



**TATHASTU**  
Institute Of Civil Services

# DAILY CURRENT AFFAIRS

## 24th March 2025



**TATHASTU**  
Institute Of Civil Services

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## THE HINDU ANALYSIS

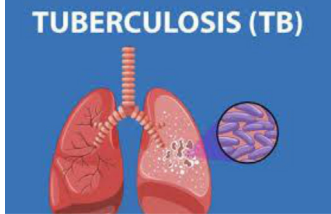
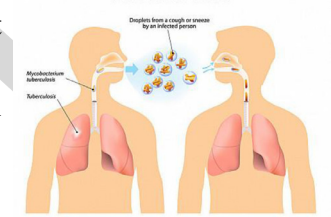
- **World TB Day - 24th March**
- **The need for universal and equitable health coverage**
- **TB treatment success rates are improving gradually in India**
- **The complex struggle for 'Kurdistan'**

## World TB Day - 24th March

### World TB Day

- **Date & Significance:**
  - ◆ Observed every year on **March 24** to raise awareness about **tuberculosis (TB)** and efforts to eliminate it.
  - ◆ Commemorates the discovery of the **TB-causing bacterium (Mycobacterium tuberculosis)** by **Dr. Robert Koch** in **1882**.
- **Status of TB in India:**
  - ◆ India has the **highest TB burden in the world**, contributing over **25% of global cases**.

### TUBERCULOSIS



**Tuberculosis (TB)** is a contagious disease, usually caused by bacteri a called **Mycobacterium tuberculosis**, that primarily affects the lungs but can also impact other parts of the body. It spreads through the air when people with lung TB cough, sneeze, or spit, and while curable with antibiotics, untreated TB can be fatal.

## The need for universal and equitable health coverage

- **Progress in TB Care in India**
  - ◆ Expansion of **molecular testing** for rapid TB and drug-resistance detection.
  - ◆ Increase in **Ni-Kshay Poshan Yojana (NPY)** benefits to ₹1,000 per month for nutrition support.
  - ◆ **TB preventive therapy** rollout and increased **community involvement**.
  - ◆ **Decline in TB incidence**
- **Challenges with Vertical Health Programmes**
  - ◆ India's health system has traditionally relied on **vertical programmes** like NTEP.
  - ◆ While effective, these programmes **limit integration with general healthcare services**.

### The need for universal and equitable health coverage

**India** has made substantial and tangible progress in Tuberculosis (TB) care, adopting new strategies to detect, treat and prevent TB. Some key areas of progress include the expansion of molecular testing for rapid detection of TB and drug resistance; the introduction of the shorter, all-oral BPaLM regimen (a combination of four drugs, Bedaquiline (B), Pretomanid (P), Linezolid (L), and Moxifloxacin (M)); doubling of the entitlement under the Ni-Kshay Poshan Yojana (NPY) for nutrition support to ₹1,000 a month; roll-out of TB preventive therapy; and an expanded role for communities through the involvement of TB survivors and Champions. The impact of the roll-out of these strategies can be seen in the 17% decline in TB incidence in India, from 227 per 1,00,000 population in 2015 to 195 per 1,00,000 population in 2022, in tandem with a 21.4% reduction in TB-related deaths.

Since Independence, India's public health system has delivered these control services through primarily vertical health programmes, such as the National Tuberculosis Elimination Programme (NTEP). While this vertical nature has allowed for concentrated focus and brought benefits in many ways, it has also been limiting. Integration of TB services within the broader public health system is key to India's pursuit of equitable, universal health coverage (UHC) for all.

**Decentralising TB care for all**  
The ambitious Ayushman Bharat National Health Protection Scheme was launched in India in 2018 to provide UHC for the Indian population. Today, TB has been integrated within both key components of Ayushman Bharat: the Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), considered the world's largest insurance scheme, which provides a comprehensive basket of primary health care services in rural and urban India. From the perspective of a person with TB symptoms, the best experience would be accessing consistently high-quality services at the first point of contact. The integration of TB services into the AB primary care system is designed to meet this need, bringing together diagnostic and preventive care under one umbrella. AAMs serve as spatio-temporal collection centres, where people with TB symptoms can give samples for testing. The NTEP has also been optimising sample collection and transportation methods through a diagnostic network optimisation exercise. A person diagnosed with TB at a secondary or tertiary care facility can undergo treatment at the health centre closest to their residence, again saving time and costs. In the first two months when people with TB are weak and drop out as well as mortality is highest, community health officers positioned at the AAMs and their teams must be trained to identify and refer such patients for admission.

