



HEALTH SAMVAAD

Engage. Exchange. Empower. Enhance Health

Quarterly Newsletter

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Initiative by : Directorate of Family Welfare &
Delhi State Health Mission

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Foreword

Dear Esteemed Readers of *Samvaad*,

Tuberculosis (TB) remains a public health challenge, but Delhi is responding with renewed determination, science, and compassion under the National TB Elimination Programme (NTEP). Guided by the goal of ending TB, we are strengthening our response through early detection, patient-centred care, and sustained community engagement.

The key strategy interventions are intensified active case finding in vulnerable populations, focused outreach in high-risk municipal wards, better engagement of private sector, and comprehensive awareness drive to address the stigma and myths on TB. These efforts have improved detection of missing TB, strengthened linkage to treatment, and reduced the time between symptom onset and diagnosis.

Delhi is also embracing innovation. Portable handheld AI-enabled machines have been used for chest X-ray screening and predictive analysis to help us screen presumptive TB cases, including asymptomatic individuals who might otherwise be missed. The expanding use of the Ni-kshay digital platform, strict adherence monitoring, and ABHA-based registration of TB patients and AADHAR-based disbursement of incentives has made programme delivery more robust and outcome-oriented.

Policy initiatives such as TB Mukht Bharat Abhiyaan 100-Days intensified Campaign currently underway from 24 March 2026, nutritional support through Ni-kshay Poshan Yojana, providing food baskets to TB patients under Nikshay Mitra Initiative and the adoption of shorter, more effective treatment regimens for drug-resistant TB are improving adherence and outcomes.

These interventions are translating into stronger programmatic outcomes: early diagnosis, improved treatment success, and a more responsive and patient-centred health care delivery system. As we move forward, let us continue to combine innovation with equity to achieve TB-free Delhi.


(RUPESH KUMAR THAKUR)

Editors Desk



Dear Readers of *Samvaad*,

As we are aware that Tuberculosis continues to be a major public health challenge, but it is also a disease we can prevent, detect early, and cure with timely action. Under the National TB Elimination Programme Delhi, our strongest priority must be **early detection through comprehensive screening**, especially among vulnerable and high-risk populations, so that no case is missed and treatment begins without delay.

In this effort, chest X-ray screening through AI-based handheld machines is emerging as a powerful tool. By enabling faster identification of presumptive TB cases, it supports outreach in communities where access to diagnostic services may be limited. Combined with quality confirmatory testing through rapid molecular tests, prompt treatment initiation, and good quality patient-centred care, such innovation strengthens the entire continuum of services.

Equally important is the need to reduce stigma. Fear, misinformation, and social discrimination often prevent people from coming forward for testing and treatment. Through sustained awareness campaigns, community engagement, and communication tools, we can end stigma, build trust and encourage appropriate health-seeking behaviour. TB is curable, and no one should suffer in silence or shame. As we move ahead, let us reaffirm our commitment to public health action rooted in equity, dignity, and compassion. Early detection, quality care, and informed communities are the foundation of a TB-free Delhi.



(Dr.A.G. Radhika)



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Dear Readers of *Samvaad*,

Tuberculosis continues to remain one of our most important public health challenges for India as well as Delhi, but it is also a disease that can be defeated through early detection, timely treatment, and sustained community engagement. Under the National TB Elimination Programme Delhi, our foremost priority has been to strengthen TB screening at every peripheral level, particularly among vulnerable, under-served, and high-risk populations, so that no case is missed and every person in need of care is identified early.

In this context, chest X-ray screening through AI-based handheld machines has emerged as an important tool for decentralised mass screening. It enables faster triaging of presumptive TB cases, expands access to screening, and supports early diagnosis even in settings where conventional pathways may be delayed. With availability of rapid molecular testing tools, prompt treatment initiation, counselling, uninterrupted treatment support and financial incentives under Nikshay Poshan Yojana to improve treatment outcome, it contributes significantly to better outcomes and reduced transmission. At the same time, we must continue to raise awareness across communities, workplaces, schools, and households to dispel myths, reduce stigma, and encourage people to seek care without hesitation or fear.

I also extend my heartfelt gratitude to the Secretary (Health & Family Welfare), Delhi, the Mission Director, Delhi State Health Mission, the Director General Health Services, Delhi, and the entire NTEP team at the State and District levels for their commendable dedication and support. Their tireless efforts have strengthened the programme and brought us closer to our shared public health goals. I would also like to convey my regards to Editor of *Samvaad* for prioritizing TB through dedication of this edition to National TB Elimination Programme.

As we look ahead, we must intensify our efforts with even greater resolve, innovation, and collaboration. Together, let us work towards a healthier, more informed, and TB-free Delhi.

(Dr. Nilesh Saini)

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FEATURE ARTICLES

Key Programmatic Updates Under NTEP: TB Prevention Diagnosis & Treatment

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Healthcare providers often face confusion regarding the latest approaches to tuberculosis (TB) diagnosis, treatment, follow-up protocols, latent TB detection, and Tuberculosis Preventive Therapy (TPT). With rapid updates under the National TB Elimination Programme (NTEP), there is a growing need to simplify concepts and bridge knowledge gaps among healthcare professionals. This article aims to provide a practical and simplified overview of modern TB diagnosis, treatment strategies, preventive approaches, and recent programmatic developments under NTEP.

Latent TB vs Active TB – Understanding the Difference

Feature	Latent TB Infection (LTBI)	Active TB Disease
Disease Status	Person is infected with <i>Mycobacterium tuberculosis</i> but disease is inactive	Bacteria are actively multiplying and causing illness
Symptoms	No symptoms	May present with cough, sputum, fever, night sweats, hemoptysis, weight loss, breathlessness, or weakness
Infectiousness	Not infectious	Can transmit infection, especially pulmonary TB
Risk	Can progress to active TB in immunocompromised individuals (HIV, diabetes, malnutrition, etc.)	Requires prompt diagnosis and treatment
Common Sites	No active disease	Pulmonary or extrapulmonary involvement
Management	Screening and Tuberculosis Preventive Therapy (TPT) in eligible individuals	Full Anti-TB Treatment (ATT) required

Active TB may sometimes be asymptomatic or present with vague symptoms, particularly in extra-pulmonary TB, making clinical suspicion important.

A) Classification of Active TB – Simplified Approach

The earlier system of Category I, Category II, relapse, and defaulter has now been replaced with a simpler classification:

Major Classification	Types Included
Drug-Sensitive TB (DS-TB)	TB sensitive to first-line anti-TB drugs
Drug-Resistant TB (DR-TB)	RR-TB, Isoniazid-Resistant TB, H-mono DR-TB, H-poly DR-TB, MDR-TB, Pre-XDR TB, and XDR-TB

The revised classification enables more individualized, evidence-based, and patient-centric treatment approaches

B) Rapid Molecular Diagnostics – Recent Advances in Delhi

One of the major programmatic priorities under Delhi NTEP has been strengthening rapid molecular diagnostics for early and accurate detection of TB and drug resistance.

Modern Nucleic Acid Amplification Test (NAAT) platforms can detect TB from various body fluids including sputum, pus, pleural fluid, cerebrospinal fluid (CSF), and other clinical samples.

Commonly Used Molecular Diagnostic Platforms

- **CBNAAT (GeneXpert)**

CBNAAT remains the most commonly used first-line molecular diagnostic platform. It rapidly detects TB along with Rifampicin resistance. The system offers good sensitivity but requires air-conditioned laboratory settings.

- **Truenat**

Truenat is a portable, battery-operated platform particularly useful in peripheral and field settings. It does not require air-conditioning and is highly useful for decentralized testing. However, Rifampicin resistance detection requires an additional testing cycle.

- **PathoDetect**

PathoDetect is an advanced molecular diagnostic platform capable of simultaneously detecting TB along with Rifampicin and Isoniazid resistance in a single test, making it highly useful for dual resistance detection.

- **Culture and Line Probe Assay (LPA)**

Advanced drug susceptibility testing is performed at Intermediate Reference Laboratories (IRLs) and C&DST laboratories equipped with Biosafety Level-3 (BSL-3) facilities.

- **Liquid Culture (MGIT)**

Liquid culture systems such as MGIT provide faster culture positivity compared to solid culture methods. Positivity is generally detected within 10–21 days, while complete drug susceptibility testing may take 3–6 weeks.

- **Line Probe Assay (LPA)**

LPA enables rapid detection of resistance to first- and second-line drugs directly from sputum or cultured isolates, with results typically available within 3–5 days.

Test	Detects	Key Advantage	Limitations	Best Use Case
PathoDetect	TB bacteria + Rifampicin (Rif) + Isoniazid (INH) resistance simultaneously	Detects both Rif & INH resistance in one go	Bulky machine; requires air - conditioning (AC)	Ideal where dual resistance testing is priority
CBNAAT (GeneXpert)	TB bacteria + Rif resistance	Good sensitivity	Requires AC; detects only Rif resistance initially	Most common first -line test
Truenat	TB bacteria first, then Rif resistance (two -step process)	Portable, battery - operated, no AC needed; useful in field settings	Requires two cycles for Rif resistance detection	Field clinics, peripheral areas, and mobile screening

c) **DR-TB Treatment – A Major Paradigm Shift**

Drug-Sensitive TB (DS-TB) continues to follow the conventional HRZE regimen:

- Intensive Phase: 2 months HRZE
- Continuation Phase: 4 months HR

However, the management of Drug-Resistant TB has undergone a major transformation.

Earlier prolonged injectable regimens with significant toxicity are now being replaced by shorter, safer, all-oral regimens with improved treatment outcomes.

Treatment decisions for DR-TB remain complex and are guided by standardized national algorithms, drug replacement guides, Line Probe Assay results, and Culture & DST findings. District DR-TB Committees and Nodal DR-TB Centres located at RBIPMT, NITRD, AIIMS, and LNJP continue to guide individualized treatment selection.

Broad Categories of DR-TB Treatment

H-mono / H-poly DR-TB Regimen

Isoniazid-resistant TB is managed using a 6-month oral regimen of Levofloxacin, Rifampicin, Ethambutol, and Pyrazinamide (LfxREZ), with modifications as guided by DST and national replacement protocols.

Rifampicin-Resistant Regimens

BPaLM Regimen – The Preferred Regimen

The WHO-recommended BPaLM regimen (Bedaquiline + Pretomanid + Linezolid + Moxifloxacin) has emerged as the preferred six-month all-oral regimen for eligible MDR/RR-TB patients.

Eligibility criteria broadly include age ≥ 14 years, fluoroquinolone susceptibility, and no prior exposure to key drugs included in the regimen.

The regimen offers: shorter treatment duration, improved adherence, reduced toxicity, and significantly higher cure rates.

WHO aims for at least 90% of eligible DR-TB patients to be initiated on BPaLM.

Other Bedaquiline-Based Regimens

Patients not eligible for BPaLM are managed with shorter or longer Bedaquiline-containing oral regimens as per national guidelines.

In some patients, additional resistance detected during treatment may require regimen modifications according to CTD replacement guides. A small subset of extensively drug-resistant (XDR) patients may still require injectable drugs.

Simplified Overview of DR-TB Treatment Regimens

Regimen Type	Key Drugs / Regimen	Duration	Key Features	Eligibility / Remarks
H-mono / H-poly DR-TB Regimen	Levofloxacin + Rifampicin + Ethambutol + Pyrazinamide (LfxREZ)	6 months	Fully oral regimen; modifications guided by DST and national replacement protocols	Used for Isoniazid - resistant TB
BPaLM Regimen (Preferred WHO Regimen)	Bedaquiline + Pretomanid + Linezolid + Moxifloxacin	6 months	Shorter all-oral regimen with improved adherence, reduced toxicity, and higher cure rates	Eligible MDR/RR-TB patients aged ≥14 years, fluoroquinolone-sensitive, and without prior exposure to key drugs
Other Bedaquiline - Based Regimens	Shorter or longer Bedaquiline - containing regimens	Variable	Oral regimens tailored as per resistance pattern and national guidelines	Used in patients not eligible for BPaLM
Modified / Individualized Regimens	Drug modifications based on DST, LPA, and CTD replacement guides	Variable	Regimens adjusted if additional resistance emerges during treatment	Managed through District DR-TB Committees and Nodal DR-TB Centres
Injectable - Containing Regimens	Selected second -line injectable drugs with individualized regimens	Variable	Reserved for limited complex cases	Some XDR-TB patients may still require injectables

D) Latent TB and Tuberculosis Preventive Therapy (TPT)

One of the important focus areas under NTEP has been scaling up Tuberculosis Preventive Therapy (TPT) among vulnerable populations.

The principle remains:

“Always rule out active TB before initiating preventive therapy.”

High-risk asymptomatic individuals such as household contacts, people living with HIV, diabetics, malnourished individuals, and children under five years

Undergo screening with chest X-ray. If the chest X-ray is normal, Cy-TB testing may be performed.

Cy-TB Testing

Cy-TB is a modern IGRA-based intradermal skin test that is more specific than the traditional Tuberculin Skin Test. A reaction of ≥ 5 mm after 48 hours is considered positive.

Individuals with positive Cy-TB results are eligible for Tuberculosis Preventive Therapy (TPT).

Despite strong WHO recommendations, TPT uptake in India remains suboptimal, largely due to provider hesitancy and lack of awareness. However, scaling up TPT is expected to significantly reduce future TB burden.

E) Digital Innovations Under NTEP

Digital technologies continue to strengthen surveillance, treatment monitoring, adherence support, and patient engagement.

I. Ni-kshay Portal

The national web-based platform for TB notification, patient registration, treatment monitoring, adherence tracking, and Direct Benefit Transfer (DBT).

II. TB Aarogya Sathi App

A patient-centric mobile application providing information on symptoms, medicines, side effects, nearby TB centres, treatment progress, and DBT details.

III. 99DOTS

A mobile-based adherence monitoring system using specially designed blister packs with hidden toll-free numbers for dose reporting and remote adherence monitoring.

IV. TB Mukh Bharat App

An unified platform supporting patients, healthcare workers, and Ni-kshay Mitras. It includes multilingual AI-enabled support through the chatbot “Khushi,” nutrition kit tracking, reminders, and community engagement tools.

V. National TB Call Centre – Ni-kshay Sampark

The national multilingual support helpline (1800-11-6666) operates seven days a week from 7 a.m. to 11 p.m. for counselling, patient support, and grievance redressal.

Conclusion

Delhi NTEP continues to strengthen rapid diagnostics, sample transport systems, preventive therapy implementation, and modern DR-TB treatment approaches as part of India's goal of TB elimination.

By updating our knowledge, removing outdated concepts, and adopting evidence-based modern practices, healthcare providers can diagnose earlier, treat smarter, improve adherence, and prevent future cases more effectively.

TB PREVENTIVE THERAPY IN DELHI

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Delhi sits at the sharp end of India's tuberculosis burden. With the Annual Case Notification Rate (ACNR) exceeding 500 cases per 100,000 population in recent years, Delhi is among the highest TB-burden cities in the world. Treating active disease alone will never bend that curve.

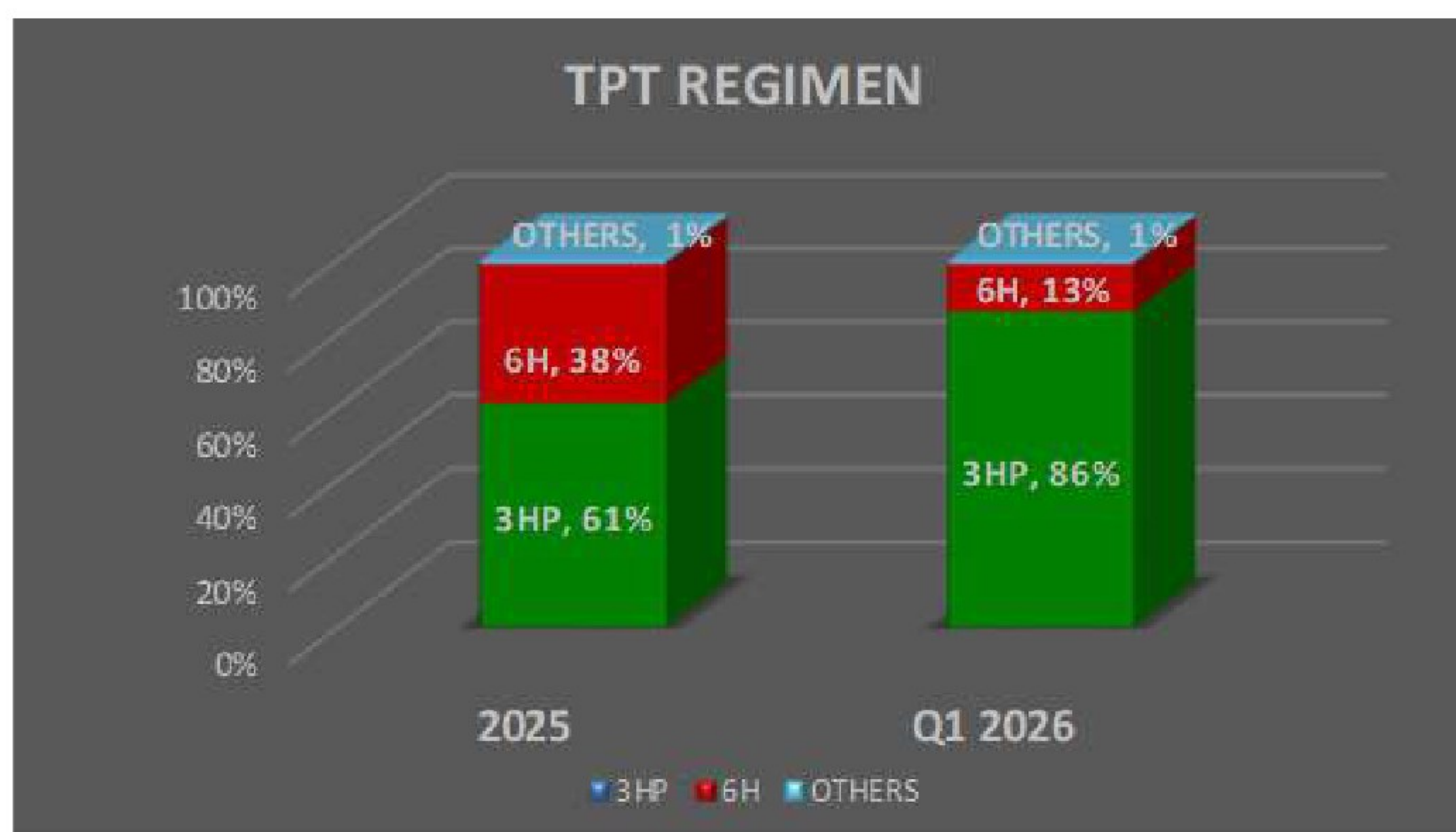
While the global TB research pipeline holds promise, no novel TB vaccine is expected to reach public health programmes for at least the next five years. In the interim, the available arsenal for TB prevention remains essentially two-pronged: Airborne Infection Control (AIC) and TB Preventive Treatment (TPT). AIC addresses transmission at its source, through administrative measures like early case detection and cough hygiene, environmental controls such as ventilation and ultraviolet germicidal irradiation, and personal respiratory protection, thereby reducing the probability that an exposed individual acquires infection in the first place. TPT, by contrast, acts downstream, targeting those already infected with *M. tuberculosis* and preventing progression to active disease. Together, these two strategies represent the only currently scalable, evidence-based tools for reducing TB incidence beyond case finding and treatment.

