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AIDSFree
Strengthening High Impact Interventions for an AIDS-free Generation

SUMMARY TABLE OF HIV/TB CO-INFECTION TREATMENT REGIMENS

DECEMBER 2017

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AIDSFree

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Contents

ACRONYMS

3TC	lamivudine
ABC	abacavir
AMP	amprenavir
AIDSFree	Strengthening High Impact Interventions for an AIDS-free Generation
ART	antiretroviral therapy
ARV	antiretroviral
ATV	atazanavir
ATV/r	atazanavir/ritonavir
AZT	zidovudine
bDNA	branched deoxyribonucleic acid
CCR5	cysteine-cysteine chemokine receptor 5
CD4	cluster of differentiation 4
CDC	Centers for Disease Control and Prevention
d4T	stavudine
ddI	didanosine
DRV	darunavir
DRV/r	darunavir/ritonavir
EFV	efavirenz
ELISA	enzyme-linked immunosorbent assay
ETV	etravirine
FDC	fixed dose combination
FPV	fosamprenavir

FPV/r	fosamprenavir/ritonavir
FTC	emtricitabine
HAART	highly active antiretroviral therapy
HBV	hepatitis B virus
HCV	hepatitis C virus
IDV	indinavir
IDV/r	indinavir/ritonavir
LIP	lymphocytic interstitial pneumonia
LPV/r	lopinavir/ritonavir
MDR TB	multidrug-resistant tuberculosis
MTCT	mother-to-child transmission
MVC	maraviroc
NFV	nelfinavir
NNRTI	nonnucleoside reverse transcriptase inhibitor
NRTI	nucleoside reverse transcriptase inhibitor
NVP	nevirapine
OHL	oral hairy leukoplakia
OI	opportunistic infection
PCR	polymerase chain reaction
PI	protease inhibitor
PI/r	protease inhibitor/ritonavir
PMTCT	prevention of mother-to-child transmission
RAL	raltegravir
RNA	ribonucleic acid

RT	reverse transcriptase
RTV	ritonavir
sdNVP	single-dose nevirapine
SQV	saquinavir
SQV/r	saquinavir/ritonavir
T20	enfuvirtide
TB	tuberculosis
TDF	tenofovir
TLC	total lymphocyte count
TPV	tipranavir
TPV/r	tipranavir/ritonavir
TWG	technical working group
WHO	World Health Organization
XDR TB	extensively drug-resistant TB

INTRODUCTION

AIDSFree has built upon the National Treatment Guidelines Database developed during AIDSTAR-One. The objective of the Database is to provide policymakers, program planners, and clinicians with the most up-to-date treatment guidelines available; create a central location to house updated national guidelines (facilitating cross-country comparisons and serving as a resource to implementers in multiple country settings); and provide a Summary Table that includes an evaluation of concordance with the World Health Organization's (WHO) 2015 Consolidated Guidelines (enabling countries to determine if their treatment guidelines require updating); and provide multiple treatment guidelines per country (i.e., adult and pediatric HIV, TB, HIV/TB co-infection, and post-exposure prophylaxis (PEP) all in one location, thus increasing ease of access to guidelines for global audiences.

The following tables provide summary HIV/TB co-infection treatment guidelines for adults, adolescents, children, and pregnant and breastfeeding women that have been collected and summarized by AIDSFree. Guidelines were reviewed for 24 countries in 2017 including Angola, Botswana, Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Myanmar (Burma), Namibia, Nigeria, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Efforts were made to identify the most up-to-date treatment guidelines available through internet searches and contacting JSI's and other AIDSFree partner's country offices. In some cases there may be updated treatment guidelines that the AIDSFree team did not obtain.

The tables include information on screening people living with HIV for TB, criteria for starting TB prophylaxis, criteria for starting antiretroviral first-line and second-line treatment, and indicate whether HIV/TB co-infection was addressed under the country's HIV guidelines.

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Angola - Normas de Tratamento Antirretroviral (Antiretroviral Treatment Guidelines) (2015)					
Adults and adolescents, pregnant women	Not mentioned	Eligible if active TB has been excluded and if there are no contra-indications for INH.	Continue ART making changes to the regimen when necessary. Avoid NVP, LPV/r, IDV, RTV.	Start with TB treatment first, followed by ART as soon as possible and within 2-8 weeks after initiation of anti-TB treatment. TDF + 3TC + EFV Alternatives: AZT + 3TC + EFV ABC + 3TC + EFV	
Children ≥3 years old	Not mentioned	Eligible for IPT regardless of history of TB contact, if active TB has been excluded.			
Children 1-2 years old				AZT+3TC+ABC	
Children <12 months old		Eligible for IPT if history of TB contact and active TB has been excluded Newborn child born to mother with active TB is eligible for IPT.			

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Botswana - Handbook of the Botswana 2016 Integrated HIV Clinical Care Guidelines (2016)					
Adults	Y People living with HIV must be routinely screened for TB in all places where they receive medical care including: ARV clinics, hospital wards, PMTCT facilities & HIV testing and counseling centers. TB Screening results must be documented at each and every patient encounter.		If patient is on: TDF/FTC (TRU) + DTG AZT/3TC (CBV) + DTG ABC + 3TC + DTG Adjustment for anti-TB treatment: Double dose of DTG to 50 mg twice daily *Note: Upon completion of ATT ensure that the DTG dose is adjusted back to 50mg once daily. If patient is on: AZT/3TC (CBV) + EFV or NVP TDF/FTC (TRU) + EFV or NVP ABC + EFV or NVP Make NO Adjustment for anti-TB treatment If patient is on: AZT/3TC (CBV) + ATA/r TDF/FTC (TRU) + ATA/r ABC + 3TC + ATA/r AZT/3TC (CBV) + LPV/r TDF/FTC (TRU) + LPV/r ABC + 3TC + LPV/r Adjustment for anti-TB treatment: 1. Stop ATA/r or LPV/r 2. Maintain original NRTI backbone 3. Initiate DTG 50 mg twice daily 4. Upon completion of ATT make sure that the DTG dose is adjusted back to 50mg once daily. Highly treatment experienced patients on RAL/DAR and NRTI backbone regimens: **Adjustment for anti-TB treatment:** Discuss with HIV/TB Specialist	ART naïve patients (or those restarting treatment for any reason) - Adults - Pregnant women - Adolescents (> 40 kg) Always initiate anti-TB treatment first, followed by ART as soon as possible, but no later than 8 weeks. Patients with CD4 count <100 cells/µl: start ART as soon as the patient is tolerating anti-TB treatment. Patients with CD4 count >100 cells/µl: start ART within 8 weeks. Preferred first line regimen: TDF/FTC (TRU) 1 tablet once daily + DTG 50 mg twice daily Alternative: TDF/FTC/EFV (FDC)	
Children	Y	All HIV-infected children < 12 years who are in contact with a TB patient should be fully assessed for TB infection. Those HIV-infected children who are asymptomatic for TB should receive IPT for 6 months.			
		Any child, regardless of age, who is asymptomatic but has been identified as an MDR-TB contact should not receive IPT.			

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Burundi - Directives Nationales D'Utilisation des Antiretroviraux pour la prévention et le traitement du VIH (2016)					
Adults	Not mentioned	All PLHIV who screen negative for active TB. For six months give INH 300 mg/d. To be repeated every 5 years.	If patient on TDF + 3TC + EFV: continue same treatment. If patient on NVP: substitute NVP by EFV.	Initiate TB treatment first, followed by ART whenever the patient tolerates the TB treatment, if possible within 4 weeks. If immunosuppression is severe (e.g. CD4 <50), start ART within 2 weeks of TB treatment initiation. TDF/3TC/EFV In case of contraindications to EFV: TDF or AZT + 3TC + ABC	If patient is on second line containing PI: If on LPV/r: double the dose. If on ATV/r: change to LPV/r double dose.
Children	Not mentioned	All PLHIV who screen negative for active TB. For six months give INH 10 mg/kg daily (not exceeding 300mg/d) To be repeated every 5 years.	Regimen containing NVP or EFV Regimen containing NVP or EFV 3 - 10 years: If patient on EFV: continue with EFV based regimen. If patient on NVP: substitute NVP with EFV while keeping the other ARVs of the regimen. Alternative: AZT + 3TC + ABC Less than 3 years: AZT + 3TC + ABC	< 3 years old: AZT + 3TC + ABC 3-10 years old: ABC + 3TC + EFV Alternative: AZT + 3TC + EFV AZT + 3TC + ABC	
			Regimen containing LPV/r 3 - 10 years Substitute the LPV/r with EFV Alternative: continue the regimen with LPV/r and double the dose of LPV/r If the child has a history of therapy failure on NVP or EFV, give: AZT + 3TC + ABC Or continue the regimen containing LPV/r by double the dose of LPV/r Less than 3 years: AZT + 3TC + ABC Alternative: Continue with the LPV/r regimen and double the dose of LPV/r		

