MINISTRY OF HEALTH

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Date:25th September 2025

To: All County Directors for Health

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The Chief Executive
Council of Governors
Delta House- Westlands
NAIROBI

RE : ROLL-OUT OF NEW TB PREVENTIVE THERAPY REGIMENS

Tuberculosis infection (TBI) represents a dormant state where individuals harbor *Mycobacterium tuberculosis* bacteria without active disease symptoms or infectiousness, though they remain at risk for developing active TB. TB preventive therapy (TPT) effectively reduces this progression risk by 33-90% depending on the regimen used.

Following WHO's 2024 guidelines recommending expanded TPT use, the Ministry of Health will implement a new **6-month levofloxacin regimen** specifically for contacts of rifampicin-resistant and multidrug-resistant TB patients, effective **January 1st, 2026**.

RATIONALE

Drug-resistant TB(DRTB) poses significant risks of mortality and morbidity to patients and their contacts. This makes it essential to take all measures possible to lower the risk of secondary cases of MDR/RR-TB through appropriate TPT with regimens of proven effectiveness. Table 1 summarizes considerations when using a 6-month levofloxacin TPT regimen.

Table 1: Levofloxacin (6-month) TPT Regimen for DR-TB Contacts

Features	Description
Target Population	Household and close contacts of bacteriologically confirmed MDR/RR-TB patients (within the past 12 months)
Eligibility	**To be initiated among those who have;** - No TB symptoms/negative TB screening - No contraindications to fluoroquinolones - Provided informed consent

	- Pregnancy status: defer until 2nd trimester (unless benefit outweighs risk)
Exclusions	**To be avoided in those with;** -Active TB disease - Fluoroquinolone resistance in the index case - Allergy to fluoroquinolones - Severe renal/hepatic disease - Already on another TPT regimen
Pre-treatment requirements	**Before starting a patient on levofloxacin TPT clinician should;** - Check the type of resistance of the index case -Confirm TB infection (IGRA/TST if available) - Rule out active TB (clinical evaluation, chest X-ray, molecular testing, e.g, GeneXpert) - Baseline assessments: HIV status, pregnancy test, comorbidities, Liver and Renal function tests (if available)
Dosing &Administration (Table1.1 &1.2 below)	**Children (<15 yrs):** 150–750 mg/day of 100mg dispersible tablets **Adults (≥15 yrs):** 750–1000 mg/day
Follow-up	**Once a patient is initiated on treatment, the following will be undertaken;** - Monthly monitoring at facility (aligned with index patient care) - Screen for TB symptoms at each visit -Perform laboratory tests for symptomatic patients during treatment - Report adverse drug reactions immediately -Emphasize that full adherence and completion are critical **Once a patient has completed treatment;** -Conduct clinical follow-up for 2 years post-exposure (quarterly after treatment ends)

Levofloxacin Dosing Recommendations

Table 1.1: Levofloxacin dosage and weight bands for children aged <15 years

Weight (kg)	Dosing (mg/day)	Administration
5-9 kg	150 mg/day	1.5 dispersible tablets once daily
10-15 kg	200-300 mg/day	3 dispersible tablets once daily
16-23 kg	300-400 mg/day	4 dispersible tablets once daily
24-35 kg	500-750 mg/day	5 dispersible tablets once daily OR 1 (500mg) tablet once daily

Table 1.2: Levofloxacin dosage for adults (Age ≥15 years)

Weight (kg)	Dosing (mg/day)	Administration
36-45 kg	750 mg/day	1 (750mg) tablet once daily OR 1 (500mg) + 1 (250mg) tablet once daily
≥46 kg	1000 mg/day	2 (500mg) tablets once daily

REPORTING

Clinicians must document all TPT management activities—including contact line-listing, symptom screening, investigations, regimen initiation, and treatment outcomes—in designated registers, with monthly reporting through the TIBU platform. Adverse events must be reported to the Pharmacy and Poisons Board using existing tools. Healthcare administrators are urgently requested to disseminate this information to their staff, ensure proper implementation for eligible high-risk populations, and maintain comprehensive reporting of all TPT initiations

Dr. Patrick Amoth, ***EBS***
DIRECTOR GENERAL FOR HEALTH