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Original Research Article

Uptake of tuberculosis preventive therapy and its associated factors among health care workers in Nairobi City County, Kenya

Paul W. Maleya[1]*, Isaac Mwanzo[1], Glennah Kerubo[2]

[1]Department of Family Medicine Community Health and Epidemiology, Kenyatta University, Kenya
[2]Department of Medical Microbiology and Parasitology, Kenyatta University, Kenya

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***Correspondence:**
Paul W. Maleya,
E-mail: Paulwashikah@gmail.com

ABSTRACT

Background: Tuberculosis (TB) remains a major occupational risk among healthcare workers (HCWs), with latent TB infection (LTBI) serving as a reservoir for future active disease. Tuberculosis Preventive Therapy (TPT) is an effective strategy to reduce this risk; however, uptake among HCWs remains suboptimal. This study examined the association between knowledge of the LTBI policy, general knowledge of TPT, and personal attitude and perception factors with willingness to uptake TPT among HCWs in Nairobi City County, Kenya.
Methods: An analytical cross-sectional study was conducted among HCWs in selected health facilities in Nairobi City County. Data was collected using structured questionnaires assessing knowledge of the LTBI policy, knowledge of TPT, attitudes and perceptions toward TPT, and willingness to uptake therapy. Descriptive statistics, bivariate analyses, and multivariable logistic regression were used to identify factors associated with TPT uptake.
Results: A total of 288 HCWs participated, of whom 60% were female. Nurses constituted 45% of respondents, and 62% reported awareness of the LTBI policy. Knowledge of the LTBI policy was significantly associated with TPT uptake ($p<0.001$). In multivariable analysis, knowledge of TPT was a strong predictor of uptake (OR>3, $p=0.001$). Pharmaceutical technologists and HCWs in other professions had significantly lower odds of uptake compared to clinician. Attitude and perception were not independently associated with uptake.
Conclusions: Knowledge of the LTBI policy is a key determinant of TPT uptake among HCWs. Strengthening policy dissemination and addressing profession-specific barriers may improve TPT uptake in healthcare settings.

Keywords: Tuberculosis preventive therapy, Latent TB infection, Healthcare workers, Knowledge, Attitude, Perception

INTRODUCTION

Tuberculosis (TB) continues to pose a significant global public health challenge, particularly among health care workers (HCWs) who face increased occupational exposure to Mycobacterium tuberculosis.[1] In Kenya, TB remains a leading cause of morbidity and mortality, with HCWs also being at high risk of infection.[2] Latent TB Infection (LTBI) represents a critical stage where infected individuals harbour dormant bacilli without symptoms but remain at risk of progressing to active disease.[3] Tuberculosis Preventive Therapy (TPT) is a proven intervention to reduce the progression from LTBI to active TB and is recommended for HCWs exposed to TB patients.[1] Despite national policies advocating for TPT uptake, acceptance among HCWs to administer TPT remains suboptimal, attributed partly to lack of knowledge, attitudes, and perceptions toward LTBI and TPT.[4] Understanding the role of knowledge of the LTBI policy and personal attitude and perception-based factors is essential to designing effective interventions that

increase willingness and acceptability of TPT uptake. This study aims to determine the association between knowledge of the LTBI policy and willingness of TPT uptake among HCWs in Nairobi City County. Additionally, it evaluates how personal attitudes and perceptions influence acceptance of TPT.

METHODS

Study design and setting

An analytical cross-sectional study was conducted between January and March 2024 among HCWs in selected health facilities within Nairobi City County, Kenya. Nairobi was chosen due to its high TB burden and diverse healthcare workforce.

Study population

The study population included doctors, nurses, pharmaceutical technologists, laboratory technologists, and other cadres involved in direct patient care or laboratory services. Inclusion criteria were HCWs currently employed in the selected facilities with at least six months of service.

