



77TH TB SEAL CAMPAIGN SOUVENIR - 2026

₹5 Gender Equality - Break The Bias



समान इलाज, स्वस्थ समाज - भेदभाव तोड़ो!
2026 TB Association of India

₹5 Gender Equality - Break The Bias



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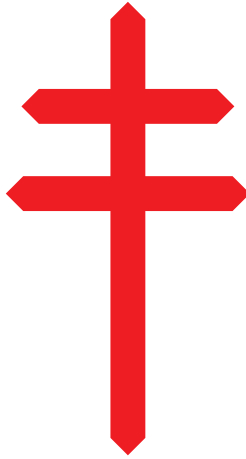
समान इलाज, स्वस्थ समाज - भेदभाव तोड़ो!

Gender Equality - Break The Bias

THE TUBERCULOSIS ASSOCIATION OF INDIA

3, Red Cross Road, New Delhi-110 001

ACKNOWLEDGEMENT



The Tuberculosis Association of India is grateful and indebted to all the dignitaries who have sent their valued messages published in the following pages. The messages will cause deeper impact in mobilizing public opinion and means to fulfil our obligations towards service to humanity and in alleviating human suffering.

The contents of this Souvenir mainly comprise of Messages from dignitaries and material on Health Education and Scientific articles and in which the views expressed are those of the contributors

TB seals credit : Reeya Rene Rajpal and Mr. Sayan Pandit Delhi College of Art

VISION STATEMENT

“TAI envisions a TB-free India through collaborative efforts with Government, health care providers and NGOs in healthcare sector for a healthier future for all.”

MISSION STATEMENT

“The mission of TAI is to combat the TB epidemic by providing comprehensive support, education, and resources through strategic partnerships, advocacy and research driven initiatives to reduce stigma, transmission and increased access to quality care. Our ultimate goal is to reinforce the efforts of National TB Programme towards eradication of TB.”



Dr. Vishwa Mohan Katoch
President TAI



Prof. Dr. V.K. Arora
Chairman



तरनजीत सिंह संधू
उपराज्यपाल
Taranjit Singh Sandhu
Lt. Governor

लोक निवास
दिल्ली-११००५४

LOK NIWAS
DELHI-110054

D.O. No. LN/2026/296
Dated: 09.09.2026

MESSAGE

I am happy to know that the Tuberculosis Association of India (TAI) is launching the new TB seals on 2nd October 2026, as part of its 77th TB Seal Campaign coinciding Gandhi Jayanti, with the theme "Gender equality – Break the bias" and is also bringing out a souvenir to mark the occasion.

TB-Mukt Bharat as envisioned by Hon'ble Prime Minister, Shri Narendra Modi is centered on eliminating the disease. The efforts in this direction made by the Association involving youth, doctors, Asha workers, TB Champions, TB patients and people at large are exemplary as well as praiseworthy.

My best wishes for the success of the campaign.

(Sardar Taranjit Singh Sandhu)



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Chairman : DR. V. K. ARORA

Vice-Chairman : DR. ASHWANI KHANNA

Asst. Hon. Treasurer : SH. N. MOHAN

Secretary-General(I) : SH. VIKRAM MALHOTRA

E-mail : tbassnindia@yahoo.co.in

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Message from President, TAI

Tuberculosis Association of India (TAI) completes 87 years of eventful journey this year. It is one of the oldest and largest voluntary organizations having State and District TB associations across the country. Since its establishment as a registered society in 1939 by incorporating the King Emperor's Anti-Tuberculosis Fund and King George Thanksgiving (Anti-Tuberculosis) Fund, TAI has been collaborating with Government, health care providers and other NGOs sharing common goals.

TAI continues to contribute to strengthen the academic and public health efforts by holding of the National Conference of Tuberculosis every year; by organising TB seal campaigns; by publication of Indian Journal of Tuberculosis; by providing financial support to short term Research Projects to encourage medical students and Doctors to add to the knowledge base on Tuberculosis; by honouring those who contribute to generation of knowledge and implementing the same for patient care/ public health; and by contributing to health education of the people.

Since 1950 organising the TB seal campaigns is one of important activities of TAI. Each year this TB Seal Campaign is inaugurated on 2nd October – the Gandhi Jayanti Day. These campaigns serve the objectives of bringing about awareness of the problem of tuberculosis in the country among masses and health care providers and raising funds for promoting and intensifying voluntary anti-TB work in the country. Theme of this year's 77th TB Seal Campaign is "Gender equality- Break the

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Chairman	:	DR. V. K. ARORA	Vice-Chairman : DR. ASHWANI KHANNA
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-2-

bias". This theme is named after our pan-India campaign being launched from 1st January 2027 to sensitize all stakeholders in the country for equity in treatment of women TB patients, fight against stigma faced by women in TB treatment for better health outcomes. This campaign is a key component of our ongoing "Action against Stigma" and "Community Empowerment" campaigns launched in 2025 & 2026 respectively. On behalf of TAI and on my personal behalf, I take this opportunity to appeal for generous support and active participation of one and all in this campaign.

All through its history, TAI has supported the efforts of National Tuberculosis Elimination Programme (NTEP) towards eradication of tuberculosis from India. New Delhi TB Centre is one of important examples of its partnership with government. In future also, TAI we will continue to work with various governmental and non-governmental organisations as well as individuals who support the efforts of Government of India to eradicate tuberculosis from our country.

Jai Hind!

(Vishwa Mohan Katoch)

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Message

Tuberculosis is a major public health challenge affecting large sections of society, men and women, rich and poor alike. The Tuberculosis Association of India has always been with NTEP in its endeavours to control TB in India by involvement of NGOs, medical institutions, youth, and healthcare providers. It has contributed towards dissemination of knowledge about TB through its quarterly publication - Indian Journal of Tuberculosis, its annual programmes viz. The TB Seal Campaign, National Conference of TB & Respiratory Diseases (NATCON), financial assistance to Short term Research projects and campaigns for Community involvement, civil society engagement, patient empowerment and counseling.

I am happy to state that the Campaigns of the Association starting with the Action against Stigma Campaign in 2025, the ongoing leg of the campaign i.e. "Community Empowerment" in 2026 and the launch of associated "Gender Equality- Break the Bias" campaign starting in 2027 have enabled us to reach large sections of vulnerable sections of the society by addressing the socio economic aspects of the public health challenge.

The theme of the present TB Seal Campaign "Gender Equality- Break the Bias" which will be inaugurated at the 81st NATCON at Patiala on 2nd October 2026 will open new avenues of engagement with the public, a psychological hand holding for TB patients sorely missed in their treatment. I wish all the success to our stakeholders to carry forward the message of the 77th TB Seal Campaign for a TB Mukta Bharat.

Prof. Dr. V.K. Arora

Chairman

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Message

It is a matter of pride to know the launch of 77th TB Seal campaign of Tuberculosis Association of India on 2nd October 2026.

The Tuberculosis Association of India has been serving the cause of tuberculosis since 1939. It is one of the oldest and largest voluntary organizations having its affiliates all over the country with the aim of prevention, control, treatment and relief of tuberculosis.

The TB seal campaign plays an important role in raising public awareness about the disease and its prevention and cure. Growing awareness of the importance of early diagnosis together with proper administration of drugs has brought us closer to tackling this debilitating disease.

I wish all success for the 77th TB Seal Campaign.

Dr. Ashwani Khanna

Vice Chairman

TB Association of India

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Message

Heartiest congratulations to the TB Association of India on the release of the 77th TB Seal on 2nd October 2026.

This year's inspiring theme, "Gender Equality: Breaking the Bias," is particularly relevant to our efforts towards ending tuberculosis. Gender-related barriers continue to influence access to diagnosis, treatment, care and social support, and addressing these inequities is essential for achieving a truly people-centred TB response.

The TB Seal has been an important symbol of awareness, advocacy and collective commitment towards a TB-free India. May this year's Seal further strengthen our resolve to ensure that no person is left behind because of gender-based barriers or discrimination.

My best wishes to the TB Association of India for the successful release and for continued leadership in the fight against tuberculosis.

Dr Kamal Chopra

Consultant

TB Association of India

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NEW DELHI TUBERCULOSIS CENTRE

State TB Training & Demonstration Centre



Ref No.....

Dated.....



Message

It is heartening to know that Tuberculosis Association of India is going to launch its 77th TB Seal Campaign on 2nd October 2026.

Since 1950, the Association has been undertaking this activity successfully every year. The funds collected through these campaigns have helped the association to fulfill its avowed objective of, "Prevention, control, treatment and relief of Tuberculosis".

Tuberculosis is a disease that requires continuous engagement with patients, along with a robust system for ensuring adherence to and supervision of treatment. In India, the best way to achieve this is by ensuring that all healthcare providers become an integral part of the NTEP and by transforming the fight against TB into a true mass movement.

