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# CIVIL SOCIETY ADVOCACY FOR EFFECTIVE CHILDHOOD TB RESPONSES

Lessons learned from CaP TB Advocacy Small Grants project



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Pediatric AIDS Foundation  
Fighting for an AIDS-free generation



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All photos by Kevin Ouma, 2021.

## **NOTES**

While EGPAF strives to use photos which accurately depict the actions, topics, or populations referenced, unless specifically indicated, the photographs in this document do not imply program participation, health status, attitude, behavior, or action on the part of persons who appear therein.

The research into the evidence in this report were carried out by EGPAF with funding from Unitaïd. The views expressed in the report do not necessarily reflect the views of the donor organization.

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# 1. INTRODUCTION

## **TUBERCULOSIS, A MAJOR CONTRIBUTOR TO CHILDHOOD MORBIDITY AND MORTALITY**

Childhood TB is a preventable and curable infectious disease that represents a major contributor to childhood morbidity and mortality worldwide. Nonetheless, for too long, childhood TB has remained poorly addressed by the global public health agenda and often has been neglected by health policymakers and TB control programs. Data from the WHO 2021 global TB report estimate that children younger than 15 accounted for 11% of the total burden of TB in 2020, but only approximately 40% of the cases were reported to national TB programs (NTPs), leaving the majority of children not diagnosed or not reported. The estimated number of TB deaths in children in 2020 was 226,000. TB coinfection with HIV also continues to represent a great threat to child health. Mortality data show that 10% of the HIV-positive people who died from TB globally in 2020 were children.

## **URGENT RESPONSE TO CHILDHOOD TB CRISIS**

During the past decade, the international community has recognized the need to put more effort into the fight against childhood TB. The Roadmap Towards Ending TB in Children and Adolescents, developed in 2018, set new recommendations for how to target children from 0 to 9 years old and young people ages 10 to 19 and called for sustained advocacy, strong and clear commitment, funding, and resource mobilization to tackle TB in children and adolescents. In 2018, at the UN High Level Meeting on TB, world leaders committed to reach key concrete targets by 2022, many of them specifically addressing childhood TB. However, progress toward the childhood TB targets in 2018 and 2020 remained slow, showing that more needs to be done to reach the agreed targets.

Catalyzing Pediatric TB Innovations (CaP TB) is a Unitaid-funded project implemented by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) from 2017 to 2022. The objective of CaP TB is to reduce pediatric TB-related morbidity and mortality by reaching undiagnosed children through the integration of systematic tuberculosis screening into services for HIV, nutrition, and maternal and child health and the decentralization of capacity to manage pediatric TB at the lower level of the health care system, where most of the children access care. The project has also aimed at strengthening child contact investigation and access to TB prevention.

## **ADVOCACY, A CRITICAL FUNCTION TO ENSURE EQUITY IN ACCESS TO CHILDHOOD TB SERVICES**

Advocacy is acknowledged as a necessary component to address inequities in health and to ensure sustainability and scalability of quality services. EGPAF's advocacy efforts seek to drive global and local focus, support leadership, and provide resources needed to end the epidemic in children, adolescents, and families.

Under CaP TB, EGPAF has advocated for increased, sustainable, and affordable access to quality TB services for children through innovative models of care. EGPAF has actively engaged in direct advocacy with national authorities, donors, technical agencies, and other stakeholders to increase political and financial support for implementing innovative models of care for children. Advocacy has been mainstreamed across all project outcomes and included a broad range of interventions, from demand creation to sensitization for policy and social change to resource mobilization and accountability in the provision of health services.

EGPAF has worked closely with national and local civil society and with community organizations and networks to influence policy change, increase political and social awareness and sensitization about childhood TB, create demand for quality services, and ensure accountability. One mechanism that EGPAF implemented to support civil society and community childhood TB advocacy was the provision and implementation of advocacy grants. These catalytic grants were made available through the CaP TB project to contribute to policy changes and the sustainability of the program. Advocacy grants were provided to 10 civil society organizations (CSOs) in 8 countries (Cameroon, Democratic Republic of Congo, India, Kenya, Malawi, Tanzania, Uganda, and Zimbabwe). The approach and type of interventions were tailored to national and local contexts and realities. They were implemented over a 10- to 12-month period starting in Q4 2020 and ending by August 2021 (except for India, where they ended in October 2021).