Sampling techniques and sample size determination

A purposive sampling approach was used to identify health facilities within Nairobi City County with the highest TB burden. Facilities were selected based on TB prevalence data retrieved from TIBU, Kenya's national TB reporting system. The selected sites included major hospitals, health centres, and dispensaries with active TB treatment and prevention services. Within these facilities, HCWs serving in all departments were considered eligible. A convenience sampling technique was then used to recruit HCWs who were present and willing to participate during the data collection period. This approach was adopted for its logistical feasibility given the high workload in the selected facilities. The sample size was determined using Cochrane's formula whereby calculate sample size was 288 health care workers.

Data collection

Data were collected using a structured questionnaire. The questionnaire captured sociodemographic data, knowledge of the LTBI policy, attitudes toward TPT, perceptions of TB risk, and willingness and acceptability of TPT uptake.

Variables

The independent variables in this study were knowledge of the LTBI policy, as well as knowledge, attitude, and perception of TPT, while the dependent variable was the uptake of TPT.

Statistical analysis

Data were analyzed using R software. Descriptive statistics summarized participant characteristics. Associations between variables and uptake of TPT were assessed with chi-square tests and multivariate logistic regression model. Adjusted odds ratios (AOR) with 95% confidence intervals (CI) were reported, and significance was set at $p<0.05$.

RESULTS

Participant characteristics

A total of 288 HCWs participated with a majority of them (60%) being were female. The median age was 34 years (IQR 28-42). The predominant healthcare workers were nurses (45%), followed by doctors (20%), pharmaceutical technologists (15%), and laboratory technologists (10%). Approximately 62% of participants reported awareness of the LTBI policy.

Association between knowledge of LTBI policy and TPT uptake

We conducted a Pearson's Chi-squared test to examine the relationship between knowledge about latent TB policy and the uptake of TPT. The analysis revealed that health care workers who have knowledge about the latent TB policy are significantly more likely to take TPT compared to those who do not have this knowledge ($p<0.001$) (Table 1).

Table 1: Chi-square results for knowledge of LTBI and acceptability of uptake of TPT.

Test	DF	P value
Pearson's chi-squared test	1	2.94×10^{-6}

Logistic regression analysis examined factors associated with the uptake of TPT among HCWs who were aware of the latent TB infection (LTBI) policy. Compared to clinicians, pharmaceutical technologists (OR=0.02, 95% CI: 0.00–0.36, p=0.01) and those in the "Other" profession category (OR=0.25, 95% CI: 0.08–0.67, p=0.01) had significantly lower odds of taking TPT (Table 2). However, no significant associations were observed for laboratory technologists, medical doctors, nurses, or nutritionists.

Age and gender were not significant predictors, with males (OR=0.66, 95% CI: 0.30–1.45, p=0.30) and HCWs aged 35 years and above (OR=0.95, 95% CI: 0.44–2.04, p=0.89) showing no significant difference compared to their respective reference groups (Table 2). Education and marital status were key determinants of TPT uptake. HCWs with secondary education had significantly higher odds of taking TPT (OR=17.71, 95% CI: 2.61–453.40, p=0.02) compared to those with a diploma, while university education did not show a significant effect.

Single HCWs were more likely to take TPT (OR=4.82, 95% CI: 1.18–19.70, p=0.03) compared to their divorced or separated counterparts. Although not statistically significant, HCWs working in outpatient departments (OR=2.33, 95% CI: 0.87–6.53, p=0.10) and TB clinics (OR=2.28, 95% CI: 0.83–6.57, p=0.12) showed a trend toward higher TPT uptake. These findings highlight the influence of profession, education, and marital status on the likelihood of HCWs initiating TPT despite being knowledgeable about the LTBI policy (Table 2). Personal attitude, knowledge and perception base factors associated with willingness and acceptance of uptake of TB Preventive Therapy among Health Care Workers in Nairobi City County.

Table 2: Logistic regression on TPT uptake among HCWs with knowledge of LTBI policy.