I urge everyone to support the government and medical fraternity in building partnerships and help in realizing the ultimate goal of TB control. I wish the Tuberculosis Association of India every success in the 77th TB Seal Campaign and in its continued efforts towards the prevention, control and elimination of Tuberculosis in India and globally.

Dr. Sanjay Rajpal

Director (I)

New Delhi TB Centre

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77th TB SEAL CAMPAIGN

2 OCTOBER 2026



I am very pleased to extend warm greetings to the Tuberculosis Association of India on the launch of the 77th TB Seal Campaign, observed on Gandhi Jayanti each year, and continuing a proud tradition of public health advocacy and community commitment for a TB-free India.

Tuberculosis remains one of the world's leading infectious killers. In 2024, an estimated 10.7 million people developed TB and 1.23 million died from the disease globally. India accounted for approximately one quarter of the global TB burden. These figures remind us that although TB is preventable and curable, too many people are still diagnosed late, miss timely treatment, or die despite the availability of effective tools.

India has made important progress. Between 2015 and 2024, the estimated TB incidence rate declined by 21% – nearly twice the global average over the same period. Treatment coverage increased to 92%, and the gap between estimated TB incidence and case notifications has narrowed significantly.

This progress reflects strong political commitment and sustained programme innovation under the flagship initiative Pradhan Mantri TB Mukt Bharat Abhiyaan. Expanded rapid molecular testing, differentiated care, the 100-day community-based screening campaign, digital adherence support, and shorter, safer treatment regimens are bringing quality services closer to those who need them. The Nikshay Poshan Yojana and Nikshay Mitra initiatives also recognize that effective TB care must address nutrition, social support and the economic burden faced by affected individuals and families.

Yet the task ahead remains urgent. Every TB death is one too many, and most can be prevented through early detection, prompt and appropriate treatment, risk-based care, uninterrupted support and adequate nutrition. Greater attention is needed for people who are vulnerable, asymptomatic or difficult to reach; those with drug-resistant TB; and those with undernutrition, diabetes, HIV co-infection or other conditions that increase risk.

The TB Seal Campaign has a vital role in sustaining public awareness and translating commitment into collective action. I call upon government institutions, health-care providers, communities, academia, the private sector, and the media to help find TB early, counter stigma, support the completion of treatment, and ensure that no person affected by TB is left behind. In the spirit of Mahatma Gandhi, our response must be grounded in dignity, equity and solidarity.

WHO remains steadfast in its support to India's National TB Elimination Programme. I congratulate the Tuberculosis Association of India and its partners on the 77th TB Seal Campaign and wish the Campaign every success.

A blue ink signature of Dr. Nilesh Buddha.

Dr Nilesh Buddha
Officer-in-Charge
WHO South-East Asia



एयर मार्शल संधीप थरेजा से मे, वि से मे एवं बार

महानिदेशक सशस्त्र सेना चिकित्सा सेवा

Air Marshal Sandeep Thareja SM, VSM & BAR.

Director General Armed Forces Medical Services

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MESSAGE

कार्यालय महानिदेशक
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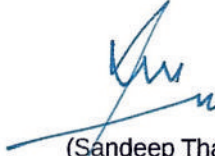
1. It is heartening to know that the Tuberculosis Association of India is launching its 77th TB seal campaign on 02 Oct 2026.
2. The campaign continues to be a symbol of hope, solidarity and the nations resolve towards a broader goal of health for all. The theme for the year "Gender Equality-Break the Bias" will surely bridge the existing gap in health seeking behavior of women and will alleviate the stigma associated with Tuberculosis amongst the vulnerable populace.
3. It gives me immense pleasure to announce that the AFMS too has been actively contributing towards the goal of TB elimination and is fully inclined towards the national goal of TB elimination by 2030. The AFMS will continue screening and awareness campaigns in future too.
4. On this landmark occasion, I applaud the commitment and dedication of the TB Association of India for playing a pivotal role not only in the field of prevention, control, treatment but also by contributing immensely towards research in the field of Tuberculosis and spearheading the awareness campaigns. I wish them success in their resolve of TB Mukh Bharat.

सर्वे सन्तु निरामया!

"Jai Hind"

Station: New Delhi

Dated : 15 Sep 2026


(Sandeep Thareja)
Air Marshal
DGAFMS



THE TB SEAL

A SYMBOL OF HOPE AND RESILIENCE

The TB seal has a rich history in the fight against tuberculosis, dating back to the early 20th century. In 1903, Danish postman Einer Holboell conceived the idea of selling Christmas Seals to support children afflicted with TB. This simple yet powerful symbol has since become a global phenomenon, with various designs and adaptations.

The TB seal's significance extends beyond fundraising; it represents hope, community action, and the collective fight against TB. Its evolution reflects changing attitudes towards the disease, from the initial white cross on a red background to modern designs emphasizing health and wellness. The seal's impact is evident in its widespread adoption by National TB Associations and international organizations like the World Health Organization (WHO) and the Stop TB Partnership.

Today, the TB seal continues to inspire action and awareness, symbolizing the enduring commitment to combating TB. Despite progress, TB remains a global health challenge. The TB seal serves as a poignant reminder of the progress made and the ongoing fight for a TB-free world. Its legacy is a testament to the power of community-driven initiatives and the importance of continued investment in TB research and treatment.

On the occasion of the 77th TB seal campaign, result to keep up the spirit of Christmas seals.

V.K. Arora, K.K. Chopra
The Tuberculosis Association of India



THE DOUBLE-BARRED CROSS

AN ENDURING EMBLEM AGAINST TUBERCULOSIS

The Double-Barred Cross, also known as the Cross of Lorraine, has a storied history dating back to the Crusades. In 1099, Godefroyde Bouillon, Duke of Lorraine, displayed the double red cross on his standard when capturing Jerusalem. Upon his return to France, it became the emblem of the House of Lorraine.

In 1902, Dr. Serson proposed the Double-Barred Cross as the international emblem for the campaign against tuberculosis at the Berlin International Tuberculosis Conference. The proposition was unanimously adopted. The International Union Against Tuberculosis (IUATLD) officially endorsed it in 1928, recommending national associations register the emblem to prevent commercial misuse.

Today, the Double-Barred Cross remains a powerful symbol of resistance and awareness. The Tuberculosis Association of India patented it in 1959 to prevent fraudulent use. Beyond its medical significance, the Double-Barred Cross represents French heritage and patriotism, with uses in heraldry, architecture, art, and literature. Its evolution from an ancient symbol to a global emblem underscores its enduring impact in the fight against tuberculosis.

On this day we at TAI will continue to show resilience to fight against tuberculosis.

V.K. Arora, K.K. Chopra
The Tuberculosis Association of India

GENDER EQUALITY AND TUBERCULOSIS, BREAKING THE BIAS

K.K. Chopra¹, V.K. Arora²

1. Consultant, New Delhi Tuberculosis Centre,

2. Chairman, TB Association of India, 3 Red Cross Road, New Delhi, 110001, India.

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Tuberculosis (TB) affects person of all ages and genders.¹ However, men aged 15 years and above have high burden of disease, face more barriers to diagnosis and treatment, and may experience low favorable treatment outcomes than women.² The effects of these extends beyond men's health. Recent research suggests that transmission from affected men is responsible for most new infections in both males and females.

Gender is one of the most important social determinants of health and should be a critical component of strategies to end (TB) epidemic. Gender-responsive approaches that address cultural, social, and individual determinants are essential to accelerate progress toward achieving global targets to reduce TB disease and mortality. So removing disparities through gender-responsive approaches to TB prevention and care is critical for achieving equitable health outcomes and accelerating progress towards ending the TB epidemic.

In 2024, an estimated 54% of people who developed TB were men, 35% were women, and 11% were children and young adolescents in low- and middle-income countries. National TB prevalence surveys consistently show a higher burden of disease among men than women, with men accounting for 66–75% of adults with TB². The National TB Prevalence survey (India, 2019-2021) demonstrated a marked gender disparity, with the prevalence of bacteriologically confirmed pulmonary TB among adults being approximately 2.8 times higher in men than in women, highlighting the need for gender-responsive TB screening and case -finding strategies.

Gender disparities in TB are shaped by biological, sociobehavioural and structural factors, influenced by underlying gender roles and norms.

Health-related risks of TB are different between men and women. Patient cost surveys consistently show that while men may face higher direct out-of-pocket cost (due to occupational exposure), women face crippling indirect cost (Loss of household food security, borrowing money for transport, childcare arrangements). The evidence suggest that female-headed households are disproportionately poorer and more vulnerable to catastrophic costs due to lower baseline income and fewer social safety nets Globally, alcohol use and smoking are more prevalent among men³, while HIV infection is more prevalent among women, although coverage of antiretroviral

treatment is lower among men than women⁴. There is gender-based violence as a deterrent to seeking care, pregnancy and postpartum physiological vulnerability, the opportunity cost of clinic waiting time (which conflict with unpaid domestic/ caregiving labor), and the risk of marital dissolution following a positive diagnosis.