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Cameroon - National Guideline on the Prevention and Management of HIV in Cameroon (2015)					
Adults Adolescents Pregnant women	Y It is recommended to actively look for TB in all PLHIV each time the patient visits the health facility using a simplified TB screening algorithm based on the presence of four clinical symptoms: cough (whatever the duration), night sweats, fever or weight loss. Whenever possible a molecular biology TB screening test (Xpert for example) should be performed in PLHIV suspected of MDR-TB.	All PLHIV must receive IPT at the start of ART after excluding active tuberculosis. These are: - Adults and adolescents who have little risk of suffering from active tuberculosis based on the clinical algorithm; -Adults and adolescents successfully treated for TB in secondary prophylaxis for an additional period of six months; - Pregnant women, preventive treatment with isoniazid is safe in pregnant women. Dosage of isoniazid and duration of IPT: One 300 mg tablet per day, for 6 months	For patients already on ART: make sure that the protocol is compatible with TB treatment. Change if the current protocol includes NVP or PI. 1st line: 2NRTI 1 NNRTI (EFV) or 3 NRTIs if contraindicated to EFV Standard protocol: TDF + 3TC (or FTC) + EFV Alternative protocols: AZT + 3TC + ABC AZT + 3TC + EFV	TB treatment should be initiated primarily in adults and children regardless of CD4 count and followed by ART as soon as possible within 8 weeks after anti-TB treatment initiation. For co-infection patients not yet on ART: choose the protocol compatible with anti-TB treatment.	Substitute Rifampin with Rifabutin (less interactions with PIs and NNRTIs) If Rifabutin not available: TDF + 3TC (or FTC) + LPV/r Double the dose of ritonavir. If ritonavir is not available separately, double the dose of LPV/r.
Children	Children >12 months of age: actively look for TB in all PLHIV each time the child visits the health facility using a simplified TB screening algorithm based on the presence of three clinical symptoms: low weight gain (< -2 Z-score or confirmed weight loss of >5% since the last visit or flattening growth curve), fever, contact with a TB case.	All PLHIV must receive IPT at the start of ART after excluding active tuberculosis. These are: - Children, regardless of their age who have the following symptoms: low weight gain, fever, cough, or have been in contact with a TB case, and whose screening for tuberculosis is negative; - Children above 12 months, with no suspicious symptoms of active TB and not in contact with a TB case; - Children below 12 months in contact with a case of tuberculosis and in whom investigations to look for tuberculosis were negative; - Children who have successfully completed their treatment against tuberculosis in secondary prophylaxis for an additional period of 6 months.	Child on antiretroviral treatment who has TB: - Start TB treatment as soon as the diagnosis is made; - ARV treatment should not be interrupted, but we must ensure the compatibility of the current protocol and therefore consider the change of certain molecules. Recommended protocols in HIV/TB co-infected children on ART and who have to receive TB treatment: Children under 3 years: Continue NVP, ensure that the NVP dose is 200 mg/m^2 or Triple NRTI (AZT + 3TC + ABC). Children aged 3 years and above: If the child receives EFV, continue the same regimen If the child receives NVP, substitute with EFV or Triple NRTI (AZT + 3TC + ABC).	Initiate ART after 2-8 weeks of TB treatment regardless of CD4 count or clinical stage. Patients with profound immunosuppression (CD4 <50/mm3) should receive antiretroviral treatment within 2 weeks following TB treatment initiation. Child > 3 years: ABC + 3TC + EFV or AZT + 3TC + EFV or AZT + 3TC + ABC Child < 3 years: Two NRTIs + NVP: ensure that NVP dose is 200 mg/m² or Triple NRTI (AZT + 3TC + ABC).	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Cameroon - National Guideline on the Prevention and Management of HIV in Cameroon (2015)					
Children		All PLHIV must receive IPT at the start of ART after excluding active tuberculosis. These are: - Children, regardless of their age who have the following symptoms: low weight gain, fever, cough, or have been in contact with a TB case, and whose screening for tuberculosis is negative; - Children above 12 months, with no suspicious symptoms of active TB and not in contact with a TB case; - Children below 12 months in contact with a case of tuberculosis and in whom investigations to look for tuberculosis were negative; - Children who have successfully completed their treatment against tuberculosis in secondary prophylaxis for an additional period of 6 months.	Children on standard regimen containing PIs: Children under 3 years: Triple NRTI (AZT + 3TC + ABC) or Substitute LPV/r with NVP, ensure that NVP dose is maximum 200 mg/m^2 or Continue LPV/r and increase RTV dose to get the therapeutic dose of LPV in mg (ratio 1:1). Children aged 3 years and above: If the child has no past history of therapeutic failure of a combination including NNRTIs: Substitute with EFV or Triple NRTI (AZT + 3TC + ABC) or Continue LPV/r and increase RTV dose to get the LPV therapeutic dose in mg (ratio of 1:1). If the child has past history of therapeutic failure of a combination including NNRTIs: Triple NRTI (AZT + 3TC + ABC) or Continue LPV/r and increase RTV dose to get the LPV therapeutic dose in mg (ratio of 1:1).	Initiate ART after 2-8 weeks of TB treatment regardless of CD4 count or clinical stage. Patients with profound immunosuppression (CD4 <50/mm3) should receive antiretroviral treatment within 2 weeks following TB treatment initiation. Child > 3 years: ABC + 3TC + EFV or AZT + 3TC + EFV or AZT + 3TC + ABC Child < 3 years: Two NRTIs + NVP: ensure that NVP dose is 200 mg/m² or Triple NRTI (AZT + 3TC + ABC)	

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Côte d'Ivoire - Directives 2015 de Prise en charge des personnes vivant avec le VIH en Côte d'Ivoire (2015)					
Adults	Y Systematic TB screening to be done at every clinic visit.			All PLHIV with TB should receive ART, regardless of their CD4 cell count. Preferred regimen: TDF + 3TC + EFV ART will begin 2 weeks after initiation of TB treatment. In case of neuro-meningeal tuberculosis, ART will be initiated after a month of properly followed anti-TB treatment. If there is a contraindication to EFV and if the CD4 count >200 / mm3: The triple therapy regimen based on 3 NRTIs is recommended. The recommended combination is: AZT + 3TC + TDF	TDF + 3TC + LPV/r with double dose of Ritonavir
Children	Y Systematic TB screening to be done at every clinic visit.	IPT indicated in children 0-5 years old		Initiate ART regardless of the type of tuberculosis. Start ART two weeks after the initiation of TB treatment. If age <3 years: AZT + 3TC + ABC If age ≥ 3 years or weight >10 kg and age <10 years: ABC + 3TC + EFV If age ≥ 10 years: TDF + 3TC + EFV	

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Democratic Republic of Congo - Guide de Prise en Charge Intégrée du VIH en République Démocratique du Congo (2016)					
Adults	Y Active TB screening for all PLHIV at every contact, even when the patient is taking IPT. TB screening algorithm based on: cough, night sweats, fever, weight loss, contact with a patient with active TB.	All PLHIV who screen negative for active TB (using the clinical screening tool) are eligible for IPT.	If the patient is already on ART, initiate TB treatment immediately.	If TB is diagnosed in an ART naïve patient, it is recommended to delay initiation of ART until two weeks after initiation of TB treatment.	
Children		Eligible for IPT: - HIV-infected children who screen negative for active TB (using the clinical screening tool). - Newborns of a mother with active TB. - Children <5 years old who live under the same roof with a person with sputum smear positive TB.			