Predictor	OR	Lower 95% CI	Upper 95% CI	P value
Profession-clinician reference variable				
Laboratory technologist	0.47	0.01	24.41	0.69
Medical doctor	0.87	0.21	4.07	0.85
Nurse	0.47	0.14	1.49	0.20
Nutritionist	0.96	0.19	5.88	0.96
Other	0.25	0.08	0.67	0.01
Pharmaceutical technologist	0.02	0.00	0.36	0.01
Age group- 35 years and below reference variable				
Age group 35 years and above	0.95	0.44	2.04	0.89
Gender-female reference variable				
Male	0.66	0.30	1.45	0.30
Education level-diploma reference variable				
Secondary	17.71	2.61	453.40	0.02
University	1.22	0.60	2.49	0.58
Marital status-divorced/separated reference variable				
Married	2.28	0.65	7.59	0.18
Single	4.82	1.18	19.70	0.03
Widow	1.94	0.20	21.62	0.57
Department-CCC reference variable				
Laboratory	4.20	0.20	327.55	0.45
Other	0.71	0.24	2.03	0.52
Outpatient department	2.33	0.87	6.53	0.10
Pharmacy	1.35	0.18	19.19	0.79
TB clinic	2.28	0.83	6.57	0.12

Table 3: Logistics regression table showcasing factors influencing tuberculosis preventive therapy uptake among healthcare workers with knowledge of TPT.

Predictor	OR	Lower 95% CI	Upper 95% CI	P value
Profession(clinician) reference variable				
Laboratory technologist	0.13	0.01	1.16	0.10
Medical doctor	1.22	0.33	5.28	0.78
Nurse	0.86	0.33	2.28	0.77
Nutritionist	2.31	0.55	12.56	0.28
Other	0.45	0.19	1.02	0.06
Pharmaceutical technologist	0.06	0.00	0.69	0.04
Age group 35 years and below reference variable				
35 years and above	0.98	0.51	1.89	0.95
Female reference variable				
Male	0.91	0.48	1.77	0.79
Diploma (reference variable)				
Secondary	7.38	1.77	55.46	0.02
University	1.19	0.64	2.21	0.58
Divorced/separated reference variable				
Married	1.76	0.52	5.62	0.35
Single	2.90	0.78	10.41	0.10

Continued.

Predictor	OR	Lower 95% CI	Upper 95% CI	P value
Widow	1.09	0.14	8.90	0.93
Department CCC reference variable				
Laboratory	4.23	0.41	111.81	0.28
Other		0.15	1.10	0.08
Out patient	1.13	0.45	2.76	0.79
Pharmacy	0.73	0.13	5.03	0.73
TB clinic	1.16	0.46	2.87	0.75

Table 4: Logistics regression showing association between profession and attitude among healthcare workers.

Predictor	OR	Lower 95% CI	Upper 95% CI	P value
Profession(clinician) reference variable				
Laboratory technologist	0.41	0.07	2.20	0.30
Medical doctor	1.60	0.44	6.89	0.50
Nurse	0.84	0.34	2.05	0.69
Nutritionist	1.97	0.52	8.79	0.34
Other	0.43	0.20	0.90	0.03*
Pharmaceutical technologist	0.20	0.02	1.53	0.11
Age group 35 years and below reference variable				
35 years and above	0.88	0.48	1.62	0.68
Gender female reference variable				
Male	0.94	0.51	1.73	0.84
Education diploma (reference variable)				
Secondary	5.31	1.58	25.02	0.01*
University	1.16	0.66	2.06	0.61
Marital status divorced/separated reference variable				
Married	1.20	0.37	3.60	0.75
Single	2.03	0.57	6.81	0.26
Widow	0.94	0.12	7.70	0.95
CCC reference variable				
Laboratory	0.82	0.18	4.13	0.80
Other	0.32	0.13	0.76	0.01*
Out patient	1.03	0.44	2.38	0.95
Pharmacy	0.91	0.18	5.94	0.91
TB clinic	1.10	0.46	2.61	0.82

*OR=Odds Ratio; CI=Confidence Interval. Reference categories are indicated in the table. $p<0.05$ denotes statistical significance.