Structural determinants of TB (e.g. poverty, and living and working conditions) also contribute to gender disparities in TB. Occupational exposures (e.g. in the mining sector) increase men's risk of disease, while precarious informal employment and lack of social protections are cited as key barriers for men accessing TB care⁵. TB patient cost surveys indicate that the risk of experiencing catastrophic costs may vary by gender and primary income earner status; however both male and female-headed households because of reasons, Community, and gender assessments have revealed that women, men and people with diverse social structures face distinct barriers in accessing TB services, including stigma, discrimination, and exclusion from health systems⁶. Gender norms and expectations further constrain access: and financial dependence may limit women's preference to care, while male characteristics may discourage men from seeking care.

Collection and analysis of disaggregated data must inform action. TB programmes should implement gender-responsive policies tailored to the needs of both sexes.

Prevalence survey results have led to the implementation of targeted TB screening activities to find and treat men in several countries. In Myanmar, screening focused on areas where men predominate (e.g. construction, mining, migrant worker communities and prisons) and was conducted outside regular working hours. Similarly, in the Philippines, screening focused on male-dominated workplaces (e.g. taxi companies and construction sites), and was accompanied by the development of male-specific communication materials and TB clinics operating outside regular office hours⁷. Implementation partners and researchers have explored men-only clinics in Lesotho⁸, male-friendly TB services in Uganda⁹, screening in occupational settings¹⁰, and screening in sociocultural congregate settings in Nigeria¹¹ and Zambia¹².

These examples demonstrate how programmes can devise services to reach greater numbers of men and overcome gender-related barriers to care. Further action is needed through multisectoral approaches to address risks of exposure and disease.

Gender mainstreaming – that is, integrating gender considerations into both programmatic approaches and institutional operations so that all are included – is essential to ensure that TB policies and programmes do not reinforce inequalities. This requires the meaningful participation of women, men and people with diverse social determination in the design, implementation and evaluation of TB prevention and care strategies, to ensure that gendered concerns and experiences are considered, and to assess the implications of strategies for male and female.

Gender disparities in TB burden, access to care and outcomes are well established. Men bear a higher burden of TB and face significant barriers to care; these challenges also impact the health of women, girls, boys and people with diverse social structure. Regarding the TB diagnoses, and survival, the evidence is not that men have high mortality and the solution is not just building parallel men's clinics but fundamentally redesigning primary care.

Addressing these disparities requires comprehensive, gender-responsive strategies that engage affected populations where they live, work and socialize, while tackling the social and structural determinants, health system barriers and gender norms that encourages inequities. Expected benefits extend across both sexes.

A gender-responsive approach to TB prevention and care is critical to achieving the goal of ending TB for all. A gender-sensitive NTEP response recognizes that gender influences the risk of TB, health-seeking behaviour, diagnosis, treatment adherence, stigma, and treatment outcomes. India has operationalized this through the National Framework for a Gender – Responsive Approach to Tuberculosis, which integrates gender considerations into all four pillars of the National Strategic Plan (Detect, Treat, Prevent, Build). Men account for the majority of notified TB cases in India, but women often face greater barriers to timely diagnosis and care. Gender influences every stage of the TB care cascade from exposure and diagnosis to treatment completion and socioeconomic impact. NTEP's gender – responsive framework aims to provide equitable, inclusive, stigma-free TB services for women, men and transgender person.

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COMMUNITY EMPOWERMENT IN TUBERCULOSIS ELIMINATION

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Dr. Ankita Anand

In public health, meaningful community engagement has consistently been linked to improved access to timely diagnosis, strengthened treatment adherence, reduced stigma, and better overall health outcomes, particularly among marginalized and underserved populations. Effective engagement fosters trust, enhances service utilization, and promotes sustained care-seeking behavior. However, genuine empowerment extends beyond simple participation in health programs; it encompasses the ability of communities to influence local governance processes and address broader social determinants such as nutrition, sanitation, education, and livelihood security, while functioning as a dynamic and transformative process that shifts communities from passive beneficiaries to active agents of health action.

Community empowerment operates through interconnected logistical and psychological pathways. Logistical support improves access to diagnosis, treatment continuation, and linkage with health systems, while psychosocial reinforcement through peer support and survivor engagement strengthens motivation, reduces internalized stigma, and sustains long-term adherence. At the same time, empowerment is shaped by local socio-economic realities, including poverty and livelihood insecurity, and may face risks such as volunteer burnout, stigma toward community workers, inequitable reliance on unpaid labor, and limited financial sustainability—underscoring the need for ethical safeguards and social protection.

Tuberculosis (TB) remains a major global public health challenge despite the availability of effective chemotherapy. According to the World Health Organization, TB continues to affect millions annually and remains a leading cause of infectious disease mortality worldwide. Within the End TB Strategy, community engagement and civil-society participation—including contributions from national and nongovernmental organizations—are recognized as critical to sustainable TB control.

TB elimination therefore requires not only biomedical interventions but also ethically supported, economically feasible, and institutionally sustained community empowerment capable of transforming participation into shared ownership of tuberculosis control.

Introduction

Tuberculosis (TB) is a predominantly preventable and generally curable infectious condition; however, it persists as a major global health challenge. Each year, more than 10 million people develop active TB and over 1 million succumb to the disease, sustaining its status as the leading cause of death due to a single infectious pathogen, as reported in the World Health Organization Global Tuberculosis Report 2025[1]. Despite advancements in molecular diagnostics, shorter multidrug regimens, and digital adherence technologies, the epidemic continues to be driven by structural determinants including poverty, malnutrition, overcrowding, migration, gender inequities, and entrenched stigma [2].

Historically, TB control strategies have emphasized biomedical interventions—directly observed therapy (DOT), laboratory strengthening, standardized treatment protocols, and pharmacovigilance systems. While these approaches have significantly reduced mortality, they insufficiently address the socio-ecological milieu within which TB transmission thrives [3]. The World Health Organization (WHO) has consistently recognized that sustainable TB control necessitates active community participation and structured partnership models that extend beyond facility-based care [2].

Community empowerment represents a paradigmatic shift from passive beneficiary models toward shared governance and co-production of health services. The ENGAGE-TB framework institutionalizes collaboration between national TB programmes and civil society organizations (CSOs), embedding community-based TB activities into national strategies [4–6]. WHO’s 2023 consolidated guidance on community and civil society engagement reaffirms that meaningful participation of affected communities is indispensable to achieving End TB Strategy targets [7].

Conceptual Foundations of Community Empowerment

Community empowerment entails redistribution of decision-making authority, technical knowledge, and accountability from centralized health systems to local constituencies. WHO’s guiding principles emphasize partnership, mutual respect, inclusivity, and capacity building as prerequisites for effective community involvement [2].

The ENGAGE-TB operational guidance provides structured mechanisms through which NGOs and CSOs contribute to TB prevention, case detection, treatment support, and advocacy [4,5]. Training modules for community health workers (CHWs) and volunteers further enhance grassroots implementation capacity and improve linkage between communities and formal health services [6,8].

Empowerment transcends service delivery. It encompasses participatory planning, monitoring, and evaluation processes, ensuring that affected populations influence policy formulation. WHO’s 2023 guidance formalizes measurable indicators for assessing meaningful engagement within national TB responses, thereby institutionalizing participation as a normative requirement rather than a discretionary practice [7].

Empirical evidence supports this approach. Systematic reviews demonstrate that community-based TB interventions improve case detection and treatment outcomes, particularly when integrated within primary health systems [9,10]. Thus, empowerment is operational, institutional, and epistemological—it redefines who produces knowledge and governs care.

Importantly, empowerment is not merely descriptive but transformative. It enables communities to transition from passive recipients of services to active agents capable of influencing programme design, resource allocation, and accountability structures. This dynamism reflects a shift toward shared ownership of TB elimination, where lived experience, social capital, and collective agency become integral components of public health action.

Mechanisms Through Which Community Empowerment Advances TB Elimination

1. Early Case Detection and Transmission Interruption

Delayed diagnosis perpetuates community transmission. Community-led active case finding, contact tracing, and symptom screening reduce diagnostic delays by leveraging trusted local networks. The ENGAGE-TB framework explicitly integrates community actors into surveillance and outreach activities, expanding detection beyond health facilities [4,5].

Evidence from cluster-randomized and quasi-experimental studies indicates that community-based active case finding significantly increases TB notification rates compared to passive facility-based detection [11]. In India, the National Tuberculosis Elimination Programme (NTEP) institutionalizes community participation through TB Champions, community forums, and decentralized outreach systems [12]. The India TB Report 2024 documents increased case notification and improved linkage to care in districts with strengthened community engagement mechanisms [13].

Sustained participatory surveillance reduces the infectious period at the population level, contributing to measurable epidemiological impact when implemented longitudinally [11].

2. Treatment Adherence and Prevention of Drug Resistance

Adherence to multidrug regimens remains central to TB control, particularly in the era of multidrug-resistant TB (MDR-TB). Community-based treatment support mechanisms, endorsed under ENGAGE-TB guidance, demonstrate that trained volunteers and CHWs can supervise therapy effectively while simultaneously providing psychosocial reinforcement [5,6].