## 2. LESSONS LEARNED FROM CaP TB CIVIL SOCIETY AND COMMUNITY ADVOCACY GRANTS

This report gathers the lessons learned of the CaP TB Advocacy Small Grants project as a way to effectively strengthen childhood TB advocacy.

### A. METHODOLOGY

A desk review was conducted of country proposals and final reports to customize a semistructured questionnaire for each country. Interviews were conducted with 17 individuals, including members of EGPAF country teams, CSO members implementing the advocacy grants, an NGO representative involved in the IMPAACT4TB grants, and a government official closely involved with the small grant project in Cameroon.

Impact was analyzed using Oxfam's evaluation of advocacy model,<sup>1</sup> which maps actions against six impact areas, shown in Figure 1.

### B. MAIN RESULTS: CATALYZING IMPACT TOWARDS OPTIMAL CHILDHOOD TB SERVICES

The project contributed to achieving concrete results, catalyzing momentum, and contributing to ongoing advocacy work towards improving childhood TB management. Examples of tangible change include:

- inclusion of systematic screening for pediatric TB in local guidelines (Cameroon);
- increased media coverage of pediatric TB (Uganda and Kenya);
- abolition of medical point-of-care consultation fees for TB diagnosis (DRC);
- increased district-level budget for pediatric TB activities (Tanzania);
- community scorecards established to rate TB services (Zimbabwe);

- TB communities mobilized to advocate on pediatric TB, whether through pediatric TB champions (India) or through women in communities (Cameroon); and
- policy papers produced with clear demands from civil society, targeted at Parliamentarians and decisionmakers (Malawi, DRC, Kenya).

Results were achieved across all impact areas, as summarized in Annex A. However, due to the short implementation period of the advocacy grants, only two countries achieved a change in policy. All small grant projects achieved heightened awareness, changed opinions, and resulted in positive change in people's lives.

While the projects yielded value towards the overall CaP TB theory of change—including the implementation of innovative models of TB care and treatment, an enabling policy environment, and cost and health efficiencies—most interviewees felt that these projects should have higher envelopes, run for longer, and run from the initiation of larger projects, rather than beginning in the middle or toward the end.

Several key results were observed and can be summarized as follows:

1. TB Champions—Community Voices Bringing Change
2. Community Health Workers Driving Accountability and Creating Linkages to Services
3. Increasing TB Literacy and Awareness at the Local and National Levels
4. Engagement with Parliamentarians and with Local and National Decision Makers
5. Amplifying Attention to Pediatric TB through Media Engagement
6. Policy Change to Support Pediatric TB Innovations

These are illustrated in Figure 2.



**FIGURE 1.** Oxfam's evaluation of advocacy model

1 Roche CJR. Impact Assessment for Development Agencies: Learning to Value Change. Oxford, UK: Oxfam GB; 1999:198



**FIGURE 2. Key Results**

### C. COLLABORATIVE ADVOCACY WORK TO ACHIEVE RESULTS

Interactions between the CSOs and the EGPAF team were valued very positively by interviewees. Participants did mention during the implementation calls<sup>2</sup> that “the process was very inclusive between EGPAF and the CSOs allowing for discussions from beginning to end.” The collaborations between EGPAF and CSOs happened at different levels—from the provision of administrative support to collaboration at the technical level to strategic dialogues—and helped to strengthen partnership between EGPAF and the implementing CSO. EGPAF supported CSOs in strengthening their relations with government officials. Inversely, CSOs could also potentially build some bridges with local authorities with which EGPAF would not yet have regular contacts. It was also acknowledged that CSOs, having a very good understanding of community needs, proposed approaches that were tailored to those needs and dynamics.

Interviewees underlined the importance of advocacy for TB programming. One interviewee described the complementarity of local CSOs in advocacy alongside donors and implementing partners and the value of working together.

*“I think that there is definitely value in [advocacy], ... especially in a project like CaP TB, which is trying to catalyze new innovative approaches and technologies in a country where there is usually a lot of hesitancy at government level to introduce new things. Having different organizations from the society and community to advocate shows that there is a need from the beneficiaries of these treatments.”*

—Roland Van de Ven, Technical Director, EGPAF Tanzania

Mike Frick, Co-Director of TB Projects at Treatment Action Group (TAG), echoed positivity on the need for TB advocacy, particularly regarding the role of national civil society in “beating the drum” and driving demand creation, and the value of EGPAF as a technical partner on an advocacy grant.

