expensive and requiring uninterrupted electricity or air conditioning, making it unfeasible for remote areas.
- **TrueNat (Molbio):** This Indian-made tool was highlighted as the test that can truly be Point-of-Care. It is affordable, portable, and battery-operated (with a solar rechargeable option available) and provides results within 60 minutes. The Molbio team would be demonstrating the machine later.
- **Other Important Diagnostics:**
 - **LF-LAM (Lateral Flow Urine Lipoarabinomannan Assay):** This urine sample test is highly recommended for PLHIV as it is easy, reasonably priced and does not rely on sputum. It was noted that advocacy had secured a commitment from the Additional Secretary for its national rollout following a final pilot at NITRD.
 - **Latent TB (LTBI):** The Tuberculin Skin Test (TST) is used to detect dormant TB infection but the new Cy-TB test, though ICMR approved, is currently being held back by the government program.

Overview of HIV Diagnostics in India

Ms. Rosalynn L then presented on "Overview of HIV Diagnostics in India," highlighting key statistics, diagnostic challenges and the crucial role of the community in advancing access.

The session was introduced by a challenge concerning the paradox between TB and HIV: why does India, which has an incurable HIV epidemic (with approximately 60,000 new infections annually), report significantly fewer new cases than curable TB (with 2.8 million)? This question underscored the necessity of robust diagnostic and treatment adherence systems and the need for the community to be active in both fields.

Current HIV Landscape and the Value of Early Diagnosis

The presentation established that over 2 million people are living with HIV (PLHIV) in India, with the epidemic concentrated among key populations (PWIDs, FSWs, MSM, Transgender individuals). A critical discussion point was the concern that the "low" prevalence rate among the general population may be misleading due to a lack of mass testing and proper awareness campaigns, noting that half information is very dangerous.

The Importance of Early Diagnosis:

- **Timely ART and Prevention (U=U):** Early diagnosis is paramount as it enables timely ART initiation. This rapidly reduces HIV transmission and prevents the progression to AIDS and opportunistic infections, with TB being the biggest killer.

The discussion emphasized that when a person adheres to ART, their viral load becomes undetectable (below 50), making the virus untransmittable.

- **Protecting the Negative:** Ms. Rosalynn L highlighted that one PLHIV on successful ART can protect their entire negative family, proving that awareness is critical for the general population, not just the positive community.

Diagnostic Tools, Guidelines and Point-of-Care (POC)

India's national testing guidelines (NACO) follow the WHO recommendations, which stress the 3 A's for testing: it must be Accessible, Acceptable and Accurate.

- **Testing Methods:** The national algorithm uses Rapid Diagnostic Tests (RDTs) for initial screening, ELISA for confirmation and PCR tests for early infant diagnosis (EID) and indeterminate cases.
- **Advocacy for POC:** The community's primary ask is for POC diagnostics that can overcome barriers of distance and cost. Like in the TB discussion, the indigenous TrueNat machine was highlighted as a preferred solution because it is portable, battery operated and can be taken directly to the community in remote areas.

Key Challenges and the Community's Call to Action

The session identified persistent barriers to equitable access, along with innovative solutions:

- **Systemic and Stigma-Related Challenges:**
 - **Financial & Logistical Burdens:** High transport costs, long travel times and the need for accommodation prevent villagers from accessing testing.
 - **Stigma:** The fear of being recognized or facing judgmental attitudes at facilities prevents people from seeking tests or returning for results.
 - **Service Gaps:** Socio-economic constraints limit access to services, particularly Early Infant Diagnosis (EID).
- **Innovative Solutions:**
 - **HIV Self-Testing (HIV ST):** This method has seen increasing uptake (over 93,000 kits distributed in 50 districts in 2021-2022) and is vital because it reduces not testing because of stigma and reaches hidden populations.

The session concluded with a challenge to the community to be activists and advocates, noting that the community is still struggling with gaps in confirmatory testing and weak linkage to care. It was urged that through snowballing techniques, community members must push for policy changes and ensure services such as syringe exchange programs or condom

distribution, are available 24/7 to meet community needs, rather than only during restrictive office hours.

The participants then broke for lunch. It was announced that upon return, the session agenda would be shifted to prioritize the Panel Discussion on TB and HIV Challenges in Diagnosing, followed by Dr. Darivianca E. Laloo's session on Introduction to Molbio and POC Diagnostics and the TrueNat demonstration.

The Panel Discussion

Post lunch, the panel discussion focused on moving from theoretical challenges to real-life experiences from the field in diagnosing both Tuberculosis (TB) and Human Immunodeficiency Virus (HIV).

The panel comprised four key experts, each bringing a unique perspective from their organization and years of field experience in combating TB and HIV:

- **Ms. Prabha Mahesh, Director of Alert India**, introduced herself as a TB survivor, emphasizing her dedication to working for TB patients. Her organization focuses on TB, HIV and community health, specifically implementing the Patient Provider Support Agency (PPSS) under the National Immunocompromised TB Patients Program (NPEP). Her work centres on building the capacity of TB survivors to become advocates and identifying gaps in service delivery.
- **Ms. Jagruti Devankar, representing Doctors for You**, serves as a Project Coordinator for the Private Provider Support Agency (PPSA). Her primary goal is to strengthen private sector engagement within the National Tuberculosis Elimination Program (NTEP), supporting patients from enrolment in the Nikshay portal through diagnosis, treatment and nutrition support (Nikshay Poshan Yojana).
- **Ms. Shabana Patel, a founder member of the Network of Maharashtra People with HIV (NMP+)**, provided a crucial community perspective. As a person who has been living with HIV for 28 years, her experience is deeply rooted in HIV/AIDS activism and she currently uses her platform to advocate for treatment literacy and monitoring for both HIV and TB.
- **Mr. Vikas Kulkarni, from HLFPPPT** working on the **Shashakti Project (HIV and TB)**, specializes in corporate engagement. His objective is to assess TB services in private corporate hospitals, build the capacity of medical and paramedical staff and strengthen Nikshay reporting to ensure complete treatment and continuity of care for patients in the private sector.

Following the introduction of the experts, the panel discussion began with each of the four panellists being asked the same question to get an understanding of the diagnostic barriers they face based on their real-life experiences from the field.

Question 1: What are the diagnostic challenges in the area you work in (TB or HIV) and can you provide an example of a real-life incident?

- **Ms. Prabha Mahesh** highlighted the major challenge of cost for Extrapulmonary TB (EPTB). She shared a heart breaking incident where a 32-year-old woman in a remote slum, suffering from pleural effusion (a form of EPTB), was left at home in agony. This was because the government had recently stopped the free reimbursement for EPTB tests, which cost around ₹7,000 privately. Her organization and the local community had to mobilize funds to pay a private doctor ₹500 to perform the necessary pleural tapping and testing, exposing a gaping flaw in the public health system's service delivery.
- **Ms. Jagruti Devankar** focused on the extended Turnaround Time (TAT) for confirmed TB results. Although treatment is often started based on clinical and X-ray evidence, the time taken to get a definitive CB-NAAT/TrueNat result frequently exceeds the one-week norm. This delay slows down the official initiation of the right regimen and reporting.
- **Ms. Shabana Patel** spoke powerfully about the dangers of misdiagnosis and poor treatment literacy in TB. Despite her 28 years of experience as a PLHIV and deep knowledge of ART, she was recently misdiagnosed with TB after fluid was detected in her lungs. She was put on the full 4-drug TB regimen (including Rifampicin, INH) for 10 days, experiencing severe side effects like extreme fatigue and orange colored urine, before a private consultation confirmed she did not have active TB. She stressed that while PLHIV are 100% literate about ART, TB treatment literacy is very poor in the community and among service providers.
- **Mr. Vikas Kulkarni** pointed to issues in the private healthcare sector, which handles a large volume of TB cases. He noted that private hospitals often test for TB but fail to ensure the treatment is completed and crucially, do not report cases to the government's Nikshay portal. He also echoed the challenge of Extrapulmonary TB, where the high cost of sample extraction often prevents severe cases from receiving timely diagnosis and treatment.

Question 2: What are some of the solutions or strategies that can be implemented to address the challenges you have shared?

The panel offered practical, community-driven solutions focusing on decentralization, monitoring and capacity building.

- **Ms. Prabha Mahesh** proposed decentralization as the core strategy, urging the government to establish small sample collection centres close to patients' homes to eliminate major travel and cost burdens. She also recounted a time where reports were delayed for 10-12 days due to a simple issue: a broken printer. She personally bought and installed a new printer, illustrating that community proactiveness and small, smart interventions can solve major bottlenecks when bureaucracy fails.
- **Ms. Jagruti Devankar** explained her organization's solution to the TAT problem: creating a Hub-and-Spoke model with active Sample Collection Agents who are monitored via a digital dashboard. This system ensures immediate collection of samples upon patient identification and rapid transport to the lab, successfully reducing the Turnaround Time.
- **Ms. Shabana Patel** advocated for two key shifts: Stronger Bi-Directional Linkage (ensuring all TB patients are tested for HIV and vice-versa) and increased Community Ownership. She stressed that the PLHIV community must take responsibility for increasing their peers' TB treatment literacy and monitoring to successfully manage co-infection.
- **Mr. Vikas Kulkarni** highlighted the strategy of Capacity Building in the Corporate Sector. His project conducted massive training sessions for 1,400-1,500 lab technicians across 28 states. The objective was to teach them the correct procedures for Nikshay reporting and to collect detailed patient addresses with landmarks. This simple step ensures that even if a patient transfers out, they can be traced and linked back to complete their government-supported treatment. This intervention was reported to have already reduced patient TAT in the corporate system.

