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Ethiopia

The following provides a summary of specific guidelines from the country's national guidance strategy. Use the jump links in yellow to access details by patient population. This summary can be downloaded or e-mailed to yourself or a colleague. The original country guidance document can also be found below the jump links for download.

Patient Population [Download summary page as PDF](#) [E-mail this page](#)

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- [Adults & Adolescents](#)
- [Pregnant Women \(with TB\)](#)
- [Children & Infants](#)

Adults & Adolescents

Year Issued:

Guidelines: 2008, Updates: 2013

Reference:

Guidelines For Management Of Opportunistic Infections And Anti Retroviral Treatment In Adolescents And Adults In Ethiopia; [TECHNICAL UPDATES ON ADOPTED RECOMMENDATIONS ON ADOLESCENT AND ADULT ANTI-RETROVIRAL TREATMENT]

Screening for PLHIV for TB Every Visit? (Y/N) (Intensified Case Finding):

Yes

All HIV-positive persons should be routinely screened for TB, at entry to care and during each subsequent visit.

Criteria for Starting TB Prophylaxis Among TB-Exposed PLHIV:

The national TB/HIV guidelines recommend administration of INH Preventive Therapy (IPT) to HIV-infected persons after exclusion of active TB. Refer to the TB-HIV national guidelines for eligibility criteria to initiate IPT.

Isoniazid Preventive Therapy consists of daily, self-administered Isoniazid at a dose of 5mg/kg i.e., a maximum dose of 300mg/day for a period of six months.

Pyridoxine at a fixed daily dose of 25mg is indicated in order to reduce the risk of developing INH- induced peripheral neuropathy.

Criteria for Starting TB Prophylaxis Among Unknown TB-Exposed PLHIV:

In settings where there is no CXR service, better not to start IPT for symptomatic clients (WHO Clinical stage 3 and 4). It would be advisable to evaluate WHO stage 3 and 4 HIV patients 3 months after start of ART for TB so as to decide on whether to put them on IPT or not even if CXR is available.

Criteria for Starting: ARV 1st Line Regimen:

ART is recommended for **all** HIV positive patients with active TB disease **regardless of CD4 count**.

Guide for management of patients presenting with TB before initiation of ART:

- Start TB treatment first

CD4 count:

<200/mm³:

- Start ART as soon as TB treatment is tolerated (usually between 2 -8 weeks of TB treatment).
- Concomitant TB Rx:(TDF or AZT) +(FTC or 3TC) +EFV EFV containing regimen is preferred.
 - However, if drugs are unavailable or there are problems with EFV (adverse effects with intolerance) use triple nucleoside regimen with caution.
 - If patient develops ABC hypersensitivity continue NVP but monitor liver function every month.
 - Timing of ART initiation should be up to clinical judgment based on other signs of immunodeficiency indicating progression of HIV disease. For TB patients in WHO clinical Stage IV, ART should be started as soon as TB treatment is tolerated irrespective of CD4 count.
 - ABC + 3TC + AZT ***NVP (200 mg daily for 2 weeks followed by 200 mg twice daily) may be used in place of EFV in absence of other options. NVP containing regimens include: TDF/3TC/NVP or AZT/3TC/NVP.

>200/mm³:

- Start ART after 8 weeks (after intensive phase) of TB treatment.
- TDF (or AZT) + 3TC + EFV

Patient develops TB following 3-6 months of ARV therapy

Continue ARV therapy throughout TB treatment.

Patients on first-line therapy containing nevirapine should be changed to efavirenz:

- TDF (or AZT) + 3TC + EFV
 - If EFV is not available or there are problems with EFV, use triple nucleoside containing ABC.
 - If patient develops ABC hypersensitivity continue with NVP and monitor liver function every month.

Patient develops active TB after more than six months of ART:

The possibility of treatment failure should be considered when diagnosis is extra-pulmonary tuberculosis and there are concomitant diseases suggesting advanced immune deficiency.

If treatment failure is established, the patient should be managed with an appropriate second-line regimen (see 2nd line regimen).

In the absence of evidence for ARV treatment failure, the patient should be managed the same way as patients who develop TB 3-6 months after ART initiation.

ARV 2nd Line Regimen:

If treatment failure is established, the patient should be managed with an appropriate second-line regimen decided by an experienced physician. This must be started as soon as the patient tolerates the anti TB drugs. Since PIs are usually used in 2nd line regimens, delaying the initiation of the 2nd line until completion of the intensive phase is better since rifabutin is not available. It is also recommended to do a liver function test every two weeks for at least eight weeks to determine the risk of added hepatic toxicity.