A Cochrane review comparing community-based DOT with facility-based supervision found comparable or improved treatment outcomes in community-supported models [14]. Further studies demonstrate that patient-centered and community-delivered care models enhance adherence and reduce catastrophic costs [15].

Under NTEP, community engagement strategies include treatment supporters, nutritional support (Nikshay Poshan Yojana), and direct benefit transfers to mitigate socioeconomic barriers

[12,13]. WHO's 2023 guidance emphasizes integrating social protection mechanisms within adherence frameworks to address structural determinants of treatment interruption [7].

By embedding social support within therapeutic supervision, empowerment-based models mitigate loss-to-follow-up and reduce emergence of drug resistance.

3. Stigma Mitigation and Behavioural Transformation

Stigma remains a formidable barrier to timely care-seeking. Community empowerment initiatives counter misinformation through culturally resonant education, survivor advocacy, and engagement of local leaders. WHO's foundational guidance underscores that community participation fosters trust and dismantles discriminatory narratives surrounding TB [2].

Qualitative and mixed-methods research demonstrates that survivor-led advocacy reduces perceived stigma and improves willingness to undergo testing [17]. India's TB Champion initiative—where cured patients engage in advocacy and peer support—has normalized dialogue around TB and encouraged early testing behaviour [12,13].

Empowered communities shift discourse from concealment to solidarity, strengthening health literacy and facilitating earlier engagement with care services.

4. Strengthening Health System Accountability and Governance

Community empowerment enhances transparency and accountability within TB programmes. WHO's 2023 engagement framework introduces indicators to measure civil society participation in planning and monitoring processes [7].

Participatory governance models—such as district TB forums and community monitoring platforms—improve responsiveness and programmatic oversight [13]. Evidence suggests that community monitoring contributes to improved service quality and equity in public health programmes broadly, including TB services [17].

Institutionalizing community oversight transforms beneficiaries into co-architects of TB elimination policy.

5. Cross-Cutting Pathways: Logistical and Psychological Support

Community empowerment operates through interconnected logistical and psychological pathways. Logistically, community actors facilitate treatment access, accompany patients to diagnostic centres, support adherence monitoring, and bridge gaps between households and health systems. These functions reduce structural barriers such as distance, cost, and administrative complexity.

Psychologically, empowerment fosters trust, hope, and social solidarity. Peer supporters and survivor advocates normalize treatment-seeking behaviour, counter internalized stigma, and sustain motivation during prolonged therapy. Together, logistical facilitation and psychosocial reinforcement create an enabling environment that strengthens continuity of care and improves treatment outcomes.

Global and National Frameworks Supporting Community Empowerment

The WHO End TB Strategy identifies community engagement as central to Pillar 2, emphasizing bold policies and supportive systems [3]. The ENGAGE-TB approach operationalizes this mandate by integrating CSOs into national TB programmes through structured collaboration [4–6].

WHO's 2023 guidance further advances this framework by defining measurable engagement indicators and advocating sustainable financing streams [7].

India's NTEP represents one of the most comprehensive implementations of community empowerment principles. Through TB Mukht Bharat initiatives, Panchayati Raj engagement, TB Champions, and decentralized governance, community participation has been embedded within the national elimination roadmap [12,13].

Civil society organizations and nongovernmental actors play a catalytic role in scaling empowerment. Organizations such as the Tuberculosis Association of India (TAI) have historically contributed to awareness generation, advocacy, and nationwide community engagement campaigns. Their involvement complements governmental programmes by mobilizing public participation, strengthening outreach, and sustaining national discourse on TB elimination.

Implementation Challenges

Despite normative support, operational challenges persist:

1. **Capacity Constraints:** Sustained training and supervision of community volunteers require long-term investment [6].
2. **Fragmented Integration:** Weak coordination between community actors and formal health systems undermines continuity of care [5].
3. **Financing Gaps:** Dedicated budget allocations for community-led interventions remain inconsistent [7].
4. **Measurement Limitations:** Conventional TB indicators emphasize biomedical outcomes while underrepresenting empowerment metrics [7].
5. **Limits of Empowerment and Local Economic Constraints:** While empowerment frameworks are conceptually compelling, their effectiveness is shaped by local socio-economic realities. Communities experiencing poverty, food insecurity, or unstable livelihoods may face constrained capacity to participate consistently in TB programmes. Economic precarity can limit volunteer availability, reduce adherence despite counselling, and shift priorities toward immediate survival needs. Recognizing these limits is essential to avoid over-romanticizing community action and to ensure that empowerment initiatives are paired with tangible social protection and financial support mechanisms.

Addressing these constraints necessitates institutional financing mechanisms, integration of community cadres within health information systems, and adoption of participation-sensitive indicators.

Ethical and Governance Dimensions

Community empowerment is intrinsically ethical. Excluding affected populations from decision-making perpetuates inequity and undermines legitimacy. WHO frameworks emphasize dignity, partnership, and shared accountability as ethical imperatives within TB elimination strategies [2,7].

Embedding TB elimination within broader social protection, nutrition, and poverty alleviation frameworks enhances sustainability. Community-led governance structures enable multisectoral convergence, aligning biomedical objectives with social justice imperatives.

Although voluntary engagement is foundational to community action, excessive reliance on unpaid labour risks exploitation, burnout, and inequitable burden-sharing—particularly among economically vulnerable groups. Structured community participation, supported through training, supervision, and appropriate incentives, offers a more sustainable alternative. Community-based working models distribute responsibility collectively, enhance resilience, and promote long-term programme continuity compared with purely voluntary approaches.

Future Directions

To institutionalize empowerment within TB elimination frameworks, priority actions include:

1. Formal inclusion of community representatives in national and district TB governance bodies [7].
2. Dedicated financing streams for community-led interventions [4,7].
3. Integration of digital adherence technologies with inclusive community outreach [12].
4. Development of standardized participation metrics [7].
5. Expansion of survivor leadership networks to influence policy dialogue [12,16].

Operational research should further evaluate cost-effectiveness, long-term epidemiological impact, and sustainability of empowerment-based models [9,11].

Potential Risks Within Empowerment Frameworks

Community empowerment initiatives must also anticipate unintended consequences. These include stigma toward volunteers, emotional fatigue and burnout among peer supporters, economic strain due to uncompensated time, and the possibility of tokenistic participation without real decision-making authority. Ethical programme design therefore requires safeguards such as fair compensation, psychosocial support for community workers, anti-stigma protections, and genuine inclusion in governance processes.

Conclusion

Tuberculosis elimination cannot be achieved through biomedical innovation alone. While chemotherapy eradicates *Mycobacterium tuberculosis* at the individual level, empowerment

addresses the structural determinants sustaining transmission. WHO frameworks, ENGAGE-TB operational guidance, and national programmes such as India's NTEP collectively affirm that community participation enhances early detection, strengthens adherence, mitigates stigma, and reinforces accountability.

Without equitable safeguards, empowerment risks becoming symbolic; with sustained support, protection from exploitation, and meaningful inclusion in decision-making, it becomes a transformative force capable of accelerating tuberculosis elimination.

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ENDING TB BY COMMUNITY EMPOWERMENT: CHALLENGES TO ACCESS

K.K. CHOPRA¹, V.K. ARORA²

For a successful and sustainable TB response, it is essential that TB-affected communities and civil society are meaningfully engaged at every stage. This includes the prioritization, implementation, monitoring, review, advocacy, and governance of TB interventions. To end TB, these communities must be empowered, capacitated, and funded to actively participate and lead in the fight against the disease.

WHO expressed the need for the participation of various stakeholders in addition to governments, such as the involvement of the private and public sectors. The forms of community empowerment need to be designed in response to and prevention of tuberculosis.¹ India ranks first among the world's 22 high-burden TB countries. TB is still stigmatized in the southeast Asia countries.² Meaningful engagement should focus specifically on TB survivors and TB vulnerable populations who face unique challenges in accessing TB services. These groups need targeted investment and capacity-building to strengthen community systems at the local, national, regional, and global levels.

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THE POWER OF COMMUNITIES

“COMMUNITY ENGAGEMENT is defined as the process of working collaboratively with and through communities to address issues affecting their well-being”. Despite the best efforts of health systems, about one third of people who develop TB globally are still either not diagnosed, or their cases are not reported. Difficulty in accessing health facilities is one of the reasons why people with TB may not be diagnosed, and can also have a negative impact on treatment adherence. Access to health care can be affected by social and political factors (such as stigma and discrimination, and the availability of cross border services for migrants), and economic barriers (for example, the cost of transport). The role of community engagement in contributing to TB prevention, diagnosis and treatment, especially where people with TB have poor access to formal health services, is therefore well recognized.