Following the Panel Discussion, a brief Q&A session was opened to the participants, during which three key questions were posed. The core of the discussion centred on how to manage Adverse Drug Reactions (ADR) to TB medication and how to apply lessons learned from the HIV response to address TB treatment challenges.

Question 1: How should Adverse Drug Reactions (ADR) to TB medication be managed and what is the proper protocol when a patient, facing side effects like itching or vomiting, stops taking their medicine?

The question was posed to the panellists, specifically addressing the reality of patients dropping out due to side effects. The panellists emphasized that the solution lies in pre-treatment counselling and a coordinated effort between the patient, their family and the doctor.

Ms. Prabha Mahesh explained that comprehensive treatment literacy and counselling must be delivered before the patient starts the medication. Crucially, family members should be involved in this counselling so they can recognize side effects and support the patient when they are distressed. The immediate advice is to go to the doctor for advice, not to stop the medication, as the doctor is the only one who can decide whether to alter or substitute the drug regimen. She stressed that while the patient must endure the necessary side effects, continuous mental support from the family and counsellor is essential for adherence.

Mr. Vikas Kulkarni (adding in the HIV context) noted that for PLHIV/TB co-infection cases, his team does home counselling and works to track patients who default. They encourage patients to speak to the ART counsellors, as sometimes the patient is confused about whether the side effect is from the ART or the TB drugs.

The discussion ended with a consensus that the current government system lacks specific counselling support. While NGOs and PPSA models fill the gap, institutionalizing counselling (like the pre and post-test counselling available for HIV) within the TB program is necessary due to the high burden of the disease (2.8 million annual incidence).

Question 2: Given the history of dropouts and side effects when ART started for HIV, how did the HIV community successfully tackle those challenges and what lessons can be applied to the TB program?

This question sought to leverage the successful strategies developed by the HIV community. Ms. Shabana Patel highlighted that the HIV community tackled dropouts by increasing treatment literacy and community ownership. While a brief response was given due to time constraints, the core idea was to ensure that people living with HIV (PLHIV) were well-informed about their medication, empowering them to manage the side effects and advocate for themselves. The implication was that the TB program needs a similar push for patient literacy.

Question 3: What is the main barrier preventing proper counselling from being done?

This question aimed to identify the systemic issue behind the lack of pre-treatment counselling. The panellists agreed that the main barrier is the overburdened staff in government settings. DTOs and other healthcare providers are required to handle multiple tasks, including diagnosis, dispensing medicine, entering data into the Nikshay portal and managing other schemes. This workload prevents them from dedicating specific, essential time to professional pre-treatment counselling, which must be institutionalized as a separate, mandatory system within the TB program.

Introduction to Molbio and POC Diagnostics

The session began with Dr. Darivianca E. Laloo presenting the Molbio TruNAT platform as a solution to the diagnostic challenges discussed earlier. She opened by sharing a patient study from the Philippines, which highlighted that despite 88% of people being aware of TB, the

majority learned about it from family and friends and a substantial number of cases were identified through active case finding rather than spontaneous clinical visits.

Dr. Darivianca E. Laloo then introduced the TruNAT real-time quantitative micro PCR platform, emphasizing its core value as a molecular diagnostic tool brought to the Point-of-Care (POC). The platform's primary advantage is its speed and accessibility: it provides early and accurate diagnosis of TB and drug resistance within one hour of sample collection, drastically reducing the Turnaround Time (TAT) that plagues traditional methods. Its design is revolutionary for low-resource settings, being fully automated, portable (it can be carried in a suitcase), battery-operated (lasting up to 8 hours) and capable of being charged via solar panels, making it independent of complex lab infrastructure.

She detailed Molbio's strategic vision for a multi-disease elimination strategy, noting that the TruNAT is endorsed by the WHO and ICMR, is integrated with India's Nikshay portal and supports over 35 different assays for diseases like HIV, Hepatitis, Dengue and COVID, besides TB. Dr. Darivianca E. Laloo challenged the audience to overcome the mind set of "protecting what's ours" in government programs and advocate for sharing the platform between various disease programs (such as TB and HIV) to maximize its utility. Furthermore, the simple 1-hour workflow includes a TruePrep extraction step that yields a large amount of processed sample (elute), which can be stored and used for multiple subsequent tests without needing to recall the patient for a new sample.

Looking to the future, Dr. Darivianca E. Laloo showcased forthcoming innovations, including a new system that will use a tongue swab for TB sampling, reducing the total result time to a maximum of 40 minutes. She also presented the Prodigy platform, which functions as an end-to-end electronic medical system that digitally connects all diagnostic tools for seamless patient registration and data management. This end-to-end vision is further realized with the ProRAD Atlas, an ultra-portable X-ray system with AI that rapidly screens for presumptive TB, linking patients directly to TruNAT for immediate molecular confirmation.

Addressing its use in HIV, she confirmed the TruNAT chips offer 100% sensitive viral load monitoring and that Molbio is actively working with NACO to integrate the platform for confirmatory NAT testing into the national HIV algorithm. She cited a successful community-led "same-day test and treat" study in Manipur where trained community members used the platform to confirm results for People Who Use Drugs (PWUD) and initiate treatment in an average of 6 hours. Dr. Darivianca E. Laloo's final call to action was for the participants to spread the word and demand access to these available solutions, arguing that lack of awareness is the only thing preventing communities from benefiting from "bringing the lab to the people."

The session concluded with an impromptu display of a non-TB/HIV product, the iBREST, a handbag-sized, non-invasive device for breast cancer screening that was presented as a pain-free alternative to painful mammograms. During this transition, a question was asked about

the side effects of the iBREST machine, to which the Dr. Darivianca E. Laloo immediately confirmed that there were "No side effects of anything."

The session transitioned to a brief presentation and demonstration of the iBREST exam, a non-invasive screening device for breast health, led by Ms. Preeti Negi of UE Life Sciences.

Ms. Preeti Negi introduced the iBREST exam as a solution to address the barriers associated with traditional mammography, particularly the pain, trauma, radiation exposure (being an X-ray) and the need for specialized infrastructure and personnel. She highlighted the device's adherence to the "Three A's" of healthcare: accessibility, affordability and availability at the point-of-care.

The iBREST exam is a small, portable and non-radiation device that functions similarly to how a doctor performs a palpation, using a sensitive sensor to detect abnormal lumps or lesions in breast tissue in real-time. The entire screening takes about 10 minutes. This is intended as a population-level screening tool, allowing for home-to-home screening in rural areas and during corporate health check-ups, making it ideal for women who often deprioritize their own health. The data is stored on the cloud and the results are generated within 8-10 minutes.

The device is marketed as a screening tool, not a diagnostic tool, similar to how the ProRAD X-ray is a screening tool for TB. If the result is positive (i.e., a lump is found, which can be benign like a cyst or adenoma), the patient is then referred to a specialist for a confirmatory test like an ultrasound, mammogram, or biopsy.

Ms. Preeti Negi shared the device's accuracy metrics, stating the sensitivity is between 84-86% and specificity is 92%. She particularly highlighted its strong Negative Predictive Value (NPV) of 98%, meaning it is highly accurate at confirming when a lump is not present. She noted that its accuracy is comparable to that of 2D digital mammograms, but it avoids radiation and physical pain.

The participants had a few questions i.e. -

- **What is the cost of this?**
The system itself is approximately less than 6 lakhs.
- **You are saying that after this a mammogram has to be done anyway?**
No, only if a lump is found, then a confirmatory test (ultrasound, mammogram, or biopsy) is required.
- **What is the accuracy?**
Sensitivity is 84-86%, specificity is 92% and the negative predictive value (NPV) is 98%.

- **Will they have to pay for the test? How?**

Like, if we have a mass screening. The cost model depends on the setting (public or private). The main recurring cost is the sensor cartridge, which can perform 500 scans and costs approximately ₹1,35,000, making the cost per test around ₹270.

Mr. Prasad Mali from the Molbio team then demonstrated the ProRAD Atlas ultra-portable X-ray system, emphasizing the seamless integration of screening and diagnosis with the TruNAT.

Portability and Specifications: The X-ray machine is a high-frequency, 2ms 70 kV device weighing only 2.8 kg. The total kit, including the flat panel detector (3 kg) and lead safety accessories, weighs 17 kg and is designed to be easily carried to rural areas for outreach initiatives.

AI-Driven Screening: The machine incorporates an on board AI software that has an accuracy of 96%. Critically, the AI can analyse the X-ray image (displayed on the screen) and generate a report in 2-2.5 minutes without needing an internet connection (unlike other competitor machines). The report identifies "TB symptoms" or an abnormality, indicating a need for a confirmatory test, but does not provide a definitive TB diagnosis.

End-to-End Workflow: The workflow is simple: screen with the ProRAD X-ray (3 minutes), the AI flags a presumptive case and the patient is immediately sent for confirmation using the portable TruNAT machine, allowing for a rapid "screen and confirm" process.

Multipurpose Use: The device is versatile; while excellent for TB screening, it can also be used to screen for other conditions like fractures in health camps, making it a valuable investment beyond TB alone.

Ms. Blessina Kumar then returned to wrap up the session with a strong advocacy message, urging the community members to recognize and act upon the availability of these point-of-care devices. She emphasized that if the community is convinced of the device's effectiveness, it is their responsibility to advocate for it and create demand. She used a local analogy, stating, "Even a mother does not feed the child until it cries" to drive home the point that the community must demand access to these better tools or the government/policymakers will continue to lack focus and jump from one unmeasured solution to the next. The diagnosis, she stressed, remains the biggest problem in the fight against TB and the TruNAT and ProRAD systems offer a tangible solution.