While TB services have been free within the public health system, over 50% of all people with TB symptoms continue to seek care in the private sector. Uneven standards of care across the vastly heterogeneous private health sector has led to delays in diagnosis and contributed to poor outcomes as well as significant out-of-pocket expenditure (OoPE) for families. It is imperative to strengthen referrals from the private to the public health system, particularly for those who cannot afford to incur substantial expenditure on health and who may not be aware that TB services are freely available in the public health system. It is equally essential to ensure that the AB PM-JAY provides full insurance coverage for those who seek care for TB in the private or public sector, particularly those who are severely ill.

**Equitable and decentralised care for all**  
What does the road to equitable TB care look like? There are five key steps we can take to accelerate our progress towards TB elimination and universal health coverage (UHC).  
First, while we work to achieve decentralisation, we must strengthen person-centred care approaches, and deliver them at scale. There have been model interventions in several States that have assessed people with TB for social and clinical vulnerabilities and linked them to care. In Tamil Nadu, the Tamil Nadu Kaanoor Erapala Thalam (TKERT), or "TB death-free project", has been successful in achieving reduced TB mortality through a robust system of identifying those most vulnerable or sick, and referring them for a brief period of admission. Similarly, there have been other interventions focusing on tribal communities, migrants, and homeless populations. One clear pathway to achieving UHC and increased utilisation of the public health system is by strengthening investment in the traditional 'supras' for health and streamlining their functioning – human resources, supplies and infrastructure.  
Second, we must develop mechanisms to recognise interconnections. Multiple factors such as gender, age, caste, disability, socio-economic status, and occupation determine health seeking intent and access to health and TB services. The interconnection of these aspects of identity can both positively and adversely impact TB outcomes. The NTEP has adopted the national framework for a gender responsive approach to TB, recognising that women, men, and LGBTQIA persons experience TB differently. Improving understanding of gender will take time, and inevitably challenge personal behaviours and norms, but is essential to equitable care. Similarly, there has been some early work to better understand TB and disability, which must be built upon.  
Third, integrated care remains a challenge for India's health system. How do we ensure that someone who comes with TB symptoms is tested for Chronic obstructive pulmonary disease (COPD) or asthma? How can a person with TB be screened for depression or hypertension and linked to appropriate services and counselling? We must adopt models of integrated general health screening in community settings, for example, test for TB and COPD through validated Artificial Intelligence (AI)-enabled chest x-rays and sputum molecular testing, along with screening of common non-communicable diseases through blood pressure, blood glucose, and body mass index (BMI) monitoring.  
Fourth, UHC approaches are centred around minimising OoPE, thereby eliminating health-related debt. Schemes such as the Aary have helped alleviate the financial burden on families, by providing monetary support for access to nutritious food. Case-finding approaches, such as the ongoing '100 Days' campaigns, can help reduce OoPE prior to diagnosis. However, there are still several significant indirect costs that remain. Expanding social protection by extending nutrition support to the family, piloting wage loss schemes to offset a loss of income during TB treatment and ensuring livelihood programmes for TB survivors are potential first actions.

**Lessons from COVID-19, communication**  
Finally, equity in terms of access to information and knowledge is critical. TB remains severely misunderstood. Recall how widely we were able to extend public understanding of COVID-19 through a flood of science-based information using a multitude of platforms. We need similar approaches for TB, to encourage people to seek care and adopt simple measures to reduce transmission within homes and communities. Promoting knowledge about drug resistant TB, in the context of growing anti-microbial resistance (AMR) is vital. Decimating TB stigma is critical to ensuring early detection and successful treatment outcomes for people with TB.  
An equitable TB programme is one where every individual receives the highest quality of person-centred care that takes into account individual needs. Equity is a cornerstone of health care, and is essential to achieving TB elimination and universal health coverage. India's TB response is well-poised to define global standards and benchmarks. Applying the equity lens will only accelerate our progress.