Community engagement for TB covers a wide range of activities that contribute to the detection, referral and treatment of people with drug-susceptible, drug-resistant and HIV-associated TB. They are conducted outside the premises of formal health facilities (e.g. hospitals, health centres and clinics) in community-based structures (e.g. schools, places of worship, congregate settings, markets) and homesteads. The knowledge level of the community, cadres, and TB patients in the program areas are better than non-program areas. Respondents in non-program areas are many who do not know the cause of tuberculosis, diagnose disease, modes of transmission and treatment for 6-9 months. It happens because of they only receive information through printing and electronic medias or from school lessons. Therefore, suffering and illness become as barriers in empowering TB patients due to less acknowledgement of disease. The key barrier is lack of access to TB services due to geographic, economic, and cultural problems. There are difference on community and cadres attitude against tuberculosis in program areas and non-program areas, while there is no difference among TB patients. Respondents in the non-intervention region agree to be laid off and alienated from their family if they suffer from TB. They also agree to stop treatment if face any side effects without consultation. Other research shows TB stigma cause a self-isolation behaviour and decrease self-esteem as consequences of health personnel or community prejudices.³

Community health workers contributed a better TB control program than an approach by health facilities. Clear policy regarding the role of community health workers in TB Control Programs and other settings is needed at international and local levels. Thus, resources are required to support this component of health care.⁴

COMMUNITY ENGAGEMENT FOR TB CARE (Screening, Referral, Treatment adherence support, Social and livelihood support)

Community health workers and community volunteers carry out community-based TB activities, depending on the national and local context. Screening for TB and TB-related morbidity (ex. HIV counselling and testing, diabetes), contact tracing, sputum collection and transport, including through home visits. Referring for diagnosis of TB and related diseases, linking with clinics, transport support and facilitation, accompaniment, use of referral forms. Home visits, adherence counselling, stigma reduction, pill counting, home-based care. Cash transfers, insurance schemes, nutrition support and supplementation, voluntary savings and loans, inclusive markets, income generation.

Awareness creation and stigma reduction

Awareness-raising, behaviour change communications, community mobilization and reduction of stigma and discrimination. By ensuring that TB-affected communities are not only heard but also supported and empowered, we can create a more inclusive and effective response to end TB. Decentralising tuberculosis control measures beyond health facilities by harnessing the contribution of the community could increase access to effective tuberculosis care. This review of

community-based health care initiatives in developing countries gives examples of the lessons for community contribution to tuberculosis control learned from health care programmes. Sources of information were Medline and Popline databases and discussions with community health experts. Barriers to success in tuberculosis control stem from biomedical, social and political factors. Lessons are relevant to the issues of limited awareness of tuberculosis and the benefits of treatment, stigma, restricted access to drugs, case-finding and motivation to continue treatment.

The experience of other programmes suggests potential for an expansion of both formal and informal community involvement in tuberculosis control. Informal community involvement includes delivery of messages to encourage tuberculosis suspects to come forward for treatment and established tuberculosis patients to continue treatment. A wide range of community members provide psychological and logistic support to patients to complete their treatment. Lessons from formal community involvement indicate that programmes should focus on ensuring that treatment is accessible. This activity could be combined with a variety of complementary activities: disseminating messages to increase awareness and promote adherence, tracing patients who interrupt treatment, recognising adverse effects, and case detection.

There are certain challenges in community involvement in TB control like complex network. TB control involved patients, health workers, volunteers, policymakers, NGOs, and entire communities working together. There are conflicting priorities like, medical protocols clash with community needs while resource constraints create additional tension. Other challenge includes High-Stakes Risks like misalignment leads to reduced program effectiveness, increased stigma, and poor treatment adherence.

Role of AI and Social Media

Artificial Intelligence can transform TB control from a centralized, reactive system to a community-driven, predictive, and responsive model. When ethically deployed, AI strengthens local ownership, improves outcomes, and accelerates progress toward TB elimination. Social media has emerged as a powerful tool to support community engagement and accelerate efforts toward ending tuberculosis (TB). In high-burden countries like India, where community awareness, stigma reduction, and early care-seeking are critical, social media can significantly strengthen TB control initiatives. Social media is not merely a communication channel but a community empowerment platform. When strategically integrated into TB programs, it strengthens awareness, reduces stigma, mobilizes action, and enhances accountability-bringing us closer to the goal of ending TB.

Programmes should generally take heed of existing political and cultural structures in planning community-based tuberculosis control programmes. Political support, the support of health professionals and the community are vital, and planning must involve or stem from the patients themselves.

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INAUGURATION OF THE 76TH TB SEAL FUNCTION AT TAI OFFICE DELHI





76TH TB SEAL FUNCTIONS HELD IN STATES



**76th Tb Seal 2025 Function
Andhra TB Assn**



**76th Tb Seal 2025 Function
Delhi TB Assn**



**76th TB Seal 2025 function
MP TB Assn**



**76th TB Seal Function
Andhra TB Assn**



**76th TB Seal Function
Patna Bihar TB Assn**



**76th TB Seal Function
Raj Bhawan, Vijaywada**



**76th Tb Seal Function
Telangana TB Assn Hyderabad**



**76th TB Seal Function
Tripura TB Association**



**76th TB Seal Telangana TB Assn
at Raj Bhawan**



TB SEAL AWARDS

2024-25





AWARD RECIPIENTS

2024-25

The list of Award recipients of the 74th TB Seal Campaign (year 2024) and for general activities and achievements for the period 2024-25 who were felicitated at the Annual General Meeting of the Association on 16th March 2026 is as under :-

1	Khushi Ram Shield for excellent activities and certificate	Bihar State TB Association
2	Bhai Mohan Singh Cup and certificate for general activities and achievements	UP State TB Association
3	Special award for all round activities	Telangana State TB Association
4	Special certificate for consistently good performance	Anti TB Association of Tamil Nadu
Awards for 74th Campaign		
5	TB Seal Trophy for highest collections	Anti TB Association of Tamil Nadu
6	Runner up Cup for second highest collections	Delhi State TB Association
7	Special Silver Cup for highest collections	Andhra Pradesh State TB Association
8	Special TB Seal Award for second best collections	Gujarat State TB Association
9	Special Souvenir / Certificate for TB Seal sale	Telangana State TB Association

TAI PAN INDIA CAMPAIGN FOR COMMUNITY EMPOWERMENT

- The Action Against Stigma campaign, launched pan-India in 2025, will continue through 2026.
- The logo initiated by TAI will be retained for Community Empowerment also to ensure continuity.
- Community Empowerment has been formally added as a parallel and complementary pillar.

Three-more issues for Community Empowerment introduced

a) Awareness

- Improving community understanding of TB symptoms, diagnosis, and curability.
- Communicating that TB treatment is free of cost and available through government and supported private facilities.
- Use of local language IEC materials (posters, pamphlets, slides, standees).
- Awareness programs at schools/colleges and work places

b) Access

- Ensuring Mobile diagnostic clinics reaching to remote areas
- Ensuring utilization of nearby DOT centers and diagnostic facilities.
- Addressing barriers such as stigma, fear, and misinformation.
- Emphasizing that patients become non-infectious within 10–15 days of treatment compliance.

c) Support

- Providing psychological, social and financial support.
- Enabling communities to participate in decisions affecting their welfare.
- Facilitating community-led problem solving with TB Association of India support.

Role of TB Association of India vis-à-vis Government Programmes

- The TB Association of India is supplementing and supporting the National TB Elimination Program (NTEP) of Govt of India.
- The Association will act as a supporting hand, not as a parallel structure.

Key focus areas include:

- Treatment compliance
- Patient registration at DOT centers
- Completion of therapy

Financial and Technical Support

- TB Association of India will continue financial and technical assistance to State Associations.
- In the previous year, 25,000 per Association was provided, with additional support released upon request during AAS campaign.
- Funds for World TB Day-linked intensified activities will be released by 1 March 2026.
- IEC materials and technical guidance will be centrally supported.