Moderated Discussion – Field Insights & Ground Realities

The final session of the day, a Moderated Discussion on Field Insights & Ground Realities, led by Ms. Meera Yadav, aimed to shift the focus to the real-world barriers and challenges faced by patients and community workers in accessing TB and HIV diagnostics.

The discussion aimed to gather first-hand accounts from participants working at the grassroots level. Participants raised several interconnected issues spanning diagnostics, treatment adherence and healthcare delivery:

1. Gaps in Diagnostic and Treatment Flow:

- **Delayed Drug-Resistant TB (DRT) Treatment:** One participant noted that the protocol for diagnosis and subsequent treatment change (based on DRT results) is not properly followed, leading to delays and potential adverse side effects for the patient while waiting for results and treatment modification.
- **Poor Sputum Sample Quality:** Challenges exist in teaching patients how to properly provide a sputum sample, leading to poor sample quality and false negative results, thus delaying the start of necessary treatment.
- **The "Missing Millions" in Diagnosis:** Many TB cases are initially clinically diagnosed (based on symptoms and X-rays) rather than being microbiologically confirmed (via lab test/molecular). This is a particular challenge in Extra-Pulmonary TB (EPTB), where sample collection is difficult and in cases of empirical treatment where doctors start treatment without molecular confirmation, potentially leading to misdiagnosis (e.g., mistaking cancer for TB, or long-term infertility due to undiagnosed EPTB).

2. Patient-Related Barriers and Stigma:

- **Stigma and Fear:** Stigma remains a major challenge. Even after proper counselling and diagnosis, patients are often afraid to return to the centre for follow-up or treatment, fearing how they will be seen by their community.
- **Reluctance to Test/Seek Care:** Many clients, especially those without obvious symptoms, show reluctance or apathy towards testing. They feel they don't have time or are in denial about their health status, despite the availability of services.
- **Pill Burden:** A significant barrier for patients living with HIV and TB is the combined "pill burden"—taking four TB medicines, one HIV pill, plus medications for Non-Communicable Diseases (NCDs) like BP and sugar. This high pill count causes reluctance, poor adherence and a desire to skip tests to avoid starting more medication.
- **Self-Medication/Mismanagement:** Particularly among youth, there is a trend toward self-medication (e.g., buying ART medicines from Amazon without a doctor's prescription) and relying on information from online groups, leading to the mismanagement of their condition.

3. System and Counselling Gaps:

- **Lack of Proper Counselling:** For key populations like Injecting Drug Users (IDUs), a lack of proper counselling at ART centres is a major problem. Counsellors often lack the time or proper training to explain the necessity of treatments like the six-month IPT (Isoniazid Preventive Therapy) course, leading clients to refuse or discontinue it.
- **Migrant Worker Issues:** Migrant workers pose a unique challenge. Their different language, combined with their mobility for work (taking medicine for only a month before leaving for two months), disrupts the continuity of treatment and follow-up. Their focus on work also makes effective health awareness difficult.
- **Healthcare Provider Behaviour:** A participant from Mumbai noted that stigma and discrimination from healthcare providers themselves is a critical issue, with negative or judgmental behaviour causing more than half of patients to drop out of care, particularly in the educated, younger population.

Proposed Solutions and Way Forward:

Towards the end, the discussion shifted briefly to solutions, with participants sharing their mitigation strategies:

- **Mobilization of Mobile Health Services:** To overcome the hurdle of long-distance travel, especially in urban, rural and tribal areas, mobile health services should be mobilized to bring health services and medicines directly to small pockets and remote communities.
- **Sensitization of Healthcare Providers:** It is very important to sensitize the healthcare provider to address the stigma and discrimination that leads to high patient dropout rates, even in a metropolitan city like Mumbai.

Ms. Blessina Kumar concluded the day by challenging the participants to stop focusing solely on what should be done by external bodies, but rather, to reflect on what each individual participant will personally do in their own space as an act of advocacy, leaving this as the key action point for the next day's session.

Workshop Day 2 (7th October 2025)

Recap of Day 1 and Clarifications

The second day of the workshop began with a crucial Recap of Day 1 and Clarifications, where two participants shared their key takeaways, effectively consolidating the previous day's learning. They reinforced the core diagnostic barriers identified, such as the persistent challenge of stigma and fear causing patients to skip follow-up even after diagnosis, the

reluctance to adhere to long regimens due to pill burden (the combination of HIV, TB and NCD medications) and the systemic gaps in providing proper counselling and continuity of care, especially for migrant workers. This session served as a strong transition, reminding participants of the challenge posed the previous evening to shift focus from problem identification to generating actionable, individual solutions, thereby priming them for the day's main discussion.

This was followed by an in-depth session on the Introduction to Advocacy, moderated by Ms. Blessina Kumar.

The session commenced by establishing a working definition of advocacy, with participants contributing ideas such as bringing changes in policy, acting as a voice for the voiceless and seeking justice for others. Ms. Blessina Kumar solidified this by stating that advocacy is inherently linked to the issue of justice and must always be a collective effort, emphasizing that a lone advocate cannot achieve systemic change; success requires working together, whether through writing letters, protesting, or simple vocal unity.

A central concept introduced was Equitable Access, which was carefully distinguished from simple equality. Ms. Blessina Kumar explained that equality means giving everyone the same amount, which fails because people's needs are different. Equity, conversely, means giving more resources to those who need them most so that everyone can achieve the same health outcome, such as prioritizing those with comorbidities or the elderly during a vaccine rollout. This principle, she asserted, must be the guiding star for all health advocacy efforts, ensuring resources are directed where the vulnerability is highest.

The discussion then moved to the practicalities, outlining what and who to advocate for. The target issues included demanding safer and better drugs (a point passionately reinforced by the participant who shared her horrible experience with old TB medication and another who took TB drugs for eight years), improved counselling facilities and crucially, securing enhanced domestic funding to reduce dependence on external sources. The advocacy targets were broad, ranging from the Health Minister and TB Program Director to drug manufacturers (citing successful civil society battles against companies like Johnson & Johnson over Bedaquiline and its patents) and even powerful funding agencies.

A highlight of the discussion was a critique of structural injustice in global health funding. Ms. Blessina Kumar condemned the common practice where community members are used to share their compelling stories to secure multi-billion dollar grants, yet the community itself only receives a tiny fraction of the final money for grassroots work, while the majority goes to administrative costs and high executive salaries in Geneva or the US. This, she declared, is an injustice that community leaders must unite to challenge respectfully but firmly, even if it leads to personal consequences, because failing to do so renders the "voice for the voiceless" ineffective.

Finally, the session explored different types of advocacy and practical tools. Advocacy was categorized as either reactive (responding to an event like a drug stock out) or proactive (planning ahead, such as developing community educational materials on new drugs like BPAL before their rollout). Ms. Blessina Kumar presented an eight-step planning process, stressing the need for clear goals, thorough research, identifying allies even within the government and rigorous monitoring and evaluation (M&E). Tools ranged from traditional methods like protesting, petitioning and lobbying to innovative new methods like web activism (using social media), videography (30-second impactful clips) and craftivism (using crafts to symbolize a campaign). The closing advice focused on the "Dos and Don'ts," underscoring that advocates must be transparent, honest, provide accurate information and numbers and always offer solutions not just problems to build respect and consensus with decision-makers.

Group Work – Advocacy strategy for POC diagnostic access

The workshop's most crucial output was the shift from discussion to actionable plans. Out of all the participants, four groups were formed and each was given the task of developing a robust, evidence-based Advocacy Action Plan to address a critical challenge in TB/HIV diagnostics and care. These plans were then presented, questioned and refined with feedback.

Group 1: Decentralizing Point-of-Care Diagnostics

Advocacy Goal: To ensure the immediate availability and effective use of Point-of-Care (POC) diagnostic machines for TB in all community centres, especially in semi-urban and rural areas (e.g., Palghar side near Virar).

The Rationale (The Problem): The presenters highlighted that while POC machines are available at tertiary centres (Mumbai city), their absence at the periphery level and in rural community centres forces patients to travel far, causing transport issues, significant delays in diagnosis and delayed initiation of treatment. Their ask was direct, to make the machines readily available for early diagnosis and treatment.

The Action Plan:

1. **Targets:** NTP staff (STS, Treatment Coordinator, Health Visitor), DTOs (District TB Officer), local VMCO hospitals, MSWs (Medical Social Workers) and Counsellors.
2. **Activities/Steps:**
 - **Need Assessment and Mapping:** Conducted with the community to identify the precise locations where machines are missing, focusing on high-TB-burden pockets.
 - **Consultation Meeting:** Organized with community members, civil bodies, TB Champions and district officials to present the findings.
 - **Dissemination:** Share evidence-based findings with the State Body of the Government and submit a formal letter requesting the rollout of machines or efficient utilization of existing ones.

3. **Time Frame:** Six months, with potential for extension.
4. **Organizing Lead:** TB Champions and Community Champions, supported by NTP, local NGOs, DTOs, CTOs and legal experts (Lawyers Collective).

