Elizabeth Glaser Pediatric AIDS Foundation
Fighting for an AIDS-free generation

Unitaid
Innovation in Global Health

Defeat Childhood TB:

A Multicountry Assessment of National Policies and Preparedness for Childhood TB Programming

Call to Action

Childhood TB, a preventable and curable infectious disease, continues to negatively affect the lives of millions of children and adolescents every year. In 2020, children (younger than 15) accounted for 11% of the total burden of TB in 2019, but the majority of them remain undiagnosed and untreated.[1] For too long, childhood TB has been poorly addressed by the global public health agenda and often has been neglected by health policymakers and TB control programs. Whereas the international community has recognized the need to put more effort into the fight against childhood TB during the past decade, progress toward the childhood TB global targets remains slow.[1]

As part of its Unitaid-supported Catalyzing Pediatric Tuberculosis Innovations project, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) carried out assessments of the national policy landscape and country preparedness for childhood TB in 2018 and 2021 in 10 countries (Cameroon, Côte d'Ivoire, Democratic Republic of Congo, India, Kenya, Lesotho, Malawi, Tanzania, Uganda, and Zimbabwe).

The purpose of the 2021 assessment is to

- evaluate progress made by the countries over a period of three years,
- identify areas that need sustained efforts, and
- propose recommendations to bridge the gaps.

This assessment is intended to be an advocacy tool for countries, governments, civil society, patients' groups, technical agencies, and donors to identify the remaining gaps and act on them.

The findings of the 2021 assessment show an improvement in the childhood TB policy landscape compared to 2018 in the 10 countries assessed. Nonetheless, important gaps remain in ensuring an effective TB response in children.Childhood TB is a preventable and curable infectious disease. But for too long it has remained poorly addressed by the global public health agenda and often has been neglected by health policymakers and TB control programs.

Global and national leaders should never forget that addressing TB in children and adolescents is a human rights imperative and is achievable with leadership and political support.

This assessment shows an overall improvement in the childhood TB policy landscape from 2018 in the 10 countries assessed. But important gaps remain in ensuring an effective TB response in children and in achieving the global targets.

Political leadership and advocacy will remain critical to ensuring specific budget lines and the inclusion of targets for childhood TB within countries' national plans. Whereas this assessment found improvements from 2018 in the adoption of the latest policies for case finding, diagnostics, and treatment policies, there remains a need to ensure that more effective tools, programmatic innovations, and models of care are included in the national policy landscape. Furthermore, there is a long way to go in terms of policies and recommendations promoting integration of childhood TB care into other services, especially nutrition services.

Based on the findings and recommendations of this assessment, EGPAF calls on national policymakers and TB advocates to do the following:

1. **Foster political leadership and accountability.** This is the primary requirement to achieve an effective and fully funded TB response for children and to achieve the targets of the United Nations political declaration on TB and the end TB strategy. To achieve this, countries must

    - address in a comprehensive way in their NSPs for TB the problem of childhood TB, including a description of the burden and challenges and actions needed to prevent, diagnose, treat, and record and report TB and DR-TB in children and adolescents;
    - establish clear and achievable national targets for childhood TB case detection, treatment, and prevention;
    - engage in regular community awareness and public communication outreach campaigns and promote knowledge of childhood TB among the population to fight stigma and discrimination;
    - ensure training and capacity building of HCWs at all levels to ensure appropriate interventions for childhood TB;
    - advocate for detailed and realistic budgets for childhood TB activities that reflect the ambitions of the NSPs and the established targets on prevention, diagnosis, and treatment of childhood TB;
    - advocate for increased domestic and international resources to implement childhood TB policies, address inequities faced by children regarding access to TB services, and move toward the global goal of universal health coverage; and
    - support advocacy and stakeholder engagement to increase awareness and accountability among global and national leaders, the private sector, health policymakers, service providers, and communities about the specific needs of children and adolescents with TB and to adopt the best policies and standards of care.