IMPLEMENTATION OF THE CAMPAIGN

No.	Decisions	Action to be taken	Time Line
1	Dissemination of Community Empowerment framework and slides to all State TB associations	Secy General	Immediate
2	Mapping of state-level stakeholders (Doctors, NGOs, ASHA, TB Champions, CSR)	Hon. Secys of All State TB Assns.	By 31 Jan 2026
3	Formal engagement with State TB Cell, STOs and DTOs	Hon. Secys of All State TB Assns.	February 2026
4	Release of funds for intensified Community Empowerment Activities	Sh S K Saini, Consultant (Accounts)	By 1 March 2026
5	Planning and execution of intensified activities around World TB Day with stake holders involving NGOs, IMA, Dental Assn Teachers etc.	Hon. Secys of All State TB Assns.	12–24 March 2026
6	Virtual experience-sharing meeting with State TB Assns	Secy General	24 March 2026

No.	Decisions	Action to be taken	Time Line
7	Youth-focused awareness programmes/activities in Schools (8th to 12th class) involving the teachers.	Hon. Secys of All State TB Assns	April 2026
8	Community and slum-based empowerment activities	All State & District TB Assns	May-June 2026
9	PAN India Mass media and CSR-supported campaigns	Hon. Secys of All State TB Assns.	July 2026
10	Activities in DOT Centres	All State & District TB Associations	August, 2026
11	To involve elected representatives (Panchayat members, local leaders, administration etc) who has reach among the mass	All State & District TB Associations	Sept., 2026
12	Monthly reporting and impact feedback to TBAI HQ	State TB Assns	Ongoing
13	Monthly guidance, reminders, IEC templates and contents support will be provided by TAI	Secy. General	



GLIMPSES OF THE 80TH NATCON, 2025 AT KOLKATA



Chairman TAI



Inaugural Function



President TAI



Lighting of Lamp



Inaugural Function



Award Ceremony



Award Ceremony



Award Ceremony Natcon



Award Ceremony



Award Ceremony



Award Ceremony



**Dr Varsha
Faculty Technical session**



Technical NITRD Session



Technical Session



Release of MDR Book



Release of Natcon



Release of Natcon



Session TB Quiz



Session TB Quiz



Session TB Quiz Main



Release of TB Seals Book



Award Ceremony



Award TB Video



Award TB Video



Valedictory Felicitation



**Valedictory Session
Award Ceremony**



Valedictory



Valedictory Group Photo



TAI COMMUNITY EMPOWERMENT CAMPAIGN & WORLD TB DAY DAY FUNCTIONS



A walkathon was organised from the Government General & Chest Hospital, Erragadda to S.R Nagar Metro Station during Campaign for Community Empowerment.



World TB Day was organised on 24th March, 2026 at Alumni Education Society, Gandhi Medical College Campus, Hyderabad.





CME conducted for health worker and other officials at Dr. Baba Saheb Ambedkar Medical College, Rohini on 23.03.2026.



Nukkad Natak conducted on 23.03.2026 by Baptist Church Trust Association in collaboration with NDTB Centre for TB Awareness of the patients.



CME conducted on 24.03.2026 at NDTB Centre.



On the occasion of World TB Day, Department of Dermatology & STD organized Guest Lecture on 25th March 2026 on "Diagnostic modalities and recent advances in the management of tuberculosis"



CALENDAR OF TUBERCULOSIS WORKERS' CONFERENCE

- 1st The First Conference of Tuberculosis was organised in New Delhi in November, 1934 by the King George Thanks-giving (Anti-Tuberculosis) Fund. Twenty-four delegates attended this three-day conference. Under the auspices of the Tuberculosis Association of India, the First All India Tuberculosis Workers' Conference was held in New Delhi in 1934. Fifty-five delegates attended it.
- 2nd The Second Conference was held in New Delhi in November, 1940. This was attended by ninety delegates.
- 3rd The Third Conference was held in New Delhi in March, 1945. Seventy delegates attended. Sir Joseph Bhore presided.
- 4th The Fourth Conference was held in New Delhi in November, 1946 and was attended by 110 delegates.
- 5th The Fifth conference was held in January, 1948 at Madras. Over hundred delegates attended it. His Excellency, Sir Archibald Nye, Governor of Madras, inaugurated the conference.
- 6th The Sixth Conference was held in Calcutta in December, 1948. Dr. R. B. S. Billiomira was its President. Dr. B. C. Roy, Premier of West Bengal, inaugurated the Conference. 130 delegates attended.
- 7th The Seventh Conference was held in Bombay in November, 1949. Its President was Dr. A. C. Kulkarni, Rakumari Kamat, Minister of Health, Government of India, and President of the Tuberculosis Association of India, chaired the conference. 130 delegates attended.
- 8th The Eighth Conference was held in Hyderabad in February, 1951. Dr. K. Vasudeva Rao was its President. Over 150 delegates attended it. It was inaugurated by Dr. K.C.K. Raja, Director-General of Health Services and Chairman, Tuberculosis Association of India.
- 9th The Ninth Conference was held in February, 1952 in Lucknow. Dr. P. V. Benjamin was its President. Over 170 delegates attended. It was inaugurated by Dr. K.C.K.E. Raja, D.G.H.S. and Chairman, Tuberculosis Association of India.
- 10th The Tenth Conference met in Mysore in February, 1953. Dr. K.L. Wig presided in the absence of Late R.B. Lal, the President-elect. It was inaugurated by Rajkumari Amrit Kaur, Union Health Minister and President of the Tuberculosis Association of India.

- 11th The Eleventh Conference was held in Nagpur in February, 1954. Dr. K. L. Wig was its President. About 130 delegates attended. Dr. Pattabhi Sitaramayya, Governor of Madhya Pradesh, inaugurated it.
- 12th The Twelfth Conference was held in Amritsar in February, 1955 with Dr. B.B. Yodh as the President. About 175 delegates attended. Shri C.P.N. Singh, Governor of Punjab, inaugurated the Conference.
- 13th The Thirteenth Conference was held in Trivandrum in January 1956. Dr. T.J. Joseph was its President. About 150 delegates attended. His Highness the Rajpramukh of Travancore inaugurated it.
- 14th The Fourteenth Conference was held in Madras in January, 1958. Dr. K.S. Sivanthi was its President. About 200 delegates attended, it was inaugurated by Shri Bishnuram Medhi, Governor of Madras.
- 15th The Fifteenth Conference was held in Jaipur, 1959. It was inaugurated by Dr. D.P. Karmarkar, Union Health Minister. Over 200 delegates attended. Dr. B.K. Sikand was the President of this conference.
- 16th The Sixteenth Conference was held in Poona in January, 1960. Over 250 delegates attended. Dr. P.K. Sen was its President. It was inaugurated by Rajkumari Amrit Kaur, Union Health Minister and President, Tuberculosis Association of India.
- 17th The Seventeenth Conference was held in Cuttack in January-February, 1961. It was inaugurated by Shri Y.N. Sukthankar, Governor of Orissa. Over 200 delegates attended. A new feature of the conference was that Dr. A.S. Moli was its President.
- 18th The Eighteenth Conference was held in Bangalore in January, 1962. Dr. R.N. Thomas its President. Over 300 delegates attended. The conference was inaugurated by the Maharaja, Shri Jayachamraja Wadiyar Bahadur, Governor of Mysore.
- 19th The Nineteenth Conference was held in Delhi in April, 1964. Dr. L.R. Dongre was its President. Over 400 delegates attended. The conference was inaugurated by Dr. Sushila Nayar, Union Minister for Health.
- 20th The Twentieth Conference was held in Ahmedabad in February, 1965 and was presided over by Dr. M.D. Deshmukh. The conference was inaugurated by Nawab Mehdi Nawaz Jung, Governor of Gujarat. About 300 delegates attended.
- 21st The Twenty-first Conference was held in Calcutta in February, 1966. Dr. K.N. Rao, Director-General of Health Services and Chairman, TB Association of India, was its President. About 350 delegates attended. The conference was inaugurated by Smt. Padmaja Naidu, Governor of West Bengal.

- 22nd The Twenty-second Conference was held in Hyderabad in February, 1967. Major (Dr.) Khusdeva Singh of Patiala was the President of the Conference. It was inaugurated by Shri Pattom Thanu Pillai, Governor of Andhra Pradesh. Over 250 delegates attended.
- 23rd The Twenty-third Conference was held in Bombay in January, 1968. Dr. R. Viswanathan was its President. It was inaugurated by Dr. P.V. Cherian, Governor of Maharashtra. Over 300 delegates attended.
- 24th The Twenty-fourth Conference was held in Trivandrum in January, 1969. The President of the Conference was Dr. N.L. Bordia. It was inaugurated by Shri V. Viswanathan, Governor of Kerala. Over 300 delegates attended.
- 25th The Twenty-fifth National Conference was held in Patiala, Punjab, in January, 1970. Dr. M. Umesh Rao was the President of the Conference. It was inaugurated by Dr. E.C. Pavate, Governor of Punjab. About 250 delegates attended.
- 26th The Twenty-Sixth Conference was held in Bangalore in January, 1971. Dr. K. Somayya was its President. Shri Dharma Vir, Governor of Karnataka, inaugurated the Conference. About 300 delegates attended.
- 27th The Twenty-seventh Conference was held in Patna in November, 1972. Dr. K.N. De of Calcutta was its President. Shri Dev Kant Barooah, Governor of Bihar, inaugurated the Conference. About 250 delegates attended.
- 28th The Twenty-eighth National Conference was held in Madras, in January 1974. Dr. S.P. Pamra was its President. Shri K.K. Shah, Governor of Madras, inaugurated the conference. Over 300 delegates attended.
- 29th The Twenty-ninth Conference was held in New Delhi in November, 1974. This was combined with the IXth Conference of the Eastern Region of the I.U.A.T. Due to the absence of Dr. M.S. Chadha, Shri S. Ranganathan, President of the Association, Presided over the Conference. Conference were inaugurated by Dr. Fakhruddin Ali Ahmed, President of India and addressed by Dr. Karan Singh, Union Minister for Health and Family Planning. Over 400 delegates attended the conference.
- 30th The Thirtieth Conference was held in Hyderabad in November, 1975. Dr. H.B. Dingley was its President. Over 200 delegates attended the Conference. It was inaugurated by Shri S.V. Subi Reddy, Governor of Andhra Pradesh.
- 31st The Thirty-first Conference was held in Lucknow in November, 1976. Dr. Tahir Mirza was its President. Over 300 delegates attended the conference. It was inaugurated by Shri M.M. Chaudhary, Governor of Uttar Pradesh.