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Ethiopia - National Guidelines for Comprehensive HIV Prevention, Care and Treatment (2017)					
Adults	Y At every visit conduct screening for TB. Adults and adolescents living with HIV should be screened for TB with clinical algorithm, those who report any one of the symptoms of current cough, fever, weight loss or night sweats may have active TB and should be evaluated for TB and other diseases. Xpert MTB/RIF test (GeneXpert Test) is recommended as an initial diagnostic test for all presumptive TB cases (individuals with TB symptoms) among HIV infected people. AFB Microscopy is indicated for HIV infected presumptive TB cases when access to XPERT MTB/RIF test is limited. Sputum culture is the gold standard for the diagnosis of tuberculosis in general.	Screening for exclusion of active TB in HIV infected persons is the single most important step that should precede the decision to initiate IPT. Contraindications for IPT: - Symptoms compatible with tuberculosis even if the diagnosis isn't yet confirmed. - Active hepatitis (chronic or acute) - Regular and heavy alcohol consumptions - Prior allergy or intolerance to isoniazid - Symptoms of peripheral neuropathy	Start anti-TB treatment Preferred regimen for TB/HIV co-infected patients is TDF+3TC+EFV - Modify ART regimen to avoid drug-drug interaction - Evaluate for treatment failure	ART should be started in all TB-HIV co-infected patients, including those with drug-resistant TB, irrespective of the CD4 count. Anti-tuberculosis treatment and co-trimoxazole (CPT) should be initiated first, followed by ART as soon as possible within the first 8 weeks of anti-TB treatment. The HIV-positive TB patients with profound immunosuppression such as CD4 counts less than 50 cells/mm3 should receive ART immediately within the first two weeks of initiating TB treatment. TDF + 3TC + EFV	
Children	Y Children living with HIV who have any of the symptoms of poor weight gain, fever, current cough or contact history with TB case may have active TB and should be evaluated for TB and other conditions.	> 12 months old: Eligible for IPT if active TB has been excluded AND if child has no contra-indications for INH. (Contraindications include active hepatitis (acute or chronic) or symptoms of peripheral neuropathy).	**< 3 years old:** Child on standard NNRTI-based regimen (two NRTIs + EFV or NVP): Continue NVP, ensuring that dose is 200 mg/m2 Or Triple NRTI (AZT + 3TC + ABC) Child on standard PI based regimen (two NRTIs + LPV/r): Triple NRTI (AZT + 3TC + ABC) or Substitute NVP for LPV/r, ensuring that dose is 200 mg/m2	**< 3 years old:** ART should be started as soon as tolerated within 8 weeks of initiating anti-TB. Two NRTIs + NVP, ensuring that dose is 200 mg/m2 or Triple NRTI (AZT + 3TC + ABC) (An age-appropriate PI- or NNRTI based regimen should be restarted when rifampicin-based therapy ends.)	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Ethiopia - National Guidelines for Comprehensive HIV Prevention, Care and Treatment (2017)					
Children	Y Children living with HIV who have any of the symptoms of poor weight gain, fever, current cough or contact history with TB case may have active TB and should be evaluated for TB and other conditions.	< 1 year old: Eligible for IPT if child has a history of household contact with a TB case AND active TB has been excluded AND if child has no contra-indications for INH. (Contraindications include active hepatitis (acute or chronic) or symptoms of peripheral neuropathy.	**≥3 years old:** If the child is receiving EFV, continue the same regimen. If the child is receiving NVP, substitute with EFV or Triple NRTI (AZT + 3TC + ABC) Child on standard PI based regimen (two NRTIs + LPV/r): Substitute PI with EFV or Triple NRTI (AZT + 3TC + ABC)	**≥3 years old:** Two NRTIs + EFV or Triple NRTI (AZT + 3TC + ABC)	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Ghana - Guidelines for Antiretroviral Therapy in Ghana (2016)					
Adults	Y TB screening should be done at each visit to the clinic using the TB screening algorithm.		Maintain client on ART, but replace Nevirapine with Efavirenz if client was on Nevirapine. Start TB treatment as soon as possible. NB: Where EFV is contraindicated or not tolerated, use AZT + 3TC + ABC or AZT + 3TC + TDF (triple nukes) for the duration of TB treatment and revert to standard first line after completion.	Start ART in all HIV/TB co-infected individuals. The ART must be started as soon as practicable within two weeks but not later than 8 weeks of starting TB treatment. In clients with MDRTB and HIV co-infection ART is the same as above.	
Children		IPT to be given only: - to HIV-exposed infants born to mothers with active TB who started anti-TB treatment < 2 months before delivery, - or to infants and children with exposure to an adult with active TB disease.	Start anti-TB treatment immediately. If on 2NRTIs + NVP: If < 3 years old: substitute LPV/r for NVP If ≥ 3 years old: substitute EFV for NVP If substitution with EFV or LPV/r is not possible, ensure that NVP is dosed at the maximum of 200 mg/m2 per dose, twice daily, or substitute NVP with ABC for the duration of the anti-TB treatment.	Any HIV infected child with active TB should begin anti-TB treatment immediately and start ART as soon as tolerated but not later than 8 weeks after the initiation of anti-TB treatment. < 3 years old: The preferred first-line ARV regimen is: 2NRTIs + LPV/r > 3 years old and adolescents: The recommended first line ARV regimen is: 2NRTIs + EFV	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Haiti - Normes Nationales pour la Prise en Charge des Personnes Vivant avec le VIH Resume Executif (2016)					
Adults	Active screening for TB is recommended for all HIV-infected adults, adolescents and children prior to the initiation of ART and during ART. Further screening for TB with GeneXpert is recommended for all HIV-infected adults, adolescents and children with signs and symptoms suggestive of TB. TB screening with GeneXpert is recommended for any HIV-infected child in close contact with a person with active TB, even if the child is asymptomatic.	Isoniazid prophylaxis for at least 36 months or for life is recommended for all adults and adolescents living with HIV who have no evidence of active TB.		TB treatment will be initiated first followed by ART as soon as possible within 2-8 weeks. TDF + 3TC + EFV If intolerance to EFV: TDF or AZT + 3TC + ABC	
Adolescent 10 - 19 years old				ARV therapy should be initiated for any child with active TB as early as possible and within 2-8 weeks after initiation of TB treatment TDF + 3TC + EFV	
Children 3 - 10 years old		INH prophylaxis for at least 6 months is recommended for all children 12 months and older who are infected with HIV who have no evidence of active TB. INH prophylaxis for at least 6 months is recommended for children less than 12 months of age who are infected with HIV and who have close TB contact and for whom TB screening is negative.		ARV therapy should be initiated for any child with active TB as early as possible and within 2-8 weeks after initiation of TB treatment. ABC + 3TC + EFV AZT + 3TC + EFV TDF + 3TC + EFV AZT or TDF + 3TC + ABC (if intolerance to the EFV)	
< 3 years old				ABC + 3TC + AZT during the duration of TB treatment only	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Kenya - Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya (2016)					
Adults Children	Y TB and prevention services should be offered to ALL PLHIV at every clinical visit and to all household contacts of active TB patients. Symptom-based TB screening using the ICF tool MUST be performed for all PLHIV at every clinic visit to rule out active TB.	Patients who screen negative on the ICF tool should be evaluated for isoniazid preventive therapy (IPT). The following client categories are eligible for IPT: - HIV-infected children less than 12 months of age who have had recent close contact with sputum positive TB disease with no evidence of active TB. - All children under 5 years old, irrespective of HIV status, who have had recent close contact with sputum positive TB disease with no evidence of active TB. - All PLHIV above 12 months of age (children and adults including pregnant and breastfeeding women) who screen negative for active TB (using the ICF tool), regardless of TB exposure. - Prisoners who screen negative for active TB (using the ICF tool) (irrespective of their HIV status), regardless of TB exposure.	Patients with TB/HIV co-infection who are already on ART should start anti-TB treatment immediately and continue ART, making any required adjustments to the ART regimen based on predicted drug interactions.	Start TB treatment immediately. Initiate ART as soon as anti-TB medications are tolerated, preferably within 2 weeks.	
			If on PI-based regimen: < 3 years old: super-boost LPV/r with additional RTV. If not able to tolerate super-boosted LPV/r + RTV, use AZT + ABC + 3TC for duration of TB treatment. After completion of TB treatment revert back to the original regimen. 3-15 years (< 35 kg body weight): Super-boost LPV/r with additional RTV to a ratio of 1:1. If unable to tolerate super-boosted LPV/r switch to EFV for duration of TB treatment. > 15 years old OR ≥ 35 kg body weight: Continue PI/r; use rifabutin for anti-TB treatment.	**< 4 weeks:** Start anti-TB treatment immediately; start ART after 4 weeks of age, once tolerating anti-TB drugs (follow the regimen recommendations for children 4 weeks to < 3 years of age). **4 weeks - < 3 years:** ABC + 3TC + LPV/r + RTV If not able to tolerate super-boosted LPV/r + RTV use AZT + ABC + 3TC for duration of TB treatment. After completion of TB treatment revert back to the recommended 1st line regimen. **3 - 15 years (< 35 kg body weight):** ABC + 3TC + EFV **3 - 15 years (≥ 35 kg body weight):** TDF + 3TC + EFV **> 15 years :** TDF + 3TC + EFV	
			If on EFV-based regimen: continue same regimen.	**PWID > 15 years:** TDF + 3TC + ATV/r (using rifabutin-based anti-TB treatment).	
			If on NVP-based regimen: < 3 years old: Switch to AZT + ABC + 3TC (as soon as TB treatment is completed switch back to original regimen). ≥ 3 years old: Switch to EFV.		
			If on RAL-based regimen: Give double the standard dose of RAL.		
			If on DTG-based regimen: Give standard dose of DTG twice daily.		