**Dr. Soniya Samarthan**  
is Chairman, N.S. Sasmithan Research Foundation (NSRF)

**WORLD TB DAY**





- ◆ Decentralisation of TB care is essential for **Universal Health Coverage (UHC)**.
- ◆ Over **50%** of TB patients seek **private care**, leading to **high out-of-pocket expenditure (OOPE)**.

- **Integration of TB Care**

- ◆ **Ayushman Bharat (AB-PMJAY)** integrates TB services into health coverage.
- ◆ **Ayushman Arogya Mandirs (AAMs)** offer primary TB diagnosis, treatment, and prevention.
- ◆ Local health centres **reduce cost** and **travel burden** for TB patients.

- **Steps for Equitable TB Care and UHC**

1. **Person-Centered TB Care**

- ◆ **State-led interventions** to address social and clinical vulnerabilities.
- ◆ Example: **Tamil Nadu's TB death-free project (TN-KET)** successfully reduced mortality.
- ◆ Special focus on **tribal communities, migrants, and the homeless**.

2. **Recognizing Intersectionalities in Healthcare**

- ◆ **Gender, age, caste, disability, and socio-economic factors** impact TB outcomes.
- ◆ **National gender-responsive TB framework** addresses gender-specific TB challenges.

- **Reducing Financial Burden**

- ◆ **Minimizing OOPE** to prevent **healthrelated debt**.
- ◆ **Expanding social protection:**
  - **Nutrition support** for families of TB patients.
  - **Wage-loss compensation** during TB treatment.
  - **Livelihood support** for TB survivors.

4. **Awareness and Reducing Stigma**

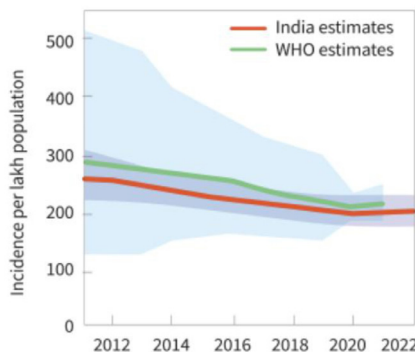
- ◆ **Learning from COVID-19** to improve **public awareness** of TB.
- ◆ **Science-based communication campaigns** to promote early diagnosis and care.
- ◆ **Fighting stigma** associated with TB to improve treatment success rates.

**TB treatment success rates are improving gradually in India**

- **Decline in TB Cases & Deaths**

- ◆ In **2015**, **237 people per lakh** had TB. By **2022**, this dropped **below 200 per lakh** (a **16% decrease**).

**Chart 1:** The chart shows the incidence of TB per lakh population



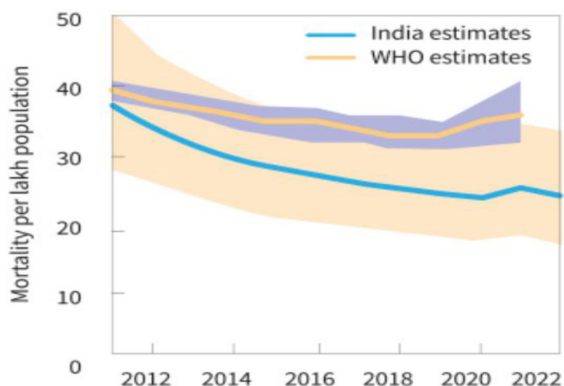


TB mortality was 23 per lakh population — an 18% decline compared to 2015

28 deaths per lakh population in 2015

23 deaths per lakh population in 2022

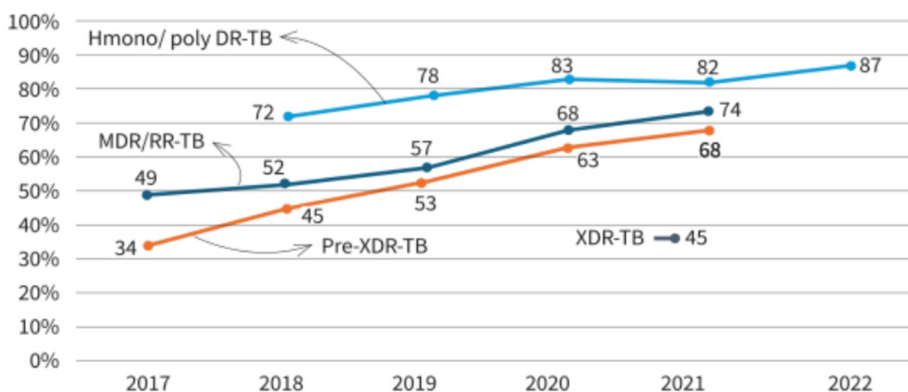
**Chart 2:** The chart shows the TB mortality per lakh population



