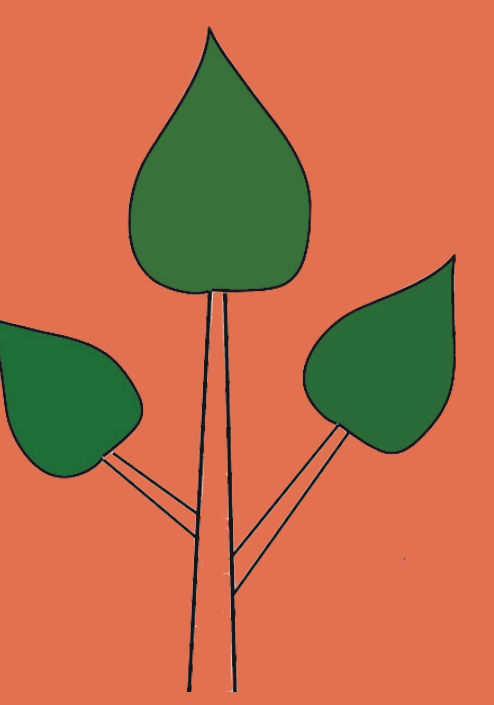


Reaching the Unreached: Desire, Determination & Love

A model Community TB Programme

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INTRODUCTION

There is growing evidence of significant gaps between the health status of adivasi ('tribal') communities and that of majority populations. This poster highlights the **disproportionately high rates of morbidity and mortality from tuberculosis (TB) among adivasi (tribal) populations**, and encourages experts of TB control to address **broader social and political determinants of the disease**. TB is among the most important causes of premature death for adivasi people. Researchers and policy makers seem to brand health issues in tribal populations as 'tribal health' than looking into the causes of health inequalities therein.

TB & ADIVASI POPULATIONS

A systematic review of existing studies carried out in 2015 arrived at a **pooled pulmonary TB prevalence estimate of 703 per 100,000 population for the adivasi populations** - significantly higher than that estimated for India, 256 per 100,000 population, at the time. **"Reports from tribal areas of our country show that the average body weight of men and women with TB is 30-35 kg! Prevalence rates of TB are directly correlated with socio-economic status, with people in the lowest quintile having 3-4 times the rate of TB than those in the highest."**



WHAT PROGRESS HAS BEEN MADE SINCE?

India has announced that TB will end in the country by 2025. WHO says, globally 8.3% reduction in 'TB incidence rate', 23% reduction in 'Number of TB deaths' and 49% reduction in the percentage of TB-affected households facing catastrophic costs - all are 2024 data in comparison to that of 2015.

Ekta Niketan TB centre gives a different picture of TB in remote rural India, particularly among marginalised tribal populations.

EKTA NIKETAN TB CENTRE

Ekta Niketan (EN), established three decades ago, is a popular TB Centre in the district of **Deoghar**, Jharkhand. It is a showcase community TB programme - an innovative model to reach out TB patients in remote villages - adivasi (tribal) and other marginalised communities. Unlike most TB centres **Ekta Niketan is managed by a team of village health workers with minimal formal education.**



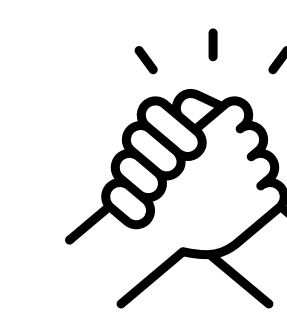
WHERE THERE IS NO TB DOCTOR

Over **90% of patients accessing the TB centre are from the Santal tribe**, so the health workers of EN. From a mud-built house, like other buildings in the village, EN delivers quality TB care - from **clinical diagnosis, microscopy and dispensing anti-TB drugs correctly to keeping records and monitoring of treatment through phone or home visits**. It demonstrates how a TB care can be delivered with limited resources.

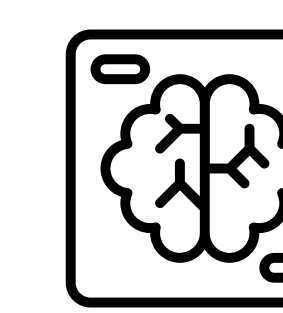
AN INNOVATIVE MODEL

Ekta Niketan combines intercultural and social accountability approaches, the former's emphasis on trust-building which complements the latter's focus on delivery. **Having similar cultural, educational and economic status as their patients, health workers are trained to deliver quality TB care**, hence the popularity of the centre which is reflected in the rising number of patients accessing TB care in a remote village. A **trained doctor is available for advice**; the NTEP provides anti-TB medical and laboratory supplies even though the doctor is not always present in person.