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Lesotho - National Guidelines on the Use of Antiretroviral Therapy for HIV Prevention and Treatment (2016)					
Adults Adolescents	Y TB screening must be done during the initial assessment and during every clinical encounter for all people living with HIV. Every HIV-positive individual should be actively screened for TB at each clinical encounter using a TB screening tool that includes the following questions: 1. Are you coughing? 2. Have you lost weight (without trying)? 3. Do you have drenching/soaking sweats at night? 4. Do you have fevers? If the answer to any of the questions is 'yes', then the patient is a TB suspect and needs to be investigated further.	Isoniazid Preventive Therapy (IPT) Given the high prevalence of latent TB infection in Lesotho, every individual with HIV greater than 1 year of age who has no signs or symptoms of active TB should be started on IPT as soon as possible, regardless of CD4 count, WHO clinical stage, and ART status. Additionally, IPT should be provided after the completion of TB treatment for all TB/HIV co-infected persons. Patients should not be offered IPT if they report: - Acute or chronic liver disease. Signs and symptoms suggestive of active hepatitis are: nausea, vomiting, right upper quadrant pain, jaundice, and dark urine, or o Regular and heavy alcohol consumption or o Symptoms of severe peripheral neuropathy or o History of epilepsy or convulsions or o Kidney failure	Adults and adolescents, including pregnant and breastfeeding women: Patients on NVP: switch to EFV. The NRTIs should not be changed. Patients on EFV should remain on their ART regimen. Patients on LPV/r or another protease inhibitor: If there is a history of previous ART failure on a NNRTI-based regimen (NVP or EFV), continue the protease inhibitor and: - Give additional ritonavir tablets to achieve LPV/RTV dosing of 400/400mg twice daily or - Give double dose of LPV/r (800/200 mg twice daily) - An alternative regimen is to switch to an integrase inhibitor-based second line regimen for the duration of TB treatment (RAL or DTG) i) The dose of raltegravir and dolutegravir must be doubled during TB treatment (e.g. raltegravir 800 mg BD and dolutegravir 50 mg BD) ii) After completion of TB treatment, RAL or DTG should be switched to an appropriate PI (LPV/r or ATV/r).	All TB/HIV co-infected patients should be started on ART within 2-4 weeks of TB treatment initiation, irrespective of the CD4 cell count. TB/HIV Co-infected patients not yet initiated on ART: Adults and adolescents (≥ 10 years and ≥35 kg), including pregnant and breastfeeding women: The preferred 1st line regimen is: TDF + 3TC + EFV	Adults and adolescents with TB co-infection who are failing a NNRTI-based first-line regimen have 2 second-line ART regimen options: 1. PI-based second-line regimen with additional ritonavir boosting a. Give additional ritonavir tablets to achieve LPV/RTV dosing of 400/400mg twice daily or b. Give double dose of LPV/r (800/200 mg twice daily) 2. Integrase inhibitor-based second-line regimen for the duration of TB treatment (RAL or DTG) a. The dose of raltegravir and dolutegravir must be doubled during TB treatment b. After completion of TB treatment, RAL or DTG should be switched to an appropriate PI (LPV/r or ATV/r)

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Lesotho - National Guidelines on the Use of Antiretroviral Therapy for HIV Prevention and Treatment (2016)					
Children	Every HIV-positive individual should be actively screened for TB at each clinical encounter using a TB screening tool that includes the following questions: 1. Has the child been coughing? 2. Has the child had a fever? 3. Failure to thrive / faltering growth, or signs of severe malnutrition? 4. Has the child been in contact with someone with TB disease? If the answer to any of the questions is 'yes', then the patient is a TB suspect and needs to be investigated further.	Every individual with HIV greater than 1 year of age who has no signs or symptoms of active TB should be started on IPT as soon as possible. Additionally, HIV-positive children <10 years exposed to TB through household contacts without signs or symptoms of active TB, including infants <1 year, should be given IPT.	Children 3-9 years or ≥ 10 years but <35kg: - Patient on NVP-based regimen: switch to EFV - Patient on EFV: continue the same regimen - Patient on LPV/r or another protease inhibitor who previously failed NVP or EFV: switch to AZT + 3TC + ABC and consult an expert HIV clinician. i) An alternative ART regimen is to switch the PI to raltegravir for the duration of TB treatment but this should only be done in consultation with an HIV expert.	Children 3-9 years or ≥ 10 years but <35kg: The preferred 1st line ART regimen is - ABC + 3TC + EFV	
			Children <3 years or ≥ 3 years but < 10kg: - Patient on LPV/r: switch to NVP, which should be dosed at the maximum dose of 200 mg/m2/dose given twice daily due to interactions with rifampin - Alternatively give AZT + 3TC + ABC. - Patient on NVP: continue NVP and ensure the maximum NVP dose of 200 mg/m2/dose twice daily. - After the completion of TB treatment, patients previously on LPV/r should be switched from NVP or the triple NRTI regimen back to LPV/r.	Children <3 years or ≥ 3 years but < 10kg: - The preferred 1st line ART regimen is ABC + 3TC + NVP. Nevirapine must be dosed at the maximum dose of 200 mg/m2/dose given twice daily due to interactions with rifampin. - An alternative regimen for this group is a triple NRTI regimen of AZT + 3TC + ABC, which should be used if the child has a history of failing a NNRTI-based regimen in the past. After the completion of TB treatment, patients should be switched to ABC + 3TC + LPV/r.	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Malawi - 3rd Edition of the Malawi Guidelines for Clinical Management of HIV in Children and Adults (2016)					
Adults	Y Routine TB Screening: Screen all patients at each visit for signs of active TB using 4 standard screening questions: - Cough of any duration - Fever - Night sweats - Weight loss / failure to thrive / malnutrition	HIV infected adults in the 10 high burden districts (Lilongwe, Blantyre, Mangochi, Machinga, Chikwawa, Mzimba North, Thyolo, Mulanje, Nsanje, Chiradzulu) in whom active TB has been ruled out using the screening questions, should start IPT. In the 10 high burden districts: - New patients: start IPT together with ART and CPT. - Patients already on ART: start IPT regardless of the time on ART. - Give IPT regardless of previous TB treatment or prior use of IPT. - Continue IPT for life as long as the patients remains in a high burden district. - IPT can be taken in pregnancy and combined with CPT and ART. IPT contraindications: - Suspected or confirmed active TB - Active hepatitis, liver damage, chronic alcohol abuse - Severe peripheral neuropathy		TDF + 3TC + EFV - Start ART within 14 days of diagnosis - TB treatment + ART can be started on the same day if the patient is stable. Don't delay TB treatment or ART.	Patients with ART failure may develop active TB. In this case, second line ART needs to be combined with TB treatment. Do not combine ATV/r with rifampicin-containing TB treatment. Give LPV/r instead of ATV/r for the duration of TB treatment and move (back) to ATV/r once TB treatment has been completed. Double the daily dose of LPV/r (4 tablets of LPV 200mg / r 50 mg every 12 hours) for the duration of rifampicin treatment. Alternatively, replace rifampicin with rifabutin in patients on LPV/r (normal dose). Give rifabutin 150 mg daily. Other TB drugs in regimen should also be continued.
Children		Children under 5 years – regardless of HIV status - who live with a patient with pulmonary TB (sputum smear negative or positive; in all districts) should start IPT.		< 3 years old: AZT + 3TC + NVP ≥ 3 years old and < 35 kg: AZT + 3TC + EFV - Start ART within 14 days of diagnosis - TB treatment + ART can be started on the same day if the patient is stable. Don't delay TB treatment or ART.	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Mozambique - "Tratamento Antiretroviral e Infecções Oportunistas do Adulto, Adolescente, Grávida e Criança" Antiretroviral treatment and opportunistic infections in adults, adolescents, pregnant women, and children (2016)					
Adults	Y All people living with HIV should be screened for TB at every clinical consultation.	Any HIV infected adult (including pregnant women) without any symptoms or signs of active TB, and regardless of any TST result, is eligible for IPT for the duration of six months. Contraindications for IPT: - Active TB - Acute or chronic liver disease - Severely ill patients (because of the difficulty to exclude active TB) - Peripheral neuropathy - Alcohol abuse - Poor adherence - Intolerance or allergy to INH	If patient is on NVP, substitute EFV or LPV/r + R for NVP.	Start with TB treatment first. TDF + 3TC + EFV Alternatives: ABC + 3TC + EFV AZT + 3TC + EFV TDF + 3TC + LPV/r + R	
Children <3 years old or <10 kg		HIV infected children are eligible for six months of IPT in the following cases: The child has no symptoms or signs suggestive of active TB, AND: - The child is >12 months old - The child is < 12 months old and has a contact history with a person with active TB.	If child on AZT+3TC+NPV or on AZT+3TC+LPV/r: change to AZT+3TC+ABC	Start with TB treatment first, followed by ART within 8 weeks after initiation of anti-TB treatment.	If child receiving a LPV/r based regimen, super boost ritonavir up to a 1:1 proportion with LPV for the duration of rifampicin treatment.
Children ≥3 years old AND ≥10 kg			If child on AZT+3TC+NPV: change to AZT+3TC+EFV If child on AZT+3TC+LPV/r: change to AZT+3TC+ABC		
Children ≥5 years old AND ≥35 kg			If child on TDF+3TC+EFV: continue TDF+3TC+EFV If child on AZT+3TC+LPV/r: change to AZT+3TC+ABC		