The TPT rollout in Delhi has entered a new phase: shorter, more tolerable regimens of TPT now dominate, PLHIV have a shorter option, contacts of drug-resistant TB patients are covered for the first time, and a more specific, intradermal TB infection test has been deployed. Delhi's own programmatic data now shows both what is working and how much further there is to go.

From 6H to 3HP: A Shift Already Complete

For most of the programme's history, six months of daily isoniazid (6H) was the only available regimen of TPT. Daily treatment for six months is hard to sustain in a dense, working-class city, which affects the adherence and completion rates in addition to its acceptability among House Hold Contacts (HHC). The nationwide rollout of 3HP (three months of once-weekly isoniazid plus rifapentine) has materially changed that.

Delhi's own data captures the pace of the shift in real time. In 2025, 3HP accounted for 61% of all TPT regimens initiated in Delhi, with 6H still making up 38%. By Q12026, 3HP had reached 86% and 6H had fallen to just 13%, a near-complete transition in under a year.



1HP for PLHIV and Regimens for DR-TB Contacts

For people living with HIV (PLHIV), NACO's December 2024 guidance introduced 1HP -one month of daily isoniazid plus rifapentine, just 28 doses as the preferred regimen at ART centers, tracked through Ni-kshay. With PLHIV at dramatically elevated risk of TB progression, maximizing completion is clinically critical, and 1HP's ultra-short duration addresses a major barrier to adherence.

For household contacts of MDR/RR-TB patients, previously excluded from TPT, NTEP now recommends 6Lfx (six months of daily levofloxacin) and 4R (four months of daily rifampicin) depending upon the resistance pattern of the index patient. Delhi was among twelve states and UTS where this was first piloted from October 2021.

Cy-TB: Precision Infection Testing, Improving Access

Infection testing has also improved. Cy-TB, developed by the Serum Institute of India and introduced under NTEP policy, uses M. tuberculosis-specific antigens, the same ESAT6/CFP-10 platform underlying IGRAs delivered as a skin test. Its key advantages are improved specificity compared to tuberculin sensitivity testing (TST) and cost effectiveness as compared to Interferon Gamma Release Assay (IGRA). Cy-TB tests are currently approved for 18 years and above, and when available are used among HHC and other vulnerable group to test for TB infection after ruling out active TB disease. If the test is positive, patient is counselled and TPT is provided.

TPT Care Cascade in Delhi

In 2025, Delhi notified 1,00,186 TB patients, with an estimated 3,00,558 household contacts. Of these, 1,20,513 were enrolled, a 40% enrolment rate. By Q1 2026, that rate had improved to 56%, with 41,307 contacts enrolled from an estimated 73,830, a meaningful upstream gain.

TABLE 1- HOUSEHOLD CONTACT ENROLMENT

PERIOD	NOTIFIED TB PATIENTS	ESTIMATED HHC (NOTIFIED * 3)	HHC ENROLLED	% ENROLLED
2025	100186	300558	120513	40%
Q1 2026	24610	73830	41307	56%

TABLE 2- ELIGIBILITY TO TPT INITIATION

PERIOD	ENROLLED HHC	ELIGIBLE HHC	PROVIDED TPT	% PROVIDED TPT
2025	120513	92070	39432	42.8%
Q1 2026	41307	34185	15137	44.3%

Despite rising contact enrolment, getting eligible household contacts to actually start TPT remains a challenge. In 2025, 43% of eligible contacts were initiated on preventive treatment, with only marginal improvement to 44% in Q1 2026. More contacts are being reached and screened than before, which is encouraging. The gap now lies in converting an eligible contact into a treated one.

The major hindrance to starting TPT among eligible persons is hesitancy. Two forms of hesitancy contribute. Provider hesitancy, more common in the private sector, means eligible contacts are assessed but not always started on treatment. Beneficiary hesitancy is more pronounced. A person who feels well has little immediate motivation to take months of medication, and health-seeking behavior for preventive care is still developing in the community.

The programme is responding by pairing structured counselling with Cy-TB skin testing. A positive test result gives the contact something tangible, personal evidence of infection, which can meaningfully shift the conversation from abstract risk to concrete action.

The Path Forward

Delhi's TPT programme in 2025-26 looks genuinely different from three years ago. The near complete transition to 3HP, the addition of 1HP for PLHIV, the extension of 6Lfx and 4R to DRTB contacts, and the availability of Cy-TB for precise infection testing represent real, consequential programmatic advances. Contact enrolment is rising meaningfully from 40% to 56% in a single quarter.

Yet the data are unambiguous: being enrolled and being treated remain two entirely different things. The eligibility-to-initiation gap is stuck at 43-44% and has not moved despite rising enrolment upstream. Closing that gap through expanding TB infection testing and treatment to the private sector, reliable supply chain reaching every District TB Centre, task-sharing with ASHAs and community health workers, and streamlined Ni-kshay documentation could improve the rate of decline in notifications and other performance indicators and reshape the programme.

TB Elimination Strategies in India: TB-HIV Integration, Vaccine Progress, and Differentiated Care

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Tuberculosis (TB) remains the leading cause of mortality among people living with HIV (PLHIV) in India. Scientifically, HIV weakens cell-mediated immunity—particularly CD4 T-cells—which significantly increases the risk of progression from latent TB infection to active disease. PLHIV are estimated to have a 20–30 times higher risk of developing TB compared to HIV-negative individuals.

To address this dual burden, India has adopted a robust, integrated strategy under the National TB Elimination Programme (NTEP) and the National AIDS Control Programme (NACP).

A cornerstone of this approach is bidirectional screening—all TB patients are tested for HIV, and all PLHIV are routinely screened for TB symptoms. Early detection enables rapid initiation of treatment. Patients diagnosed with TB–HIV co-infection are started on Anti-TB Treatment (ATT) immediately, followed by early initiation of Antiretroviral Therapy (ART), regardless of CD4 count. Evidence shows that timely ART reduces TB-related mortality by improving immune recovery.

India has further strengthened service delivery through a “single window system”, integrating TB and HIV services at ART centres. This reduces delays, improves adherence, and minimizes loss to follow-up. In addition, molecular diagnostics (Pathodetect/CBNAAT/Truenat) are widely used for rapid detection of TB and Rifampicin resistance, ensuring appropriate treatment.

Preventive strategies play a critical role in reducing morbidity and mortality among people living with HIV (PLHIV). TB Preventive Treatment (TPT) significantly lowers the risk of progression to active TB, while Cotrimoxazole Preventive Therapy (CPT) reduces the incidence of opportunistic infections. In line with recent programmatic advancements, the National TB Elimination Programme (NTEP) has introduced a shorter TPT regimen—1HP (Isoniazid and Rifapentine fixed-dose combination for one month)—for PLHIV aged 13 years and above, aimed at improving adherence and treatment completion. Collectively, these interventions substantially enhance survival outcomes and improve quality of care.

Community engagement remains central to the response. TB Vijeyta (cured patients who volunteered for community service w.r.t. TB) and outreach initiatives promote awareness, reduce stigma, and support adherence—especially among vulnerable and key populations, including transgender communities.

The focus of TB–HIV collaborative activities includes strengthening cascade monitoring of TB–HIV co-infected patients, intensifying systematic TB screening among core and bridge populations, and expanding screening among inmates in prisons and other closed settings, with a strategic emphasis on improving treatment outcomes and reducing morbidity and mortality among TB–HIV co-infected individuals.

In conclusion, while challenges such as gaps in universal drug susceptibility testing, delayed diagnosis, and persistent stigma remain, the strengthened collaboration between NACP and NTEP continues to serve as a critical pillar for programmatic improvement and service integration. The seamless convergence of TB and HIV services—through shared platforms, coordinated screening, and integrated care delivery—has significantly enhanced patient outcomes and reduced mortality. With continued focus on innovation, data-driven decision-making, and community engagement, this collaborative framework holds immense potential to accelerate progress toward India's goal of ending TB by 2030, ensuring equitable and high-quality care for all.

TB Vaccines: Progress, Challenges, and India's Path to SDG 2030

Currently, the BCG vaccine—in use for over a century—offers strong protection against severe childhood TB but provides limited and variable protection against adult pulmonary TB. To address this gap, global research has intensified, with several candidates in advanced stages. Among them, M72/AS01E has shown ~50% efficacy in preventing progression to active TB in adults, representing a major scientific advance.

India is also contributing significantly to vaccine research through large-scale trials of candidates such as VPM1002 (recombinant BCG) and Immuvac (MIP vaccine). While these have demonstrated safety and partial efficacy, a highly effective adult vaccine remains an unmet need.

In parallel, India launched a programmatic Adult BCG revaccination initiative in 2024 in selected states, targeting vulnerable populations. This is being implemented as a stratified cluster randomized study aimed at evaluating the effectiveness of BCG vaccination in reducing TB incidence among adults over a 36-month follow-up period. The study assesses key outcomes such as:

- Reduction in notified TB cases using Nikshay data
- Vaccine effectiveness against active TB (using case-control analysis)
- Safety through monitoring of adverse events following immunization (AEFI)

Annual and bi-annual reviews are being conducted, and follow-up is ongoing to generate robust real-world evidence on the role of adult BCG vaccination in TB prevention.

Scientifically, TB vaccine development remains complex due to the need for strong cell-mediated immunity (CD4+ T-cell response) and challenges posed by latent TB infection. For India, an effective vaccine—combined with ongoing strategies under the National TB Elimination Programme (NTEP)—could be transformational in reducing transmission and accelerating progress.

In conclusion, while global progress is encouraging, innovations such as India's adult BCG revaccination initiative and promising vaccine candidates offer hope. A safe and effective adult TB vaccine will be a critical tool in achieving SDG 2030 goals and ending TB in India and world.

Differentiated TB Care: A Patient-Centred Approach

Differentiated TB care is a patient-centred approach that ensures individuals receive care based on their clinical risk and needs. Through comprehensive assessment and diagnostics, high-risk patients—such as those with severe disease, drug-resistant TB, or comorbidities—are prioritized for intensive care, while low-risk patients are managed through community-based follow-up and regular monitoring. This approach improves efficiency while ensuring continuity of care and better patient outcomes.

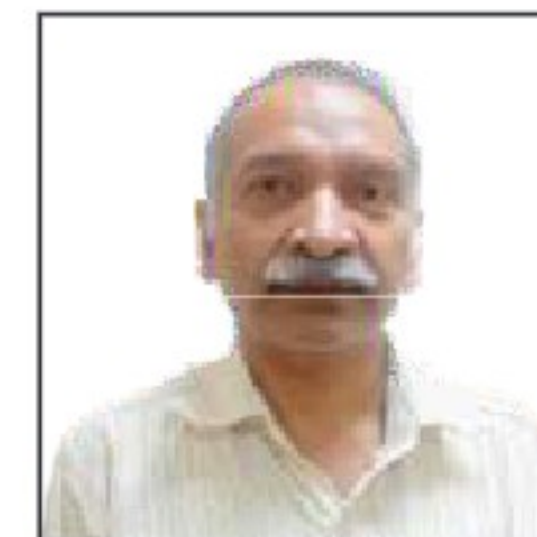
The model is inherently flexible and can be adapted to regional healthcare capacities and epidemiological trends, ensuring sustainability and scalability. A strong component is integrated monitoring and continuous feedback through robust follow-up mechanisms, including tools such as TB Social Autopsy (TBSA) and verbal autopsy, which help identify system gaps and understand the true causes of TB-related deaths. These processes are monitored at the level of the Medical Officer at Ayushman Arogya Mandirs, ensuring timely corrective action and strengthening decentralized, quality service delivery. Additionally, the integration of technology, including the potential use of Artificial Intelligence (AI), enhances early identification of high-risk patients, strengthens clinical decision-making, and enables timely interventions, particularly for patients with severe disease or comorbidities.

Overall, by combining clinical care, continuous monitoring, timely IPD and OPD referrals, and ensuring prompt hospital admission when required, differentiated TB care significantly reduces morbidity and mortality, improves adherence, and accelerates progress toward TB elimination in India.

Extra Pulmonary Tuberculosis

Dr. B. K. Vashishat

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Extra pulmonary TB (EPTB), often paucibacillary, comprises 15-25% of all cases & remains a diagnostic and therapeutic challenge with protean clinical presentations involving almost any organ in the human body, difficulty in obtaining samples for diagnosis, reduced drug efficacy because of poor penetration into certain tissues, difficulty in treatment response monitoring, and unclear duration of treatment. Each case of EPTB needs to be assessed holistically and a multidisciplinary, evidence-based, personalized approach is required to improve patient outcomes. Clinicians at all levels, irrespective of their specialty or level of training, thus need to be trained in EPTB to achieve rapid diagnosis & proper management.

EPTB training module, spearheaded by the Department of Medicine, AIIMS (New Delhi), represents the collective intelligence, share division, review of existing literature and team work of experts across all specialties and experts from Central TB division and WHO country office. These guidelines have evidence-based information related to EPTB and the standardized procedures followed from screening to the last leg of treatment for healthcare providers and medical staff across all verticals & thus provide impetus to realize the vision of a TB-free India, by expanding the scope of the program beyond pulmonary TB and efficiently utilizing the current state of infrastructure for EPTB.

These EP TB guidelines aim to promote uniformity in practice among clinicians, help in identifying presumptive EPTB cases, basic investigations to be done at their level & when to refer these patients to higher centre to strengthen our endeavors to Eliminate TB.

Diagnosis of EPTB:

Timely detection of TB is one of the critical pillars to achieving TB elimination. Diagnostic services are provided free of cost. Extrapulmonary TB has a wide range of presentations, from non-specific signs and symptoms (for example, As cites, Pleural effusion, and Gibbus deformity) to organ and system-specific symptoms based on the site involved.

All efforts should be made for bacteriological confirmation of TB, including for Extrapulmonary TB. However, in case of high clinical suspicion and the presence of supportive laboratory tests, the expertise of clinicians can be used to diagnose EPTB.

Tools for Microbiological Confirmation of EPTB:

Up front NAAT are offered to all presumptive EPTB patients as per the NTEP programmatic guidelines.

Microbiological Tests (To Confirm Mycobacterium Tuberculosis - MTB)				
Test	Why It's Used?	Sample Used	Turnaround Time	Limitations
CBNAAT	Rapid detection of MTB DNA & rifampicin resistance. High sensitivity for lymph node & CNS TB.	Lymph node aspirate, CSF, pleural fluid, pus, biopsy	~2 hours	Less sensitive in CSF/pleural fluid due to low bacterial load.
Line Probe Assay (LPA)	1st Line LPA Detects rifampicin & isoniazid resistance faster than culture.	CSF, pus, tissue biopsy, pleural fluid, ascitic fluid	~48 hours	Not suitable for all specimens, requires bacterial load.
Liquid Culture (MGIT - Mycobacteria Growth Indicator Tube)	Gold standard for TB confirmation. Used when CBNAAT is negative but suspicion remains high.	CSF, biopsy, bone aspirate, peritoneal fluid	~2-6 weeks	Expensive, requires biosafety level-3 labs.
Ziehl-Neelsen (ZN) Stain/Fluorescent Microscopy	Direct identification of acid-fast bacilli (AFB).	FNAC, biopsy, pus, pleural fluid, CSF	~24 hours	Low sensitivity (~30-40%) in EPTB due to low bacterial count.

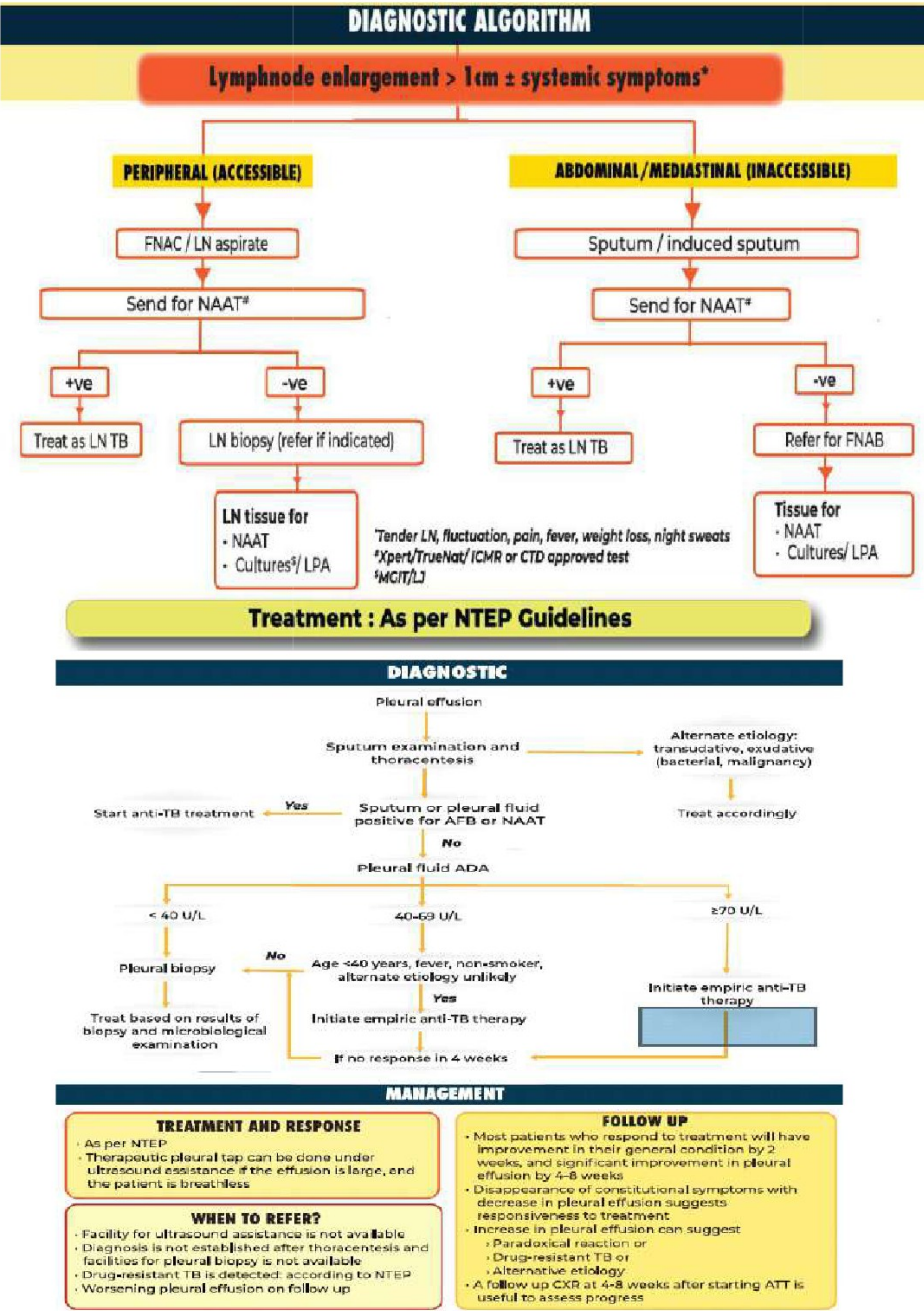
Biochemical & Molecular Markers (Supportive Diagnosis)			
Test	Why It's Used?	Sample Used	Cutoff Value Suggestive of TB
ADA (Adenosine Deaminase)	Marker of cell-mediated immunity in TB pleuritis, pericarditis, peritoneal TB.	Pleural/peritoneal fluid, CSF	>40 U/L (highly suggestive of TB)
CSF Analysis (for TB Meningitis)	Classic triad: low glucose, high protein, lymphocytosis.	CSF	Glucose <40 mg/dL, Protein >100 mg/dL, Lymphocytes >50%
Tuberculin Skin Test (TST)/IGRA (Interferon-Gamma Release Assay)	Identifies TB exposure (not active disease).	Blood	Positive but does not differentiate active from latent TB.