Personal factors play a significant role in uptake of medication for different health conditions. Therefore, it was crucial to determine if personal factors affected the uptake of TPT among healthcare workers and if the effect was significant.

The investigation for the significance of the effect was based on the hypothesis that there was no significant association between personal factors and uptake of TPT among healthcare workers. Logistic regression analysis examined the association between knowledge, attitude, and perception with the likelihood of having taken TPT.

The model included three independent variables: knowledge, attitude, and perception, all categorized as "yes" or "no." Results were presented on a table and plotted in a forest plot for easy visualization (Figure 1). The findings showed that knowledge significantly influenced TPT uptake. Specifically, individuals who reported having knowledge about TPT were more than three times as likely to have taken it, with a statistically significant coefficient of 1.275 ($z=3.212$, $p=0.00132$) as compared to those without TPT knowledge (Figure 1). This suggests that knowledge plays a crucial role in encouraging individuals to take TPT.

In contrast, attitude and perception were not statistically significant predictors of TPT uptake. The coefficient for attitude ("Yes") was 0.329 ($z=0.219$, $p=0.82$), indicating that a positive attitude toward TPT did not have a meaningful effect on whether individuals had taken it.

Similarly, the coefficient for perception ("Yes") was -0.030 ($z=-0.069$, $p=0.94$), suggesting that perception also did not significantly influence the likelihood of TPT uptake (Figure 1).

Exploring factors influencing tuberculosis preventive therapy uptake among healthcare workers with knowledge of TPT

A logistic regression analysis was conducted to examine if there were factors associated with uptake of TPT among those HCWS with knowledge on TPT. The model included only HCWs who reported having knowledge of TPT. The dependent variable was whether they had taken TPT (Yes/No). Odds ratios (OR), 95% confidence intervals (CIs), and p-values are reported in (Table 3).

Our results indicate that profession was not a strong predictor of TPT uptake, with the exception of pharmaceutical technologists, who were significantly less likely to take TPT compared to clinicians (OR=0.056, p=0.039). Other professions, such as laboratory technologists, nurses, medical doctors, and nutritionists, showed no significant differences in uptake rates. Education level appeared to influence TPT uptake, as HCWs with only secondary education were significantly more likely to take TPT than those with a diploma (OR=7.384, p=0.017).

However, having a university education did not show a significant association with uptake. Marital status also showed some variation, with single HCWs having higher odds of taking TPT compared to those who were divorced or separated, though this was not statistically significant. The department in which HCWs worked did not have a significant impact on TPT uptake. While those in laboratories had higher odds of taking TPT compared to staff in comprehensive care clinics (CCC), (OR=4.23) the difference was not statistically significant(p=0.28). Similarly, no notable variations were observed among HCWs working in outpatient clinics, pharmacies, TB clinics, or other departments (Table 4).

Profession and TPT uptake among HCWs with a positive attitude toward TPT

Among HCWs who had a positive attitude toward TPT, profession played a role in TPT uptake. Compared to clinicians, those categorized as "Other" professionals had significantly lower odds of taking TPT (OR=0.43, p=0.03) (Table 4). However, no significant differences were observed among laboratory technologists, medical doctors, nurses, nutritionists, or pharmaceutical technologists, suggesting that attitude alone did not necessarily translate to higher TPT uptake across professions (Table 4).

Facility department and TPT uptake among HCWs with a positive attitude toward TPT

HCWs working in other departments (outside of comprehensive care clinics, CCC) were significantly less likely to take TPT compared to those in CCCs (OR=0.32, p=0.01) (Table 4). However, no significant differences in uptake were found among HCWs working in laboratories, outpatient clinics, pharmacies, or TB clinics (Table 4).