### TB treatment success rates are improving gradually in India

- **TB Treatment Success Rates (2021)**
  - ◆ **Severely drugresistant TB: Lowest success rate at 45%.**
  - ◆ **MDR/RR-TB (multidrug-resistant TB): 74% success rate.**
  - ◆ **Pre-XDR-TB (more resistant form of MDR-TB): 68% success rate.**
  - ◆ Overall, **treatment success rates are improving over time.**

**Chart 3:** The chart shows the trend of treatment success rate of M/XDR-TB patients



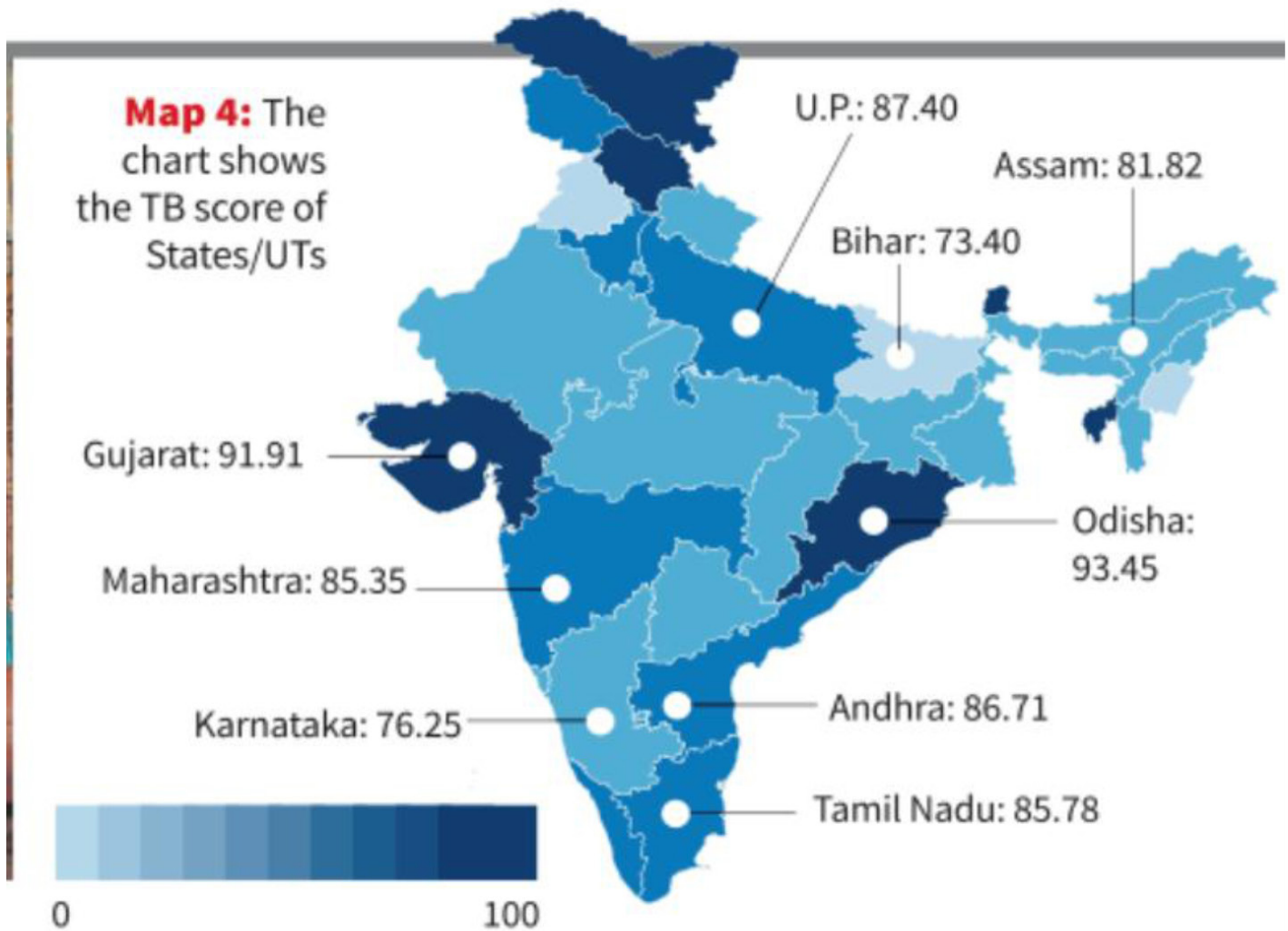
XDR-TB: Extensively Drug-Resistant TB, MDR/RR-TB: Multidrug-Resistant/ Rifampicin-Resistant TB