- 32nd The Thirty-second Conference was held in Trivandrum in November, 1977. Dr.K.V. Krishnaswami was its President. About 400 delegates attended the conference. Smt. Jyoti Venkataraman, Governor of Kerala, inaugurated the Conference.
- 33rd The Thirty-third Conference was held in Bhopal in November, 1978. Dr. J.L. Bhatia was its President. The Conference was inaugurated by Shri C.M. Poonacha, Governor of Madhya Pradesh. About 300 delegates attended.
- 34th The Thirty-fourth Conference was held in Jaipur in October, 1979. Dr. M.L. Mehrotra was its President. Shri Braham Singh Shekhawat, Chief Minister of Rajasthan, inaugurated the Conference. About 300 delegates attended.
- 35th The Thirty-fifth Conference was held in Bombay in November, 1980. Dr. M.M. Singh was its President. Shri Haridev Mukherjee, Governor of Gujarat, Maharashtra, inaugurated the conference. About 500 delegates attended.
- 36th The Thirty-sixth Conference was held in Baroda in November, 1981. Dr. GD. Gothi was its President. Shri Sardare Mukherjee, Governor of Gujarat, inaugurated the Conference. About 500 delegates attended.
- 37th The Thirty-seventh Conference was held in New Delhi in November 1982. Dr. B. Trivedi was its President. Shri M. Hayatullah, Vice-President of India, inaugurated the Conference. About 600 delegates attended.
- 38th The Thirty-eighth Conference was held in Panaji in October, 1983. Dr. S. Sivaramanu was its President. Shri K.T. Satarwalla, Lt. Governor of Goa, Daman & Diu, inaugurated the Conference. About 700 delegates attended.
- 39th The Thirty-ninth Conference was held in Cuttack in January, 1985. Dr. A.G. Patel was its President. Shri B.N. Pandey, Governor of Orissa, inaugurated the Conference. About 500 delegates attended.
- 40th The Fortieth conference was held in Shillong in November, 1985. Dr. Umapathy Rao was its President. Smt Mohsina Kidwai, Union Minister for Health and Family Welfare, inaugurated the Conference. About 400 delegates attended.
- 41st The Forty-first Conference was held in Hyderabad in October, 1986. Dr. S.P.D. Gupta was its President. Smt Kumudben Manishankar Joshi, Governor of Andhra Pradesh, inaugurated the Conference. About 500 delegates attended.
- 42nd The Forty-second Conference was held in Lucknow in December 1987. Dr. P.A. Deshmukh was its President. Shri Loknathi Tripathi, Minister for Health and F.W., U.P. inaugurated the Conference. About 500 delegates attended.

- 43rd The Forty-third Conference was held in Calcutta in December 1988. Dr.S.P.Tripathy was its President. Prof. S. Nurul Hasan, Governor of West Bengal inaugurated the Conference. About 450 delegates attended.
- 44th The Forty-fourth National Conference on Tuberculosis and Chest Diseases was held in Madras in December, 1989. In the absence of Dr. S.C. Kapoor, President of Conference, Dr. K. Jamanth Prasad over the Conference. Dr. T. Deivanar, Minst. for Health & Family Welfare, Government of Tamil Nadu, inaugurated the Conference. About 600 delegates attended.
- 45th The Forty-fifth National Conference on Tuberculosis and Chest Diseases was held in Rohtak (Haryana) in January 1991. Col. M. Mohanty was its President. Shri Dhanik Lal Mandal, Governor of Haryana, inaugurated the Conference. About 400 delegates attended.
- 46th The Forty-sixth National Conference on Tuberculosis and Chest diseases was held in New Delhi in November 1991. Dr. S.B. Trivedi was its President. Dr. M.S. Chandra, President, Tuberculosis Association of India, inaugurated the Conference. About 450 delegates attended.
- 47th The Forty-seventh National Conference on Tuberculosis and Chest Diseases was held in Bombay in November 1992. Dr. P.V. Verma was its President. Shri C. Subramaniam, Governor of Maharashtra, inaugurated the Conference. About 600 delegates attended.
- 48th The Forty-eighth National Conference on Tuberculosis and Chest Diseases was held in Bhopal (Madhya Pradesh) in December 1993. Dr. M.M. Siddhu was its President. Shri Mohammed Shafi Qureshi, Governor of Madhya Pradesh, inaugurated the Conference. About 450 delegates attended.
- 49th The Forty-ninth National Conference on Tuberculosis and Chest Diseases was held in Pondicherry in October 1994. Dr. R.C. Jain was its President. Shri Paban Singh Ghatowar, Union Dr. minister for Health and Family Welfare inaugurated the Conference. About 500 delegates attended.
- 50th The Golden Jubilees National Conference on TB & Chest Diseases was held in Trivandrum in December 1995. Dr. C. Srinivasa Rao was its President. Shri P. Shiv Shankar, Governor of Kerala, inaugurated the Conference. About 550 delegates attended.
- 51st The Fifty-first National Conference on TB & Chest Diseases was held in Bangalore (Karnataka) in November 1996. Dr. Dhoni Bas was its President. His Excellency Shri Khursheed Alam Khan, Governor of Karnataka, inaugurated the Conference. About 600 delegates attended.

- 52nd The Fifty-second National Conference on TB & Chest Diseases was held in Ahmedabad in December 1997. Dr. P.R. Bhogal was its President. Shri Dilipbhai Parikh, Hon'ble Chief Minister of Gujarat, inaugurated the Conference. About 600 delegates attended.
- 53rd The Fifty-third National Conference on TB & Chest Diseases was held at Bhubaneswar (Orissa) from 27th to 30th December, 1998. Dr. I. Ranga Rao was the President of the 53rd National Conference. Shri Jagannath Rout, the Hon'ble Minister of Urban Development, Orissa, inaugurated the Conference which was attended by about 400 delegates.
- 54th The Fifty-fourth National Conference on Tuberculosis and Chest Diseases was held at M.R. Nursing Institution, Bailey Road, Patna (Bihar), from 26th to 29th December, 1999. Dr. M.S. Agnihotri was the President of this 54th National conference which was attended by about 400 delegates.
- 55th The Fifty-fifth National conference on TB & Chest Diseases was held at Nagpur, Calcutta from 7th to 10th December, 2000. Dr. B. Dhounsule was the President of the Conference, which was attended by about 500 delegates.
- 56th The Fifty-sixth National Conference on Tuberculosis and Chest Diseases was held at Hotel Le Royal Meridian, Chennai from 9th to 12th October, 2001. Dr. M. Pradhan was the President of the Conference, which was attended by about 550 delegates.
- 57th The Fifty-seventh National Conference on Tuberculosis and Chest Diseases was held at Kalpa Academy, Panaji, Goa from 26th to 29th September, 2002. Dr. S.N. Tripathy was the President of the Conference, which was attended by about 500 delegates.
- 58th The Fifty-eighth National Conference on Tuberculosis and Chest Diseases was held at Taj Lands Ends, Mumbai from 2nd to 4th January, 2004. Dr. P.J. Jagota was the President of the Conference, which was attended by about 600 delegates.
- 59th The Fifty-ninth National Conference on Tuberculosis and Chest Diseases was held at LRS Instt. of TB & Respiratory Diseases, New Delhi from 3rd to 6th February, 2005. Dr. V.K. Arora was the President of the Conference, which was attended by about 600 delegates.
- 60th The Sixtieth National Conference on Tuberculosis and Chest Diseases was held at K.G. Medical University, Lucknow, from 23rd to 26th February, 2006. Dr. P.R. Narayana was the President of the Conference, which was attended by 500 delegates.
- 61st The Sixty-first National Conference on Tuberculosis and Chest Diseases was held at RNT Medical College, Udaipur (Rajasthan) from 23rd to 25th February, 2007. Lt. General Dr. J. Jayaswal was the President of Conference, which was attended by about 500 delegates.