Questions and Discussion Points:

- **Question (Credibility):** Ms. Blessina Kumar asked those presenting "If I am an NTP official, you come to me and say, this is a point of care...I ask you, how do you know? Who told you? Who are you? Are you a doctor? Do you have any research? What will be your response?"
 - **Response (Community-Based):** Advocates must cite community examples (e.g., "Shital's TB diagnosis took her 6 months") and reference government data like the Nikshay reporting to show a lacuna (patients enrolled but not starting treatment). Advocates need to be clear that they are not promoting a company but advocating for what is beneficial for the patient (like BPAL over other regimens).
 - **Response (Knowledge):** Advocates should have knowledge from workshops, read the machine brochure and state that the device is cost-saving, fast, simple and portable for doorstep testing.
- **Crucial Intervention (Dr. Darivianca E. Laloo):** The focus was redirected from buying new machines to utilization. It was revealed that 9,000 TrueNat machines are already available across India but are underutilized. The new task was to find the list of these locations and direct patients there immediately to save costs. The advocates were also urged to highlight the machine's multi-purpose capacity (doing 40 types of tests by changing the chip) to appeal to different health departments (HIV, Hepatitis).

Group 2: Mobilizing Political Will for TB Elimination

Advocacy Goal: To increase and enhance quality development for TB programming by sensitizing political leaders about the burden of TB and the importance of eliminating it by 2025 (or 2030).

The Rationale (The Problem): The primary problem identified was the lack of political support and visibility (advertisement) necessary to achieve the TB elimination goal.

The Action Plan:

1. **Targets:** High-level political and administrative figures: Chief Minister, Department Secretaries, Health Minister, Planning Commission, Media and Influencers.
2. **Activities/Steps:**

- **Follow-up Meetings:** Conduct regular meetings with TB Survivors / Champions (e.g., Meera, Prabha) and the community.
 - **Research & Review:** Review existing guidelines and evidence (HIV operational guideline, TB guideline) to identify gaps for advocacy.
 - **Drafting:** Prepare formal draft letters to convey messages to the government.
 - **Stakeholder Meetings:** Plan meetings to hold stakeholders accountable for their 2025/2030 elimination promises and ask for political support.
 - **Two-Level Advocacy:** External (influencing politicians) and Internal (ensuring TB survivors and HIV-positive people know the TB guidelines to advocate for themselves).
3. **Time Frame:** Till the next quarter/January 2026 (to align with the February budgeting process).
4. **Organizing Lead:** TB Survivor Group in Bombay, with support from other TB-working agencies.

Questions and Discussion Points:

- **Facilitator Suggestion (Structural):** HIV-positive people are officially supposed to be members of the District TB Committee (DTC), which meets quarterly. Advocates should work closely with these existing members to raise their issues at the district and state levels.
- **Question from Participants:** "Why don't you demand the use of the government device in these centres that will benefit this population?"

Response/Strategy: The portable POC machines should be advocated for use in existing vulnerable population centres (for People Who Inject Drugs, Sex Workers, etc.) because these groups avoid general hospitals due to stigma. The facility can borrow the machine from a PHC to conduct a day-long testing camp, bringing the device to the community instead of sending them to the hospital.

Ms. Meera Yadav noted that while HIV-positive people are on paper invited to DTC meetings, they are not consistently invited in practice, indicating a need for advocacy on policy implementation.

Group 3: Mandatory Pre- and Post-Test Counselling for TB

Advocacy Goal: To make free pre- and post-test counselling compulsory for TB testing, similar to the mandatory protocol in government ICTCs for HIV.

The Rationale (The Problem): Lack of proper counselling in TB testing is identified as a major factor leading to high rates of LFUs (Lost to Follow-Up) and refusals for testing. A

critical secondary issue is the poor quality of samples (e.g., saliva instead of correct sputum) due to patients not being properly informed, leading to wrong diagnoses.

The Action Plan:

1. **Targets:** State Health Department, Health Secretary, Central TB Division, Director General of TB India (Top-to-bottom approach).
2. **Activities/Steps:**
 - **Research:** Quantify the percentage of LFUs and refusals in TB compared to the lower rates in HIV to show the program's lacuna. Also, research the impact of poor sample quality.
 - **SOP Development:** Develop a proper SOP (Standard Operating Procedure) for TB counselling in collaboration with the Indian Medical Association (IMA), counselling teams and peer groups/survivors (who provide crucial ground-level information).
 - **Capacity Building:** Provide proper training and capacity building for healthcare workers and counsellors on the new SOPs.
 - **Policy Enforcement:** Ensure private practitioners follow the government's mandatory SOPs for TB testing and patient notification.
 - **Monitoring and Evaluation (M&E):** Monitor adherence to the mandate in both public and private sectors and evaluate the reduction in LFUs and the increase in early diagnosis numbers.
3. **Time Frame:** By 2027 for the full change, with a proposal ready for the PIB (Public Investment Board) by early 2026 for the next government budget.
4. **Organizing Lead:** NGOs working for TB and HIV, supported by Government/NDEP authorities and new support groups.

Questions and Discussion Points:

- **Personal Connection:** Ms. Meera Yadav reinforced the need, stating the issue was "very close to my heart" because she lost a lot of time herself due to a lack of pre-test counselling. She stated that even with the latest devices, counselling is the basic foundation missing.
- **Resource Mobilization:** The group suggested leveraging existing resources like the MSF office, which is willing to support with resources and training and utilizing the TI (Targeted Intervention) model of screening and counselling in new areas.
- **HR and Budget:** The group advocated for including HR counsellors in the public health system budget, drawing a parallel to the counsellors already present in the ICTCs for HIV. They suggested starting with a pilot model in the PIB proposal to prove feasibility before a larger scale-up.

Group 4: Activating Underutilized Multi-Purpose Machines

Advocacy Goal: To ensure the activation and full utilization of the existing 9,000 TrueNat machines for multi-purpose testing (not just TB) in all Public Health Centres (PHCs).

The Rationale (The Problem): Based on the evidence shared, the group focused on the problem that 9,000 machines are already available but are not activated and lack awareness/education on their multi-purpose use. The machines are not reaching the grassroots, especially in rural PHCs.

The Action Plan:

1. **Targets:** Local MLAs (Members of Legislative Assembly), Health Minister, Health Commissioner and all relevant departments (PNCO, HWCO, Tribal/Rural Health Departments).
2. **Activities/Steps:**
 - **Community Meeting:** Hold a meeting to share the facts (machine is needed, time-loss is occurring).
 - **Local MLA Engagement:** Have community members meet their local MLAs, provide a letter of need from their organization and have the MLA write to the Health Minister/Commissioner.
 - **Personal Meetings:** Once a reply is received, escalate to personal meetings with the Health Minister and Health Commissioner.
 - **Dissemination:** Educate all health departments on the machine's relevance for issues beyond TB, highlighting its capacity for 40 types of tests to increase demand.
 - **Resource Mobilization:** Seek support from CSRs, NGOs and CBOs for small budgets to cover things like community travel for mobilization.
3. **Time Frame:** A measurable period of six months to monitor activation efforts, with a regular follow-up system.
4. **Organizing Lead:** Community groups working at the local level.

Questions and Discussion Points:

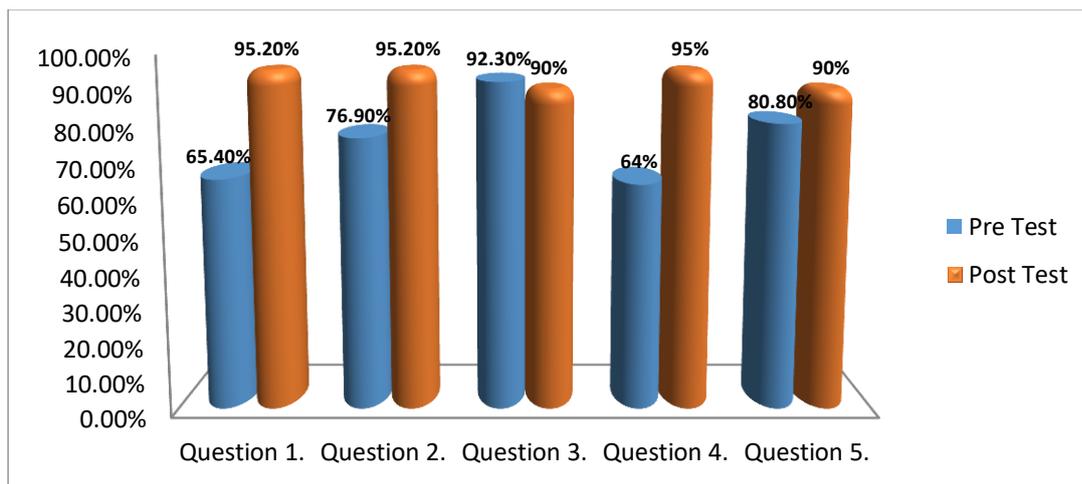
- **Funding Challenge:** When asked about funds, the group stated they would seek support from CSR, NGOs and CBOs, but the Ms. Blessina Kumar suggested they also focus on proving the machine's value.
- **Demand Strategy:** The group focused on increasing the machine's demand by constantly highlighting its multi-purpose nature (40 types of tests) to local doctors and hospitals, arguing that this capability makes it a shared resource, not just a TB-specific tool.

- Phased Approach:** They emphasized a stepped approach: start at local health facilities, write to MLAs, then seek personal meetings with the Health Commissioner and finally the Health Minister. The overall goal remains to activate the 9,000 existing machines through consultation and collective efforts.