Histopathology (For Tissue-Based Diagnosis)		
Test	Why It's Used?	Sample Used
FNAC (Fine Needle Aspiration Cytology)	Detects caseating granulomas, common in lymph node TB.	Lymph node, soft tissue
Biopsy (Histopathology)	Gold standard for bone, CNS, or disseminated TB; confirms granulomas and necrosis.	Bone, pleura, meninges, synovium

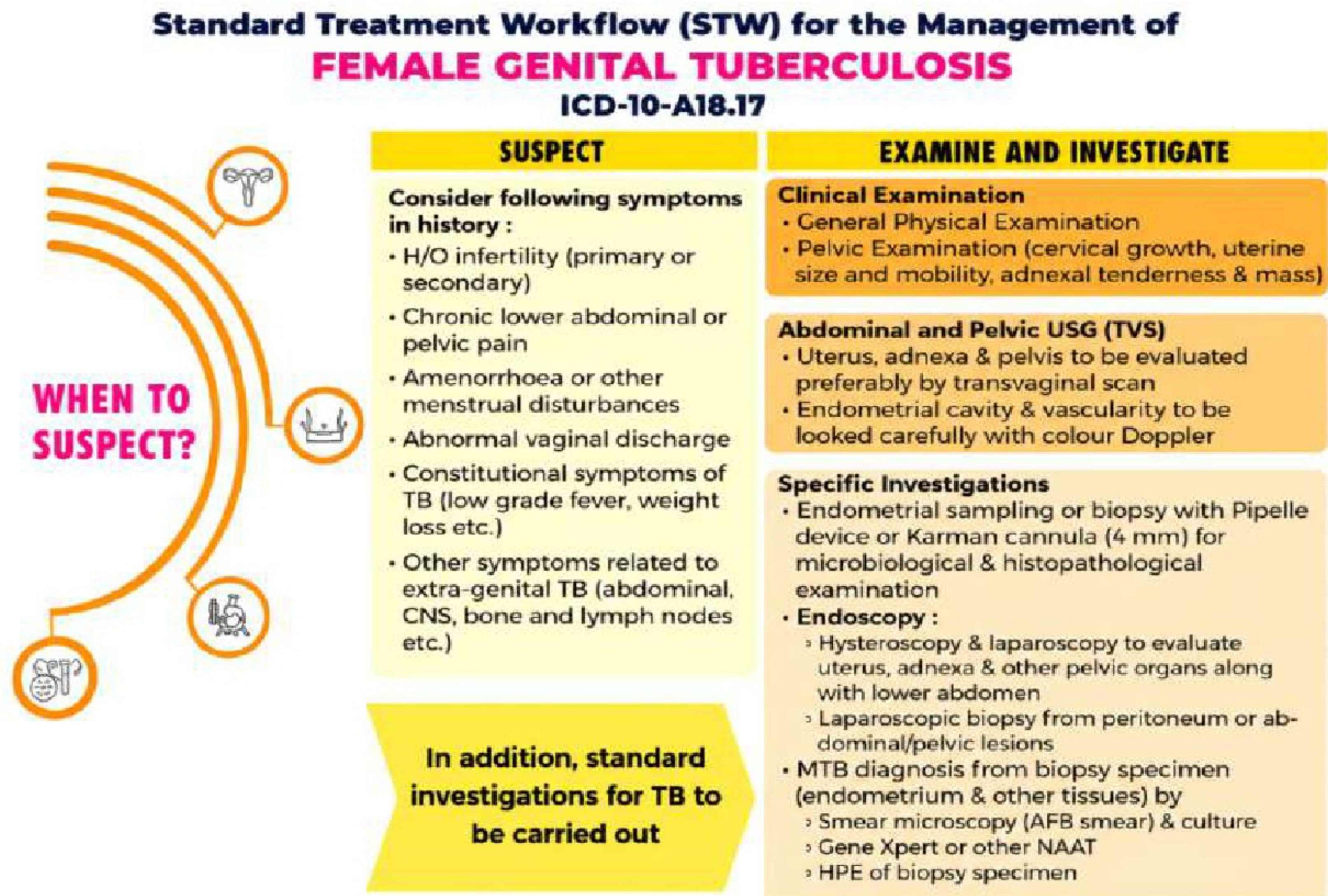
Imaging (For Anatomical Localization)		
Imaging	Use Case	Findings Suggestive of TB
Chest X-ray	For associated pulmonary TB.	Cavitary lesions, hilar lymphadenopathy.
Ultrasound (USG)	Detects abdominal TB, lymphadenopathy, peritoneal TB.	Thickened bowel loops, ascitic fluid with septations.
CT/MRI Brain	CNS TB (Tuberculoma, Meningitis).	Basal meningeal enhancement, hydrocephalus, infarcts.
MRI Spine (for Pott's TB)	Evaluates spinal involvement.	Vertebral destruction, cold abscess, cord compression.

In this article two of the commonest forms of EPTB & Female Genital TB with STWs have been described

STWs have been prepared by national experts of India with feasibility considerations for various levels of healthcare system in the country. These broad guidelines are advisory, and are based on expert opinions and available scientific evidence. There may be variations in the management of an individual patient based on his/her specific condition, as decided by the treating physician. There will be no indemnity for direct or indirect consequences . (For more information visit the web portal (stw.icmr.org.in). © Indian Council of Medical Research and Department of Health Research, Ministry of Health & Family Welfare, Government of India).



- Standard treatment workflows - Central Tuberculosis Division



DIAGNOSIS	
SUGGESTIVE FINDINGS IN FGTB Imaging and Radiological • HSG : to be avoided in acute phase - Findings : blocked fallopian tubes, usually cornual stoscope pouch appearance of the tubes, beaded tubes; filling defect in the uterine cavity (Asherman syndrome) • USG : cogwheel appearance of tubes; uterine cavity may show thin diffuse endometrium with irregular borders • CT/MRI : can be used for tubo-ovarian mass Endoscopy • Hysteroscopy : To look for tubercles, pale endometrium & endometrial adhesions • Laparoscopy : Direct visualization of tubercle like lesions on the uterus, tubes and other pelvic organs including peritoneum, & caseous nodules	FEMALE GENITAL TB (STEPWISE DECISION) • Clinical history • General physical and pelvic examination • Pelvic ultrasound • HSP as indicated in infertility HSG Definite FGTB needing ATT if any of the following tests are positive • AFB microscopy positive • AFB culture positive • Gene Xpert or other NAAT +ve • Histopathological demonstration of epithelioid granuloma Probable FGTB needing ATT if any of following positive • Clinical findings/suspicion of TB with tubo-ovarian masses on imaging studies • Clinical findings/suspicion of TB with laparoscopic findings of beaded tubes, caseous nodules, tubercles, adhesions, hydrosalpinx & pyosalpinx etc. • Clinical findings/suspicion of TB with hysteroscopic findings of tubercles, caseous nodules, pale endometrium, intrauterine adhesions etc. Negative FGTB is No ATT • No microbiological, histological, radiological, laparoscopic & hysteroscopic evidence of FGTB Menstrual blood should not be used for NAAT.
MANAGEMENT	
TREATMENT • Treatment of FGTB should be as per NTEP • Patients requiring specific treatment such as infertility, Asherman syndrome & tubo-ovarian mass etc. should be referred to higher centres	FOLLOW UP Follow-up of the patient should be flexible depending on the clinical presentation and response to ATT • 1 month : Clinical Evaluation (General & Gynaecological) • 3 months : Clinical Evaluation (General & Gynaecological) • 6 months : Clinical Evaluation & Investigations (endometrial biopsy, hystero-laparoscopy & USG as needed)

Treatment of EPTB

EPTB treatment regimen and duration are contingent upon the affected site and drug-susceptibility pattern: Drug-susceptible EPTB (DS-EPTB) or Drug-resistant EPTB (DR-EPTB).

For DS-EPTB the standard injection – free combination of our oral drugs treatment regimen is implemented across the country for the duration of 6 months. However, the regimen and duration of treatment could vary according to the affected site and at clinicians discretion.

Drug-resistant EPTB is managed by All Oral H Mono/Poly DR-TB Regimen shorter oral Bedaquiline (Bdq) containing MDR/RR-TB regimen and longer oral MDR/RR-TB regimen as per DST results.

As patient follow-up is an essential component, a coordinated effort by all State/District PPM coordinators, senior DR-TB/HIV supervisors, STS, and staff from PPSA (if present) is critical to ensure proper implementation of care cascade as per the NTEP guideline (For further details please refer to: Guidelines for Programmatic Management of Drug Resistant Tuberculosis in India-2021 : Ministry of Health and Family Welfare (tbcindia.gov.in))

Household contacts of EPTB patients are not one of the eligible populations for TPT currently as per the programmatic guidelines. Eligibility for TPT relies on ruling out active TB and risk versus benefit assessment.

Private providers are also provided financial incentives as per NTEP for notifying TB patient and reporting their treatment outcome.

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DR-TB: The Toughest Frontier in India's TB Elimination Journey

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Understanding the Burden, Programmatic Response, Prevention Strategies & Emerging Research in Drug-Resistant Tuberculosis

Drug-Resistant Tuberculosis (DR-TB) remains one of the most challenging barriers to global TB elimination efforts. While the overall TB incidence is gradually declining, resistance to key anti-TB drugs such as Rifampicin and Isoniazid has created a “disease within a disease” — one that is more difficult to diagnose, more challenging to treat, and significantly more taxing psychologically and socially.

The Global and National Burden: A Persistent Weak Spot

The WHO Global Tuberculosis Report 2025 highlights an important paradox: while India has achieved the fastest global decline in TB incidence, with a 21% reduction from 2015 levels, the country still remains the world’s largest contributor to Drug-Resistant TB.

Key Highlights

Indicator	Current Status
Global Contribution	India accounts for nearly 32% of global MDR-TB and Rifampicin-Resistant TB (RR-TB) cases
Treatment Success Rate – Drug-Sensitive TB	Approximately 85–90%
Treatment Success Rate – MDR/RR-TB	Approximately 65–75%
MDR-TB in New Cases	Around 2.8%
MDR-TB in Previously Treated Cases	Approximately 11.6%–17%
Highest Risk Groups	Patients with prior treatment failure, relapse, or treatment default

This significant treatment gap highlights the complexity of managing second-line regimens, prolonged therapy, adverse drug reactions, and treatment adherence challenges.

Strengthening the Nodal Network: The NMC Mandate

To strengthen DR-TB management, the National Medical Commission (NMC) and Ministry of Health & Family Welfare have integrated DR-TB services into the core infrastructure of medical education and tertiary healthcare systems.

Mandatory DR-TB Nodal Centres

Every medical college in India is now mandated to function as a DR-TB Nodal Centre. This has helped decentralize:

- advanced diagnostics such as CBNAAT and Truenat,
- specialized DR-TB treatment protocols,
- and expert clinical decision-making.

The move aims to improve accessibility, reduce delays in diagnosis, and strengthen management of complicated DR-TB cases.

Integration of Tobacco Cessation Services

Recent 2024 NMC directives have also mandated the establishment of Tobacco Cessation Centres (TCCs) in all medical colleges. Given that smoking is a major contributor to increased TB incidence, treatment failure, relapse, and poor treatment outcomes, the integration of tobacco cessation services has become an important component of holistic DR-TB management.

Specialized Prevention Strategies: DR-TB Preventive Therapy (TPT)

Tuberculosis Preventive Therapy (TPT) is no longer considered a “one-size-fits-all” strategy. For household contacts of Drug-Resistant TB patients, conventional Isoniazid-based preventive therapy may not be effective due to existing resistance patterns.

Current DR-TB Preventive Therapy Approaches

Type of Index Case	Recommended Preventive Therapy
MDR/RR -TB Contacts	Levofloxacin for 6 months
H-mono / H -poly DR -TB Contacts	Rifampicin for 4 months

Newer Shorter Regimens: Transforming DR-TB Treatment

One of the most important breakthroughs in DR-TB management has been the introduction of shorter all-oral regimens.

BPaLM Regimen

The BPaLM regimen of **Bedaquiline, Pretomanid, Linezolid and Moxifloxacin** has revolutionized DR-TB care by reducing treatment duration to just 6 months compared to the older regimens lasting 18–24 months. The regimen offers improved adherence, reduced toxicity, better patient acceptability, and significantly improved treatment outcomes.

Psychosocial Implications: The Invisible Burden

DR-TB is not only a biological disease but also a major psychological, social, and economic challenge.

Major Psychosocial Themes Affecting DR-TB Patients

1. Emotional Instability

Patients commonly experience fear, anxiety, uncertainty, depression, and hopelessness.

2. Drug-Induced Psychological Distress

Second-line anti-TB drugs such as Cycloserine may sometimes lead to severe mood disturbances, psychosis, behavioural changes, and suicidal ideation.

3. Social Isolation and Stigma

Fear of stigma often results in family disruption, social withdrawal, discrimination, and loss of emotional support systems.

4. Catastrophic Financial Burden

Despite free diagnostics and medicines under NTEP, indirect costs related to travel, nutrition, wage loss, and prolonged treatment duration often push families into cycles of debt and poverty.

The Horizon Ahead: Novel Drugs and Emerging Research

Scientific efforts across the world are now focusing on newer molecules and precision targeted therapies against *Mycobacterium tuberculosis*.

Emerging Areas of Research

- **MmpL3 Inhibitors**

Compounds such as **MSU-43085** are being studied for their ability to inhibit bacterial cell wall synthesis in both acute and resistant TB strains.

- **Pks13 Targets**

Research on the **Mt-Pks13 enzyme** is opening newer avenues for computer-aided drug design and development of more potent antimycobacterial therapies.

- **Gene-Specific Precision Research:** New studies are identifying specific resistance mutations such as:

- **rpoB Ser531Leu** (Rifampicin resistance)
- **katG S315T1** (Isoniazid resistance)

to develop highly targeted “designer drugs” capable of bypassing existing resistance mechanisms.

Conclusion

Drug-Resistant TB continues to remain one of the greatest challenges to TB elimination in India and globally. However, strengthening diagnostic networks, decentralizing DR-TB services, introducing shorter oral regimens, expanding preventive therapy, integrating psychosocial care, and investing in newer research are collectively reshaping the future of DR-TB management.

A sustained multidisciplinary approach involving clinicians, public health systems, mental health professionals, researchers, and communities will remain essential in achieving the vision of a TB-Free India.

Comparative Epidemiological Analysis of the Burden of DRTB Delhi vs. National Aggregate as per India TB Report 2024

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Background : Bacteriologically confirmed Tuberculosis is a Diagnosed Tuberculosis in a biological specimen by smear microscopy, culture, or a WHO-endorsed rapid molecular test adopted by NTEP like Nucleic Acid Amplification Testing. Further, Drug Susceptibility Testing (DST) and Drug Resistance Testing (DRT): Refers to in-vitro testing using either of the phenotypic and genotypic methods to determine susceptibility and resistance respectively. Any Diagnosed TB Case is subjected to the Universal Drug Susceptibility Testing (UDST) under the Programme to ascertain the Resistance pattern of Rifampicin of any Bacterio – logically Confirmed Case. Further the Programme is aiming towards expanding the scope of undertaking Drug susceptibility testing for Fluoroquinolone Resistance along with Rifampicin.

A Presumptive Drug Resistance Tuberculosis (DR-TB) refers to the patient who is eligible for Rifampicin Resistant screening at the time of diagnosis OR/and during treatment for Drug Sensitive Tuberculosis (DS-TB) or H Mono/Poly Drug Resistant Tuberculosis.

Key definitions :

Rifampicin resistant TB (RR-TB) is TB caused by Mycobacterium Tuberculosis (MTB) strains that are resistant to Rifampicin, with or without resistance to other anti-TB drugs. It includes any resistance to Rifampicin in the form of mono-resistance, poly-resistance, MDR-TB, or XDR-TB.

Mono-resistant TB (MR TB): TB caused by MTB strains that are resistant to one first- line anti-TB drug only.

Poly-drug resistant TB (PDR-TB): TB caused by MTB strains that are resistant to more than one first-line anti-TB drug other than Isoniazid and Rifampicin.

Isoniazid-resistant TB (Hr-TB): TB is caused by MTB strains that are resistant to isoniazid, and susceptibility to rifampicin has been confirmed.

Multidrug-resistant TB (MDR-TB): TB caused by MTB strains that are resistant to both H and R with or without resistance to other first-line anti-TB drugs.

Pre-extensively drug-resistant TB (Pre-XDR-TB): TB caused by MTB strains that fulfill the definition of MDR/ RR-TB and are also resistant to any fluoroquinolone (FQ).

