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Ethiopia

The following provides a summary of specific guidelines from the country's national TB guidance strategy. Use the jump links in yellow to access details on case definitions, diagnostic methods, standard protocols, and DOTS recommendations. 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.

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Adults

Year Issued:

2008

TB Screening Frequency for PLHIV:

The regular screening for TB among HIV-positive clients, at every stage of the disease, is one key TB/HIV collaborative activity, with the aim to reduce the burden of TB in PLWH.

Screening Recommendations during TB Treatment:

- New smear positive cases: As a routine, all sputum-positive patient on TB treatment must have one sputum specimen examined at the end of the 2nd, 5th and 7th 'month'.
- Smear negative pulmonary and extrapulmonary cases: Any PTB- patient, whose condition has not improved or gets worse by the end of the intensive phase should be assessed by a physician and two specimens of sputum should be examined. If one smear is positive, two other specimens should be examined.
- Re-treatment cases: The sputum is examined at the end of the intensive phase of 12 weeks.

Case definition:

Smear-positive pulmonary TB (PTB+)

A patient with at least two initial sputum smear examinations positive for AFB by direct microscopy,

Or

A patient with one initial smear examination positive for AFB by direct microscopy and culture positive,

Or

A patient with one initial smear examination positive for AFB by direct microscope and radiographic abnormalities consistent with active TB as determined by a clinician.

Smear-negative pulmonary TB (PTB-)

A patient having symptoms suggestive of TB with at least 3 initial smear examinations negative for AFB by direct microscopy, and

1. No response to a course of broad-spectrum antibiotics, and
2. Again three negative smear examinations by direct microscopy, and
3. Radiological abnormalities consistent with pulmonary tuberculosis, and
4. Decision by a clinician to treat with a full course of antituberculosis

Or

A patient whose diagnosis is based on culture positive for M. tuberculosis but three initial smear examinations negative by direct microscopy

Diagnostic methods:

All suspects of any form of TB must be examined according to the standardized diagnostic procedures of which the microscopic examination of sputum is the most important and reliable. Every individual suspected of having tuberculosis must have an examination of 3 sputum smears, to determine whether or not they have infectious tuberculosis. By rank of importance the diagnostic methods to confirm/exclude TB are:

- Microscopic examination of sputum smears
- Radiological investigation
- AFB culture
- Histo-pathology

Standard TB Treatment Protocols:

Category I:

New sputum smear-positive

- Seriously ill* new sputum smear-negative
- Seriously ill* new EPTB
- Others:2ERHZ/ 6EH.

*'Seriously ill' includes:

- Life threatening disease = acute disseminated miliary TB, TB meningitis or TB peritonitis.
- Risk of severe disability = spinal TB, TB pericarditis, bilateral TB pleural effusion, renal TB.
- Extensive X-ray lesions without cavitation in immunocompromised patients, e.g., diabetics, HIV-positives, or patients with other concomitant disease.

Category II:

Sputum smear-positive Relapse

- Sputum smear-positive Failure
- Sputum smear-positive Return after default
- PTB- patients who become smear positive after 2 months of treatment (case definition = other).
- Return after default from re-treatment (only once retreatment again).
- Relapses after retreatment (only once retreatment again). This regimen is to be prescribed for patients previously treated for more than one month with TB drugs and who are still smear positive. The treatment regimen for this category is:2 S(ERHZ) / 1(ERHZ) daily / 5 E3 (RH)3 (three times per week)

Category III:

New sputum smear-negative, not seriously ill. New EPTB, not seriously ill:2ERHZ/ 6EH.

DOTS Recommendations:

In 1992 a standardized TB prevention and control programme, incorporating Directly Observed Treatment, Short Course (DOTS), was started as a pilot in Arsi and Bale zone, Oromia Region. The DOTS strategy has been subsequently scaled up in the country and implemented at national level.

PUBLIC-PRIVATE MIX (PPM) DOTS

The term 'PPM DOTS' has evolved to represent a comprehensive approach to link all relevant healthcare providers for DOTS implementation. It incorporates all forms of public-private (e.g. government health office with not-for-profit private health facility), public-public (e.g. hospitals, public health centers with army, prison, etc) or private-private (e.g. traditional healers with private-for-profit health facility) collaborations for the common purpose of controlling TB in a community.

Community Based DOTS

Community DOTS supporters have the role to sensitize the community about tuberculosis through delivering health education about the disease in public gatherings and through house to house visit. Community DOTS Supporters also trace individuals with symptoms of TB and motivate and convince them to go to health facilities where sputum examination service is given. After the patients are diagnosed to have TB, Community DOTS Supporters will directly observe the patients treatment.

Children

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Case definition:

Primary pulmonary tuberculosis:

Supportive Evidence:

- Mediastinal lymphadenopathy with or without infiltration
- TS-positive

Diagnostic Confirmation:

- Positive sputum culture (rare, only if there is fistulization of the lymphadenitis into the bronchi)

Post-primary pulmonary tuberculosis:

Supportive Evidence:

- Pulmonary infiltration affecting upper zones with cavities

Diagnostic Confirmation:

- AFB on smear and culture of sputa/gastric

Diagnostic methods:

Recommended approach to diagnose TB in children

1. Careful history (including history of TB contact and symptoms consistent with TB)
2. Clinical examination (including growth assessment)
3. Tuberculin skin test (if available)
4. Bacteriological confirmation whenever possible
5. Investigations relevant for suspected pulmonary TB (Chest X-Ray) and extra-pulmonary TB (lumbar puncture, etc.)
6. HIV testing For older children capable of expectorating, sputum samples should be collected as for adults. For all other children, gastric aspiration may be performed to get adequate material for smear examination.

Standard TB Treatment Protocols:

Category I:

New smear-positive pulmonary TB

- New smear-negative pulmonary TB with extensive parenchymal involvement
- Severe forms of extrapulmonary TB (other than TB meningitis)
- Severe concomitant HIV disease:
- Initial phase: 2HRZE Continuation phase: 4RH

Category II:

Previously treated smear positive pulmonary TB:

- Relapse
- Treatment after interruption
- Treatment failure
- Initial phase: 2HRZES/1HRZE Continuation phase: 5HRE

Category III:

New smear-negative pulmonary TB (other than in category I)

- Less severe forms of extrapulmonary TB
- Initial phase: 2HRZ* Continuation phase: 4RH*In comparison with the treatment regimen for patients in diagnostic category I, ethambutol may be omitted during the initial phase of treatment for patients with non-cavitary, smear negative pulmonary TB who are known to be HIV-negative, patients known to be infected with fully drug-susceptible bacilli and young children with primary TB.

DOTS Recommendations:

DOT should be used for all children with tuberculosis. Even when drugs are given under DOT, tolerance of the medications must be monitored closely. Parents should not be relied on to supervise DOT.

Pregnant and Breastfeeding Women

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Standard TB Treatment Protocols:

Most anti-TB drugs are safe for use in pregnancy with the exception of streptomycin. Therefore ask women patients whether they are or may be pregnant: Do not give streptomycin to a pregnant woman as it can cause permanent deafness in the baby. Pregnant women who have TB must be treated, but their drug regimen does not include streptomycin and ethambutol is used instead of streptomycin.

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