- 62nd The Sixty-Second National Conference on Tuberculosis and Chest Diseases was held at New Delhi, Teen Murti Bhawan from 14th to 16th December, 2007. Dr. S.K. Katiyar was the President of the Conference. Dr. Ambumani Ramadoss, Hon'ble Minister for Health & Family Welfare, Govt. of India, inaugurated the Conference, which was attended by about 400 delegates.
- 63rd The Sixty-third National Conference on Tuberculosis & Chest Diseases and First International Conference of South Asia Region (The Union) was held in Delhi from 8th to 10th September 2008. Dr. R.K. Srivastava, Chairman, TAI and Director General of Health Services, Govt. of India, inaugurated the Conference. About 550 delegates attended the Conference.
- 64th The Sixty-fourth National Conference on Tuberculosis and Chest Diseases was held at Science City Auditorium, Kolkata, from 27th to 29th December, 2009. Dr. Manish Pradhan was the President of the Conference. About 350 delegates attended the Conference.
- 65th The Sixty-fifth National Conference on Tuberculosis & Chest Diseases was held at Bangalore, from 9th to 11th January, 2011. Dr. Prahlad Kumar was the President of the Conference. About 450 delegates attended the Conference.
- 66th The Sixty-sixth national Conference on Tuberculosis & Chest Diseases was held at Dehradun, Uttarakhand from 19th to 20th November, 2011. Dr. B. Deva was the President of the Conference. About 350 delegates attended the Conference.
- 67th The Sixty-seventh National Conference on Tuberculosis and Chest Diseases was held at Patna, Bihar from 8th to 10th February 2013. Dr. Rajendra Prasad was the President of the Conference. About 450 delegates attended the Conference.
- 68th The Sixty-eighth National Conference on Tuberculosis and Chest Diseases was held at New Delhi from 23rd to 26th February 2014 and was inaugurated by the Hon'ble President of India, Dr. S. Chahuan who was the President of the conference was organised under auspices of the National Institute of Tuberculosis and Respiratory Diseases, New Delhi (formerly LRS Institute of TB and Respiratory Diseases). Over 600 delegates attended the conference.
- 69th The Sixty-ninth National Conference on Tuberculosis and Chest Diseases was held at RIMS Instt. of TB & Respiratory Diseases, New Delhi from 5th to 7th February 2015. Dr. Rohit Sarin was the President of the Conference. The Conference was organised in association with the Indian Association of Tuberculosis.
- 70th The Seventieth National Conference on Tuberculosis and chest diseases was held at convention center, King George Medical University, Lucknow (U.P.), in Feb.- 2016. Dr. Jai Prasad was the President of the Conference. The Conference was organised in association

with the TB Association of U.P. and the Deptt. of Pulmonary, King George University Lucknow. Over 650 delegates attended the conference.

- 71st The Seventy-first National Conference on Tuberculosis and Chest Diseases was held at PGI Chandigarh from 16 to 18th December, 2016. Dr.K. Gupta was President of the Conference. The Conference was inaugurated by Dr. Dr. Soumya Swaminathan, Director General, ICMR and Secretary, Department of Health Research, Ministry of health and Family welfare, Government of India, New Delhi. Over 650 delegates attended the Conference.
- 72nd The Seventy-second National Conference on Tuberculosis and Chest Diseases was held at Jawaharlal Nehru Institute of Medical Sciences & Research Foundation, Imphal, from 15 to 17th December, 2017. Dr. Hoti Bawa was the President of the Conference. Dr. C. Rajan Vice-Chancellor, NTR University of Health Sciences, Andhra Pradesh, inaugurated the conference. Over 450 delegates attended the conference.
- 73rd The Seventy-third Conference on Tuberculosis and Chest diseases was held at Nagpur, Maharashtra, from 4th to 6th January, 2019. The conference was organised jointly by the Department of Respiratory Medicine, Indira Gandhi Government Medical College, Nagpur, Vidarbha Chest Association and the Maharashtra State Anti-TB Association, Mumbai, under aegis of the Tuberculosis Association of India. Dr. Sunil Khadse was the President of the conference.
- 74th The Seventy-fourth Conference on Tuberculosis and Chest Diseases was held at Chennai, Tamil Nadu, from 20th to 22nd December, 2019. The conference was organised jointly by the Government Hospital of Thoracic Medicine, Tambaram Sanatorium, Chennai and the Anti-TB Association of Tamil Nadu, under aegis of the Tuberculosis Association of India. Dr. K.K. Chopra was the President of the Conference. Over 700 delegates attended the conference.
- 75th The Platinum Jubilee of National Conference of Tuberculosis and Chest Diseases (75th NATCON) was held at Indore, Madhya Pradesh, from 18th to 20th December 2020 on a 3D virtual platform. The conference was organized under the aegis of Tuberculosis Association of India, Madhya Gandhi Memorial Medical College, Indore and MP TB association. Dr. K.S. Gandhi was the President of the Conference. Over 2500 delegates attended the Conference.
- 76th The Seventy-sixth National Conference on Tuberculosis and Chest Diseases (NATCON) was held at MMC Auditorium, Mullana, Ambala, Haryana, organised by the Institute of Medical Science, Mullana, Haryana from 10 to 13th April, 2022. The conference was organised under the aegis of the Tuberculosis Association of India. Dr. Sriradhan Sharma was the president of the conference. Over 600 delegates attended the Conference.

77th The Seventy-seventh NATCON was held at Agra from 27th February to 1 March 2023 with the theme "Back to the Basics and Beyond to TB Elimination". The conference was organised by S.N. Medical College Agra in association with U.P. State TB Association of the Union, South East Asia Region under the aegis of Tuberculosis Association of India. Eight workshops were held on 1 day, many symposia, panel discussion and debates on important topics were conducted in next two days in addition to Oral Awards and deliberation by eminent speakers. More than 1200 delegates and about 200 faculty members participated which is a record gathering in NATCON history.

78th The 78th-eighth NATCON was held at Lulu International Convention Centre, Thrissur, Kerala from February 02, 03 and 04, 2024 and organised by Association of Pulmonologists, Thrissur and Academy of Pulmonary and Critical Care Medicine under the aegis of The Tuberculosis Association of India. The Conference theme was "Robert Koch to Robotics". Dr.K.N. Jain was the President of the conference.

It was a three day conference with Day-1 dedicated to pre-conference workshops. Ten workshops were conducted, in which hands on experience was given to postgraduate students about various technologies used in TUBERCULOSIS and Respiratory Diseases. These were attended by doctors and faculty in large numbers.

Two days conference was attended by more than 700 delegates from all parts of India. Faculty included renowned Indian and overseas doctors. 3 major awards were registered. Winners were given prizes which was about 600 PG students were in addition. In addition, meeting of Indian Journal of Tuberculosis Editorial Board, State Secretaries technical meeting and South East Asia Regional Union meeting were held on the sidelines of the NATCON.

79th The Seventy-ninth NATCON was organized jointly by Mahatma Gandhi University of Medical Sciences and Technology and Jain Chest Care Centre under the aegis of TAI from October 18-20 2024 in Jaipur. The theme of the Conference was "From Progressive Evolution to Revolutionary Shift". Delegates to the Conference included PG students, resident doctors, eminent researchers, experts in the field of medicine from India and abroad. The Conference was inaugurated by Chief Guest, Smt Manju Sharma MP, President TAI, Dr Vishwa Mohan Katoch was the Guest of Honour. Senior officials of the TAI, Mahatma Gandhi University of Medical Sciences and Technology and Jain Chest Care Centre also participated.

Dr. Ashwani Khanna gave the Presidential speech at the inaugural function. At the function, latest Special issue of Indian Journal of Tuberculosis on Drug Resistant TB (DR-TB) and Psychological Disorders was released. Topics like latest diagnostics, therapies, associated diseases and preventive guidelines were covered. The book, "Update on MDR TB" edited by Prof. Dr. V.K. Arora and Dr. K.K. Chopra contains chapters authored by renowned specialists working in the field of resistant TB diagnostics and management,

was also released at the function. SCIENTIFIC PROGRAMME included Symposium and panel discussions were on Artificial Intelligence in TB management and drug discoveries, challenges in rollout of PBM regimen in India, post TB rehabilitation, impact of removing Respiratory medicine in MBBS curriculum etc. was discussed. It was agreed that removal of TB and Respiratory department from undergraduate curriculum has been a retrograde step by NMC without understanding epidemiology of TB and respiratory diseases.

Bengal TB Association informed the delegates about the upcoming conference, 80th NATCON 2025 to be held at Kolkata.

In addition important meetings were held on the sidelines of the Conference viz. State Secretaries Meeting, JT Editorial Board Meeting, and the S.E.A. region Union meeting.

80th The 80th National Conference was held at Kolkata from 19-21 December 2025 with Pre-workshop on Community Empowerment on 18th. December 2025. There were over 600 participants in the Conference consisting of senior medical practitioners/ officials of medical colleges and Institutions, State TB Associations and dignitaries. The Conference was inaugurated by the President of the Association, Dr. V.M. Katoch. The Conference President's address was given by Dr. M.M. Puri, NITRD Delhi at the Inaugural function. The Oration and Life time Achievement & other Awards were given by the President TAI. TAI Mobile Application was launched at 80th NATCON , Kolkata. Two hundred Scientific papers were submitted for poster & podium presentations. A number of national & international faculties participated & shared their valuable experience.



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