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Strengthening Immunisation to Achieve TB Mukt Bharat

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Abstract

BCG vaccination and TB elimination run, in most districts, as if they were separate programmes — one delivered through routine immunisation in early infancy, the other engaging a child only once TB is suspected or an adult household case is notified. This article treats the two as points on a single continuum of paediatric TB prevention, examines why they've stayed separate despite the underlying clinical link, and makes a practical, low-cost case for integrating immunisation services with TB Mukt Bharat's contact-tracing and TPT efforts.

BCG Is Necessary, Not Sufficient

BCG's protection against severe, disseminated childhood TB — miliary disease, TB meningitis — is well established, and India's coverage is genuinely high, the product of decades of sustained immunisation investment that deserves real credit. But BCG doesn't reliably prevent pulmonary TB or infection itself, and whatever protection it confers wanes over childhood. Treating strong BCG numbers as evidence that the immunisation programme's job in TB prevention is done overstates what one vaccine, given once near birth, can achieve across a whole childhood of household exposure.

I have heard this assumption voiced in programme meetings more than once — that high coverage numbers amount to adequate paediatric TB prevention. They don't, and treating them that way leaves the household-exposure pathway, which accounts for most paediatric TB, essentially untouched by a service with enormous reach into the population.

The Missed Point of Contact

Immunisation services see nearly every child in the country repeatedly through the first two years of life — a level of coverage and repeated contact nothing else in the system matches. Yet these visits don't routinely include even a basic TB household-exposure question, despite being an ideal, high-frequency opportunity to catch contacts who need referral, long before a child is unwell enough to bring in on their own.

One question added to the existing counselling script — has anyone at home had a cough that won't go, or been diagnosed with TB — costs almost nothing in time or training, and reaches households the TB programme's notification-triggered pathway might not touch as quickly on its own.

Why Immunisation Workers Are Well Placed

ANMs, ASHAs, and vaccinators already run structured household counselling as routine work, covering feeding, danger signs, follow-up scheduling. Adding one screening question to an already-structured interaction is a smaller lift than asking a different cadre to take on something new from scratch. The trust

and the structure already exist; what's missing is the question, and a clear pathway for what happens if the answer raises a flag.

What Integration Would Actually Take

This is mostly administrative, not resource-heavy — worth saying plainly, since proposals framed as needing large investment tend to stall regardless of merit. Immunisation workers need a simple referral pathway when household risk shows up. TB programme staff need to treat immunisation-linked referrals as an expected input, genuinely built into their workflow, not an unfamiliar one arriving with no process to handle it.

District pilots that bring immunisation and TB supervisors into the same review meeting, even quarterly to start, are a realistic and cheap first step, well short of any state or national protocol change — and they'd surface the real snags in a referral pathway while the effort is still small enough to fix.

Conclusion

TB Mukt Bharat and the immunisation programme are, right now, parallel successes that barely talk to each other operationally, despite reaching overlapping children with overlapping goals. Closing that gap doesn't need much new money. It needs a decision to treat the country's highest-coverage child health touchpoint as part of the TB prevention pathway it's already, structurally, well placed to serve.

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