EN has developed tools that health workers practise the following



Psycho-social screening to help determine 'likely to interrupt treatments' patients

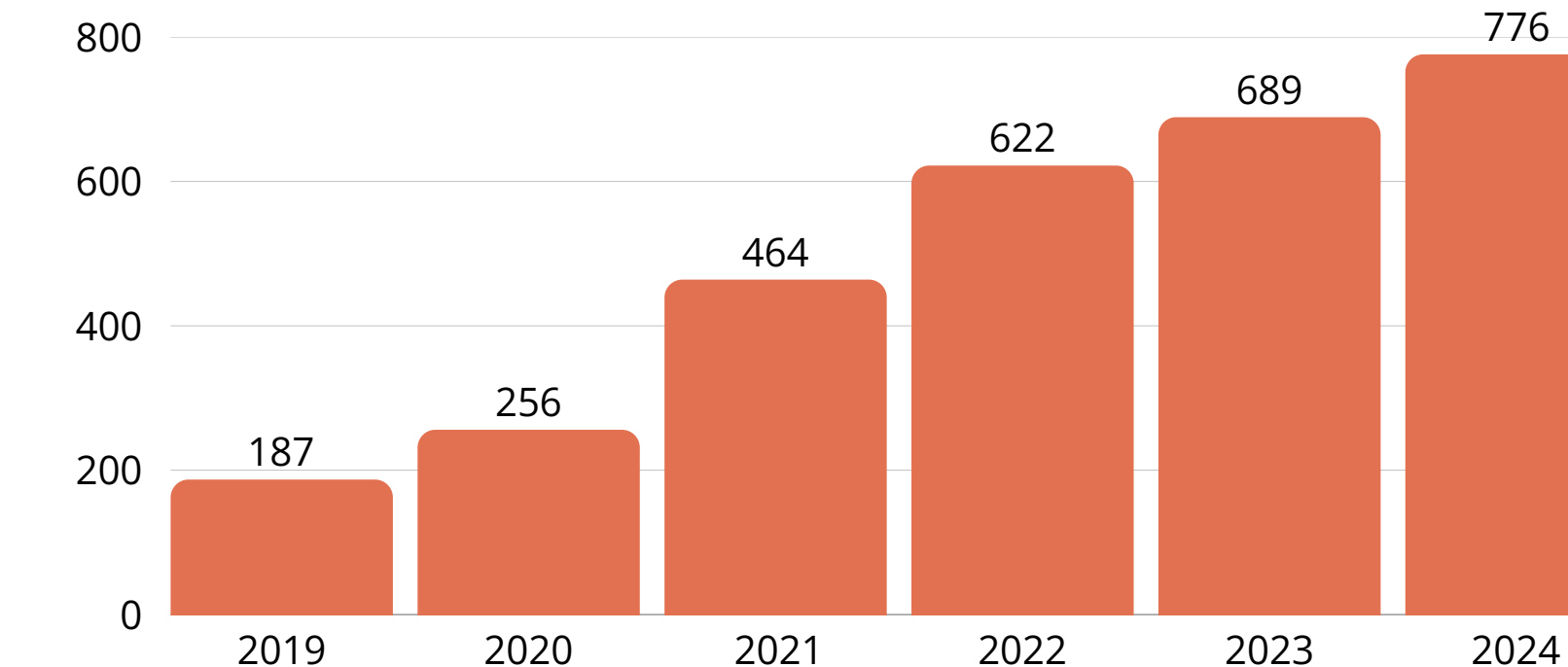


Computerised diagnostic and severity screening tool



Distant consultation with a medical professionals using online tools and techniques.

Patient numbers at Ekta Niketan TB Centre



PUBLIC PRIVATE PARTNERSHIP

Integrate private care (public-private mix) has adverse outcome in TB control in marginalised adivasi areas; it adds "out-of-pocket-cost", contributes "treatment delay", and in turn, drug-resistance. Of the total 776 patients at EN in 2024, 625 (i.e. 80%) accessed private care, trained as well as untrained.

LESSONS

In its journey to evolve a model community TB programme, Ekta Niketan has the following learnings in rural India

- The spread of TB in marginalised communities is in a precarious situation.
- Quality TB care is not available where the spread of the disease is most.
- The Public-Private partnership is a challenge in TB care for marginalised populations; lack of training add to treatment delay and drug resistance.

