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D.O. No: Z-28015/64/2021-TB
6th August, 2025

Subject: Expansion of TB Preventive Treatment (TPT)

Dear STOs,

The National Tuberculosis Elimination Program (NTEP) is advancing towards elimination with expedited diagnosis of TB, appropriate treatment, and prevention through molecular diagnostics, optimized treatment regimens, and broader access to TB preventive treatment (TPT) to curb transmission and enhance patient outcomes.

Guidelines for Programmatic Management of Drug-Resistant TB and TB Preventive Treatment in India have been released by Hon'ble Union HFM on 5th August 2021.These guidelines include the policy for expansion of preventive treatment in household contacts, PLHIVs and Other risk groups. Based on these guidelines all states are requested to scale up 3HP among pediatric age group and household contacts (HHC) of drug sensitive TB, 6Lfx for HHC of MDR-TB index patients (in whom FQ resistance has been ruled out) and 4R for HHC of H resistant index patients (in whom R resistance has been ruled out) in all age groups.

Systematic reviews and meta-analyses have demonstrated HHCs of patients with MDR/RR-TB and H mono/poly DR-TB face a significantly higher risk of TB infection. Treatment for MDR-TB infection has shown to reduce the risk of TB incidence, highlighting its effectiveness in preventing progression to MDR-TB. Additionally, cost-effectiveness analyses confirm that implementing preventive treatment strategies such as 6Lfx or 4R (based on the resistance pattern) is a valuable intervention in mitigating the spread of drug-resistant TB.

In October 2021, TPT in contacts of DR-TB patients was introduced in 12 states (Andhra Pradesh, Telangana, Delhi, Gujarat, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Meghalaya, Odisha, Punjab and Assam) for gaining in-country experience. Based on the successful implementation in these states, all states are now instructed to initiate 6Lfx and 4R as TPT among those eligible HHCs.

The following points are to be followed:

- States are requested to **plan and conduct trainings** at the state, district, and block levels for program staff and clinicians on implementing 6Lfx and 4R among household contacts (HHCs) of MDR/RR-TB patients.
- **Ruling out active TB** is essential for identifying eligible HHCs. This should be done through 10 symptom assessment and chest X-rays (CXR), followed by upfront nucleic acid amplification testing (NAAT) among all eligible.
- States must **ensure all DS-TB patients are tested for First line LPA testing and all DR-TB patients are tested for Second line LPA**.
- States should assess requirement and raise indent to **ensure sufficient stock** of 6Lfx and 4R drugs at respective centres for smooth implementation and dispensation through Ni-kshay.
- **Monitoring progress** of all those initiated on TPT (6Lfx or 4R or 3HP or 6H) is crucial for adherence and treatment outcomes. This should be tracked through Ni-kshay's 'Contact and Other Risk Group' register.
- States/UTs are requested to proactively **scale up implementation of the 3HP regimen** for pediatric age among contacts of drug sensitive (DS) TB patients' group (2–14 years) as per weight bands as mentioned in the annexure III attached.

For any queries and concerns, please feel free to contact us.

(Prof.) Dr. Urvashi B Singh

To,
State TB Officers All State/UT's

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6th August, 2025

Copy to:
1. AS&MD (NHM), MoHFW
2. Addl. Commissioner (CTD&CV AC)