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Myanmar - Guidelines for the Clinical Management of HIV in Myanmar (2017)					
Adults, adolescents	Y Children, adolescents and adults living with HIV should be screened at the time of initial presentation for HIV care and at every visit to a health facility or contact with a health-care worker afterwards.	Adults and adolescents with HIV who do not have any one of the symptoms of current cough, fever, weight loss, night sweats or lymph node enlargement have a very low probability of active TB and should be offered IPT. For patients with prior IPT history more than two years ago, IPT can be considered again if the patient has risk of developing TB, for example, close contact with TB cases. Contraindications to IPT include: - active hepatitis (acute or chronic) - alcoholism - peripheral neuropathy		ART should be started in all TB patients living with HIV, regardless of CD4 count. TB treatment should be initiated first, followed by ART as soon as possible within the first 2 to 8 weeks of treatment. HIV positive TB patients with profound immunosuppression (e. g. CD4 count less than 50 cells/mm^3) should receive ART within the first 2 weeks of initiating TB treatment. Preferred first line regimen: TDF + 3TC (or FTC) + EFV Lternative regimens: AZT + 3TC + EFV TDF + 3TC (or FTC) + DTG (In pregnant or breastfeeding women, use NVP instead of DTG) ABC + 3TC + EFV	If rifabutin is available: Standard PI-containing regimens as recommended for adults and adolescents If rifabutin is not available: Same NRTI backbones as recommended for adults and adolescents plus double-dose LPV/r (that is, LPV/r 800 mg/200 mg twice daily)

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Myanmar - Guidelines for the Clinical Management of HIV in Myanmar (2017)					
Children 3 years to <10 years	Y Children, adolescents and adults living with HIV should be screened at the time of initial presentation for HIV care and at every visit to a health facility or contact with a health-care worker afterwards.	Children living with HIV older than 12 months of age who do not have poor weight gain, fever or current cough and have no contact with a TB case are unlikely to have active TB disease and should receive IPT for 6 months at the dosage of 10mg/kg/day. Poor weight gain in children is defined as reported weight loss or confirmed weight loss (>5%) since the last visit or growth curve flattening or very low weight (weight for age ≤3 z score) or underweight (weight for age ≤2 z score).	**Child on standard NNRTI based regimen(Two NRTIs + EFV or NVP):** If the child is receiving EFV, continue the same regimen. If the child is receiving NVP, substitute with EFV. or Triple NRTI (AZT + 3TC + ABC). **Child on standard PI-based regimen(Two NRTIs + LPV/r):** - If the child has no history of failure of an NNRTI-based regimen: Substitute with EFV or Triple NRTI (AZT + 3TC+ ABC) or Continue LPV/r, adding RTV to achieve the full therapeutic dose - If the child has a history of failure of an NNRTI-based regimen: Triple NRTI (AZT+ 3TC+ ABC) c or Continue LPV/r adding RTV to achieve the full therapeutic dose.	Two NRTIs + EFV or Triple NRTI (AZT + 3TC + ABC)	
Children 12 months to <3 years			**Child on standard NNRTI based regimen(Two NRTIs + EFV or NVP):** Continue NVP, ensuring that the dose is 200 mg/m². or Triple NRTI (AZT+ 3TC + ABC).	Preferred first line regimen: Triple NRTI (AZT + 3TC + ABC)	
Children <12 months		In children with HIV who are less than 12 months of age, only those who have contact with a TB case and who are evaluated for TB using investigations such as chest X-ray should receive 6 months of IPT if the evaluation shows no TB disease.	**Child on standard PI-based regimen(Two NRTIs + LPV/r):** Triple NRTI (AZT + 3TC + ABC) or Continue LPV/r, adding RTV to achieve the full therapeutic dose.		

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Namibia - National Guidelines for Antiretroviral Therapy (2016)					
Adults	All people living with HIV should be screened for TB including asking about TB exposure/contact history at each encounter with a health worker or visit to a health facility. It is recommended that Xpert MTB/RIF should be used rather than conventional microscopy as the initial diagnostic test in adults and children suspected of having MDR-TB or HIV associated TB.	To be eligible for TB-IPT the HIV-positive individual must: - Have no symptoms or signs of TB – such as cough, fever, weight loss, night sweats, fatigue, blood in sputum, chest pain, diarrhoea, shortness of breath, enlarged lymph nodes, loss of appetite (NB: TB-IPT should not be given to patients who are unwell and where there is no explanation of the illness) - Not have current history of alcohol misuse - Have no history of active liver disease, liver insufficiency, or jaundice - Have no history of hypersensitivity to isoniazid - Have no history of exfoliative dermatitis - Be motivated for TB-IPT after being educated about the benefits, possible side-effects and risks. In addition HIV-positive persons who are close contacts of patients with infectious TB should receive IPT even if they have completed a previous course of IPT.	For PLHIV on 1st line ARV with TB, no change in regimen TDF + FTC (or 3TC) + EFV For PLHIV on boosted PI regimen: Option 1: Substitute rifampicin in the TB treatment with rifabutin Option 2: If Rifabutin is unavailable or contraindicated, maintain Rifampicin in TB and use PI based regimen super boosted with ritonavir: TDF or AZT + 3TC with LPV/r 400 mg + ritonavir 400 mg BD (LPV/RTV) **Note: ATV/r is contraindicated in patients with TB/HIV co-infection If EFV or LPV/RTV cannot be used, give: TDF + FTC (or 3TC) + AZT	ART should be initiated as soon as possible in all HIV/TB coinfected patients with active TB (within 8 weeks after the commencement of TB treatment). HIV-positive TB patients with profound immunosuppression (such as CD4 counts less than 50 cells/mm3) should receive ART immediately within the first two weeks of initiating TB treatment. TDF + FTC (or 3TC) + EFV	If a patient is already on 2nd line ART and/or 2nd line anti-TB treatment, discuss management with a relevant specialist.
Adolescents Children	Y Children and adolescents with HIV should be screened for TB including asking about TB exposure/contact history at each encounter with a health worker or visit to a health facility; eligible children and adolescents with HIV should be offered IPT. It is recommended that Xpert MTB/RIF should be used rather than conventional microscopy as the initial diagnostic test in adults and children suspected of having MDR-TB or HIV associated TB.	For all HIV-positive children and adolescents (regardless of age) who have had contact with someone with infectious TB, and infants born to mothers with untreated pulmonary TB disease, supervised isoniazid preventive therapy (TB-IPT) should be given once active TB disease has been excluded. All HIV-positive children and adolescents in whom active TB has been excluded are eligible for a 9-month course of TB-IPT, whether there has been a documented exposure to active TB or not. In addition, even if a child has already taken a course of TB-IPT and is subsequently exposed to a patient with infectious TB, another course of IPT should be given after every episode of exposure.		If the diagnosis of TB and HIV are made simultaneously, ART should be started in any child or adolescent with active TB disease as soon as possible and within eight weeks of starting antituberculosis treatment. Children with profound immunosuppression (e.g. CD4<50 cells/mm3) should receive ART immediately, within two weeks of initiating TB treatment as this carries a survival advantage in this group.	If a child is on second line ART and is diagnosed with TB, make the following temporary changes to the ART regimen: If already on 3 NRTIs + EFV: leave unchanged If already on 3 NRTIs + NVP and ≥ 3 years old or ≥ 10 kg, change NVP to EFV. If already on any other regimen or <3 years old or <10 kg, consult an HIV specialist and consider discussing TB regimen change with CCRC (Clinical Case Review Committee).