Co-Infection Addressed Under Existing HIV Guidelines? (Y/N):

Yes

Pregnant Women (with TB)

Year Issued:

2007

Reference:

Implementation Guideline for TB/HIV Collaborative Activities in Ethiopia

Screening for PLHIV for TB Every Visit? (Y/N) (Intensified Case Finding):

Yes

Criteria for Starting TB Prophylaxis Among TB-Exposed PLHIV:

None indicated

Criteria for Starting TB Prophylaxis Among Unknown TB-Exposed PLHIV:

None indicated

Criteria for Starting: ARV 1st Line Regimen:

Patient develops active TB after more than six months of ART:

The possibility of treatment failure should be considered when diagnosis is extra-pulmonary tuberculosis and there are concomitant diseases suggesting advanced immune deficiency. If treatment failure is established, the patient should be managed with an appropriate second-line regimen (see 2nd line regimen). In the absence of evidence for ARV treatment failure, the patient should be managed the same way as patients who develop TB 3-6 months after ART initiation.

Co-Infection Addressed Under Existing HIV Guidelines? (Y/N):

Yes

Children & Infants

Year Issued:

2007

Reference:

Implementation Guideline for TB/HIV Collaborative Activities in Ethiopia

Screening for PLHIV for TB Every Visit? (Y/N) (Intensified Case Finding):

Yes

Criteria for Starting TB Prophylaxis Among TB-Exposed PLHIV:

Due to limited resources and high national TB prevalence, preventive therapy is only given to the most vulnerable children, those at highest risk to develop TB following M. tuberculosis exposure/infection. The two groups of children who qualify to benefit most from initiation of preventive therapy following M. tuberculosis exposure/infection are:

- The very young (infants and children <5 years old)
- The HIV-infected children (irrespective of their age)

It is mandatory to rule out active disease (TB) prior to consideration of INH preventive therapy. Recommended dose is INH 5mg/kg, maximum 300mg daily for 6 months.

Criteria for Starting TB Prophylaxis Among Unknown TB-Exposed PLHIV:

Due to limited resources and high national TB prevalence, preventive therapy is only given to the most vulnerable children, those at highest risk to develop TB following M. tuberculosis exposure/infection. The two groups of children who qualify to benefit most from initiation of preventive therapy following M. tuberculosis exposure/infection are:

- The very young (infants and children <5 years old)
- The HIV-infected children (irrespective of their age)

It is mandatory to rule out active disease (TB) prior to consideration of INH preventive therapy. Recommended dose is INH 5mg/kg, maximum 300mg daily for 6 months.

Criteria for Starting: ARV 1st Line Regimen: Children & Infants

Recommendation for timing of ART following the initiation of TB treatment with Rifampicin containing regimen in HIV infected infants and children:

WHO pediatric clinical stage 4:

- Start ART soon after TB treatment (between 2-8 weeks following start of TB Rx)

WHO pediatric clinical stage 3: With clinical management alone:

- Start ART soon after TB treatment (between 2-8 weeks following start of TB Rx)
- If excellent response to TB treatment in the first 2-8 weeks of TB therapy, and the child is stable and is on CPT it may be reasonable to delay ART

If CD4 available:**Severe and advanced immunodeficiency:**

- Start ART soon after TB treatment (between 2-8 weeks following start of TB Rx)

Mild or no immunodeficiency:

- Initiation of ART may be delayed until after completion of TB therapy. Closely monitor response to TB therapy and reassess the need for ART after TB therapy, if no improvement, consider starting ART

In children <3 years

- Double dose Kaletra plus NRTIs, or
- Triple NRTIs

Child on standard two NRTIs and NNRTI first line regimen diagnosed with TB:

- Substitute NNRTI to double dose of kaletra or change to triple NRTI if child is below 3 years of age

In children >3 years

- NRTIs+ EFV_e, or
- Triple NRTIs

Child on standard two NRTIs and NNRTI first line regimen diagnosed with TB:

- Continue on standard two NRTIs + NNRTI first-line
- If on NVP_b substitute to EFV_c if the child is >3 years

ARV 2nd Line Regimen:

Child on standard second line regimen (NRTI plus PI) diagnosed with TB:

- Continue the same regimen, consider doubling the dose of Kaletra Consider consultation with experts for construction of salvage regimen

**Co-Infection Addressed Under Existing HIV Guidelines?
(Y/N):**

Yes

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