*“The small grant model to communities and civil society to do advocacy is really important. For pediatrics specifically and also more generally, there’s value in giving autonomy to local national civil society and community partners to take forward the advocacy happening in their country. And it is important to have a voice from the community beating the drum and driving*

*up demand for these interventions, a voice that can speak sort of separate to and in parallel with a more technical team from an implementing partner like EGPAF, and to really have the kind of country-level decision makers hear that there’s demand for some of these services or interventions originating in the community.”*

—Mike Frick, Co-Director, TB projects, Treatment Action Group

The advocacy grants were an opportunity to provide funding for CSOs to do their work. In some cases, this contributed to CSOs adding more emphasis on childhood TB in their strategic plans or putting more emphasis on childhood TB in donor funding requests and with government authorities. It also gave more visibility to the CSOs’ work on TB (particularly for those that are mostly known for their HIV work).

Mike Frick felt that the small grant model allowed CSOs to access funding that would otherwise not be available to them due to competition and the administrative burden of applying. Frick also went on to say that it would be worth having discussions to facilitate other mechanisms through which CSOs could get funding from Unitaid:

*“[Applying for Unitaid grants] is too much administrative work for an organization of our size. And we recognize that community partners may have even less access to Unitaid or may face the same challenges that we do in competing for Unitaid funding as prime recipients. So, the small grant model was really a way to carve out a way to put money directly into the hands of community partners. And I think that it works. But there may be other ways to get Unitaid support directly to groups without having this kind of middle channel mechanism. And those conversations I think are worth having as the CaP TB project and later IMPAACT4TB are evaluated and reflected on.”*

—Mike Frick, Co-Director, TB projects, Treatment Action Group

### D. SUSTAINABILITY OF ADVOCACY ACHIEVED IN CAP TB ADVOCACY GRANTS

Six CSOs involved in the CaP TB small grants obtained grants from Stop TB Partnership as part of the Challenge Facility for Civil Society: FIS (Cameroon), CAD and LNCAC (DRC), Stop TB Kenya, FACT (Malawi), and MKUTA

<sup>2</sup> Three global calls were organized during the implementation of the grant to share information, lessons learned, and challenges across countries.

(Tanzania). While Challenge Facility projects have wider scope beyond pediatric TB, some CSOs showed that work under the CaP TB project could be continued under the Challenge Facility grants. In Malawi, for example, the CaP TB grant—allocated to FACT—was focused on emphasizing the role of community health workers in scaling up screening, conducting community-led monitoring and communicating results to the National TB Program, engaging policymakers and Parliamentarians on the need for nationwide scale-up of community-led monitoring, documenting human rights abuses in TB populations, and the need for a technical working group on pediatric TB. Thokozile Nkhoma, Executive Director of FACT in Malawi, detailed how work on community health workers in particular would continue through the Challenge Facility:

*“[From a sustainability perspective,] we had a very good transition from the small grants to what we are doing right now under the Challenge Facility grants. We will still focus on pediatric TB but now we’ll be supporting community volunteers to carry out active case finding, and we’ll carry out training for over 2,300 volunteers in 10 districts across the country.”*

—Thokozile Nkhoma,  
Executive Director of FACT

While work will continue with the funding from Stop TB Partnership, Yusuf Bhamu, CaP TB Implementation Manager from EGPAF in Malawi, said that sustainability could be better achieved with “continuous flow of resources” and predictability over a longer period of time than a one-year grant.

The Zimbabwean CSO network ZNNP+ did not obtain any new funding to carry out further work on pediatric TB advocacy but spoke about how sustainability materialized because community health workers continued to ask TB communities to rate services through community scorecards despite being unfunded:

*“We visited one of the districts where we implemented the CaP TB small grant, and most of the community health agents we interacted with said that, even in the absence of the funding from CaP TB, and also in the absence of ZNNP+ continuously monitoring them, they were still using the community scorecards to help facilitate and gauge community view on whether the services are acceptable.”*

—Tonderai Mwareka,  
ZNNP+ Zimbabwe

In Tanzania, the CSO involved in the small grants project—MKUTA—successfully advocated for a budget increase for pediatric TB activities at the district level in Tabora but was unable to do so at the Singida District Council because, by the time the grant commenced, budget planning had concluded. District-level officials verbally committed to a 2022 budget increase but did not commit in writing. Rachel Jacob, from MKUTA, said that, while the Challenge Facility funding is focused elsewhere, they would continue to follow up on the 2022 verbal commitment.