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Namibia - National Guidelines for Antiretroviral Therapy (2016)					
Adolescents Children	Y Children and adolescents with HIV should be screened for TB including asking about TB exposure/contact history at each encounter with a health worker or visit to a health facility; eligible children and adolescents with HIV should be offered IPT. It is recommended that Xpert MTB/RIF should be used rather than conventional microscopy as the initial diagnostic test in adults and children suspected of having MDR-TB or HIV-associated TB.	For all HIV-positive children and adolescents (regardless of age) who have had contact with someone with infectious TB, and infants born to mothers with untreated pulmonary TB disease, supervised isoniazid preventive therapy (TB-IPT) should be given once active TB disease has been excluded. All HIV-positive children and adolescents in whom active TB has been excluded are eligible for a 9-month course of TB-IPT, whether there has been a documented exposure to active TB or not. In addition, even if a child has already taken a course of TB-IPT and is subsequently exposed to a patient with infectious TB, another course of IPT should be given after every episode of exposure.		2 weeks to <3 months old: If a child or adolescent presents TB and is not yet on ART, start ART with the following regimens: AZT/3TC + LPV/r + R	If a child is on second line ART and is diagnosed with TB, make the following temporary changes to the ART regimen: If already on 3 NRTIs + EFV: leave unchanged If already on 3 NRTIs + NVP and ≥ 3 years old or ≥ 10 kg, change NVP to EFV. If already on any other regimen or <3 years old or <10 kg, consult an HIV specialist and consider discussing TB regimen change with CCRC (Clinical Case Review Committee).
			3 months to <3 years old or weight <10 kg: If on NVP based regimen: change to ABC + AZT + 3TC If on LPV/r based regimen: change to ABC + 3TC + LPV/RTV	3 months to <3 years old or weight <10 kg: ABC + 3TC + super-boosted lopinavir/ritonavir (LPV/r + R) or AZT + 3TC + ABC Switch to standard ART regimen two weeks after completing rifampicin-based TB treatment	
			3-9 years old and weight 10 kg to < 35 kg: If on NVP based regimen, change to EFV If on ATV/r or LPV/r, change to LPV/RTV. If not possible, give ABC + 3TC + AZT	3 - 9 years old and weight 10 kg to < 35 kg: If the child has had NO previous eMTCT/PMTCT NVP exposure: ABC + 3TC + EFV If the child has had previous eMTCT/PMTCT NVP exposure: - ABC + 3TC + super-boosted lopinavir/ritonavir (LPV/r + R) or - ABC + 3TC + AZT	
			≥ 35 kg and at least 10 years old: If on ATV/r or LPV/r, change to LPV/RTV. Or change to TDF + AZT + 3TC	≥ 35 kg and at least 10 years old: TDF + 3TC + EFV If already on ATV/r or LPV/r, change to LPV/RTV. Or change to TDF + AZT + 3TC	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Nigeria - National Guidelines for HIV Prevention Treatment and Care (2016)					
Adults and Adolescents including pregnant women	Systematic screening for TB symptoms at every clinical encounter	Adults and adolescents living with HIV should be screened for any one of the symptoms of current cough, fever, weight loss or night sweats. Those in whom active TB has been safely ruled out should receive at least six (6) months of IPT as part of a comprehensive package of HIV care. IPT should be given to such individuals regardless of the degree of immunosuppression, and also to those on ART, those who have previously been treated for TB and pregnant women.		TB treatment should be initiated first, followed by ART as soon as possible within the first 2 weeks of treatment. TDF + 3TC + EFV	Preferred Options: If TDF in first line: AZT + 3TC + LPV/r, or AZT + 3TC + ATV/r If AZT in first line: TDF + 3TC + ATV/r, or TDF + 3TC + LPV/r *Rifabutin should replace rifampicin. Where rifabutin is not available, double-dose LPV/r (that is, LPV/r 800 mg/200 mg twice daily)
Children < 12 months		In children living with HIV who are <12 months of age, only those who have contact with a TB case and who are evaluated for TB (using standard lab investigations) should receive six (6) months of IPT if the evaluation shows no TB disease. All children living with HIV, after successful completion of treatment for TB, should receive IPT for an additional six months.	< 3 years old: Child on two NNRTI + EFV or NVP: Continue NVP, ensuring that the dose is 200mg/m2 OR *Triple NRTI (AZT+3TC+ABC) Child on two NRTIs+LPV/r: *Triple NRTI (AZT+3TC+ABC) OR Continue LPV/r adding RTV to achieve full therapeutic dose** *Once TB therapy has been completed, this regimen should be stopped and the initial regimen should be restarted. **Increase RTV until it reaches the same dose as LPV in mg in a ratio of 1:1	< 3 years old: TB treatment should be initiated first, followed by ART as soon as possible within the first 2 weeks of treatment. Triple NRTI (AZT + 3TC + ABC)	
Children 1-2 years		Children living with HIV who are ≥ 12 months of age and who are unlikely to have active TB on symptom-based screening and have no contact with a TB case should receive six months of IPT (10 mg/kg/day) but not more than 300 mg/day as part of a comprehensive package of HIV prevention and care. All children living with HIV, after successful completion of treatment for TB, should receive IPT for an additional six months.			
≥ 3 years old			≥ 3 years old: Child on two NNRTI + EFV: continue same regimen Child on two NNRTI + NVP: substitute NVP with EFV Child on two NRTIs+LPV/r: If the child has no history of failure of an NNRTI-based regimen: Substitute with EFV OR continue LPV/r until an LPV/r ratio of 1:1 is attained** **Increase RTV until it reaches the same dose as LPV in mg in a ratio of 1:1	≥ 3 years old: TB treatment should be initiated first, followed by ART as soon as possible within the first 2 weeks of treatment. Two NRTIs + EFV (AZT + 3TC + EFV)	

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Rwanda - National Guidelines for Prevention and Management of HIV and STIs (2016)					
Adults Adolescents (10-19 years old)	Y All HIV-positive adults should be screened for active TB infection at enrollment and regularly at each clinical encounter with a clinical algorithm using the following symptoms or signs: 1) Cough 2) Fever or night sweats 3) Weight loss 4) Contact with someone known to have TB		Patient on TDF/ABC/AZT + 3TC + EFV: - No adjustment (EFV remains 600 mg daily) Patient on TDF/ABC/AZT + 3TC + NVP: - Substitute NVP with EFV Patient on TDF/ABC/AZT + 3TC + LPV/r: - Double dosing of LPV/r during anti-tuberculosis therapy or substitute Rifampin with Rifabutin Patient on TDF/ABC/AZT + 3TC + ATV/r: - Substitute ATV/r with double-dosing of LPV/r or substitute Rifampin with Rifabutin	In co-infected patients, the priority is to first treat TB, followed by ART initiation after 2-8 weeks.	
Children	Y All HIV positive children should be screened for active TB disease at enrollment and regularly at each encounter with a health worker or visit to a health facility. Children with the following symptoms should be evaluated for TB disease: any cough, fever, loss of weight and history of contact with an infectious TB case.	Children living with HIV who are unlikely to have active TB on symptom-based screening and have known contact with a TB case should receive 6 months of IPT (10mg/kg/day).	**Children < 3 Years Old:** Patient on ABC/AZT + 3TC + EFV Adjustment: ABC + AZT + 3TC ** EFV currently not recommended under 3 years Patient on ABC/AZT + 3TC + NVP Adjustment: Increase NVP by 30%* Or switch to EFV if > 3.5kg Patient on ABC/AZT + 3TC + LPV/r Adjustment: Replace Rifampicin or Substitute LPV/r with NVP increased by 30% for < 3.5kg	TB treatment in children diagnosed with TB disease should be initiated immediately. ART should be started in any child with active TB disease as soon as possible and within eight weeks following the initiation of anti-TB treatment irrespective of the CD4 count and clinical stage.	
			Children > 3 Years Old Patient on ABC/AZT + 3TC + EFV Adjustment: ABC/AZT + 3TC + EFV Patient on ABC/AZT + 3TC + NVP Adjustment: Substitute NVP with EFV Patient on ABC/AZT + 3TC + LPV/r Adjustment: Increase the dose of Ritonavir to achieve 1:1 ratio (LPV/r) or ABC + 3TC + AZT (not a strong combination)		

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
South Africa - National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults (2015)					
Adults/adolescents	Y All people living with HIV should be screened for TB at every visit to a health facility or contact with a health worker. Symptom-based TB screening is sufficient to exclude TB among adults and adolescents living with HIV.	Pre-ART adults or adolescents must be TST positive to be eligible for IPT, regardless of CD4 count. Adults or adolescents on ART are all eligible for IPT, regardless of CD4 count.	Continue ARV treatment throughout TB treatment: First-line regimen: Patient can remain on the regimen they are taking (unless they are on NVP) Remember to boost LPV/r if patient is on second line regimen.	In TB/HIV co-infection not on ART: Start with TB treatment first, followed by ART as soon as possible and within 8 weeks. If CD4 < 50 cells/µl initiate ART within 2 weeks of starting TB treatment, when the patient's symptoms are improving and TB treatment is tolerated. If CD4 > 50 cells/µl initiate ART within 2 - 8 weeks of starting TB treatment. First line regimen: TDF + 3TC (or FTC) + EFV	The Lopinavir/Ritonavir (LPV/r) dose should be doubled (increase gradually from 2 tablets 12 hourly to 4 tablets 12 hourly) while the patient is on Rifampicin-based TB treatment. Monitor ALT monthly. Reduce Lopinavir/Ritonavir to standard dose 2 weeks after TB treatment is completed.
Pregnant or breastfeeding women		All pregnant or breastfeeding HIV-infected women are eligible for IPT, regardless of ART status or exposure.			
Children	Screening for TB in children should be part of all routine health visits.	IPT is recommended in all HIV-infected children up to 15 years old with recent exposure to a TB case, regardless of ART status and after exclusion of TB disease and other contraindications. IPT should be repeated with each new exposure to an infectious TB case. Pre-exposure IPT is not recommended for any child, regardless of HIV status. Neonates born to mother with non-infectious drug susceptible TB, after exclusion of active TB. Do not give IPT if mother has infectious drug susceptible TB or drug resistant TB.			