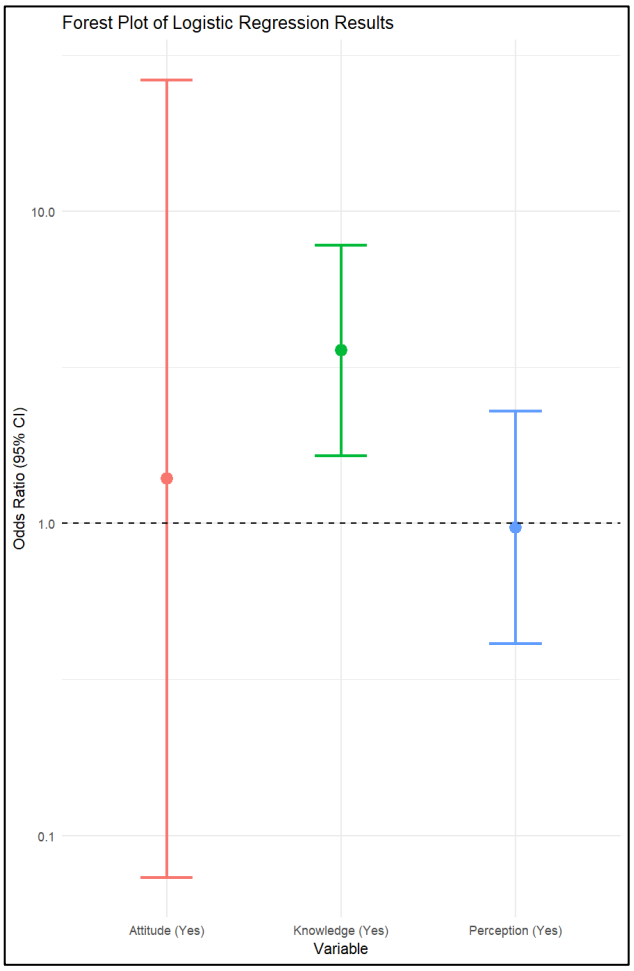

Figure 1: Forest plot for logistics regression outputs for knowledge, attitude and perception and association with uptake of TPT.

Association between HCWs perception and TPT uptake

Logistic regression was not performed because some variables had complete separation, where all respondents in certain categories had either taken TPT or not. As a result, Fisher's Exact Test was conducted to assess the association between TPT uptake and various demographic and professional factors among HCWs with a positive perception of TPT. The results showed no statistically significant associations between TPT uptake and age group (p=0.7055), gender (p=0.6744), education level (p=0.3229), marital status (p=0.417), or department of work (p=0.6725). Although married HCWs had higher odds of taking TPT (OR=2.47), the wide confidence interval (0.33-30.55) suggests considerable uncertainty. These findings indicate that a positive perception of TPT alone may not be a strong determinant of actual uptake, highlighting the need to explore additional behavioral and structural factors influencing adherence.

Insights form KII interviews

Personal factors (attitude, perception, and stigma)

Attitudes and beliefs

HCWs working outside TB clinics were found to have a poorer attitude towards TPT. This was reflected in the perception that HCWs not working in TB clinics generally held less favorable views toward TPT. Some respondents also indicated that certain HCWs believed they would require repeated courses of TPT due to continuous exposure to TB in their work environment, suggesting concerns about ongoing risk and the perceived need for repeated preventive treatment.

Perceived benefits and risks

HCWs recognized the benefits of TPT in preventing TB but had concerns about side effects and the duration of protection. TPT was perceived to reduce the risk of developing active tuberculosis, thereby contributing to reduced transmission. However, concerns were raised among healthcare workers regarding the duration of protection provided by TPT, with some questioning whether individuals working in TB clinics would need to repeat TPT after a certain period. In addition, fear of developing drug-resistant tuberculosis also discouraged some healthcare workers from accepting TPT, as it was believed that prior exposure to certain anti-tuberculosis drugs could increase the likelihood of drug resistance if TB were to develop in the future.

Stigmatization and misconceptions

Some healthcare workers expressed concerns about the side effects of TPT, associating it with severe adverse drug reactions. It was reported that some believed TPT could cause multiple side effects, such as nausea, which they felt could negatively affect overall health. In addition, there was evidence of misinformation regarding the effectiveness of TPT, with some respondents holding the misconception that once TPT is taken, an individual can never develop tuberculosis.