Extensively drug-resistant TB (XDR-TB): TB caused by MTB strains that fulfill the definition of MDR/RR-TB and are also resistant to any fluoroquinolone (levofloxacin or moxifloxacin) and at least one additional Group A drug (presently to either bedaquiline or linezolid [or both])

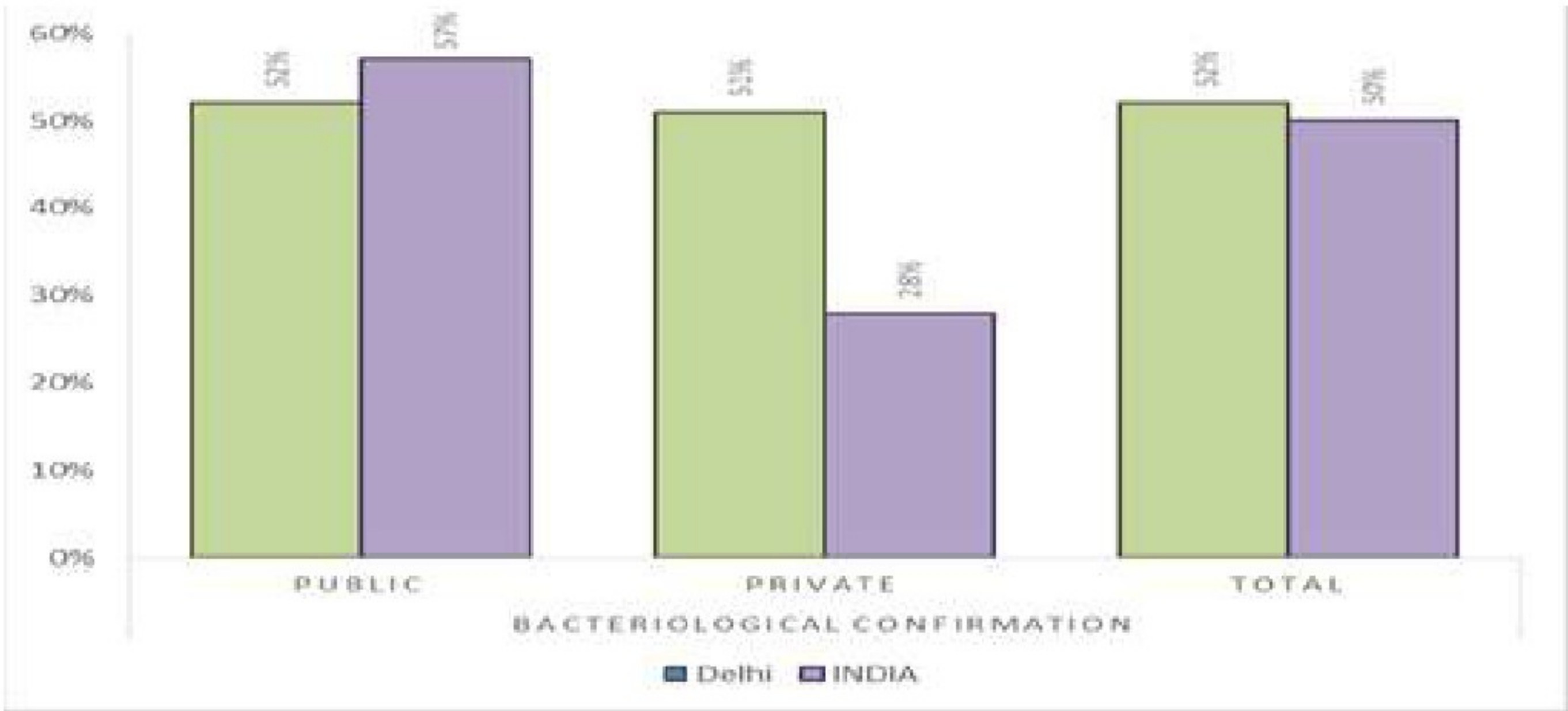
Notification-Sector wise Distribution:

Key Performance Indicators	Sector	Delhi	INDIA
Notification	Public	75,093	18,53,274
	Private	11,528	6,56,262
	Total	86,621	25,09,536

Insight: Delhi exhibits a significantly higher reliance on the public sector (86.7%) for notifications compared to the national average (73.8%).

Bacteriological Confirmation Coverage:

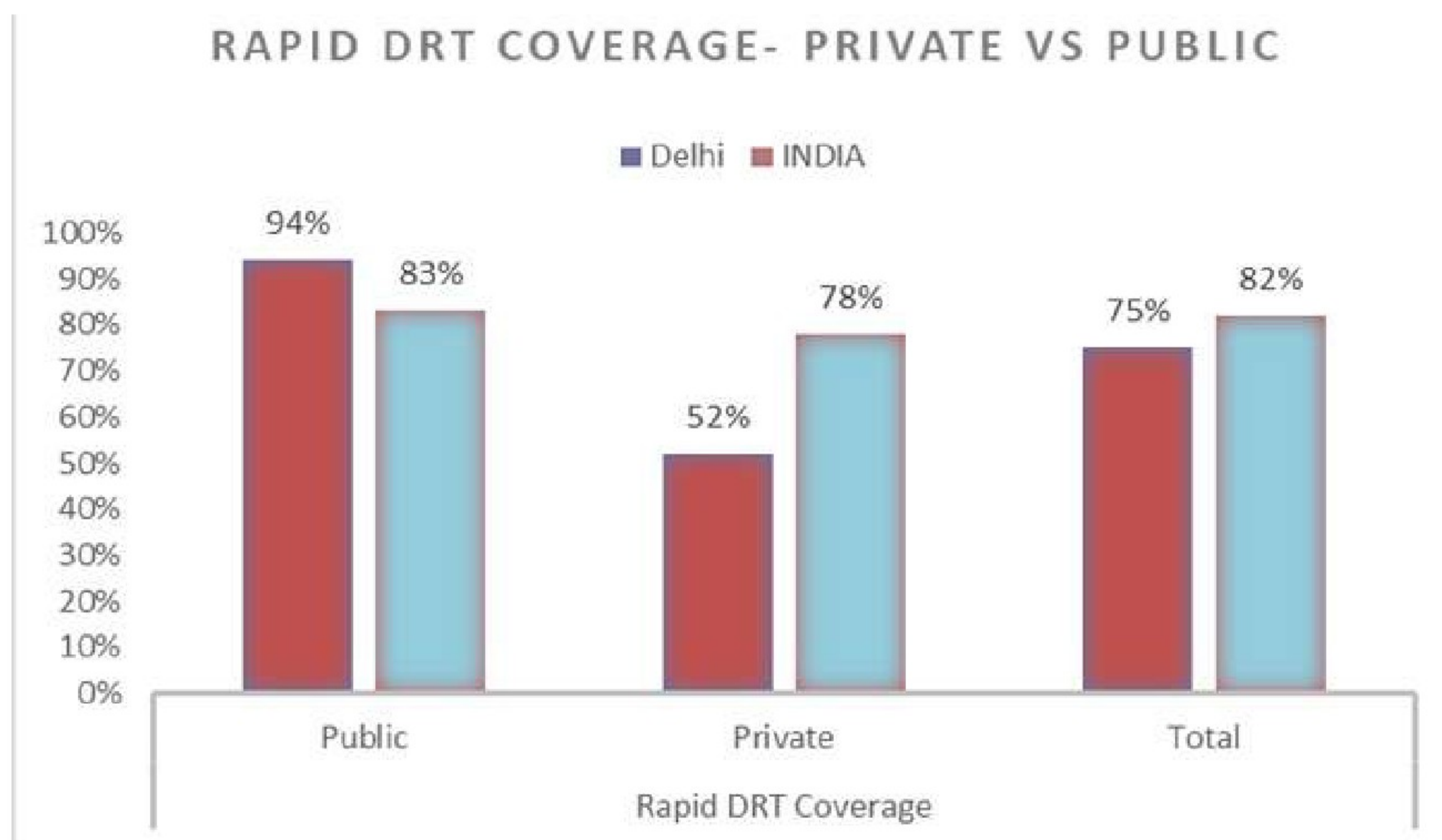
Key Performance Indicators	Sector	Delhi	INDIA
Bacteriological confirmation	Public	52%	57%
	Private	51%	28%
	Total	52%	50%



Insight: Delhi's public sector Bacteriological confirmation rate stands at 52%, slightly lower than the national average (57%). However, Delhi excels in the private sector with a 51% confirmation rate, nearly doubling the national private sector average of 28%.

Drug Resistance Testing (DRT):

Key Performance Indicators	Sector	Delhi	INDIA
Rapid DRT Coverage	Public	94%	83%
	Private	52%	78%
	Total	75%	82%



Insight : Delhi reaches an excellent 94% coverage rate for rapid DRT among bacteriologically confirmed cases, outperforming the national benchmark of 83%. However, Delhi's private sector rapid DRT coverage lags at 52%, falling behind the national private sector average of 78%.

Drug-Resistant Burden (MDR/RR-TB & FQ Resistance):

DRTB Case Finding Efforts	Delhi	INDIA
RR-TB Diagnosed	3,173	63,929
FQ Resistant Cases	534	11,749
XDR-TB Cases	2	114

Insight: Delhi diagnosed 3,173 Rifampicin-Resistant (RR) cases out of India's total 63,929 cases, representing 4.96% of the National Burden.

Delhi detected 534 Fluoroquinolone (FQ) resistant cases, accounting for 4.54% of India's total FQ-resistant pool (11,749 cases).

Treatment Cohort Outcomes:

Shorter MDR/RR -TB Regimen Outcomes (2022 Cohort)					
	Total	Treatment Success (%)	Died (%)	Lost to Follow-up (%)	Failure (%)
Delhi	348	74%	3%	18%	2%
INDIA	21,285	75%	10%	10%	2%

Isoniazid (H) Mono/Poly Drug -Resistant TB Outcomes (2022 Cohort)					
	Total	Treatment Success (%)	Died (%)	Lost to Follow -up (%)	Failure (%)
Delhi	945	85%	3%	9%	3%
INDIA	10,490	87%	5%	5%	2%
Longer Oral MDR/XDR -TB Regimen Outcomes (2021 Cohort)					
	Total	Treatment Success (%)	Died (%)	Lost to Follow -up (%)	Failure (%)
Delhi	1,129	73%	14%	10%	2%
INDIA	19,959	73%	15%	8%	2%

Insight:

H- Mono/Poly DRTB Regimen: Delhi mirrors the national success rate closely, achieving an 85% treatment success rate against India's 87%, while successfully maintaining a lower mortality rate (3% vs. 5%).

Shorter MDR-TB Regimen: Delhi achieved 74% treatment success rate equating the national average of 75%. Delhi holds a major clinical advantage with a remarkably low mortality rate of 3% compared to India's 10%. However, its Lost-to-Follow-up (LTFU) rate is critically high at 18%, compared to the national average of 10%.

Longer Oral MDR/XDR-TB Regimen: Delhi achieved a 73% treatment success rate matching the national aggregate precisely, with a slightly lower mortality ceiling (14% vs. 15%).

Challenges:

- **High LTFU rates:** Delhi caters to a high percentage of Migratory population and people living in Urban Slums and or people travelling from various neighbouring state for seeking treatment from the tertiary healthcare settings and renowned National Institutes attributing to an elevated Lost-to-Follow-up (LTFU) rate , substantially higher than the national average. Public health tracking mechanisms are being optimized to preserve patient adherence within urban slums and migrant populations.
- **Private Sector Engagement:** Owing to the lack of PPSA (Patient Provider Support Agency) &/or Vancat posts of PPM Coordinators (Public Private Mix) under NTEP Delhi, the State has struggled to engage Private Sector in the Implementation aspects of the Programme. However, now with the HR vacancy filled Interventions are targeted towards the various implementation aspects of the programme in private sector's including low DRT utilization (52%) to ensure that drug-resistance is detected early before community transmission occurs.

Strength:

- **Low Mortality Advantage:** Across all cohorts (Shorter MDR, H-Mono, and Longer Oral), Delhi maintains a consistently lower mortality rate than the national aggregate. This indicates excellent tertiary care clinical management and emergency response capabilities in the capital.
- **Newer Shorter Regimen for MDR/RR-TB (BPaLM):** The newer MDR/RR-TB Regimen namely the BPaLM Regimen, with newer Drugs - Bedaquilline, Pretomanid, Linezolid and Moxifloxacin successfully implemented since December 2024 with approximately 1500 patients initiated on the regimen across 24 Chest Clinics of Delhi with a successful outcome of ~85%.

Conclusion: Delhi bears a significant share of India's drug-resistant tuberculosis burden. Despite serving a highly mobile and diverse urban population, the capital achieves comparable or better treatment outcomes than the national average, particularly in mortality reduction. Key challenges remain in private sector engagement and treatment of migratory patients. With the recent rollout of the shorter BPaLM regimen, Delhi is well-positioned to further improve DR-TB outcomes.

Mass X-Ray Screening: A Landmark Intervention in India's TB Elimination Strategy

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Tuberculosis (TB) remains a major public health challenge in India, demanding innovative and scalable strategies for elimination. Mass chest X-ray screening has emerged as a game-changing intervention by shifting TB detection from passive diagnosis to intensified, community-based case finding. Its impact has been strongly demonstrated through the *TB Mukh Bharat Abhiyan*.

Transforming TB Detection

Conventional TB detection often depends on symptomatic presenting with symptoms such as a persistent cough. However, this approach often misses individuals who are asymptomatic or have mild symptoms, allowing continued transmission in the community, leading to missing of cases and continued transmission. Mass X-ray screening enables early identification of lung abnormalities, including subclinical and asymptomatic TB, thereby strengthening early diagnosis and reducing delays in treatment initiation.

Evidence from TB Mukh Bharat Abhiyan

Phase 1 of the *TB Mukh Bharat Abhiyan*, launched on 7 December 2024 across 347 high-priority districts in 33 States/UTs and later expanded nationwide, demonstrated the scale and effectiveness of this approach:

- **4.75 crore chest X-rays conducted**
- **27.28 lakh TB cases identified**
- **9.48 lakh asymptomatic TB cases detected**

These findings highlight the critical role of X-ray-based screening in uncovering hidden TB burden that may otherwise remain undiagnosed.

Reaching Vulnerable and High-Risk Populations

Mass screening has improved access to diagnosis among underserved and high-risk groups, including:

- Residents of urban slums, tribal, and remote areas
- Individuals in prisons, shelters, and workplaces
- Elderly persons, diabetics, undernourished individuals, and household contacts of TB patients

By providing services directly to communities, the strategy promotes equitable and inclusive healthcare delivery.

Integration with Rapid Diagnostics

The effectiveness of screening is enhanced through linkage with rapid molecular diagnostics (NAAT). Individuals with abnormal X-rays undergo same-day sputum testing, enabling faster confirmation and timely initiation of treatment, thereby reducing disease transmission.

Leveraging Technology for Scale

The deployment of portable and handheld X-ray units, along with AI-assisted interpretation tools, has significantly strengthened outreach efforts. These technologies improve diagnostic efficiency, reduce dependence on specialists, and support screening in resource-limited and field settings.

Operational Advantages

Mass chest X-ray screening is highly scalable and operationally efficient, with a single unit capable of conducting nearly 100 X-rays per session. Integration with mobile medical units and outreach platforms such as *AyushmanAarogyaShivirs* during the second phase of the 100 Days campaign has further enhanced service delivery by combining TB screening with screening for diabetes, hypertension, and undernutrition.

Conclusion

Mass chest X-ray screening has transformed TB control efforts in India by enabling early, large-scale, and inclusive detection of TB cases, including asymptomatic individuals. Supported by AI-enabled & mobile technologies, rapid diagnostics, and strong community engagement, this strategy is proving instrumental in breaking transmission chains and accelerating progress towards a TB-free India.

Integrated Efforts of NDTBC in Supporting the Vision of a TB-Free Delhi and TB-Free India

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The New Delhi Tuberculosis Centre (NDTBC) has emerged as one of the most important pillars in strengthening tuberculosis control activities in Delhi and contributing significantly towards the national vision of a “TB-Free India.” Established in 1940 as a Model TB Clinic, the institute has continuously evolved into a premier institution for tuberculosis diagnosis, training, research, and programmatic support under the National TB Elimination Programme (NTEP). Today, NDTBC functions not only as a premier referral centre for Tuberculosis and Respiratory Diseases, but also as the State TB Demonstration and Training Centre (STDC) and Intermediate Reference Laboratory (IRL) for Delhi State. It provides critical technical leadership and diagnostic support across the entire TB control network of the National Capital Territory. The Centre brought about thirteen publications this year and has various ongoing research projects. The faculty of NDTBC took active part in 92 scientific events during the year.

One of the most significant contributions of NDTBC towards achieving a TB-Free Delhi lies in its advanced diagnostic infrastructure and technological integration. The upgraded Mycobacteriology Department and BSL-3 Laboratory of the Centre are equipped with comprehensive diagnostic facilities ranging from conventional smear microscopy to advanced molecular technologies such as CBNAAT, Truenat MTB/MTB-RIF, Line Probe Assay (LPA), Real-Time PCR, Pathodetect, XDR GeneXpert 10C, Automated Liquid Culture System (MGIT-960), and Whole Genome Sequencing using Illumina MiSeq technology. These technologies enable rapid, accurate, and sensitive detection of Mycobacterium tuberculosis as well as identification of drug resistance patterns in a timely manner. Early diagnosis and prompt initiation of appropriate treatment are essential to breaking the chain of transmission and reducing disease burden within the community.

Over the years, several advanced diagnostic services have been introduced, including First-Line Line Probe Assay (LPA) in April 2011, Second-Line LPA in February 2018, First-Line Liquid Culture DST (SIRE) in May 2013, and Second-Line Liquid Culture DST for fluoroquinolones and injectable anti-TB drugs in March 2014. Further enhancing its diagnostic capacity, the laboratory-initiated Linezolid and Pyrazinamide DST in December 2020.

In December 2025, IRL NDTBC, New Delhi achieved another important milestone by receiving certification of proficiency for performing Drug Susceptibility Testing of newer anti-tubercular drugs, namely Bedaquiline and Pretomanid, using liquid culture methods. This achievement reflects the laboratory's advanced technical expertise, commitment to quality-assured

diagnostics, and preparedness to support emerging treatment strategies for drug-resistant tuberculosis under the National TB Elimination Programme.

The institute plays a particularly crucial role in the Programmatic Management of Drug-Resistant Tuberculosis (PMDT).

As the IRL for Delhi, NDTBC is entrusted with the responsibility of strengthening and maintaining the quality of TB diagnostic services across the state. The laboratory provides technical oversight, supervision, and monitoring support to microscopy centres, molecular laboratories, and chest clinics functioning under NTEP. Regular On-Site Evaluations (OSEs) are conducted across all TB diagnostic centres in Delhi to assess adherence to standard operating procedures, biosafety practices, equipment functionality, documentation systems, and quality assurance protocols.

Another major contribution of NDTBC towards a TB-Free Delhi is its role in training and capacity building. The institute also contributes extensively to operational research, academic collaboration, and diagnostic innovation, which are essential for evidence-based TB control strategies.

NDTBC has also undertaken research activities related to stigma reduction and community engagement in TB care. The Centre presented its study on the “TAI-NDTBC Stigma Self-Assessment Scale for TB” at the India Innovation Summit and also plays an important role in supporting the development of future healthcare professionals and researchers. It collaborates with reputed academic institutions by providing hands-on training to postgraduate students including MD and M.Sc. candidates.