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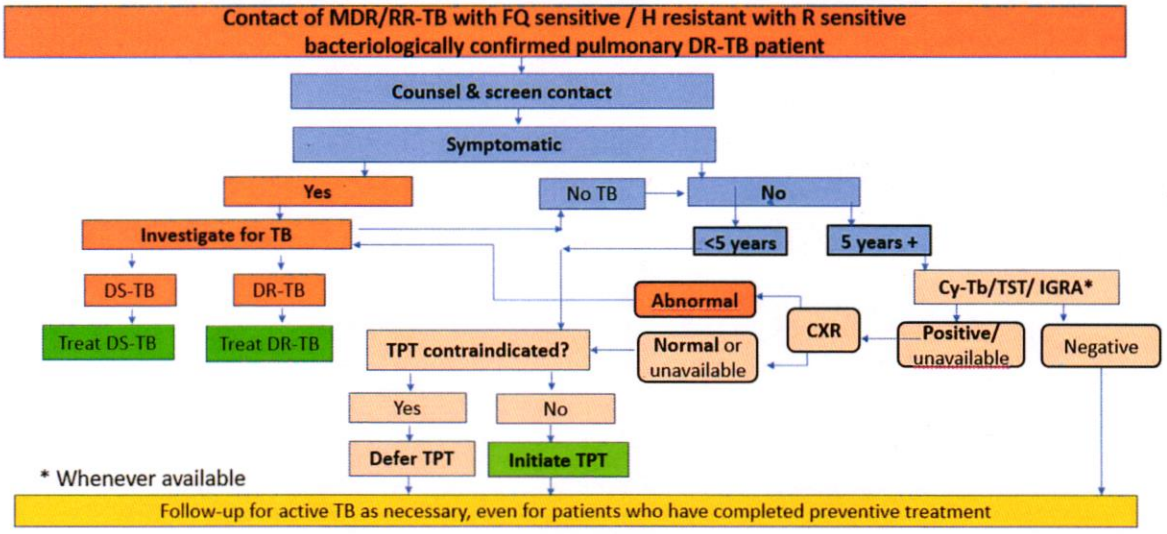
Annexures

1. Annexure I: Integrated algorithm for screening and ruling out active TB among household contact of DR-TB
2. Annexure II: TPT regimen and dosages for Contacts of DR-TB index patients
3. Annexure III: TPT 3HP regimen and dosages in pediatric age group

Annexure I: Integrated algorithm for screening and ruling out active TB among household contact of DR-TB



- Once a DR-TB patient is identified, all HHCs are counselled, screened and evaluated to rule out active TB;
- NAAT is used upfront among contacts with 10 symptoms or abnormal chest X-ray to diagnose TB;
- If the result is MTB detected with no resistance, the treatment for DS-TB is initiated.
- If the result is MTB detected with H and/or R resistance, manage as per DR-TB guidelines.
- If the result is MTB not detected, in HHC <5 years, assess for TPT and check for any contraindications.
- If the result is MTB not detected, in HHC >5 years of age and chest X-ray is normal or unavailable, with TBI test positive or unavailable check for any contraindications to TPT.
- If contraindications to TPT drugs exist, defer TPT and if no contraindication exists, offer TPT regimen as appropriate based on DST pattern of the index patient; and
- **All individuals after TPT completion should be followed up at 6 monthly intervals for 2 years** (ie. 6 months, 12 months, 18 months, 24 months)

Annexure II: TPT regimen and dosages for Contacts of DR-TB index patients

Regimen	Dose by age and weight band
Six months of daily levofloxacin (6Lfx) for contacts of R resistant FQ sensitive patients# Tab levofloxacin is available in the strength of 250 mg and 500 mg	Age > 14 years, by body weight: < 45 kg, 750 mg/day; ≥ 45 kg, 1g/day Age < 15 years (range approx. 15–20 mg/kg/day), by body weight: 5–9 kg: 150 mg/day 10–15 kg: 200–300mg/day 16–23 kg: 300–400mg/day 24–34 kg: 500–750mg/day
Four months of rifampicin daily (4R) for contacts of H resistant R sensitive patients*	Age 10 years & older: 10 mg/kg/day@ Age <10 years: 15 mg/kg/day (range, 10–20 mg)
# Lfx 100 mg dispersible tablets available for children. Children receiving 6Lfx should be watched for joint abnormalities. * In children from 0-14 years, 4R should only be used after ruling out active TB in limited geographies/populations for evidence generation to guide future scale up for country wide implementation. @ Maximum dose of R would be 600 mg/day. Note: 6H can be considered as the TPT regimen option for contacts of index patients with RR-TB with FQ and H sensitive, after ruling out active TB in them.	

Annexure III: TPT 3HP regimen and dosages in pediatric age group regimen among contacts of drug sensitive (DS) TB patients.

Three months of weekly rifapentine plus isoniazid (12 doses) (3HP)	**Age 2-14 years**					
	Medicine, formulation	10–15 kg	16–23 kg	24–30 kg	31–34 kg	>34 kg
	Isoniazid, 100 mg	3	5	6	7	7
	Rifapentine, 150 mg	2	3	4	5	5
	Isoniazid + rifapentine FDC (300 mg/300 mg)	1	1+1/2	2	2+1/2	2+1/2