### 3. LESSONS LEARNED

In summary, the lessons learned of the advocacy grants are as follows:

- I. The CaP TB advocacy grant model was effective and showed important results. Advocacy work contributed to the overall CaP TB theory of change and to CaP TB outcomes, particularly around policy change and sustainability. The grants provided an opportunity to create partnerships and strengthen relations between implementing partners, CSOs, and communities and to reach other actors that otherwise would not have been reached through the project.
- II. CSO and community advocacy is key to support the sustainability and scalability of childhood TB services. The small grants drove change through increased awareness, engagement of decision makers on neglected areas, foundational measures to increase accountability on quality of services, and the development of TB champions for future advocacy. And, despite the short timeframe of these small grants, a number of countries were able to achieve policy change by engaging decision makers and amplifying the voices of TB communities.
- III. Collaboration and coordination between implementing partners, CSOs, and communities are essential to achieve greater results. CSOs conducting advocacy placed a high value on EGPAF as a technical partner. CSOs were unanimous on the value of EGPAF as a technical partner to the advocacy small grants. CSO partners mentioned that EGPAF provided crucial technical support during training of community health workers and TB champions—and political advice when needed, for example when engaging with national authorities or supporting the translation of evidence into a political brief. In addition, EGPAF’s connections to national and district-level governments helped bring credibility and facilitated project work.
- IV. In the future, the model should factor in some of the limitations encountered within the advocacy grants. Advocacy projects should have a longer life. Both EGPAF country offices and implementer CSOs expressed that advocacy small grants should be planned at the start of the project rather than being initiated midway or toward the end of the project. Larger envelopes for funding advocacy are needed. Activities were limited by small budgets.
- V. The advocacy grants model was successful in catalyzing CSO and community TB advocacy work and in contributing to the overall CSO and community TB strategic work. CSOs interviewed recognized that, given their size and operational capacity, it would be difficult for them to be the principal recipient of Unitaid grants because of the large administrative burden that a Unitaid grant would entail. Hence, the small grant format helped to “put money directly into the hands of community partners.”
- VI. A monitoring and evaluation plan tailored to advocacy and including qualitative and quantitative indicators is very much needed to measure advocacy. More support and guidance are needed to measure advocacy. These will contribute to assessing the contribution of advocacy to the whole program. Advocacy cannot be measured or implemented following the logic of service-delivery types of programs.

## 4. CONCLUSIONS

CSO and community advocacy should be supported politically and financially from donors, governments, and technical agencies to achieve greater results, scalability and sustainability of TB interventions. Support to CSO advocacy should be included in donors grants and follow a different approach than service delivery programs, tailored to the nature of advocacy work. This includes more flexible

use of funding and adapted monitoring and evaluation tools that include qualitative and quantitative indicators. This would allow greater efficiencies and show outcomes in a clearer way. It is important to increase visibility of the broader role of communities and CSOs among donors, national authorities and technical agencies to ensure alignment, complementarity, and sustainability of their work.