2. **Scale up systematic TB screening at relevant child health entry points and appropriate active case-finding strategies among children and adolescents at risk.** An active case-finding strategy is the cornerstone of the TB cascade of care and the only way to ensure early diagnosis and treatment. To achieve this, countries must

    - recommend the use of child-adapted, symptom-based screening tools, including signs and symptoms that are characteristics of pediatric TB, and whenever

feasible, ensure the inclusion of CXR to support the identification of children with presumptive TB;

- ensure that IMCI policies and guidance are up to date and include TB screening algorithms for the appropriate recognition and management of TB in the context of child health; and
- commit to translating policies and recommendations on active case finding into practice.

3. **Adopt a comprehensive approach for pediatric TB diagnosis including clinical assessment, radiological assessment (if available), and use of WHO-recommended diagnostic assays whenever feasible**. Huge gaps remain in TB diagnosis among children and adolescents, and there is no treatment without diagnosis. To achieve this, countries must

- quickly adopt policies and recommendations on the use of WHO recommended diagnostic tools for TB diagnosis in children and adolescents;
- prioritize the use of Xpert as the first tool for diagnosis of childhood TB, rapidly introduce Xpert Ultra, and improve the access to quality CXR;
- ensure that SOPs for recommended PTB and EPTB sample collection and for interpretation of CXR are available and that related training is provided;
- endorse policies promoting the use of Xpert on stool as an additional and child-friendly strategy for TB diagnosis in the youngest children; and
- update policies on the use of LF-LAM for all eligible categories of children living with HIV, including those accessing care at OPD, with or without symptoms.

4. **Ensure the availability of child-friendly formulations of TB medicines for all children with TB.** Delay in the initiation of effective treatment can have detrimental effects on the mental and physical health of this population. Deferral of endorsement of the best standards of TB/DR-TB treatment care is not defensible anymore. To achieve this, countries must

- move rapidly toward the endorsement and provision of child-friendly formulations for the treatment of DS-TB and DR-TB, with a special focus on approval, procurement, and introduction of ethambutol 100 mg DT and all second-line pediatric drugs for DR-TB;
- ensure that children and adolescents affected by DR-TB are treated with all-oral regimens, thus translating policy into practice, and for the few countries that have not yet fully endorsed all-oral regimens for children irrespective of age, do so without any further delay; and
- prioritize early adoption of the new international policies on the treatment of TB/DR-TB in children and adolescents, about which an update is expected from WHO before the end of 2021.

5. Scale up TPT regimens for children at risk. Offering TPT to all people at risk not only is an essential component of the end TB strategy but also is a very effective action that can contribute to the reduction of morbidity and mortality among children and adolescents. It is not an "maybe" but rather a "must." This is why strong advocacy is needed to promote the scale-up of TPT to all eligible individuals. To achieve this, countries must

- rapidly endorse new policies on the provision of TPT and offer TPT to all children and adolescents, irrespective of age and HIV status, who are HH or close contacts of TB cases, after ruling out active TB, including contacts of DR-TB cases;
- adapt their guidance to include shorter and newer TPT regimens, such as 3RH, 3HP, and 1HP, taking into consideration the availability of child-friendly formulations[1]; and
- approve and recommend the use of INH 100 mg DT as an important child-friendly option for the youngest children.

6. Speed up the integration of TB services into other health services. Lack of integration of TB services for children and adolescents into other services, such as PMTCT, MNCH, nutrition, and OPD general services, is a missed opportunity to timely detect children with TB and put them on appropriate treatment, preventing TB and averting the development of the most severe forms of disease. To achieve this, countries must

- ensure the continuum of care for TB in children and adolescents across all services;
- adapt national policies to include other aspects of integration beyond TB screening, such as diagnosis, treatment, prevention, and follow-up, based on the most appropriate model of care for the specific setting; and
- ensure particular attention to case detection and prevention of TB in nutrition services.

7. Improve M&E frameworks and strategies to better inform national programs as they move toward their goals, to identify gaps and challenges, and to support the provision of quality care to patients. To achieve this, countries must

- sustain their efforts in the field of M&E of childhood TB activities and ensure that the adoption of policies is accompanied by appropriate capacity building of all HCWs and the availability of tools at all levels of care.

1 Child-friendly formulations are currently available only for RH. There is no dispersible formulation for rifapentin. Currently, HP is recommended only for children older than 2; for children younger than 2, only 3RH is currently recommended as a shorter TPT regimen.