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
South Sudan - Consolidated Clinical Guidelines on use of Antiretroviral Drugs for HIV Treatment and Prevention (2017)					
Adults Adolescents	Y TB screening among PLHIV should be done at every visit using a clinical algorithm.	To be eligible for TB-IPT the HIV-positive adults and adolescents must: - Have no symptoms or signs of TB - such as current cough, fever, weight loss, night sweats - No current history of alcohol misuse - Have no history of active liver disease, liver insufficiency, or jaundice - Have no history of hypersensitivity to isoniazid - Have no history of exfoliative dermatitis - Be motivated for TB-IPT after being educated about the benefits, possible side-effects and risks -Do not give IPT to patients on ART for more than 3 years who are doing well (CD4 >450) Isoniazid is given daily for a period of 6 months at a dosage of 300mg/per day.	Preferred ARV Treatment for TB Clients: TDF + 3TC + EFV 600 FDC preferred (Replace EFV with NVP in clients with significant psychiatric co-morbidity or intolerance to EFV). If on LPV/r: double the LPV/r dose (from 2 tablets 12 hourly to 4 tablets 12 hourly) while the client is on rifampicin-based TB treatment. Monitor ALT monthly. Reduce LPV/r to standard dose 2 weeks after TB treatment is completed. Rifabutin, a weaker enzyme inducer, is an alternative to rifampicin in adults. When used in place of rifampicin, the ART regimens need not be adjusted.	Start TB treatment (add pyridoxine to reduce risk of INH-induced neuropathy). Introduce ART within 2-8 weeks of initiating TB therapy (i.e. ART should be started within 8 weeks of TB diagnosis or within 2 weeks for persons with advanced immunosuppression) The recommended first line ART regimen for adult and adolescent ARV drug-naïve clients with TB/HIV who require ART while still on rifampicin is: TDF + 3TC + EFV.	NRTI backbone (AZT or TDF + 3TC) plus double dose LPV/r (800 mg/200mg BD) For adults, the LPV/r dose should be doubled (from 2 tablets 12 hourly to 4 tablets 12 hourly) while the client is on rifampicin-based TB treatment. Monitor ALT monthly. Reduce LPV/r to standard dose 2 weeks after TB treatment is completed.

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South Sudan - Consolidated Clinical Guidelines on use of Antiretroviral Drugs for HIV Treatment and Prevention (2017)					
Children	Y All HIV-infected children should be evaluated for TB symptoms using the TB screening algorithm at every visit to a healthcare facility. In addition, they should be evaluated for contact with a TB source case.	Protection of HIV infected infants and children from TB can be achieved through early detection and treatment of adult infectious cases and universal use of BCG at birth and IPT. BCG should not be given to infants and children with symptomatic HIV infection. - Children living with HIV who are more than 12 months of age and who are unlikely to have active TB on symptom-based screening and have no contact with a TB case should receive six months of IPT as part of a comprehensive package of HIV prevention and care. - In children living with HIV who are less than 12 months of age, only those who have contact with a TB case and who are evaluated for TB (using investigations) should receive six months of IPT if the evaluation shows no TB disease. - All children living with HIV, after successful completion of treatment for TB, should receive IPT for an additional six months . - Use of IPT is recommended for children of breastfeeding mothers with active TB. All HIV-infected infants and children exposed to TB through household contacts, but with no evidence of active disease, should begin Isoniazid preventive therapy (IPT). The recommended IPT dose for children is 10 mg/kg/day for 6 months.	Recommended regimen for children and infants initiating TB treatment while receiving ART: Child on standard NNRTI-based regimen: Younger than 3 years: Continue NVP, ensuring that the dose is 200 mg/m2 or Triple NRTI (AZT + 3TC + ABC) 3 years and older: If the child is receiving EFV, continue the same regimen If the child is receiving NVP, substitute with EFV or Triple NRTI (AZT + 3TC + ABC) Triple NRTI regimen should be stopped once TB therapy is completed and patient restarted on the initial regimen. Child on standard PI-based regimen: Younger than 3 years: Triple NRTI (AZT + 3TC + ABC) or Continue LPV/r, adding RTV to achieve the full therapeutic dose. 3 years and older: If the child has no history of failure of an NNRTI-based regimen: Substitute with EFV or Triple NRTI (AZT + 3TC + ABC) or Continue LPV/r, adding RTV to achieve the full therapeutic dose. If the child has a history of failure of an NNRTI-based regimen: Triple NRTI (AZT+3TC +ABC) or Continue LPV/r, adding RTV to achieve the full therapeutic dose Consider consultation with experts for constructing a second line regimen.	Efavirenz is preferred for use in children needing rifampicin-based TB treatment if they are at least 3 years old, 10 kg and have not had previous nevirapine for PMTCT. Younger than 3 years: Triple NRTI (AZT + 3TC + ABC). 3 years and older: Two NRTIs + EFV or Triple NRTI (AZT + 3TC + ABC).	Consider adding RTV to achieve the full therapeutic dose i.e. increase RTV until it reaches the same dose as LPV in a ratio of 1:1.

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Swaziland - Swaziland Integrated HIV Management Guidelines (2015) Memorandum: Re: Scale Up of Test and Start Strategy in all ART Providing Facilities (2016)					
Adults Pregnant and Breastfeeding Women	Y	All PLHIV who do not have active TB (screened negative using the TB symptom screening tool) qualify for IPT for 6 months. IPT should be offered to all household contacts who are HIV-positive or are children under 5, and do not have symptoms Contraindications: - Acute and chronic liver disease - History of poor adherence - Excessive consumption of alcohol	Continue ART with changes to the regimen as necessary and move patient to TB clinic from ART clinic for duration of TB treatment. Rifampicin and NVP: - If NVP is co-administered with rifampicin, closely monitor for HIV treatment failure and hepatotoxicity and start the full dose of NVP. Rifampicin and LPV/r: - LPV/r can be used with rifampicin - Boost 1: 1 lopinavir and ritonavir. Closely monitor for toxicity and also virologic failure.	Initiate TB treatment as a first priority, then initiate ART (in all TB patients, regardless of CD4 count) when TB treatment is tolerated - preferably within 2 weeks of starting TB treatment. TDF + 3TC + EFV	
Children	Y Screen all HIV positive children for TB at every visit using the TB screening questionnaire.	IPT should be offered to all household contacts who are HIV-positive or are children under 5, and do not have symptoms. All HIV-positive children in whom active TB has been ruled out: - Children ≤12 months should be given IPT with history of TB contact - Children >12 months should be given IPT routinely HIV-exposed infants who live with someone with active TB are at risk of TB infection: - Investigate for TB and if TB is excluded, give IPT for six months at a dose of 10mg/kg. - Pyridoxine (1-2 mg/kg) should be given to prevent side effects of INH. Children receiving IPT should be monitored closely for the development of active TB.	Patient on an NVP or EFV- based regimen: continue the same regimen. Patient on LPV/r: continue with 1:1 ritonavir-boosting.	In HIV/TB co-infected children, initiate TB treatment before ART to avoid severe immune reconstitution inflammatory syndrome (IRIS). All HIV-infected children diagnosed with TB should be started on ART generally between two and eight weeks of starting anti-TB treatment. < 3 years or < 10 kg ABC + 3TC + NVP or AZT + 3TC + NVP or ABC + 3TC + AZT - Children with Hb<8 g/dl should be started on ABC + 3TC + NVP - Start NVP at full dose without lead-in dose For children exposed to NVP in the last 6 months use the paediatric AZT/3TC + ABC tablets - For children with prolonged NVP exposure, switch to LPV/r based regimen after completion of TB treatment. If VL detectable at time of ATT completion. Consult Baylor Hotline.	If child is on second-line therapy before initiating TB treatment: If current regimen contains LPV/r, continue with 1:1 ritonavir-boosting. - Ritonavir 100 mg single capsules are available for older children that can swallow them. - Consult with a Dr. or call the hotline for cases in infants and young children to seek advice on the individual case.

Population	Screening PLHIV for TB every visit (Y/N) (Intensified Case Finding)	Criteria for Starting TB Prophylaxis	ART Adjustments for patients already on ART	Regimens and Timing of ART Initiation for ART naïve patients	ART 2nd Line Regimen
Swaziland - Swaziland Integrated HIV Management Guidelines (2015) Memorandum: Re: Scale Up of Test and Start Strategy in all ART Providing Facilities (2016)					
Children	Y Screen all HIV positive children for TB at every visit using the TB screening questionnaire	IPT should be offered to all household contacts who are HIV-positive or are children under 5, and do not have symptoms. All HIV-positive children in whom active TB has been ruled out: - Children ≤12 months should be given IPT with history of TB contact - Children >12 months should be given IPT routinely HIV-exposed infants who live with someone with active TB are at risk of TB infection: - Investigate for TB and if TB is excluded, give IPT for six months at a dose of 10mg/kg. - Pyridoxine (1-2 mg/kg) should be given to prevent side effects of INH Children receiving IPT should be monitored closely for the development of active TB.	Patient on an NVP or EFV- based regimen: continue the same regimen Patient on LPV/r: continue with 1:1 ritonavir-boosting.	>3 years AND > 10 kg ABC + 3TC + EFV or AZT/d4T + 3TC + NVP or ABC + 3TC + AZT or AZT/d4T + 3TC + EFV - Children with Hb<8 g/dl should be started on ABC + 3TC + NVP - Start NVP at full dose without lead-in dose - Use EFV if child can swallow capsules and adherence to treatment is optimal - For children exposed to NVP in the last 6 months use the paediatric AZT/3TC + ABC tablets - d4T is being phased out, see page 136 of this chapter for further information	If child is on second-line therapy before initiating TB treatment: If current regimen contains LPV/r, continue with 1:1 ritonavir-boosting. - Ritonavir 100 mg single capsules are available for older children that can swallow them. - Consult with a Dr. or call the hotline for cases in infants and young children to seek advice on the individual case.