The Centre has further strengthened its commitment to quality and excellence through accreditation and adherence to international standards. The Intermediate Reference Laboratory received NABL ISO 15189:2022 accreditation, reflecting its compliance with stringent quality management systems and technical standards.

As recommended under the PMDT Guidelines 2021, the Difficult to Treat TB (D3T) Clinic was established to support the management of complex and difficult drug-resistant TB cases. In Delhi State, the D3T Clinic is being conducted through the STDC ECHO Hub at NDTBC. The clinic which is moderated and operated from the STDC ECHO Hub serves as a multidisciplinary expert platform where difficult-to-manage DR-TB cases from across the state are discussed in great detail by specialists, programme managers, microbiologists, District TB Officers (DTOs), Medical Officers (MOs), and private practitioners. It helps the doctors working in NTEP of Delhi State to gain the necessary experience and expertise to manage ADRs, co-morbidities associated with difficult to treat TB cases. This virtual platform connects all the TB doctors and paramedics of Delhi State for the hands on experience and training in the clinical management of this disease.

The Diagnostic Management ECHO TB Clinic at IRL, NDTBC is a virtual knowledge-sharing and capacity-building platform designed to strengthen technical expertise and continuous learning among healthcare professionals involved in tuberculosis diagnostics and programme management.

Ongoing Research Projects :

- 1) **Redefining TB Diagnosis at Tuberculosis Diagnostic Centres in Delhi through Introduction and Scale-Up of Quality Management Systems (QMS)** An ICMR-funded study is being undertaken at NDTBC to strengthen and scale up Quality Management Systems (QMS) across Tuberculosis Diagnostic Centres (TDCs), including Designated Microscopy Centres (DMCs) and NAAT laboratories in Delhi under NTEP. The project aims to improve the quality, accuracy, and reliability of TB diagnosis, strengthen TB case detection, and promote optimal utilization of molecular diagnostic technologies in accordance with national guidelines.
- 2) **Clinical Performance Evaluation of Molecular Tests for Diagnosis of Tuberculosis (TB) and Drug-Resistant TB** – In view of the high TB burden, the Ministry of Health and Family Welfare, Government of India, through Indian Council of Medical Research (ICMR), is undertaking a multicentric study to evaluate indigenously developed, cost-effective TB diagnostic assays across multiple testing platforms. Currently, NTEP mainly relies on closed-system molecular platforms, which are associated with high cartridge costs and limited flexibility for alternative assays. The study aims to assess affordable and accessible diagnostic solutions to strengthen early TB case detection, timely reporting, and overall TB diagnostic services under the NTEP.
- 3) **Enhance Tuberculosis Diagnosis and Improve Linkage to TB treatment in Indian Children (End TB in Indian Children).** The “End TB in Indian Children” Project, supported by CDC and SHARE India, aims to strengthen childhood tuberculosis detection and improve linkage to care through innovative diagnostic approaches. The project focuses on improving TB evaluation and diagnosis among children with symptoms suggestive of TB by exploring alternative sample types such as stool and tongue swabs using molecular diagnostic technologies including Xpert MTB/RIF Ultra and Truenat MTB Plus. It also evaluates the effectiveness of these methods in comparison with standard national diagnostic algorithms and assesses the utility of Artificial Intelligence (AI)-based chest X-rays for rapid and streamlined TB screening and diagnosis in children.
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 3. Artificial Intelligence in Managing Drug Adherence, Sanjay Rajpal and Ankita Anand – Chapter published in book ' Update on MDR TB' editors, V.K. Arora and K.K. Chopra, 2024 published by Jaypee Brother, New Delhi.

4. Trends in Multidrug resistant Tuberculosis, Nishi Aggarwal, Sanjay Rajpal, and K.K. Chopra - Chapter published in book ' Update on MDR TB' editors, V.K. Arora and K.K. Chopra, 2024 published by Jaypee Brother, New Delhi, 25-28.
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SPOTLIGHT OF THE QUARTER

TB: The Mighty Leveler – Delhi's United Front Against India's Silent Epidemic

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Tuberculosis (TB) remains one of India's most formidable public health challenges. The country bears the world's highest burden of the disease, accounting for approximately 25% of all new TB cases globally in 2024. Overcrowding, widespread undernutrition, low-protein dietary habits, and the rising prevalence of co-morbidities such as diabetes, hypertension, and coronary artery disease create a vicious cycle that significantly increases TB incidence across populations.

In India, TB does not discriminate by class or economic status. Much like the “mighty leveler” described in James Shirley's poetry—where death renders everyone equal—TB strikes rich and poor alike. Healthcare professionals are not immune; for many doctors, nurses, and frontline workers, TB represents a genuine occupational hazard. Many themselves live with diabetes, obesity, or other chronic conditions that compromise immunity. Acknowledging this reality is the first step toward better self-protection and building system-wide resilience.

Stigma and the Need for Wider Screening

TB-related stigma has long been recognized as a barrier to care. However, recent studies show that while stigma persists and impacts mental health and social relationships, it does not always prevent individuals from seeking diagnosis and treatment once symptoms appear. This insight underscores the importance of expanding screening efforts beyond traditional high-risk settings such as slums. Screening must reach workplaces, healthcare facilities, and communities across all socioeconomic groups. A critical question for the medical fraternity remains: *How many doctors and health workers have undergone TB screening themselves?*

Innovative Partnerships Driving Progress

Delhi's response to the TB challenge showcases the strength of multi-stakeholder collaboration under the National TB Elimination Programme (NTEP). Government agencies, NGOs, private hospitals, and research institutions have come together to enhance detection, treatment, and prevention.

Notable contributions include:

- World Health Partners (WHP) and KHPT have trained TB Champions to promote testing and treatment adherence in communities.
- Humana is building capacity among ASHAs while providing additional manpower support.
- TBI focuses on screening homeless populations.
- REACH has trained Drug-Resistant TB (DR-TB) Champions to support patients at nodal centres.
- FIND has established a sputum collection centre near the Chest Clinic in Kingsway Camp.
- Share India is implementing Tuberculosis Preventive Treatment (TPT) at Chest Clinic Nehru Nagar and conducting screenings at ESI and BSA hospitals.

Private sector partners Medanta and Apollo Hospitals have provided vehicles for mobile screening in slums and among homeless groups. The Union has supplied 32 handheld X-ray machines along with radiographers for field-level detection. The Clinton Foundation has supported handheld X-ray deployment, while ICMR has accelerated TB research through focused workshops and provided additional handheld X-ray machines with radiographer support until March 2026.

The Delhi Government has demonstrated strong political will by procuring 448 handheld X-ray machines to decentralize diagnostics. The Chief Minister's office has also donated a PathoDetect machine capable of simultaneously detecting resistance to both Rifampicin and Isoniazid, enabling faster and more comprehensive drug-susceptibility testing.

Technological Innovations

A significant advancement is the introduction of portable, chip-based real-time PCR tests (such as Truenat or similar point-of-care molecular platforms) in select Delhi chest clinics. These battery-operated tools provide rapid results—often within an hour—directly from sputum samples. They detect *Mycobacterium tuberculosis* and key resistance markers with high accuracy, making them ideal for field use and peripheral settings where conventional laboratory infrastructure is limited.

Awareness, Community Engagement, and Quality Assurance

Delhi's TB programme has pioneered creative public awareness campaigns, including hoardings, advertisements on buses and metro trains, and TB messages displayed in PVR movie halls — a first for the capital's programme.

Active Jan Bhagidari (people's participation) has seen MLAs, MCD councillors, District Magistrates, the MCD Commissioner, Secretary (Health), and MD-DSHM actively engage with the initiative. The CRPF has organized dedicated TB awareness campaigns, while efforts to involve Corporate Social Responsibility (CSR) as NikshayMitras continue to expand, offering nutritional and infrastructural support.

These concerted efforts led to substantial case detection last year. The Delhi NTEP remains firmly committed to eliminating TB in alignment with the Sustainable Development Goals (SDGs) target of ending the epidemic by 2030.

To strengthen patient-centered care and service quality, Delhi has rolled out the MeraSwasthyaSewa app, which collects real-time patient feedback from health facilities.

A Call to Action

TB may be a mighty leveler, but a united, multi-sectoral response can level the playing field against it. Healthcare professionals must lead by example — getting screened regularly, staying vigilant about personal health, and actively championing early detection.

With sustained momentum and inclusive action, the vision of a TB-free India is within reach. The time for accelerated efforts is now.

Delhi NTEP Innovations: Reaching Every Person, Strengthening Every Life.

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The fight against tuberculosis (TB) in Delhi is not only about medicines and diagnostics — it is also about compassion, innovation, and community support. Under the National Tuberculosis Elimination Programme (NTEP), Delhi has adopted several patient-friendly and community-based initiatives to ensure that no person with TB is left behind, especially among vulnerable and hard-to-reach populations.

These innovative approaches are helping improve treatment adherence, nutritional support, counselling services, and rehabilitation opportunities for TB patients across the city.

Caring for the Homeless: Healthcare on Wheels

For over 15 years, the Delhi TB Association (DTBA) has been extending TB services to homeless individuals living near Shishganj Gurudwara and surrounding pavement areas. A dedicated medical van with a doctor regularly visits these locations to screen people for TB, collect sputum samples, and facilitate testing.

Patients diagnosed with TB are provided free anti-TB medicines, supportive medicines, protein-rich nutritional supplements, and regular meals. This outreach model has significantly improved access to care for one of the most neglected and vulnerable sections of society.

Strengthening MDR-TB Care Through Counselling and Nutrition

Patients suffering from Multi-Drug Resistant Tuberculosis (MDR-TB) often require prolonged treatment and continuous motivation. To address this, teams from GLRA conducted structured home visits and counselling sessions throughout the treatment period.

Patients received counselling at treatment initiation, every fifteen days during the intensive phase, and monthly thereafter. They were educated about medication adherence, nutritional intake, and the importance of promptly reporting adverse drug reactions. Nutritional support in the form of protein balls was also provided regularly.

This patient-centric approach contributed to better treatment completion rates and reduced treatment default among MDR-TB patients.

Expanding TB Services in Underserved Areas

The Damien Foundation India Trust (DFIT) established ten TB diagnosis and treatment centres in underserved localities lacking nearby government facilities. These centres provided infrastructure support, laboratory services, and medical consultation to ensure uninterrupted TB care.

In addition to free treatment, vulnerable and MDR-TB patients received monthly food rations including rice, pulses, flour, and groundnuts to support recovery. Importantly, the initiative also focused on rehabilitation and livelihood generation. Patients who completed treatment were offered vocational training in tailoring, sewing, and beauty services, along with support such as sewing machines and push carts to help them become financially independent.

Although funding constraints have reduced the number of active centres, the initiative remains an important example of integrated TB care and social support.

Bringing Treatment Closer to Communities

Operation ASHA introduced community-based DOT centres in South-East Delhi to make treatment more accessible. These centres were established close to patients' residences, reducing travel burden and improving convenience.

A biometric attendance system using fingerprint verification was introduced before medicine administration, ensuring treatment regularity and better monitoring. The initiative successfully improved adherence and reduced treatment interruptions.

Nutrition Support for Faster Recovery

Recognising the critical role of nutrition in TB recovery, Ramakrishna Mission has been providing eggs and bananas to TB patients along with their medicines. Such nutritional supplementation strengthens immunity and supports faster recovery during treatment.

Building Livelihoods After Treatment

Recovery from TB is not only medical but also social and economic. Several rehabilitated patients who had no stable livelihood after treatment were provided skill development opportunities in tailoring, stitching, and beauty services. Many beneficiaries have successfully established their own boutiques and beauty parlours, helping them regain confidence and financial stability.

Flexible Treatment Timings for Patient Convenience

To make treatment more patient-friendly, five evening DOT centres have been started in government dispensaries. This initiative benefits working patients and those unable to visit centres during morning hours. Additionally, nurses and pharmacists at multiple facilities have been empowered to dispense TB medicines, further improving accessibility.

Digital Innovation Through Video DOT

In collaboration with ZMQ, Video DOT services were introduced to support remote treatment monitoring. Patients are provided mobile phones to record short videos while taking their medicines at home. These videos are automatically uploaded to a central server, enabling healthcare providers to monitor adherence in real time without requiring daily physical visits.

This digital innovation has improved treatment compliance while reducing inconvenience for patients.

AyushmanArogyaMandirs as Comprehensive TB Care Centres

All AyushmanArogyaMandirs in Delhi are now functioning as TB treatment centres and are actively supporting TB diagnosis and management. Eighty-seven centres have already been equipped with TrueNat machines for rapid TB testing. In centres without testing facilities, healthcare workers collect samples and ensure transportation to nearby laboratories for timely diagnosis.

Towards a TB-Free Delhi

Delhi's TB control programme demonstrates that effective TB care extends beyond medical treatment. By integrating nutrition, counselling, digital technology, livelihood support, and community outreach, the programme is improving treatment outcomes and restoring dignity to patients.

These innovative initiatives reflect Delhi's commitment to ensuring equitable, accessible, and compassionate TB care for all — especially the homeless, poor, and underserved populations.

Together, through partnership, innovation, and community participation, Delhi continues to move steadily towards the goal of eliminating TB.

Delhi NTEP: National Tuberculosis Elimination Programme (NTEP)

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Vision of the Programme:-

- TB-free Delhi with zero deaths, disease and poverty due to TB

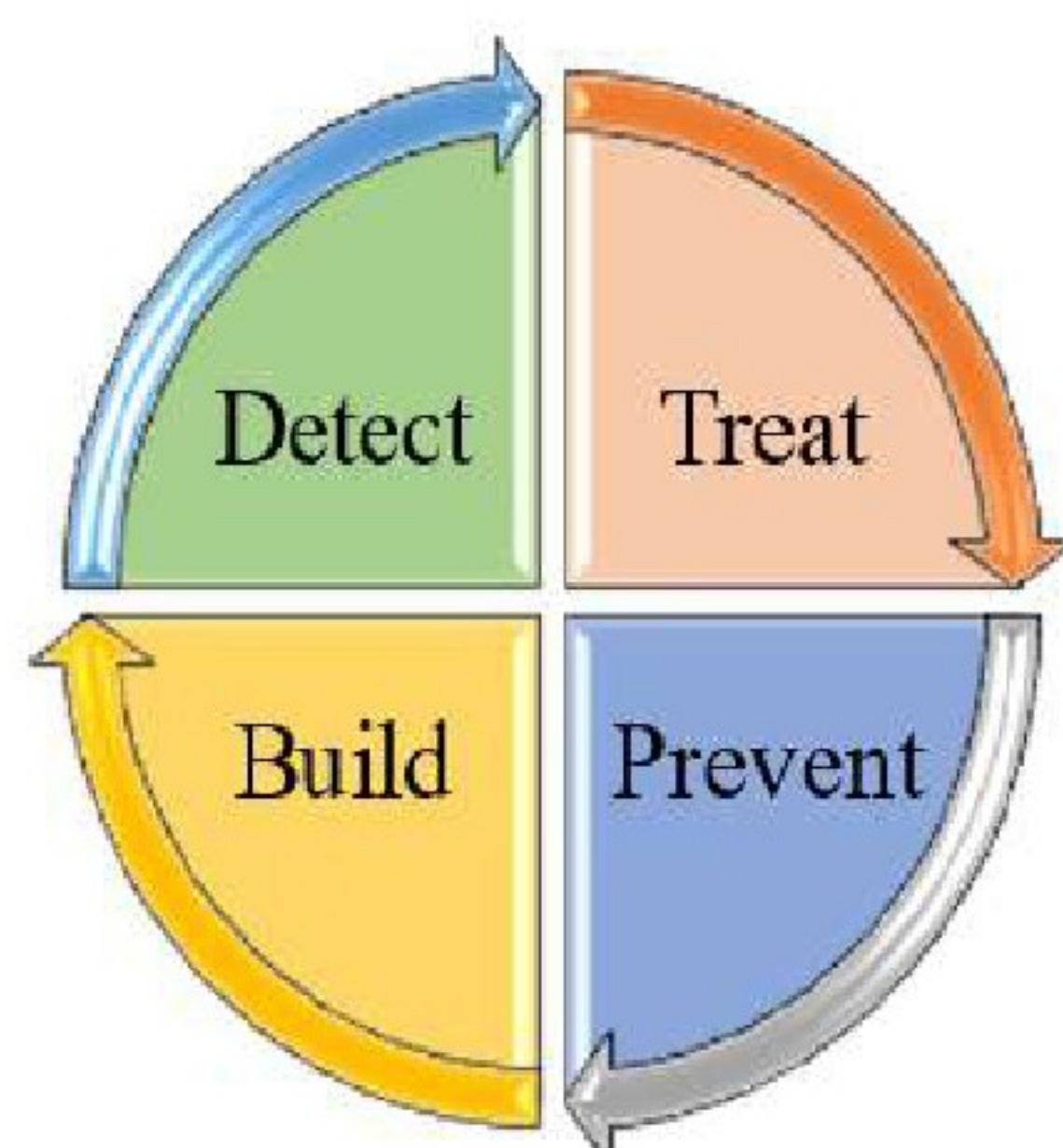
Goal

- To achieve a rapid decline in burden of TB, new cases and deaths while working towards elimination of TB in Delhi

Delhi NTEP Plan for achieving End TB Strategy (SDG3)

There are 4 Strategic Pillars of National Strategic Plan from Govt of India to achieve the goal of TB Elimination as per SDG3

NATIONAL STRATEGIC PLAN



Find all TB cases

Treat all TB cases

Prevent the emergence of TB in susceptible populations and stop catastrophic expenditure

Build and strengthen supportive systems

4 Strategic Pillars of NSP

Keeping in mind the four pillars of the National Strategic Plan, the plans and activities to make Delhi TB Free are being listed as follows:

1. DETECT ➤ Leveraging Ayushman Arogya Mandir (AAM) infrastructure to ensure timely diagnosis and treatment adherence. ➤ Ensuring screening of the vulnerable population through Chest X Ray, and if 10S positive, then diagnostic test through NAAT ➤ Establishing a Sample Collection and Transport Mechanism for timely diagnosis. ➤ Ensuring Universal Drug Susceptibility Testing (UDST) for each TB case to rule out drug resistance ➤ Facilitating active engagement of the private sector in NTEP.	1. TREAT ➤ Ensuring provision of 5 indoor Beds for TB patients at each Hospital of the NCT of Delhi ➤ Ensuring prompt treatment of all the TB patients (Drug Sensitive as well as Drug Resistant) both in the Public & Private Sector ➤ Involvement of ASHAs, Community DOT Provider/TB Champions/Family DOT Provider as Treatment Supporter. ➤ Ensuring Treatment Adherence through 99 DOTS Lite, Community DOT Providers, Ni-Kshay Sathi (Family Care Giver) ➤ Ensuring early management of Adverse Drug Reactions to prevent LFU. ➤ Ensuring Differentiated TB Care services. ➤ Ensuring timely follow up of all patients to always maintain a success rate of more than 90%. ➤ Ensure scale up of newer regimens such as BPaLM regimen to all MDR patients. Ensuring Differentiated TB Care services.
1. PREVENT ➤ Promote airborne infection control measures in the households, health facilities and community. ➤ Ensuring screening of all the Household Contacts of TB patients through Chest X Ray and, if eligible, Implementing PMTPT (TB Preventive Treatment) ➤ Implement TB infection testing via Cy-TB at both public and private health facilities ➤ Implementation of TB Preventive treatment guidelines among all vulnerable high-risk individuals after ruling out active TB in each of them. ➤ Ensure adherence of TB preventive treatment and completion of the same. ➤ Ensure monitoring and reporting of any ADRs that the beneficiaries may experience during treatment.	1. BUILD ➤ Capacity building of all NTEP manpower, private sector, stakeholders etc. ➤ Nutritional support to TB patients through DBT- Ni-kshay Poshan Yojna (NPY) Nutritional support to TB patients through DBT- Ni-kshay Poshan Yojna (NPY) ➤ Nutritional Food Baskets through Ni-Kshay Mitra Initiative. ➤ Advocacy Communication and Social Mobilisation (ACSM) activities through State TB Forum and District TB Forum Meetings with the involvement of senior state and district-level administrators ➤ Ensuring Community awareness for all through effective IEC. ➤ Multi-sectoral collaboration will be strengthened through the involvement of various Stakeholders. ➤ Strengthening the linkage with ART centres and NCD clinics. ➤ Large scale digital interventions such as 99 DOTS Lite, TB Aarogya Saathi App, Cough app, etc.

