CORRESPONDENCE

Challenges in expanding TB preventive therapy in high-burden settings: beyond logistics is evidence and ethics

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Dear Editor,
Tuberculosis (TB) preventive therapy (TPT) is the treatment of latent *Mycobacterium tuberculosis* infection (LTBI) with select drug regimens to prevent progression to TB disease. Breaking the chain of transmission of an infectious disease like TB, which has humans as the primary reservoir, is only feasible through drug treatment of LTBI or through the development of an effective vaccine that is currently unavailable.

Although TPT is considered a high-impact intervention on the road to TB elimination, application in high-burden countries has been predominantly restricted to children and people living with HIV (PLHIV), while omitting other close contacts of index TB cases.¹ Masini et al. have highlighted this public health challenge, wherein an estimated 30 million TPT-eligible beneficiaries globally are missed out due to operational and logistical issues.² Odume et al. has also shown the effectiveness of addressing the procurement challenges of isoniazid (INH) in augmenting the acceptability and uptake of TPT among the PLHIV in Nigeria.³ In high-risk populations such as PLHIV, who have an estimated 16–27 times higher risk of progression to TB disease,¹ logistical support, political will and financial commitments alone may be adequate in reaching and promoting TPT uptake in the target population. Nevertheless, there is still an absence of global country-level consensus on the expansion of TPT to contacts of active TB cases, including those at higher risk of LTBI and progression to TB disease despite the availability of shorter and safer TPT regimens (3HP/1HP). These concerns in high-prevalence countries mostly stem from the lack of presumed benefit of TPT in the non-PLHIV populations due to the continued risk of reinfection, as well as secondary unresolved ethical dilemmas like the cumulative drug-related adverse effects and their associated healthcare costs.⁴ In

India, which accounts for nearly one fourth of the global TB burden, a study found that the perceived acceptability of TPT among clinicians was suboptimal despite a high perceived susceptibility of contracting TB disease from their patients.⁵

A successful implementation of expanded TPT services in developing countries beyond the PLHIV and paediatric contacts should explore the sociocultural acceptability of TPT in adult asymptomatic contacts of TB cases. Monitoring and surveillance to determine the rates of reinfection and disease complications in individuals who receive TPT for allaying concerns over safety and the additional healthcare costs is also required.¹ Finally, evidence-based policy for the implementation of a comprehensive TPT expansion policy in a developing country must surmount the ethical challenge of diverting scarce resources away from nutritional and health promotion programmes.⁵

In conclusion, strengthening evidence, building logistics and resolving ethical issues and conflicts comprise the three central pillars that support the expansion of TPT in existing high-burden settings.

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