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Tanzania - National Guidelines for the Management of HIV and AIDS (2015)					
Adults Adolescents	Y All people living with HIV should be screened for TB on every visit.	For patients with no history of TB treatment: - All HIV positive individuals with no signs or symptoms suggestive of active TB are eligible for IPT. - A tuberculin skin test should be offered to all HIV infected individuals where possible.	When TB is diagnosed in patients already receiving ART: - Start TB treatment immediately. - Consider need to modify ART because of drug-drug interactions or to reduce the potential for overlapping toxicities - Consider whether the presentation of active TB in a patient on ART constitutes ART failure that requires a change in the ART regimen.	ART should be initiated for all people living with HIV with active TB disease irrespective of CD4 cell count. TB treatment should be started first, followed by ART as soon as possible, within the first 2 weeks of starting TB treatment. Preferred regimen: TDF + 3TC + EFV Rifampicin and NVP should not be used together due to drug interactions and hence regimens which contain NVP should not be used. When using NVP based regimen, the patient should be started on a normal dose (200mg bd). A loading dose is not required.	
		For patients with history of TB treatment: - Patients who had active tuberculosis in the past 2 years should not be considered for preventive therapy. - Patients who were treated for tuberculosis more than 2 years earlier may be considered because they may have already been re-infected with TB. - Patients who receive IPT and who are eligible for antiretroviral therapy can complete their TB preventive therapy even if ART is started as there is no interaction between Isoniazid and the current ART regimen used.			
		Other exclusion criteria for IPT include: - Alcohol abuse - Non-adherence to long term treatment - Current/past history of hepatitis - Medical contraindication to INH - Terminal AIDS (WHO clinical stage 4)			
Children	Y All people living with HIV should be screened for TB on every visit.	Children should be considered for IPT as follows: - All newborns with no symptoms of active TB disease that are born to mothers with active TB disease - All HIV-infected children less than 12 months with no symptoms of active TB disease and with a known TB contact - All HIV-infected children who are 12 months or older with no symptoms of active TB disease IPT should be initiated only after TB disease has been ruled out.	**Children <3 years old:** If child is on NVP or LPV/r: ABC + 3TC + AZT		

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Uganda - Consolidated Guidelines for Prevention and Treatment of HIV in Uganda (2016)					
Adults Adolescents Pregnant Women Breastfeeding Women	Y TB screening should be conducted at each clinic visit using the Intensified Case Finding (ICF) guide.	All PLHIV with a negative TB symptom screen should be offered Isoniazid Preventive Therapy (IPT) for six month. IPT is not recommended for contacts of patients with MDR-TB. Eligibility for IPT: i) HIV-positive infants and children <5 years with a history of TB contact and have no signs and symptoms of active TB disease. ii) HIV-positive children (≥ one year of age), adolescents and adults with no signs and symptoms of TB.	If the patient is already on ART, start TB treatment immediately and adjust the ART regimen as recommended below to decrease the potential for toxicities and drug-drug interactions. If on EFV-based regimen: Continue with same regimen and dose.	ART should be initiated in all TB/HIV co-infection people irrespective of their clinical stage or CD4 count. If the patient is not on ART, initiate anti-TB treatment immediately and start ART at two weeks of TB treatment. First-line regimen for TB/HIV co-infected patients initiating ART: TDF + 3TC + EFV	
			If on DTG based regimen: Continue the same regimen but increase the dose of DTG (give DTG 50 mg twice daily instead of once daily)		
			If on NVP based regimen: Substitute NVP with EFV. If EFV is contraindicated, give a triple NRTI regimen (ABC + 3TC + AZT).		
			If on LPV/r or ATV/r based regimen: Continue the same regimen and substitute rifampicin with rifabutin for TB treatment.		
Children 3 - < 12 years old			**If on EFV-based regimen:** Continue the same regimen. **If on NVP or LPV/r based regimen:** Substitute NVP or LPV/r with EFV. If EFV is contraindicated, give a triple NRTI regimen (ABC+3TC+AZT).	ABC + 3TC + EFV	
Children 0 - < 3 years old			**If on LPV/r or NVP based regimen:** Give triple NRTI regimen ABC+3TC+AZT	ABC + 3TC + AZT	

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Zambia - Zambia Consolidated Guidelines for Treatment & Prevention of HIV Infection (2016)					
Adults Pregnant and Breastfeeding Women Adolescents	Y Screen for TB at every service delivery point every time: - Current cough - Fever - Weight loss - Night sweats	HIV-infected pregnant and breastfeeding women, children ≥12 months old, adolescents, and adults after ruling out active TB.	If on NVP-based regimen: switch NVP to EFV (600mg) If on ATV/r: switch to LPV/r and double the dose If on LPV/r: double dose of LPV/r Evaluate for failure and consider switching to 2nd line cART in consultation with the next level Patients on cART who develop TB and on EFV 400mg/day should be switched to EFV 600mg/day	Adults, adolescents, pregnant women: Start ATT first; as soon as it is tolerated (after 2-3 weeks), start TDF + XTC + EFV (600 mg) Alternative (e.g. renal insufficiency): ABC + 3TC + EFV (600 mg) HIV-positive TB patients with profound immunosuppression (e. g., CD4 counts less than 50 cells/mm≈) should receive ART within the first two weeks of initiating TB treatment.	Adults and adolescents: If rifabutin is available: TDF + XTC + ATV-r or LPV-r or AZT + XTC + ATV-r or LPV-r If rifabutin is not available: Double dose LPV-r (LPV-r 800 mg/200 mg twice daily)
			Pregnant women: - Start ATT immediately - Continue EFV-based ART - Evaluate for failure and consider switching to 2nd line ART in consultation with next level		
Children (0 to < 10 years old)	Screen for TB at every service delivery point every time: - Poor weight gain - Reported weight loss or very low weight (weight for age less than -3 z-score) - Underweight (weight less than -2 z-score) - Confirmed weight loss (>5%) since the last visit - Growth curve flattening - Fever - Current cough - Contact history with a TB case	Criteria for starting IPT in children: - HIV-infected children <12 months old with TB contact and after ruling out active TB. - After completing a full course of ATT, HIV-infected children should be given additional IPT for 6 months.		Children 2 weeks - 5 years: ABC + 3TC + EFV	

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Zimbabwe - Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe (2016)					
Adults Adolescents Pregnant Women	Y All HIV positive clients should be screened for TB at every contact with health services in order to timely assess their eligibility to be commenced on IPT or TB treatment. Should be screened for TB at every clinic visit with a TB screening tool and an algorithm and those who report any one of the following symptoms history of current cough, fever, weight loss or night sweats are likely to have active TB and should be evaluated for TB and other disease.	Initiate IPT immediately or within 3 months and according to current practices. The following are the target groups for IPT in Zimbabwe: - Adults and adolescents including pregnant women living with HIV and unlikely to have active TB according to clinical screening criteria will receive IPT for 6 months. - Adults and adolescents (including pregnant women) will be given 6 months of IPT immediately following the successful completion of TB treatment - Children living with HIV (Pre-ART & on ART) unlikely to have active TB according to clinical screening criteria - HIV infected adults, adolescents and children contacts of active TB cases - HIV infected health care workers The following patients should be excluded: - Symptoms and signs suggestive of active TB - Patient on treatment for TB - Completion of IPT in the past 3 years - Patients who have been on ART for 3 months or less - Signs of active liver disease or history of INH induced hepatitis - In the subgroup of patients eligible and in the process of being 'worked up' for ART, there is a high prevalence of undiagnosed TB, including a considerable proportion that do not have TB symptoms. In this subgroup, it is reasonable to wait 3 months before considering initiation of IPT, during which time TB symptom screening should be repeated at each clinic visit.	Patients who develop TB when already on ART: Treat TB as per national TB guidelines.	Preferred first line regimen: TDF + 3TC + EFV (600 mg) Alternative first line regimens: In patients who have HIV-related TB but are not yet on ART, treatment of TB takes priority. ART should be started at least two weeks after the start of TB therapy i.e. during the intensive phase when the patient has stabilized on TB treatment regardless of their CD4 count status. TB/HIV co-infected patients with severe immunosuppression such as CD4 count less than 50 cells/mm3, should receive ART early i.e. within the first 2 weeks of initiating TB treatment.	AZT (or TDF) + 3TC + double dose LPV/r (800 mg/200mg BD)
Children			If HIV positive children less than 3 years develop TB, a ''triple nuc regimen'' of ABC + 3TC + AZT is recommended as an option due to the interactions of LPV/r or NVP with rifampicin. Once TB therapy has been completed, this regimen should be stopped and the initial regimen should be restarted.	ART should be started in any child with active TB disease as soon as possible and within 8 weeks following the initiation of antituberculosis treatment, regardless of the CD4 cell count and clinical stage.	

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