Infrastructure Delhi NTEP:

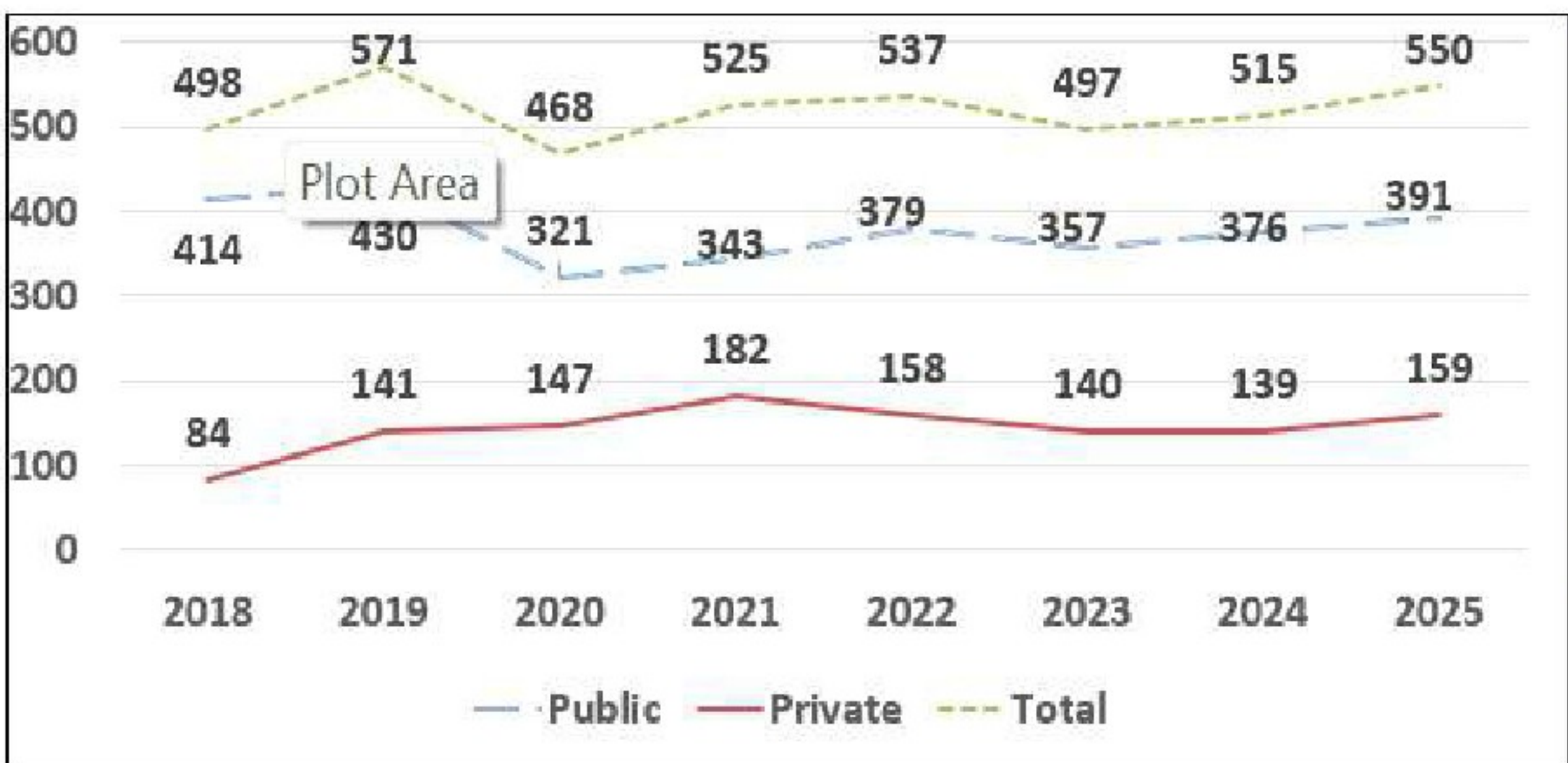
The Delhi State NTEP is being implemented through a decentralized flexible mode through 24 Chest Clinics equivalent to District TB Centre (DTC). Out of 24 Chest Clinics, MCD are running 12, NCTD-10, NDMC -1, Gol-1 Chest Clinics respectively.

State TB Training & Demonstration Centre (STDC)	1
District TB Centres (DTCs)	24 Chest Clinics
TB Units (TU)	38
Designated Microscopy Centres (DMCs)	190
Intermediate Reference Laboratory (IRL)	1. IRL –New Delhi TB Centre 2. IRL AIIMS MEDICINE DEPARTMENT
Culture & Drug Sensitivity (C&DST) Labs (excluding IRL)	NRL NITRD MEHRAULI (C&DST Lab for 4 Chest Clinics of Delhi) & RBIPMT C&DST Lab
Liquid Culture Laboratories for 2 nd line DST	IRL –New Delhi TB Centre IRL-AIIMS MEDICINE DEPARTMENT NRL NITRD MEHRAULI
Cartridge Based Nucleic Acid Amplification Testing (CBNAAT) Labs	32 CBNAAT Sites having 49 CBNAAT Machines covering all Chest Clinics
TrueNat Sites	87 TrueNat Sites (69 DUO, 17 UNO, 1 Quattro)
Nodal Drug Resistant TB Centre (DRTBC) (MDR TB Wards)	1) DRTB Centre RBIPMT 2) DRTB Centre LN Hospital 3) DRTB Centre AIIMS 4) DRTB Centre NITRD MDR TB Wards at RBIPMT, NITRD
District Drug Resistant TB Centre (DDRTBC)	District DR-TB Centers : 24 (All 24 Chest Clinics have District DRTB Centers) (MDR TB Wards- Patparganj & Nehru Nagar)

Delhi NTEP Achievements :

The Delhi State NTEP is being implemented through a decentralized flexible mode through 24 Chest Clinics equivalent to District TB Centre (DTC). Out of 24 Chest Clinics, MCD are running 12, NCTD-10, NDMC -1, Gol-1 Chest Clinics respectively.

Annualized TB Case Notification Rate (Per Lakh)



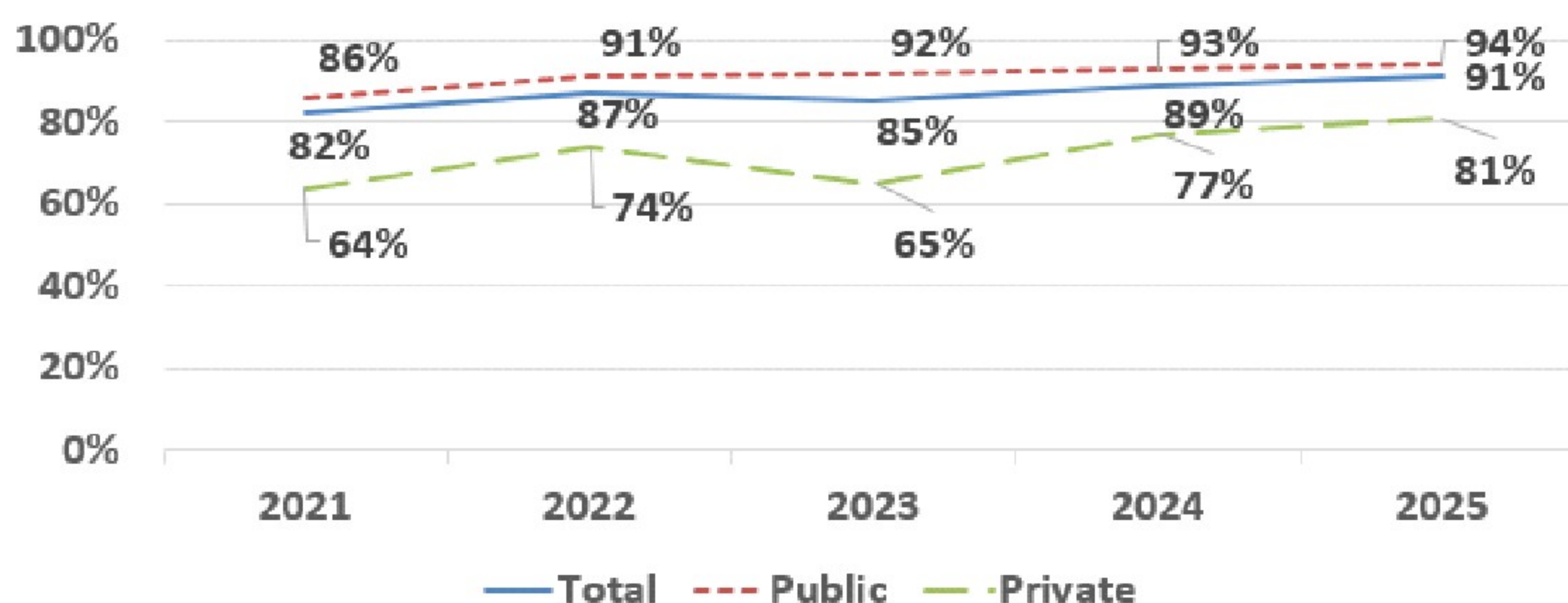
TB Notification per Lac per year ranges from 520 to 550 in last 5 years. In 2025, TB Notification rate was highest due to 100 Days intensified TB Campaign, Active Case Finding Activities as well as Upfront NAAT testing leading to early detection of TB.

TB NOTIFICATION (PUBLIC & PRIVATE)



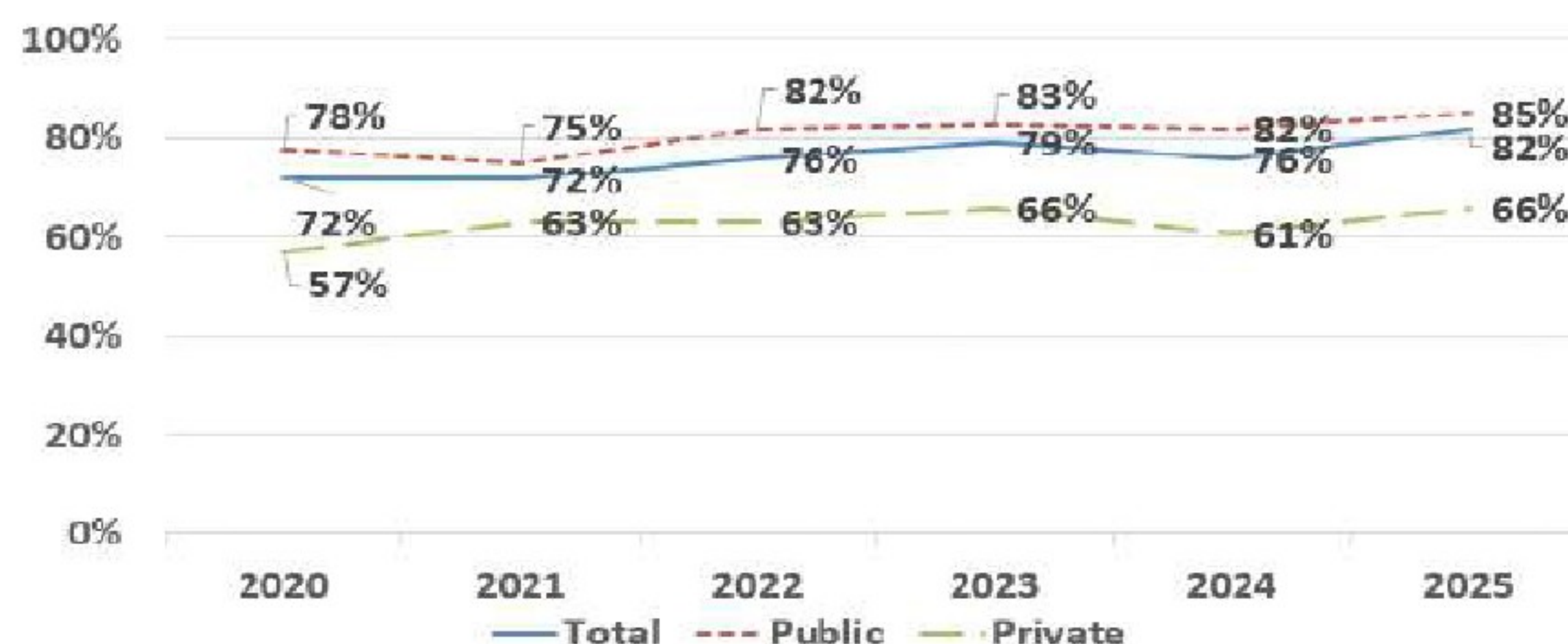
Delhi has been achieving above 90% of the target given by Central TB Division, Govt of India. In the year 2025, 112931 TB cases were notified against the target of 1,15,000 thereby achieving 98% of the target given by Govt of India.

HIV KNOWN STATUS



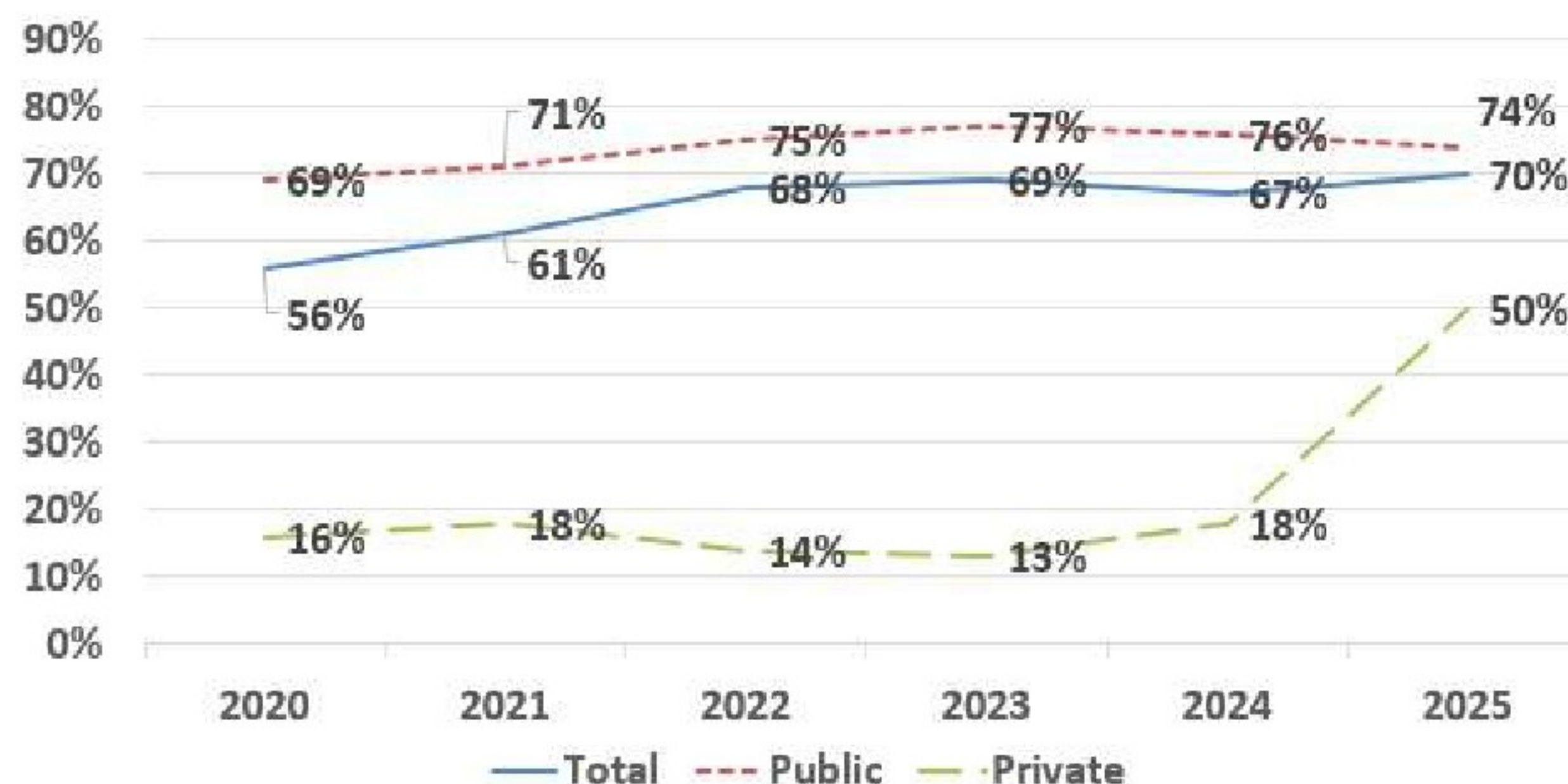
As per the mandate by Govt of India, HIV status of every TB patient should be known. Delhi has been achieving above 90% since five years. In year 2025, 91% of TB patients had been tested for HIV, in Public sector, this was 94%

TREATMENT SUCCESS RATE



Treatment Outcome is given for the TB patients put on treatment one year back. In the year 2025, 82% of TB patients had successfully completed the treatment. In Public patients, 85% of TB patients had successfully completed the treatment.