# ANNEX A: MATRIX FOR ANALYSIS

## (OXFAM evaluation of advocacy model)

### HEIGHTENED AWARENESS

Cameroon	<ul style="list-style-type: none"> <li>Eleven hundred women participated in campaigns and spoke out about the need to integrate systematic/ routine screening on pediatric TB and catastrophic costs in the Integrated Management of Childhood Illness guidelines.</li> </ul>
DRC	<ul style="list-style-type: none"> <li>Advocacy at the national assembly. Through the MP on LNAC's Board, contact was made with the parliamentary sociocultural committee on pediatric TB needs.</li> <li>Advocacy session held with Parliamentarians and advocacy note on elimination of fees produced.</li> <li>Development of banners, pennants, and other tools with messages on different funding levels for pediatric TB. These banners and pennants were displayed all over the city as a result of a collaboration with WHO and PNL (Programme National de Lutte contre la Tuberculose—National TB Programme).</li> </ul>
India	<ul style="list-style-type: none"> <li>Training of pediatric TB champions completed in all districts.</li> <li>Evidence on gap in pediatric TB reached district stakeholders, the national TB program, private sector clinicians, and the Indian Academy of Pediatrics.</li> </ul>
Kenya	<ul style="list-style-type: none"> <li>Letter signed by Stop TB Kenya and TB champions to the Minister of Health to bring in drugs with longer shelf life.</li> <li>Letter to the Cabinet Secretary and meeting with deputies to the Cabinet Secretary on the need to provide digital chest X-rays for free.</li> <li>Increased media attention and reporting on childhood TB, including a father speaking about challenges of accessing treatment for him and his child during COVID-19.</li> <li>After the project, as a result of the work of the TB champions, Evaline Kibuchi from Stop TB Kenya reported receiving numerous complaints from the community regarding access to pediatric TB commodities, as well as Facebook posts from a mother who took her child for TB screening as she thought she recognised symptoms of TB.</li> </ul>
Malawi	<ul style="list-style-type: none"> <li>Training of media houses to report on TB; stories disseminated on World TB Day.</li> <li>Policy papers on TB financing for pediatric TB given to MPs and the National TB Programme, proposing a number of key items: 1) scaling up community-led monitoring nationwide; 2) developing a TB stigma litigation strategy; 3) setting up a technical working group for TB in Malawi.</li> <li>Dissemination of findings of community-led monitoring from seven districts among members of the National Technical Working Group on TB.</li> </ul>
Tanzania	<ul style="list-style-type: none"> <li>Awareness raised among local leadership around taking extra effort to do contact tracing in households with children, and also on nonclassical symptoms of TB around children. As a result of activities under the small grant, detection of pediatric cases has doubled—"these numbers tell a story."</li> <li>Meetings with secretaries of Members of Parliament to sensitize them to gaps in pediatric TB.</li> <li>Breakfast debate at the <a href="#">Policy Forum</a> to raise gaps in pediatric TB.</li> <li>New relationships built with local leaders, including religious leaders, council members, and duty bearers, engaging them on pediatric TB; as a result, religious leaders began speaking about TB in their mosques, and community leaders did the same in their meetings.</li> </ul>
Uganda	<ul style="list-style-type: none"> <li>DJ mentions and radio jingles on Vision Radio and Radio Ankole, one of the radio stations with widest reach in Uganda. A number of parents mentioned to AIC that they had heard the radio jingles and DJ mentions.</li> </ul>
Zimbabwe	<ul style="list-style-type: none"> <li>Forty community health agents trained and made household visits as well as attended other differentiated service delivery meetings, such as community ART refill groups, reaching over 4,000 people in the community with messages about pediatric TB.</li> <li>Community scorecards introduced and deployed by community health workers; scorecards could rate services from 0 (poor) to 10 (excellent)</li> </ul>

## CONTRIBUTION TO THE DEBATE

Cameroon	n/a
DRC	n/a
India	n/a
Kenya	<ul style="list-style-type: none"> <li>Pediatric TB was consistently brought up in meetings with the ministry, resulting in acceleration of the development of stool-test algorithms for children.</li> </ul>
Malawi	n/a
Tanzania	<ul style="list-style-type: none"> <li>Stakeholders who hadn't been engaged before, such as duty bearers from the education departments, TB, HIV, administrative, and financial planning departments, were all engaged on TB.</li> </ul>
Uganda	n/a
Zimbabwe	<ul style="list-style-type: none"> <li>According to ZNNP+, there was an acknowledgment that pediatric TB was neglected.</li> </ul>

## CHANGED OPINIONS

Cameroon	<ul style="list-style-type: none"> <li>According to Pierrette Omgba, MoH in Cameroon, prior to the CaP TB small grants, “pediatricians had misconceptions about pediatric TB,” and the campaign helped to change opinions, resulting in routine screening for pediatric TB today.</li> </ul>
DRC	<ul style="list-style-type: none"> <li>EGPAF DRC reported that, before the small grant project, no one would ask for women to bring their kids for TB screening. Opinions have changed because the work of LNAC resulted in increased numbers of screenings at religious-led health facilities.</li> </ul>
India	<ul style="list-style-type: none"> <li>TB Alert India stated that, as a result of advocacy with private providers of pediatric TB services, there was increased coordination with government to report TB diagnoses.</li> </ul>
Kenya	<ul style="list-style-type: none"> <li>Journalists initially had no idea that pediatric TB was a huge problem</li> </ul>
Malawi	<ul style="list-style-type: none"> <li>Opinions changed at National TB Programme—particularly that “lay cadres” or peer/community health workers can support screening efforts.</li> <li>Finance planning persons were very tough and through this project, FACT was able to change their opinions.</li> </ul>
Tanzania	<ul style="list-style-type: none"> <li>Prior to CaP TB, health facilities did not see the need to do household contact tracing, nor did they have the capacity or resources to do so. At conclusion of the project, councils were allocating funds for this purpose.</li> </ul>
Uganda	<ul style="list-style-type: none"> <li>The district leaders and village health teams had several misconceptions about TB that were corrected through CaP TB advocacy.</li> </ul>
Zimbabwe	<ul style="list-style-type: none"> <li>Community health agents engaged numerous parents and guardians on the benefits of modern medical treatments for child TB versus witchcraft, resulting in parents bringing their children to the centers.</li> <li>The Bulawayo City Health Department was initially concerned about the value of the project but changed their opinions through project implementation.</li> </ul>