Pre-test & Post Test Evaluation

Section A – Knowledge

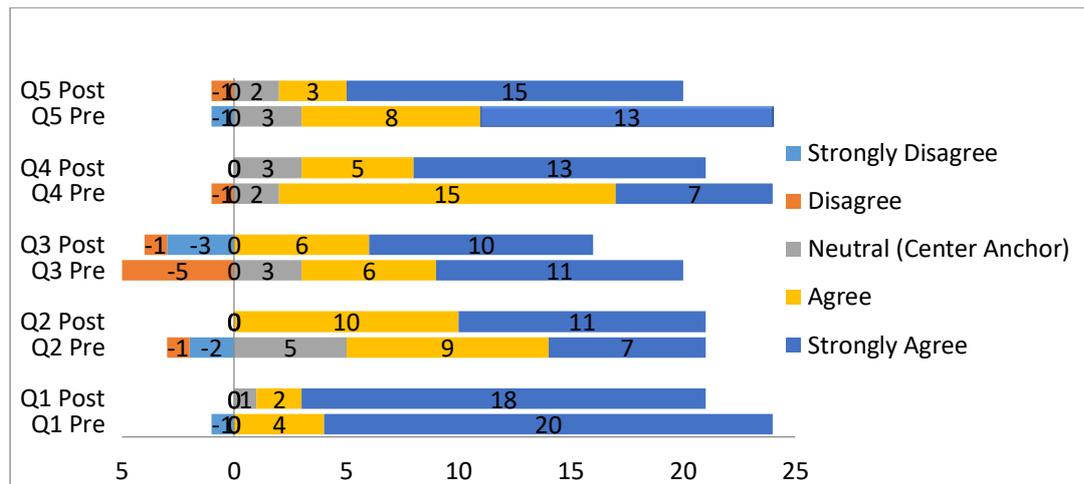
1. What does point of care diagnostic mean according to WHO?
2. What is a key advantage of using molecular POC diagnostics for HIV & TB ?
3. Which infection is commonly co-infected with TB/HIV and benefits from POC testing?
4. Which of the following is a barrier to accessing POC Diagnostics in India?
5. Who can advocate for better access to POC diagnostics?



The Knowledge section (Section A) of the assessment demonstrated a significant and positive transfer of technical information from the workshop, evidenced by notable increases in the percentage of correct answers across all five questions. Participants achieved near-perfect scores on the foundational questions concerning the WHO definition of POC diagnostics (Q1), the key advantage of molecular POC (Q2), and the Barriers to POC Access in India (Q4), the latter showing the largest gain. Overall, the results confirm that the workshop was highly effective in solidifying the participants' knowledge base regarding POC diagnostics, its context in India, and the stakeholders involved in advocacy.

Section B – Attitudes

1. Timely access to diagnostics is a health right.
2. I feel confident discussing POC tools in public forums.
3. Advocacy by communities is critical to expanding diagnostic services.
4. I believe my voice can influence government decision – makers.
5. I want to be part of a collective campaign for diagnostic equity.



The Attitudes section confirms a substantial shift toward positive advocacy beliefs and self-assurance. The most success was the complete elimination of negative sentiment (Disagreement) for two critical areas: confidence in public discussion (Q2) and the belief in personal influence on government (Q4). Furthermore, the number of respondents expressing agreement that they feel confident discussing POC tools in forums increased from 16 to 21 participants and the belief that community advocacy is critical rose from 17 to 20 participants. These results indicate that the workshop was highly effective in instilling the motivation and personal efficacy required for active community advocacy.

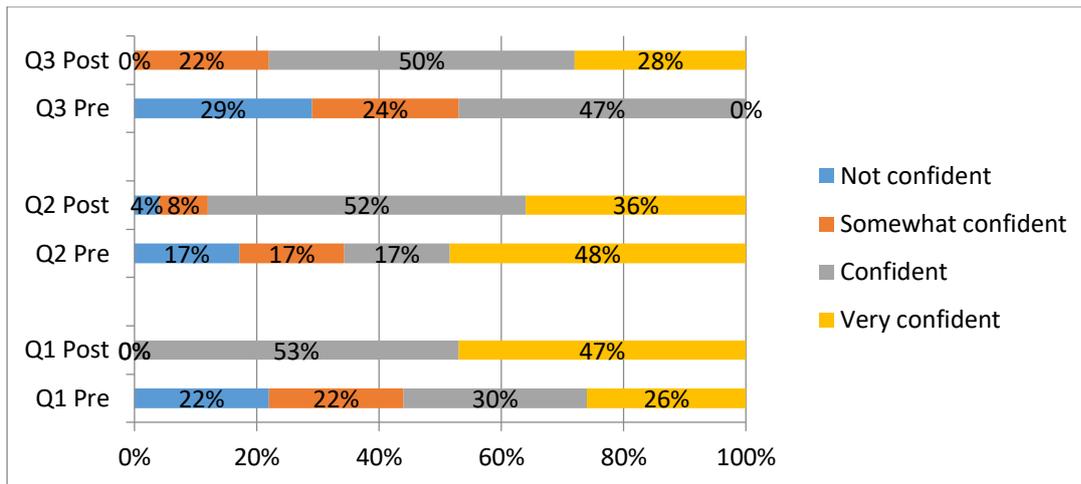
Section C - Confidence and Advocacy Skills

Pre-Test Questions

1. How confident are you in explaining what POC diagnostics are and why they matter?
2. How confident are you in speaking with local/state officials on health access?
3. Do you understand how to create an advocacy strategy to push for change?

Post Test Questions

1. How confident are you now in explaining POC tools to your peer/community?
2. How confident are you in engaging with state health authorities or media on the issue?
3. Are you ready to develop and implement a state-level advocacy plan?



The results from the Confidence and Advocacy Skills section clearly demonstrate the workshop's success in significantly shifting participant confidence from low to high across all three critical areas. For the foundational skill of explaining POC diagnostics (Q1), the entire segment of respondents reporting "Not confident" or "Somewhat confident" was completely eliminated post-test, with 100% of participants now rating themselves "Confident" or "Very confident." Confidence in engaging with officials (Q2) also saw a major positive transformation, with the initial 34% of low confidence responses dropping to just 12% post-test, and the highly confident segments expanding substantially. Most critically, the readiness to develop and implement an advocacy strategy (Q3) showed a dramatic improvement; the initial large segment of respondents reporting "Not confident" or "Somewhat confident" was entirely removed, resulting in a robust post-test outcome where the vast majority of participants felt "Confident" or "Very confident" about taking state-level advocacy action.

Section D – Open Ended

Pre-Test Responses

1. What do you hope to learn from this workshop?

- To acquire knowledge on Point-of-Care (POC) diagnostics, including new techniques for HIV/AIDS and TB testing.
- To understand the fundamental principles and operation of POC tools and strategies.
- To learn about the challenges currently encountered in diagnosing diseases at the community level.
- To explore advocacy strategies and practical plans of action for better treatment access and effective policy implementation in India.
- To learn about awareness programs, capacity building, and strategies for increasing people's participation.
- To understand new technologies, such as how portable X-ray machines function, and how to advocate for their wider use.

- To gain insights into how POC diagnostics will benefit the community and the best methods to ensure community access.
- To establish connections and networking opportunities with other organizations working in this field.
- To learn strategies aimed at ending stigma and discrimination.

2. Describe one barrier you face in your community related to diagnostics.

- **Logistical Delays:** Testing for children requires referral to government facilities, causing significant delays (up to two weeks).
- **Diagnosis Delay:** General delay in the diagnosis and identification of TB cases when using traditional methods.
- **Social Stigma:** Widespread social stigma and fear prevents people from seeking diagnosis.
- **Discrimination:** Experiences of discrimination against individuals and families, including by healthcare providers.
- **Lack of Information:** Limited knowledge within the community regarding symptoms, municipal treatments, and basic awareness.
- **Systemic Issues:** Communities are often unaware of their rights, leading to discrimination by hospitals.
- **Access Barriers:** Long travel distances, non-availability of essential medicines, and high costs for testing in the private sector.

3. Have you led or participated in an advocacy activity before? If yes, share briefly.

- No (5 responses)
- Yes, by holding workshops and conducting awareness programs.
- Yes, by engaging in advocacy with health departments.
- Yes, participated in efforts to secure medicine supply (e.g., 3rd line ART and during COVID-19).
- Yes, involved in advocacy for specific treatments (e.g., lenacapovir & 3HP).
- Yes, participated in a protest to drop medicine prices in 2018.
- Yes, through sensitization efforts and advocacy at schools and colleges regarding LGBT issues.
- Yes, involving specific organizational partnerships (REACH & MAMTA).
- Yes, advocating for the provision of regular grants for TB patients.

Post-Test Responses

1. What were the two most valuable lessons you learned during this TOT?

- Gaining skills and knowledge related to Advocacy.
- Understanding the importance of early and easy diagnostics and improvements in testing.
- Learning about advocacy techniques and treatment literacy.
- Acquiring detailed knowledge of POC testing and tools.
- Learning about TB prevention and the essentials of TB 101.

- Understanding the utility of mobile testing and X-ray machines for rural advocacy.
- Gaining clarity on the importance of POC diagnostics in Primary Health Centers (PHCs).
- Learning the nuances of advocacy and how to develop core areas for impactful strategies.
- Acquiring information about new treatment regimens (e.g., BPAL).
- Understanding the importance of teamwork, POC roles, and responsibilities.