Treatment success rate for XDR-TB — forms of tuberculosis resistant to isoniazid, rifampicin, any fluoroquinolone, and at least one second-line injectable drug — is the lowest at 45% in India in 2021

- **Best & Worst Performing States in TB Control**
  - ◆ **Top States:** Himachal Pradesh, Odisha, Gujarat.
  - ◆ **Bottom States:** Punjab, Bihar, Karnataka.



**Map 4:** The chart shows the TB score of States/UTs



- **High Health Costs for Families**

- ◆ 10% of Indians spend a huge part of their income on healthcare— **one of the highest rates** among similar-income countries.
- ◆ Even though **60% of Indians** have health insurance, **many still struggle with high medical expenses.**

### The complex struggle for 'Kurdistan'

**The Struggle to Become a People** The Kurds, a **traditionally nomadic society**, are spread across Turkiye, Syria, Iran, Iraq, and Armenia.

Unlike Armenians and Turks, they never united under a single identity, preventing them from securing a state when European powers redrew borders after World War I. The **Treaty of Sevres (1920)** came closest to granting them autonomy, but internal divisions and political realities left them stateless.



### A Revival of the Movement

After decades of repression, the Kurdish identity reemerged in the 20th century.

Economic changes created a Kurdish working class, fueling nationalist sentiments.

Political polarities deepened, leading to the formation of left-wing Kurdish movements, including the **Kurdistan Workers' Party (PKK)** in 1978, which played a defining role in the struggle.





### The Emergence of the PKK

The **PKK**, led by Abdullah Öcalan, **adopted a Marxist-Leninist ideology** and launched an armed struggle.

It targeted the Turkish state, right-wing factions, and Kurdish elites who cooperated with the government. Over time, it expanded influence beyond Turkiye, forming alliances with Kurdish groups in Syria (PYD), Iran (PJAK), and Iraq (PCDK).



### International Dynamics

While **Turkiye, the U.S., and the EU** designate the **PKK as a terrorist organisation**, Russia does not. The **PKK** has historically received Soviet-era support.

In Iraq, the **semi-autonomous Kurdistan region** flourished but faced setbacks after an unsuccessful **2017 independence referendum**. In Syria, Kurdish forces (YPG) gained control during the civil war but later faced uncertainty after U.S. policy shifts.

### The Future of Kurdistan

On **March 1, 2024**, the **PKK declared a ceasefire** with Turkiye, following Öcalan's call for disarmament. With shifting alliances and geopolitical realities, the future of a Kurdish state remains uncertain.

#### Quorum - 1

**Q. With reference to Tuberculosis (TB) in India, consider the following statements:**

1. The incidence of TB in India increased in past decade.
2. TB mortality in India declined in past decade.
3. The treatment success rate for Multi-Drug Resistant (MDR) TB in India was above 90% in 2021.
4. India has the highest TB burden in the world, contributing over 25% of global cases.

Which of the statements given above is/are correct?

- (a) 1 and 4 only      (b) 2 and 4 only  
(c) 2 and 3 only      (d) 1, 2, 3 and 4

#### Quorum - 2

**Q. Consider the following countries:**

1. Turkiye    2. Syria    3. Iran    4. Iraq    5. Armenia

**The Kurdish people are traditionally found in which of the above countries?**

- (a) 1, 2, and 3 only      (b) 1, 3, and 4 only  
(c) 1, 2, 3, 4, and 5      (d) 2, 3, and 5 only