DBT Nikshay Poshan Yojna (Paid atleast once)



Under NTEP, every TB patient on treatment is given incentive under DBT Nikshay Poshan Yojna (NPY). Rs 1000/- per month is transferred to patient's Bank Account for taking good nutrition till patient completes the treatment. Homeless TB patients who do not have Bank Account, these patients are given nutritious food items for the amount they are entitled.

100 Days TB Campaign -Phase 1

- 100 Days TB Campaign was launched on 7th Dec 2024 till 23th March 2025
- The campaign focused on **early detection, treatment adherence, awareness, and community engagement**, bringing together diverse stakeholders, including **Government bodies, Corporate sectors, Academic institutions, and community organizations**.

13390 activities were conducted by Nikshay Shivirs /Nukad Natak/Munadi/NGOs/CSOs/Community Groups/SHG/Anganwadi/youth volunteer/Tb Champions/Religious Places/Political Leaders/Corporates/PSUs/elected representatives during the 100 Days Campaign by all the Chest Clinics

Performance of 100 Days TB Campaign Phase 1

- 11,63,548 Vulnerable population screened **(40%)** out of Total vulnerable 29,45,683
- 4,93,977 Chest X ray done **(42%)** out of Vulnerable Population screened 11,63,548
- 2,82,832 NAAT test done **(78%)** out of total tests done 3,61,040 (Microscopy+NAAT)
- 43,755**(39%)** of TB patients have been paid all benefits under Nikshay Poshan Yojna
- 37,490 **(38%)** of TB patients have received Poshan Kits through Nikshay Mitra Initiative
- 51602**(40%)** of Eligible House Hold Contacts Beneficiaries have been initiated on TPT

Delhi received the **Jan Bhagidari Award** during the World TB Day Event (24th March 2025) from **Union Minister Hon'ble Sh J.P.Nadda**.

TB Mukt Bharat Abhiyan Ph 2.0 -100 Days Campaign

- 100 Days TB Campaign which has been now been extended and named **TB Mukt Bharat Abhiyan** is being implemented in all the Revenue Districts (24 NTEP Chest Clinics).
- **TB Mukt Bharat Abhiyan 2.0-100 Days TB Campaign** was flagged off in Delhi by Sec (H&FW)GNCTD,MD DSHM & DGHS GNCTD at MCD Chest Clinic Nehru Nagar on **24th March 2026** along with the National Launch
- The Campaign places special emphasis on Intensified Case Finding among **Vulnerable high risk groups**, including **patients with Past H/o TB, House Hold contacts of TB patients, Healthcare workers, individuals undergoing Dialysis/organ transplant, those on Immunosuppressive Therapy, People Living with HIV, Persons with Diabetes, Geriatrics(Above 60 Years age),Under nourished (BMI<18.5Kg/m²), smokers, Alcohol abusers etc** and offering TB Preventive Treatment to all the eligible.
- As mandated by the Central TB Division, MoH&FW, GoI, **routine screening for active Tuberculosis using Chest X-Rays and screening of latent Tuberculosis using Cy-TB test** along with Early identification of symptoms and Timely initiation of Treatment for Latent as well as active Tuberculosis, is therefore critical to prevent TB morbidity and mortality and to interrupt transmission in these high-risk Groups.

Achievements under TB Mukt Bharat Abhiyaan 2.0 24 Mar 2026 – 17 May 2026

- Total *Ayushman Arogya Shivirs* held – 1351 (285 *Shivirs* in HighRisk wards / areas)
- Population screened in *Shivirs*: 77,037
- X-ray Done : 95,188
- NAAT tests done: 46,178
- Total TB patients notified: 16,762
- Total Household Contacts provided TB preventive treatment: 13,482
- Total TB patients provided food baskets under Ni-kshay Mitra Initiative: 6447
- Total Ni-kshay Mitras registered: 120
- MLA / MPs /Counsellors engaged: 126

AWARDS & ACHIEVEMENTS

1. Delhi Secures 3rd Rank at National ACSM Review

Delhi has achieved a significant milestone by securing the 3rd rank at the National ACSM (Advocacy, Communication & Social Mobilization) Review, organized by the Government of India under the National Tuberculosis Elimination Programme (NTEP). This recognition highlights Delhi's outstanding efforts in driving innovations, impactful presentations, and community-focused strategies aimed at TB awareness and stigma reduction.

The achievement reflects the collective dedication of the state TB team in strengthening community engagement, promoting behavior change communication, and ensuring wider outreach through innovative IEC activities. Focused interventions such as awareness campaigns, stakeholder engagement, and targeted communication strategies have played a key role in addressing stigma and improving TB service uptake.

Being recognized at the national level is a testament to Delhi's commitment towards accelerating TB elimination efforts and adopting people-centric approaches under ACSM. This accomplishment not only reinforces Delhi's leadership in public health communication but also sets a benchmark for other states to replicate innovative and community-driven practices.

Kudos to the entire team for their relentless efforts and commitment to creating a TB-free Delhi.



2. Delhi has achieved the Sustainable Development Goal (SDG) targets for neonatal mortality (7 per 1,000 live births) and under-five mortality (13 per 1,000 live births), substantially outperforming the national averages of 18 and 28, respectively (SRS 2024).

Lok Nayak Hospital achieves NQAS certification

The Lok Nayak Hospital has achieved the National Quality Assurance Standards (NQAS) Certification from the Ministry of Health and Family Welfare, Government of India, achieving an outstanding score of 95.89%. The hospital was also recognized as a Kayakalp Winner in the category of hospitals with more than 500 beds for FY 2025–26, underscoring its unwavering commitment to quality healthcare, patient safety, cleanliness, infection control, and efficient hospital management. This remarkable achievement was made possible through the collective efforts and dedication of the hospital's healthcare workers, administrators, and support staff, along with the continuous guidance, technical support, and mentoring provided by the Quality Assurance Cell (QA Cell), reflecting a strong culture of quality improvement and excellence in patient care.



NQAS certification for Lok Nayak hospital

Kushagra.Dixit
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New Delhi: Lok Nayak Jai Prakash Narayan Hospital has become the country's first 2,000-bedded govt hospital to receive the National Quality Assurance Standards (NQAS) certification from Union health ministry, officials said recently.

The certification recognises Delhi govt-run tertiary care hospital's performance across critical healthcare quality indicators, including patient safety, infection control, clinical services and hospital administration.

Praising the hospital staff, medical director Dr B L Chaudhary described the achievement as a result of "collective dedication, teamwork and commitment" shown by doctors, nurses, faculty members, sanitation





below the balcony where the couple was stranded.

re on the second floor when the fire broke out. The beat of

workers, security personnel, PWD staff and administrative employees.

According to hospital authorities, LNJP Hospital secured exceptionally high scores in the NQAS assessment. It achieved 99.4% in service provision, 96.1% in patient rights, 97.6% in clinical services, 97% in infection control and 95.6% in quality management. The hospital also scored 99.5% in patient privacy and dignity while recording a patient satisfaction score of 87.3%.

Among specialised facilities, the pharmacy department scored 95.8%, the ICU 96.7% and the haemodialysis centre 97.9%.

The hospital also introduced digital monitoring and patient feedback systems, transparent grievance redressal mechanisms, improved drug inventory management and water supply.



लोकरनायक अस्पताल बना देश का पहला 2000 बेड वाला एनक्वैएस प्रमाणित सरकारी संस्थान

सर्वो निम्नलिखित 25 वर्षों में (कोलकाता शहर)। लोक नयक अस्पताल को भारत सरकार के द्वारा एक राष्ट्रीय स्तर पर सर्वोत्तम माना जा रहा है। इसकी विशेषता यह है कि यह 2000 बेड वाला अस्पताल है जो देश का पहला 2000 बेड वाला अस्पताल है जिसने एनक्वैएस प्रमाणित किया है। इसे विश्व स्वास्थ्य संगठन की ओर से राष्ट्रीय गुणवत्ता अवार्ड प्राप्त हुआ है।

अस्पताल में डॉक्टर, नर्सिंग स्टाफ और अन्य कर्मचारी शामिल हैं जो रोगियों को बेहतरीन सेवाएं दे सकते हैं। अस्पताल में अत्याधुनिक चिकित्सा उपकरण और तकनीकें हैं जो रोगियों को बेहतरीन देखभाल दे सकती हैं। अस्पताल में अत्याधुनिक चिकित्सा उपकरण और तकनीकें हैं जो रोगियों को बेहतरीन देखभाल दे सकती हैं।



एन वनव्यूएस प्रमाणित सरकारी संस्थान

एन वनव्यूएस प्रमाणित सरकारी संस्थान

लोकनायक अस्पताल बना देश का पहला 2000 बेड वाला एनव्यूएस प्रमाणित सरकारी संस्थान

एन वनव्यूएस प्रमाणित सरकारी संस्थान

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एन वनव्यूएस प्रमाणित सरकारी संस्थान

एन वनव्यूएस प्रमाणित सरकारी संस्थान

मरीज सुरक्षा से संक्रमण नियंत्रण तक करीब 100 से अधिक पैरामेडिकल स्टाफ मेंमैन पर किया अक्रेडिटेशन

एन वनव्यूएस प्रमाणित सरकारी संस्थान

एन वनव्यूएस प्रमाणित सरकारी संस्थान

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एन वनव्यूएस प्रमाणित सरकारी संस्थान

अतिरिक्त पैरामेडिकल स्टाफ की भी सुरक्षा के लिए अलग से प्रशिक्षण

एन वनव्यूएस प्रमाणित सरकारी संस्थान

एन वनव्यूएस प्रमाणित सरकारी संस्थान

Field Voices

Experiences and stories from frontline workers

Ms. Azra Jamal

State ACSM Officer- Delhi State NTEP
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Voices of Strength, Stories of Recovery

For many patients, the biggest challenge is not just the illness, but the fear and stigma associated with it. Continuous counselling and support from frontline workers help patients gain confidence and stay on treatment. Families and communities also play a crucial role. Their encouragement ensures that patients complete their full course of treatment without interruption.

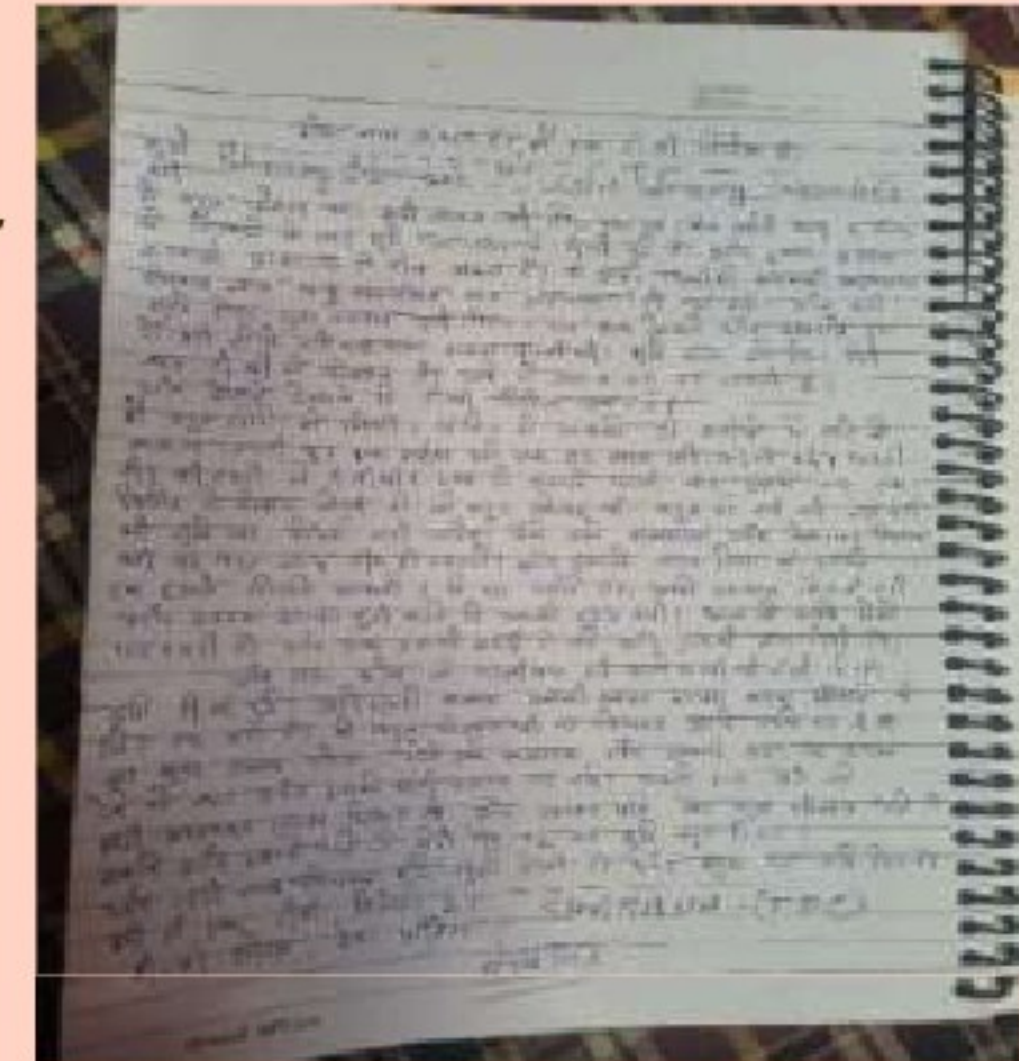
Voices of TB Vijeta

Those who have successfully completed TB treatment often emerge stronger—as TB Vijeta (TB Champions)—and become advocates for awareness and support.



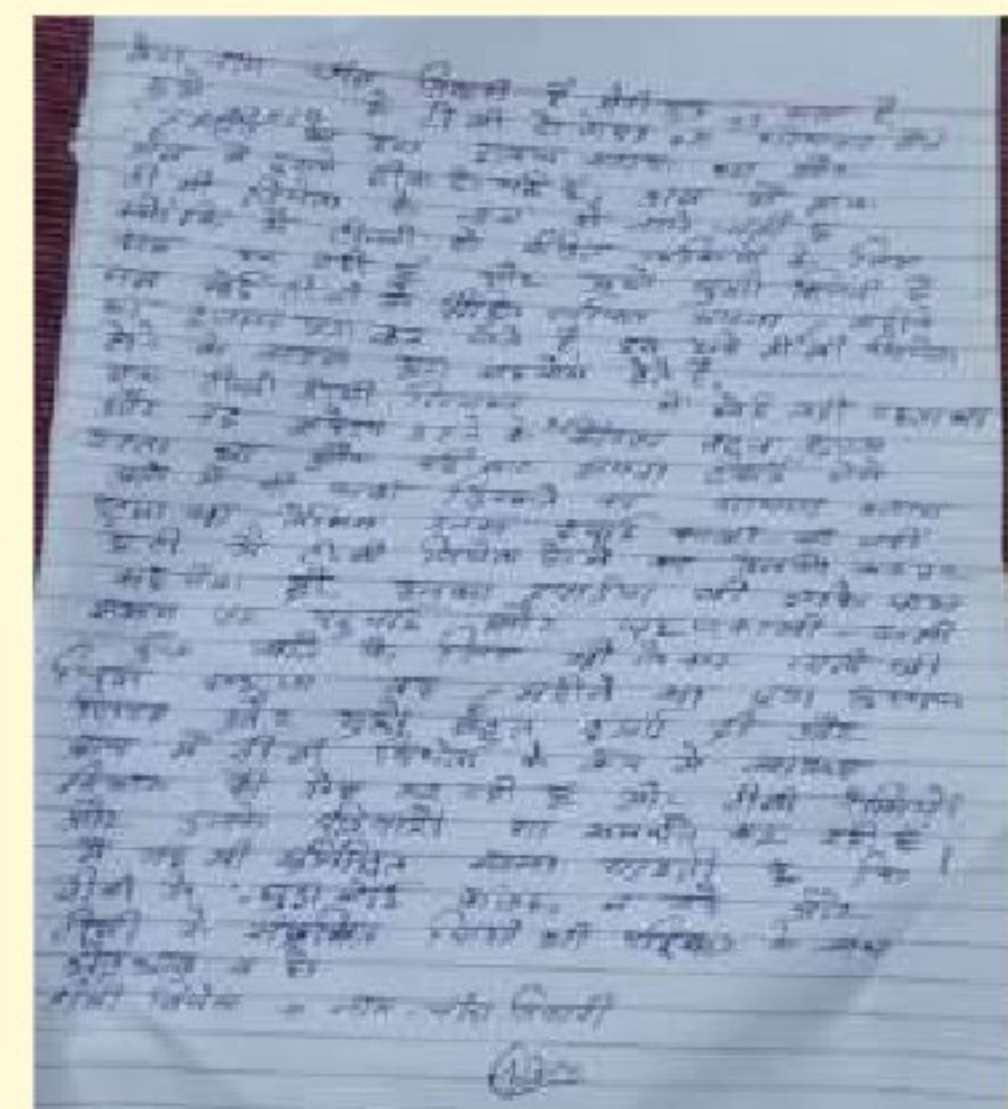
*“मैं खुद टीबी से लड़ी हूँ और इस पर जीत हासिल की है।
अब मैं दूसरे मरीजों को बताती हूँ कि टीबी का इलाज
संभव है और डरने की कोई जरूरत नहीं है।
आज मैं टीबी विजेता हूँ और टीबी के प्रति
जागरूकता फैला रही हूँ।”*

*— शबाना, टीबी विजेता
बी.जे.आर.एम. चेस्ट क्लिनिक, दिल्ली*



*“लोगों का डर और कलंक (स्टिग्मा) सबसे बड़ा
चुनौती है। इसलिए मैं समुदाय में जाकर अपनी
कहानी साझा करती हूँ, ताकि लोग समझें
कि टीबी पूरी तरह ठीक हो सकती है।”*

*— चीनू तिवारी, टीबी विजेता,
शाहदरा चेस्ट क्लिनिक, दिल्ली*



TB Vijetas are actively strengthening the program by reducing stigma, motivating patients, and encouraging treatment completion within communities. Their involvement, along with families, Nikshay Mitras, and local leaders, plays a crucial role in community engagement under NTEP, leading to better awareness, early health-seeking behavior, and improved case detection and treatment outcomes.