2. What advocacy action do you plan to take in the next 2 months?

- Conducting community camps and trainings.
- Advocating for making pre-counselling mandatory for TB testing.
- Planning to train TB & HIV communities to spread knowledge and advocate for their welfare.
- Developing an action plan with the Ministry of Social Justice.
- Initiating efforts to sensitize stakeholders at the state and district levels.
- Proposing a pilot group and setting up pre- and post-test strategies for early detection in Mumbai.
- Planning to meet the Health Minister to advocate for TrueNat machines in all PHCs.
- Advocating for the provision of free bus services to ART and TB centers for monthly testing.
- Reviewing the TB counselling manual and advocating with TB survivors.
- Starting a Social Media (SM) campaign and creating community health work initiatives.
- Advocating for the compulsory use of TrueNat in rural areas.

3. How would you support others in your state to understand and promote POC diagnostic?

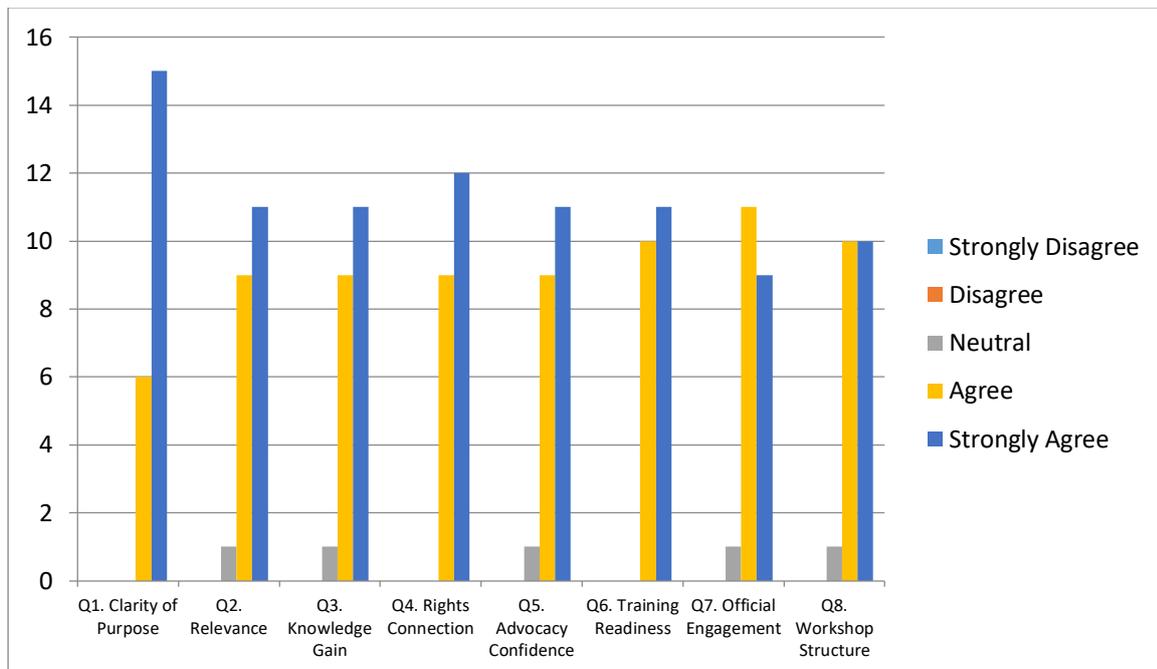
- Be vocal about TB in communities and openly discuss POC diagnostics.
- Conducting testing camps.
- Spreading awareness through health promotion and education using various media.
- Actively participating in every activity related to POC.
- Working to mobilize the community to understand the importance of early detection.
- Knowledge sharing through capacity building and providing empowerment to the TB community.
- Creating a strong advocate group and implementing community intervention and social mobilization to promote POC.
- Serving as a trainer/facilitator for others.
- Networking with relevant groups and individuals.

Participants Feedback on the Workshop

SECTION A: Content and Relevance

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree)

1. The objective of the workshop was clearly defined.
2. The workshop content was relevant to my work and community context.
3. I gained new knowledge about molecular POC diagnostics.
4. I understand the connection between diagnostics and human rights.
5. The sessions help me feel more confident about advocacy.
6. I am now better equipped to design a local/state – level training.
7. I feel prepared to speak to government /health officials on this topic.
8. The workshop gave space for peer learning and open discussion.

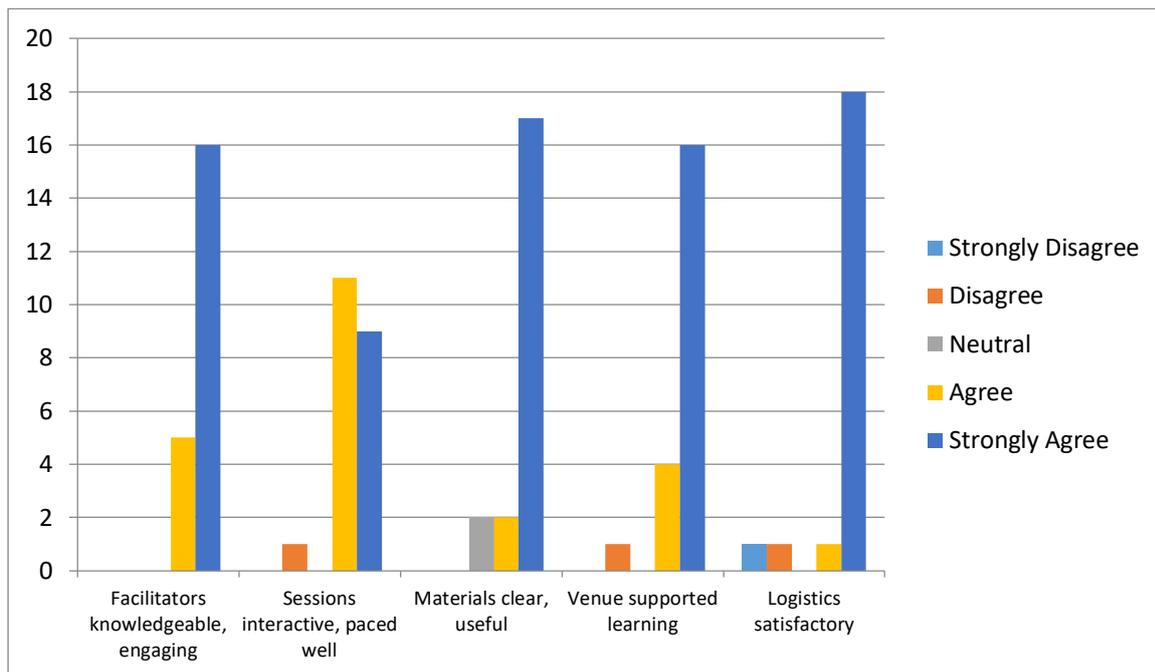


The workshop evaluation for Content and Relevance was overwhelmingly successful, with the final results confirming near-universal satisfaction and knowledge transfer across all areas. The chart analysis revealed that every single statement achieved a positive agreement rating (Agree or Strongly Agree) of 95.2% or 100.0%. Specifically, key elements like the clarity of the workshop objective, the connection between diagnostics and human rights, and participant readiness to design local training all reached a perfect 100% positive score. This outcome validates the workshop's content as highly relevant and exceptionally effective in boosting participants' knowledge and confidence.

SECTION B: Facilitation and Logistics

(1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree)

1. The facilitators/speakers were knowledgeable and engaging.
2. The sessions were interactive and well – paced.
3. Materials (slides, handouts, visuals) were clear and useful.
4. The venue and environment supported learning and discussion.
5. Food, accommodation, and travel arrangements were satisfactory.



The workshop's Facilitation and Logistics section (Section B) demonstrated overwhelming success and high participant satisfaction. Feedback was strongly positive across all five statements, with ratings heavily concentrated in the "Agree" and "Strongly Agree" categories.

- Facilitator quality and logistical arrangements both received near-perfect endorsement, with 16 and 18 respondents, respectively, giving the highest "Strongly Agree" rating.
- Satisfaction with session pacing, interactivity, and the clarity of materials was also exceptionally high.
- Minor isolated issues were noted only in the logistics statement (two minor negative ratings), but these did not detract from the overall success in creating a positive and effective learning environment.

SECTION C: Key Takeaway

1. What were the most useful sessions or topics for you, and why?

- Received instruction on the function and implementation of molecular POC diagnostics, specifically Truenat/Molbio, focusing on their efficacy and ability to deliver rapid results for TB and HIV.
- Gained practical knowledge on developing a comprehensive advocacy strategy, including partnership building, treatment literacy, and how to push for better diagnostics access.
- Acquired foundational knowledge through TB 101 and an overview of HIV diagnostics to contextualize POC tools.
- Focused on the importance of POC diagnostics in ensuring prompt patient care and understanding the practicalities of improving access to these tools.
- Valued the interaction and peer learning space provided during the sessions.
- Identified a desire for further guidance and more knowledge regarding advocacy strategy and the availability of resources in different states.

2. Do you feel ready to train others in your state on these issues?

3. Do you feel confident to lead advocacy campaigns for access to diagnostics in your state?

4. Would you be interested in further mentoring or follow-up support from GCTA?

Question	Yes Count	No Count	Maybe Count	Key Finding
Q2. Ready to train others?	18	0	3	86% feel ready to train others.
Q3. Confident to lead advocacy?	18	0	3	86% feel confident to lead campaigns.
Q4. Interested in mentoring/support?	20	0	1	95% desire further support and mentoring.