Triangulation of quantitative and qualitative findings

The integration of quantitative and qualitative data highlights a nuanced picture of TPT uptake among healthcare workers. Quantitatively, no significant demographic or professional predictors emerged for uptake among those with positive perceptions, suggesting that perception alone does not guarantee adherence. Qualitative data reveal why this may be the case fear of side effects, misconceptions, stigma, and doubts about TPT's protective duration create personal and structural barriers that impede uptake despite positive attitudes or knowledge. This triangulation underscores the complexity of behavior around preventive therapy and the importance of addressing both knowledge and attitudinal barriers in intervention design.

DISCUSSION

This study examined factors associated with the uptake of TPT among HCWs, focusing on knowledge, perception, and attitude. The findings underscore that while knowledge and positive perception are necessary, they are insufficient alone to ensure TPT uptake. This aligns with global evidence emphasizing that preventive therapy adherence is influenced by multifactorial dynamics including individual, structural, and health-system factors[5].

The lack of a significant association between positive perception and TPT uptake in this study affirms that positive attitudes do not automatically translate into preventive action. This is consistent with findings from a study in eastern China, where 62.3% of HCWs expressed positive attitudes toward TPT, yet only 0.9% initiated therapy revealing a substantial attitude–action gap.[6] Similarly, other studies have shown that although HCWs may support the idea of TPT, uptake remains low due to behavioral and institutional barriers.[7] Fear of adverse drug reactions emerged as a significant barrier, reflecting persistent misinformation and misconceptions. Previous studies in South India and South Africa have highlighted that HCWs often avoid TPT due to concerns about hepatotoxicity and drug resistance, particularly among non-TB clinicians and paramedical staff.[8,9] Such fears often unsubstantiated are compounded by a lack of clear communication on drug safety and monitoring, necessitating structured counseling and reassurance from health authorities.

Attitudinal barriers were more pronounced among HCWs outside of TB clinics, consistent with documented variability in risk perception and preventive practices across departments.[10] In Uganda, for instance, TPT prescribing was significantly reduced where HCWs perceived patients as uncomfortable with TPT or lacked proper knowledge of its benefits.[11] This finding reinforces the idea that frontline staff's attitudes and perceptions heavily influence both their own preventive actions and the promotion of such interventions to patients.

A notable and somewhat unexpected finding was the higher likelihood of TPT uptake among HCWs with secondary education compared to those with diploma or university-level education. While this contrasts with some studies showing a positive correlation between higher education and uptake, it may reflect context-specific dynamics such as departmental roles, peer influence, or perceived vulnerability.[12] This highlights the need for tailored educational strategies that address differing workplace cultures and risk perceptions across cadres.

Misconceptions about the need to repeat TPT due to continuous exposure to TB patients were also identified.

This mirror concerns raised in national program reports emphasizing the importance of clarity on the duration and protective effect of TPT regimens.[13] Educational interventions must therefore not only promote awareness but also address such nuanced misunderstandings to improve adherence.

Overall, the study's mixed-methods approach reinforces the value of integrating quantitative and qualitative data to capture the complex drivers of TPT uptake. Programs aiming to increase TPT among HCWs must go beyond passive knowledge dissemination. Active strategies addressing systemic barriers, professional attitudes, stigma, and misinformation are essential.[14] Tailored interventions, particularly those grounded in the lived experiences and working contexts of HCWs, are critical for closing the gap between knowledge, perception, and actual uptake.

CONCLUSION

Knowledge of the ltbi policy and tpt was significantly associated with tpt uptake among healthcare workers in nairobi city county. However, uptake remained lower among some professional cadres and among healthcare workers working outside tb-focused service areas. Qualitative findings revealed that concerns about side effects, stigma, misconceptions regarding tpt effectiveness, and uncertainty about the duration of protection continued to influence uptake decisions. Strengthening dissemination of ltbi policy information, improving tpt knowledge, and implementing targeted interventions for non-tb clinic staff and specific professional groups may enhance tpt uptake among healthcare workers.

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