Stories of Service and Dedication from Frontline Workers

Voice of ASHA



" आशा कार्यकर्ता के रूप में मेरा अनुभव "

मैं एक आशा कार्यकर्ता हूँ, और अपने क्षेत्र में टीबी मरीजों के साथ काम करती हूँ। जब मुझे किसी मरीज के बारे में पता चलता है, तो शुरुआत में अक्सर वह बहुत डरा हुआ होता है। कई बार मरीज और उनके परिवार वाले टीबी को लेकर गलत धारणाएँ रखते हैं और समाज के डर (stigma) की वजह से खुलकर बात नहीं करना चाहते।

मेरा पहला काम होता है उन्हें समझाना कि टीबी एक पूरी तरह ठीक होने वाली बीमारी है और सरकार द्वारा इसका मुफ्त इलाज उपलब्ध है। मैं मरीज को नियमित दवाई लेने के लिए प्रेरित करती हूँ और उन्हें यह भरोसा दिलाती हूँ कि अगर वे इलाज बीच में नहीं छोड़ेंगे तो निश्चित रूप से ठीक हो जाएंगे।

कई बार चुनौतियाँ भी आती हैं- कुछ मरीज दवाई लेने में लापरवाही करते हैं या बीच में इलाज छोड़ने की कोशिश करते हैं। ऐसे समय पर मैं उनके घर जाकर उनसे और उनके परिवार से बात करती हूँ, उन्हें समझाती हूँ और उनका हौसला बढ़ाती हूँ।

जब कोई मरीज पूरी तरह ठीक हो जाता है, तो मुझे बहुत खुशी होती है। यह मेरे लिए सिर्फ एक काम नहीं, बल्कि समाज की सेवा है। मैं चाहती हूँ कि हर व्यक्ति टीबी के बारे में जागरूक हो और बिना डर के इलाज कराए, ताकि हम सब मिलकर अपने क्षेत्र को टीबी मुक्त बना सकें।

— Beena, ASHA Worker Chest Clinic Nehru Nagar

ASHA workers play a pivotal role in the TB Program by bridging the gap between healthcare and the community. Their dedication in raising awareness, countering social stigma, and ensuring treatment adherence through constant personal support is critical to making India TB-free"



Sumit Kumar

मैं एक Treatment Supporter के रूप में काम कर रहा हूँ, और मुझे 6 साल हो गए हैं। मैं एक TB Champion के रूप में कार्यक्रम से जुड़ा था, लेकिन धीरे-धीरे मैं काम सीखता गया और TB के मरीजों को treatment के दौरान उनकी psychosocial support करना मुझे एक satisfaction देता है।

बहुत सारे doubt होते हैं patients के और डर भी, फिर इस बात का पूरा ख्याल रखना पड़ता है कि अगर कोई patient मेरे under दवाई खा रहा है तो उसे हर तरह की सुविधा में दिला सकूँ।

मेरे पास अभी 10 patients हैं। मैं BJRM Chest Clinic के under नियुक्त हूँ।

"एक Treatment Supporter के रूप में मेरा प्रयास है कि हर TB मरीज तक समय पर दवा और सही मार्गदर्शन पहुंचे। मरीजों को psychosocial support देना ही मेरे काम की सबसे बड़ी संतुष्टि है।" सुमित सिंह, ट्रीटमेंट सपोर्टर, चेस्ट क्लिनिक BJRM,

Ni-kshay Mitra

My Journey as a Nikshay

I am **Dr. Mukut Bhowmik**, WHO Consultant Gol. I am an active Nikshay Mitra, I began my journey by adopting just one TB patient. Initially, my intention was simple—to provide nutritional support in the form of ration.

However, when I started visiting the patient's home, I realized something much deeper. The family wasn't just waiting for the ration—they were waiting for me. They wanted someone to listen to them, understand their problems, and guide them.

Coming from a poor and less-educated background, they looked at me not just as a supporter, but as someone they could trust for advice and reassurance. I noticed that they were often more eager for conversations and guidance than for the ration itself.

This changed my perspective completely. I understood that beyond nutrition, psychosocial support plays a far more important role in a patient's recovery. Gradually, I increased the number of patients I support.

Later, I adopted five children from Bijwasan Chest Clinic. Along with providing them ration, I also tried to guide and support them in every possible way. Inspired by this work, even my parents became Nikshay Mitras and joined this effort.

I truly believe that the purpose of this scheme is not just to provide a nutrition basket, but to create a connection with patients—to talk to them, support them emotionally, and stand by them during their long treatment journey. Taking medicines continuously for six months is not easy for any patient, and this is where our role becomes crucial.

Through these small but meaningful efforts, I am committed to contributing towards the vision of a TB-free Delhi.



Family of the patient receiving the food basket



A patient, 15-year-old female, was diagnosed with Pulmonary Tuberculosis (PT TB). At the time of diagnosis, her condition was quite critical. She had significant weight loss, marked weakness, complete loss of appetite, frequent episodes of vomiting, and severe breathlessness. Following clinical evaluation and investigations, she was started on anti-TB treatment. In addition, supportive medications and injections were administered to help manage her breathlessness and provide early symptomatic relief.

One of the major challenges during the initial phase of treatment was her intolerance to medications. The patient experienced nausea and vomiting even at the sight of the medicines, and multiple attempts to take the drugs resulted in vomiting. To address this, continuous counselling was provided to both the patient and her caregivers. She was guided on appropriate methods of drug intake, including maintaining a time gap, taking medicines with light meals, and consuming them with foods she found palatable.

With consistent counselling, support, and adherence to treatment, the patient has shown significant improvement. Her appetite has gradually returned, her weight is increasing, and her breathlessness has reduced considerably. Most importantly, she is now able to take her medications regularly without difficulty.

This case highlights the importance of not only medical treatment but also continuous counselling and psychosocial support in ensuring successful TB treatment outcomes.

Medical Officers ensure accurate diagnosis and standardized treatment under NTEP guidelines, including management of drug-sensitive and drug-resistant TB.

Photo Feature

A glimpse into on-ground activities under NTEP Delhi—highlighting the dedication of frontline workers and community and political participation in the fight against TB.



Team Moti Nagar doing HH Survey during 100 Days TB Campaign World TB Day 2026: Beautiful Floral Displays Across NDMC Areas Promoting TB Awareness and Support



State Launch of 100-Day TB Campaign on the World TB Day 24th March 2026



Sensitisation Activities under 100-Day #TBMuktBharat Abhiyan at Sultan Puri in Presence of Shri Mukesh Ahlawat Ji, MLA – Organized by SGM Chest Clinic on 2 April 2026



TB Sensitisation Rally Conducted with Active Participation of BJRM Hospital Chest Clinic Staff, PHI Team, ANMs & ASHAs on 2 April 2026



School Activity conducted at KSV West Moti Bagh under PHI Aam Sahzada Bagh, CC Gulabi Bagh on 6th April 2026



TB Awareness Shivirs & Screening Initiatives at Ayushman Arogya Mandir, DMC Sant Nagar under Kingsway Chest Center, in Presence of Chief Guest Shri Gagan Chaudhary, Municipal Corporator (Jharoda Ward) on 5th April 2026



100-Day TB Campaign under the Leadership of Hon'ble Ms. Meenu Goyal (Municipal Councillor, Tri Nagar Ward No. 63) at Gulabi Bagh Chest Clinic on 10th April 2026



Ayushman Arogya Shivar at Bhatti Mines, Fatehpur Beri under NITRD on 10th April 2026 under #TBMuktBharat 100-Day Campaign



Ayushman Arogya Shivar at Private Facility under BJRM Chest Clinic during TB MBA on 21 April 2026



Ayushman Arogya Shivar at CC Jhandewalan: TB Awareness with BP & Sugar Screening for Early Detection on 24th April 2026



Ayushman Arogya Shivar at RCWA Conference Hall, CRPF 103 Battalion RAF under Chest Clinic Karawal Nagar dated 25th April 2026



TB Diagnosis & Treatment Centre Inaugurated by Hon'ble Health Minister Dr. Pankaj Kumar Singh at Vikas Nagar Ayushman Arogya Mandir, RTRM Chest Clinic, Delhi on 29 April 2026





Hon'ble MLA Tilak Ram Gupta graced the Ayushman Arogya Shivr at Indira Gandhi Polyclinic under Ch. Desraj Chest Clinic. CAMO Dr. N.K. Indra & DSACS (APD) Dr. Akshay were also present, adding to the occasion.



Ayushman Arogya Shivr at National highway Authority of India NHAI for Workplace TB Screening with Support from Bijwasan Chest Clinic



Orientation of My Bharat Volunteers on 21st May 2026 at Vishwa Yuva Kendra with the collaboration of Younite Global

Listening to Patients: QR-Based Feedback in Delhi's Chest Clinics

Dr. Devinder Yadav

**SPO, Quality Assurance Cell
Delhi State Health Mission**



The National Tuberculosis Elimination Programme (NTEP) aims to provide quality care to every TB patient. As part of quality improvement in chest clinics, the Quality Assurance Cell, Delhi State Health Mission (DSHM), has started a QR-based patient satisfaction system in all chest clinics of Delhi.

The idea is simple. A QR code is displayed at each chest clinic. When a patient scans it with a mobile phone, a short feedback form opens on the screen. The patient can fill it easily, without giving their name.

The form is easy to understand. It uses simple smiley faces to rate services from “poor” to “best.” Patients give feedback on many areas. These include the display of information boards, the time taken for registration, seating and fans in the waiting area, drinking water, and clean toilets. They also rate the time taken to see a doctor and to get medicines, the availability of laboratory tests and medicines, the behaviour of clinic staff, and their overall satisfaction with the treatment and services.

There is also a box where patients can write their suggestions.

This initiative gives patients a direct voice. The feedback is quick, easy, and anonymous. It helps the clinic team understand what is working well and where improvement is needed.

The Quality Assurance Cell reviews this feedback regularly. Based on the results, corrective actions are taken to improve services. In this way, patient feedback becomes a tool for continuous quality improvement.

This patient-centred approach supports the goals of the National Quality Assurance Standards (NQAS) and NTEP. By listening to patients, we can make our chest clinics more responsive, more comfortable, and more effective in the fight against TB.

प्रिय लाभार्थी,
यह चिकित्सालय आपको गुणवत्तापूर्ण प्राथमिक स्वास्थ्य सेवाएं देने के लिए चलाया जा रहा है। इस चिकित्सालय में दी जाने वाली स्वास्थ्य सेवाओं के मूल्यांकन और उनको और बेहतर बनाने के लिए आपकी संतुष्टि तथा सुझाव जानना जरूरी है। यह जानने के लिए इस पोर्टल को बनाया गया है।

क्यूआर कोड को मोबाइल से कैसे स्कैन करें?

1. फोन के कैमरे या गूगल लेंस से पोस्टर पर लगे क्यूआर कोड को स्कैन करें अपने फोन को 2-3 सेकेंड के लिए स्थिर रखें जिससे की आप कोड को आसानी से स्कैन कर सकेंगे।
2. स्कैन करने के पश्चात आपके मोबाइल पर delhi-delhi.gov.in/ का लिंक दिखेगा उस पर क्लिक करके आगे बढ़ें।
3. लिंक पर खुले मेरा स्वास्थ्य केंद्र पोर्टल के होम पेज पर दिए गए जीनरैक बटन पर क्लिक करें।
4. जीनरैक पेज पर अपनी राय दें और सबमिट बटन पर क्लिक करें।

आपकी प्रतिक्रिया और सुझाव हमारे लिए बहुमूल्य हैं।

क्वालिटी एंशुरेंस सेल
दिल्ली राज्य स्वास्थ्य मिशन
ब्लॉक 1, ए एवं बी विंग, विंगल अटच-2, सिविल लाइन्स, दिल्ली-110054

Best Practices

Best Practices: GTB Chest Clinic, Delhi

Dr. Jitendra Sharma

District TB Officer
GTB Hospital Chest Clinic
E Mail - dtodlgtb@rntcp.org



GTB Chest Clinic demonstrated an innovative, patient-centric TB care model on World TB Day 2026 through strong multi-sectoral collaboration.

A key best practice was the integration of AYUSH with TB care, providing immunity-boosting and liver-support kits to patients, promoting holistic recovery alongside standard TB treatment. The clinic also strengthened community participation by mobilizing PG students and faculty under the Nikshay Mitra initiative, enabling on-the-spot registration of supporters and distribution of nutritional kits to TB patients.

This approach of combining medical treatment with wellness support and community engagement highlights a scalable model for improving treatment outcomes and advancing TB elimination efforts.

PRO TIP POINT

Nutrition in TB Management & Recovery

Ms. Azra Jamal

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Adequate nutrition is a critical component of Tuberculosis (TB) management and plays a significant role in improving treatment outcomes. TB often leads to weight loss, weakness, and reduced immunity, making it essential for patients to maintain a balanced and nutrient-rich diet throughout the course of treatment.

A diet rich in proteins, calories, vitamins, and minerals supports faster recovery, enhances immune response, and helps the body better tolerate anti-TB drugs. Patients are advised to include protein-rich foods such as pulses, eggs, milk, and paneer, along with seasonal fruits and green leafy vegetables to meet their nutritional requirements. Adequate fluid intake is also important to maintain hydration and overall well-being.

Nutritional Support under NTEP:

To address the nutritional needs of TB patients and improve treatment outcomes, the Government of India has introduced the following key initiatives:

1. Nikshay Poshan Yojana (NPY)

Nikshay Poshan Yojana is a Direct Benefit Transfer (DBT) scheme under NTEP that provides financial assistance to all notified TB patients.

- Each TB patient receives ₹1000 per month during the course of treatment
- The amount is transferred directly to the patient's bank account via Nikshay -PFMS/IFMIS interface through DBT.
- The objective is to support patients in meeting their nutritional requirements and prevent weight loss and weakness

Benefit: Helps patients maintain adequate nutrition; improve immunity, and supports better treatment adherence and recovery.

2. Nikshay Mitra Initiative:

Nikshay Mitra is a **community support initiative** that encourages **individuals, NGOs, corporates, and institutions** to voluntarily support TB patients. Nikshay Mitras can **adopt TB patients** for the duration of their treatment. They provide **nutritional baskets, food support, and other assistance**. It also includes **emotional and social support**, reducing stigma and isolation

Benefit: Bridges nutritional gaps, strengthens community participation, and ensures holistic care for TB patients beyond medical treatment.

Together, these initiatives ensure that TB patients receive not only free diagnosis and treatment but also the nutritional and social support needed for complete recovery.

UPCOMING EVENTS



JUNE - JULY

1st June to 31st July 2026	Stop Diarrhea Campaign 2026
1st July to 31st July	Anti Dengue Month
11th July to 17th July	World Population Week
28th July	World Hepatitis Day
First week July	IUCD insertion Training for Medical Officers & State Training on AFHS
Second Week July	IUCD insertion Training for Nursing Personnel



AUGUST - SEPTEMBER

1st August to 7th August	World Breastfeeding Week
10th August	National Deworming Day
21st August	Maternal Death Review Training
March 2026 to August 2026	HPV Vaccination Campaign
August and September 2026	Special immunization Campaign (tentative)
First week of September	ToT on Maternal Health
17th September	World Patient Safety Day
28th September	International Safe Abortion Day & World Rabies Day
29th September	World Heart Day
September Month Observe as National Nutrition Month (including National Nutritional week 1st-7th Sept.)	



NOTES

DATE: _____

2026

January

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February

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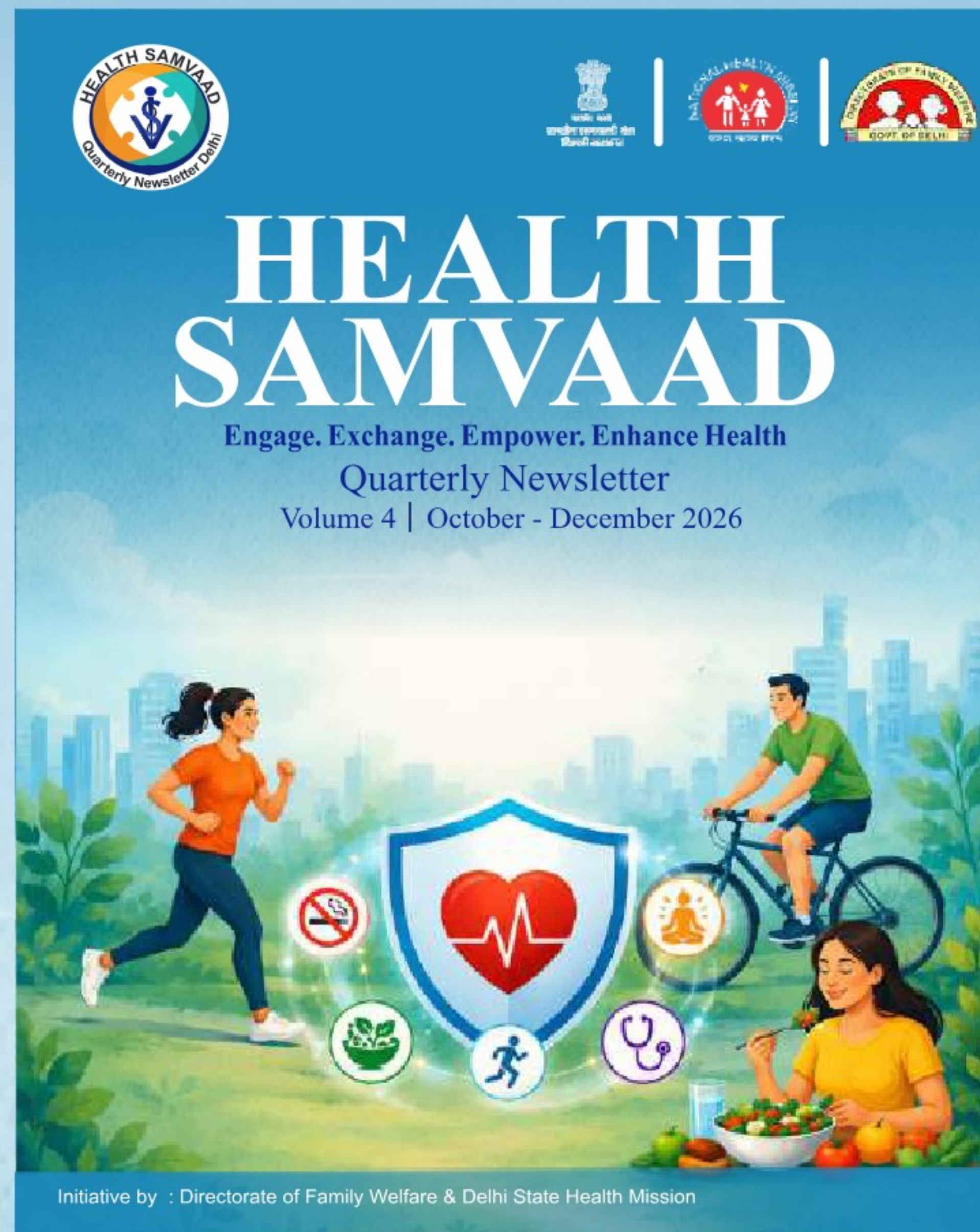
November

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December

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Forthcoming Issue



As India advances its response to the growing burden of Non-Communicable Diseases, the upcoming edition of Health Samvaad will feature promising practices, programmatic innovations, and success stories driving healthier communities and better health outcomes.



**Directorate of Family Welfare
Government of N.C.T. of Delhi**