SECTION D: Suggestions and final thoughts

1. What can we improve in future TOT workshop?

Participants provided clear recommendations to enhance the learning and application of the training:

- **Practical Exposure:** Integrate a field visit or practical experience component to supplement theoretical knowledge.
- **Vernacular Focus:** Increase the focus on vernacular languages and address language barriers that may arise for some participants.
- **Stakeholder Engagement:** Future workshops should include training on engaging private sector stakeholders and policymakers/senior officials to make advocacy efforts more comprehensive.
- **Planning & Timing:** Ensure workshops start on time and include dedicated brainstorming time for participants to collaborate on strategies.
- **Follow-up & Mentoring:** Formalize follow-up training and establish clear mentoring guidelines to support participants after the TOT.

2. Any additional comments or feedback?

The additional comments overwhelmingly validated the effectiveness and quality of the workshop:

- **High Value & Impact:** The training was described as "very informative," "good and helpful," and an "amazing learning experience."
- **Knowledge and Practice:** Participants praised the workshop for increasing their knowledge and practical skills.
- **Supportive Environment:** They appreciated the help and interaction received from other participants.
- **Interest in Continued Learning:** Multiple respondents expressed interest in future follow-up support and training.

Key Takeaways

- **Community empowerment is central** — participants reinforced that equitable access to diagnostics for TB, HIV and co-infections depends on strengthening community leadership, awareness and advocacy.
- **Diagnostics remain the weakest link** — despite technological advances like TruNAT and ProRAD, underutilization, misdiagnosis and poor sample quality persist.
- **Counselling gaps are critical** — unlike HIV, TB lacks structured pre- and post-test counselling, contributing to poor adherence and high loss to follow-up rates.
- **Systemic barriers continue** — stigma, long turnaround times, staff overload and lack of political attention impede effective diagnosis and treatment.
- **Learning from HIV advocacy works** — the HIV movement's success in treatment literacy and accountability can guide TB advocates in building stronger coalitions.
- **Technology exists but access lags** — the challenge is not invention but implementation. Over 9,000 TrueNat machines exist yet remain underused.
- **Political and social accountability is essential** — ending TB/HIV requires government responsiveness, informed communities and consistent advocacy pressure.

Next Steps and Recommendations

The following action items are recommended to transition the workshop's plans into sustained, effective regional advocacy:

I. Immediate Advocacy (6-Month Focus)

i. Activate and Utilize Diagnostic Resources:

Conduct a rapid mapping of all 9,000 TrueNat machines across the Western Region to identify functional and idle units. Use this data to direct patients for early diagnosis and to advocate for immediate government directives ensuring that all machines are operational and applied for multi-disease testing (TB, HIV and other infections).

ii. Community-Led Decentralization:

Deploy portable point-of-care (POC) diagnostic machines in rural and semi-urban areas, including temporary testing camps at Targeted Intervention (TI) centres for key populations such as IDUs, FSWs, TGs and MSM. This will help overcome barriers of stigma, travel and accessibility.

iii. Political and Local Government Engagement:

Begin a phased political advocacy plan by meeting with local MLAs and submitting formal letters demanding TrueNat activation, decentralization of services and budgetary allocation for community-based diagnostics.

Activate Representation in Decision-Making Spaces:

Ensure that people living with HIV (PLHIV) and community representatives are consistently invited to and actively participate in District TB Committee (DTC) meetings to raise diagnostic and service delivery issues at the local level.

II. Programmatic and System Strengthening

i. Institutionalize Counselling:

Develop and advocate for a Standard Operating Procedure (SOP) for mandatory pre- and post-test counselling for TB, modelled after HIV ICTC protocols. This can be pursued through collaboration and endorsement from medical bodies such as the Indian Medical Association (IMA).

ii. Integrate TB–HIV Diagnostic Services:

Promote bi-directional testing and integrated reporting systems between TB and HIV programs to improve early diagnosis, reduce loss to follow-up and streamline case management.

iii. Improve Provider Sensitization and Training:

Conduct capacity-building programs for healthcare workers to reduce stigma, improve patient interaction and enhance quality of care at both government and community levels.

iv. Enhance Community-Led Advocacy:

Strengthen regional advocacy coalitions to track commitments, gather community-level data and push for accountability through district and state health committees.

III. Policy and Budgetary Recommendations

i. Public Investment Board (PIB) Proposal:

Develop a Pilot Model Proposal focusing on TB counselling and human resource allocation for submission to the Public Investment Board (PIB) by early 2026 to align with the next government budgeting cycle.

ii. Monitoring and Evaluation Framework:

Establish a baseline and monitoring system to measure reduction in Loss to Follow-Up (LFU) cases and improvement in early diagnosis rates as key indicators of advocacy success.

iii. Leverage Technology and Media:

Use social media, storytelling and community-led campaigns to amplify advocacy messages, highlight success stories and build public awareness around equitable access to diagnostics and counselling.

Conclusion

The Western Region Training of Trainers workshop was a vital and necessary step in equipping community advocates with the capacity to fight for equitable health access. By providing detailed technical knowledge and a strategic advocacy framework, the workshop successfully channelled the participants' on-the-ground experience into a clear, unified and actionable plan: to demand the decentralization and integrated use of molecular POC diagnostics. The energy and commitment displayed by the participants confirm that the community is ready to lead the charge for faster, fairer and more accessible diagnostics for TB and HIV.

Annexure 1. Participant List

SR. NO.	NAME	ORGANISATION	PLACE
1	Raju Kakade	Sahara Aalhad	Pune
2	Kiran Shirgavkar	Dilasa Foundation	Raigad
3	Nitesh Dhawan	Sarvajanic Medical Trust	Surat
4	Manisha Solanki	Lokvikas Satha	Surat
5	Ketan Parmar	TB Survivors Association	Ahmedabad
6	Sanjay Yamgar (Meena Sashu)	Muskaan (Sangram)	Sangli
7	Sr. Jeryssa Pereira	Kiran Niketan	Goa
8	Sr. Jayakodi sfn	Asha Sadan Social Centre.	Goa
9	Balram Dewda	Helping Hands Network for TB Survivors	Madhya Pradesh
10	Bhuvneshvar Gangele	GCTA Youth Wing	Vadodara
11	Rashmi Yenaskar	NMP+	Pune
12	Rosalynn Lalawmpuii	GCTA	Delhi
13	Blessina Kumar	GCTA	Delhi
14	Dr. Darivianca E. Laloo	Molbio	Goa
15	Harshika Dhulep	Molbio	Mumbai
16	Prasad Mali	Molbio	Pune
17	Prabha Mahesh	Alert India	Mumbai
18	Deepak Tripathi	CCDT	Mumbai
19	Meera Yadav	GCTA	Mumbai
20	Vinaya Vijay More	AAWC	Mumbai
21	Rajesh Nainakwal	Support	Mumbai
22	Vikas Kurne	HLFPPT	Mumbai
23	Jagriti Dewangan	Doctors for You	Mumbai
24	Sumi Mayilamkunnath	Humsafar	Mumbai
25	Shital Dhondge	Astha Parivar	Mumbai
26	Shabana Patel	NTP+	Thane
27	Eldred Tellis	Sankalp Rehabilitation Trust	Mumbai
28	Jamshir Bagwadia	Sankalp Rehabilitation Trust	Mumbai
29	Rajashree Hatkar	Sankalp Rehabilitation Trust	Mumbai
30	Ravindra bapat	Molbio	Mumbai
31	Preeti Relggi	Molbio	Mumbai
32	Mamata Kokate	Molbio	Mumbai

Annexure 2. Meeting Agenda

WESTERN REGION TRAINING OF TRAINERS

*Advocating for Equitable Access to Molecular Point-of-Care
Diagnostics for HIV, TB and related infections*

6th and 7th October 2025

Mumbai

AGENDA

DAY 1

– 6th October 2025 –

TIME	TOPIC	SPEAKER/FACILITATOR
9:00 AM	Registration	
9:30 – 10:00 AM	Inauguration of the workshop: Welcome Opening remarks	Mr. Eldred Tellis Ms. Blessina Kumar Dr. Darivianca E. Laloo
10:00 – 10:45 AM	*Introduction of the participants *Pre Test Questionnaire *Objectives of the training *Expectations	Ms. Rosalynn L Mr. Jamshir Bagwadia Ms. Blessina Kumar
10:45 - 11:00 AM	GROUP PHOTO Tea break	
11:00 - 12 PM	TB 101 and HIV -101	Quiz – Ms. Rosalynn L
12:00- 12:45 PM	Overview of TB /HIV diagnostics in India	Ms. Blessina Kumar / Ms. Rosalynn L
12:45- 1:15	Introduction to Molbio and POC Diagnostics	Dr. Darivianca E. Laloo
1:15 - 2:00PM	Lunch	
2:00- 3:00PM	Panel Discussion 1 -TB and HIV Challenges in Diagnosing. Q&A and discussion	Moderator - Ms. Blessina Kumar Panelists - Ms. Prabha Mahesh - Ms. Jagriti Dewangan - Ms. Shabana Patel - Mr. Vikas Kurne
3:00 -4:00 PM	Demo of Truenat and Xray	Molbio Team
4:00- 4:30 PM	Tea Break	
4:30 – 5:30pm	Moderated Discussion – Field Insights & Ground Realities	Ms. Blessina Kumar and all

DAY 2

– 7th October 2025 –

TIME	TOPIC	SPEAKER/FACILITATOR
9:00 - 9:15 AM	Recap of Day 1 and Clarifications	Participants / Jamshir
9:15 - 10:15 AM	Introduction to Advocacy -Moderated Group Discussion	Ms. Blessina Kumar
10:15– 11:00 AM	Group Work – Advocacy strategy Concrete regional actionable plan - for POC diagnostic access	All
11:00-11:15 PM	Tea Break	
11:15 -12:30PM	Group presentation – Discussion and Q&A	Group Reps
12:30 -1:00PM	Summary of 2 days' work Next Steps Post workshop assessment Feedback form	GCTA / Sankalp R Trust Ms. Rosalynn L
1:00 – 2:00PM	Lunch break and Closing	

Annexure 3. Group Work

Advocacy Plan Template

Objectives	Targets	Activities	Steps	Time Frame	Organising Lead	Resources
Unavailability of POC Diagnostic machines in Rural areas as well as Semi-Urban areas	NIEP at District ↓ State ↓ Local	Assessment Mapping Consultative meeting with Community members along with Govt. members Identify the findings	Share the findings with Govt. stakeholders and expect support for availability of POC Diagnostic machines at Rural & Semi-Rural areas ↓ 6 months	6 Months ↓ On	TB Community Champions ↓ NGO's ↓ Govt People Stake holders ↓ Lawyers ↓ Experts ↓ Doctors	IEC Identify the resources from local body ↓ Social Media

Objectives	Targets	Activities	Steps	Time Frame	Organising Lead	Resources
Pre & Post TEST Counselling Mandatory for TB Testing	State Health Dept Health Secretary Central TB Division Director General TB, India	# Information, Research on LFU for Referrals for TB Testing (% age). Sample Efficacy Quality Qty of Sample Wrong Diagnosis. # Develop Content for Counselling → SOP. Field Testing. (JCTC) Reference # Involve peer group Co # Capacity building of Health care workers. Communities. # Sensitization of IMA.	Engage Risk Practitioners to follow Pre Testy Mandate. Create Mandatory SOP for Risk Practitioners. # Dissemination of the Documentary Evidence. # Monitoring System of adhying Mandate # Evaluation of Reduction in LFU & Increase in Early diagnosis	2027	NHAs work as TB & HIV. Govt → NTEP. authorize Create Support groups - peers. IMA District TB Authorities State & Central TB Authorities.	Consultant charges → Capacity Building → IMA - medical college NGO NTEP Health workers, Support Group Honorarium for Peer-Counsellors # HR Budget in Public Health System NHM National Health Mission

GROUP - 3

OBJECTIVE	TARGET	ACTIVITIES	STEPS	TIME	ORGANIZ	RESOURCES
Access to Teacher (100) Disruptors at PHC	PHC HWC Teacher & A-200 Program	Individual consultation Improving Quality of Teacher Community Group meetings Meetings with PPSA Introduction in Sample of the Trained.	1. a. Feb b. March c. April d. May e. June f. July g. August h. September i. October j. November k. December	1 month	GOVT NGO CSE TB Center + Govt. Health Local Groups	Salary for Employment material Travel Insurance etc.

To increase and enhance political commitment for T.B. prog.

Objectives	Targets	Activities	Steps	Time Frame	Organising Lead	Resources
To Sensitize Political leaders at National, State and district level about the burden of TB and the importance of eliminating it by 2030	C.M., Dep. C.M. Health minister, Secretary, Planning Commission, Influencers, Media, T.B. survivor,	^{meeting with TB survivor} ① Meetings with Govt. stakeholders, ② Letters, ③ Research Report, ④ Follow up for G.R. ⑤ Implementation	<ul style="list-style-type: none"> Follow up meeting with lead organization & supporting partners. Research of data & evidence. Draft letters. Review of TB Guidelines. Plan stakeholder meeting with activist & partner organization 	Till Jan 2026	TB Survivor Community (Mumbai) Agency & NGO for Support	Free -2500 Travel

Annexure 4. Consent Form



CONSENT FORM

I, _____, do hereby give my consent to the 'Global Coalition of TB Advocates' to use relevant information about me, and/or my experiences with HIV, TB and Related Infections in any press release, report, publication, news article, books and any other mode thereafter discussed and agreed upon by the parties mentioned above.

I understand that the content herein mentioned above may also be included in future documents both on and off the Internet, as well as through multiple broadcast channels and any and all print media.

I permit the use of the information herein mentioned above with the understanding that it will only be used for raising awareness and promotional purposes. I also understand that there are no commercial interests involved, and this information will not be "sold" to any third party.

Global Coalition of TB Advocates may publish or use (please tick whichever you are comfortable with):

- My name Yes/No
- My views/experiences Yes/No
- Photographs/posters/other visual materials featuring me Yes /No
- Videos featuring me Yes/No

Name & Signature: _____

Date: _____

Address: _____

Telephone: _____

Email: _____

Annexure 5. Pre-Workshop Assessment

WESTERN REGION TRAINING OF TRAINERS

*Advocating for Equitable Access to Molecular Point-of-Care
Diagnostics for HIV, TB and related infections*
6th and 7th October
2025 Mumbai

PRE WORKSHOP ASSESSMENT

SECTION A: Knowledge (Multiple choice questions)

1. What does "Point-of-Care diagnostic mean according to WHO?
 - a) A diagnostic test only available in central laboratories
 - b) A home remedies
 - c) A diagnostic test performed near the patient that offers quick results
 - d) A clinical trial
2. What is a key advantage of using molecular POC diagnostics for HIV and TB?
 - a) Required hospitalization
 - b) Delays treatment
 - c) Enables early and accurate detection
 - d) Only used in emergencies
3. which infection is commonly co-infected with TB/HIV and benefits from POC testing?
 - a) Spondylitis
 - b) Hepatitis C (HCV)
 - c) Diarrhea
 - d) Malaria
4. Which of the following is a barrier to accessing POC Diagnostics in India?
 - a) Free tests
 - b) Close proximity to clinics
 - c) Long travel distance, stigma, and limited infrastructure
 - d) Online access

5. Who can advocate for better access to POC diagnostics?
- Only health ministers
 - Community networks, PLHIV/PWTB leaders, civil society
 - Only lab technicians
 - None of the above

SECTION B: Attitudes (Likert Scale – 1 to 5)

(1= strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree)

- Timely access to diagnostics is a health right. _____
- I feel confident discussing POC tools in public forums. _____
- Advocacy by communities is critical to expanding diagnostic services. _____
- I believe my voice can influence government decision – makers. _____
- I want to be part of a collective campaign for diagnostic equity. _____

SECTION C: Confidence and Advocacy Skills

(Options: Not confident – Somewhat confident – Confident – very confident)

- How confident are you in explaining what POC diagnostics are and why they matter?
- How confident are you in speaking with local/state officials on health access?
- Do you understand how to create an advocacy strategy to push for change?

SECTION D: Open – Ended

- What do you hope to learn from this workshop?
- Describe one barrier you face in your community related to diagnostics.
- Have you led or participated in an advocacy activity before? If yes, share briefly.

Annexure 6. Post-Workshop Assessment

POST WORKSHOP ASSESSMENT

SECTION A: Knowledge (Multiple choice questions)

1. What does “Point-of-Care diagnostic mean according to WHO?
 - e) A diagnostic test only available in central laboratories
 - f) A home remedies
 - g) A diagnostic test performed near the patient that offers quick results
 - h) A clinical trial
2. What is a key advantage of using molecular POC diagnostics for HIV and TB?
 - e) Required hospitalization
 - f) Delays treatment
 - g) Enables early and accurate detection
 - h) Only used in emergencies
3. which infection is commonly co-infected with TB/HIV and benefits from POC testing?
 - e) Spondylitis
 - f) Hepatitis C (HCV)
 - g) Diarrhea
 - h) Malaria
4. Which of the following is a barrier to accessing POC Diagnostics in India?
 - e) Free tests
 - f) Close proximity to clinics
 - g) Long travel distance, stigma, and limited infrastructure
 - h) Online access
5. Who can advocate for better access to POC diagnostics?
 - e) Only health ministers
 - f) Community networks, PLHIV/PWTB leaders, civil society
 - g) Only lab technicians
 - h) None of the above

Annexure 7. Workshop Evaluation Form

WORKSHOP EVALUATION FORM

SECTION A: Content and Relevance

Please rate the following statements on a scale of 1 to 5

(1= strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree)

1. The objective of the workshop was clearly defined. _____
2. The workshop content was relevant to my work and community context. _____
3. I gained new knowledge about molecular POC diagnostics. _____
4. I understand the connection between diagnostics and human rights. _____
5. The sessions help me feel more confident about advocacy. _____
6. I am now better equipped to design a local/state – level training. _____
7. I feel prepared to speak to government /health officials on this topic. _____
8. The workshop gave space for peer learning and open discussion. _____

SECTION B: Facilitation and Logistics

Please rate the following statements on a scale of 1 to 5

(1= strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree)

1. The facilitators/speakers were knowledgeable and engaging. _____
2. The sessions were interactive and well – paced. _____
3. Materials (slides, handouts, visuals) were clear and useful. _____
4. The venue and environment supported learning and discussion. _____
5. Food, accommodation, and travel arrangements were satisfactory. _____

SECTION C: Key Takeaway

1. What were the two most useful sessions or topics for you, and why?

2. Do you feel ready to train others in your state on these issues?

Yes ___

No ___

Maybe (please explain) _____

3. Do you feel confident to lead advocacy campaigns for access to diagnostics in your state?

Yes ___

No ___

Maybe (please explain) _____

4. Would you be interested in further mentoring or follow-up support from GCTA?

Yes ___

No ___

Maybe ___

SECTION D: Suggestions and final thoughts

1. What can we improve in future TOT workshop?

2. Any additional comments or feedback?

Annexure 8. Photos & Event Highlights