## CHANGED POLICY

Cameroon	<ul style="list-style-type: none"> <li>Integration of new indicators on systematic screening into the national transition plan.</li> <li>Systematic screening for TB incorporated into the Integrated Management of Childhood Illness guidelines.</li> <li>Action taken to integrate costs of systematic screening into the next universal health coverage plan.</li> </ul>
DRC	<ul style="list-style-type: none"> <li>Elimination of consultation fees of about \$4–\$5 (8000–10,000 CDF) per child.</li> </ul>
India	<ul style="list-style-type: none"> <li>Project too short to create policy change.</li> </ul>
Kenya	<ul style="list-style-type: none"> <li>Development of algorithms for stool tests for children.</li> </ul>
Malawi	<ul style="list-style-type: none"> <li>Project too short to create policy change.</li> </ul>
Tanzania	<ul style="list-style-type: none"> <li>EGPAF working on policy to get shorter regimens, but this took time due to a change of leadership.</li> <li>Tabora District Council budget allocated funding to pediatric TB. Funds had already been allocated at the Singida council at the time of project initiation, but they have verbally committed to include pediatric TB allocations for 2022.</li> </ul>
Uganda	<ul style="list-style-type: none"> <li>Project too short to create policy change.</li> </ul>
Zimbabwe	<ul style="list-style-type: none"> <li>Community scorecards introduced and deployed by community health workers; scorecards could rate services from 0 (poor) to 10 (excellent). These were different from the USAID scorecards used specifically for TB diagnostics.</li> </ul>

## POLICY CHANGE IMPLEMENTED

Cameroon	n/a
DRC	<ul style="list-style-type: none"> <li>Yes—the circular on the elimination of fees for pediatric TB was distributed among health facilities run by religious institutions; given that the majority of facilities are run by religious institutions, this was implemented widely.</li> </ul>
India	n/a
Kenya	n/a
Malawi	<ul style="list-style-type: none"> <li>Project too short to implement policy.</li> </ul>
Tanzania	<ul style="list-style-type: none"> <li>Project too short to implement policy.</li> </ul>
Uganda	n/a
Zimbabwe	<ul style="list-style-type: none"> <li>The implementation of community scorecards is being implemented very informally—there is no specific written policy endorsing them.</li> </ul>

## POSITIVE CHANGE IN PEOPLE'S LIVES

<b>Cameroon</b>	<ul style="list-style-type: none"> <li>• Yes—increased screening for pediatric TB.</li> </ul>
<b>DRC</b>	<ul style="list-style-type: none"> <li>• Community health workers can go into communities and bring children to health facilities; this has a large-scale impact on the health of communities.</li> </ul>
<b>India</b>	<ul style="list-style-type: none"> <li>• Parents of TB champions as well as children living with TB were able to exchange views and experiences at the training sessions and were able to speak directly to the National TB Programme about their concerns.</li> </ul>
<b>Kenya</b>	<ul style="list-style-type: none"> <li>• According to Phelix Mboya from EGPAF Kenya, through the work with TB champions, a child who had been misdiagnosed was referred to TB services, correctly diagnosed, and placed on a pediatric TB treatment regimen.</li> </ul>
<b>Malawi</b>	<ul style="list-style-type: none"> <li>• One parent told EGPAF Malawi that, prior to the engagement with “lay cadres,” they went to traditional healers, but since their engagement they have attended the TB facility and the child is now on treatment.</li> </ul>
<b>Tanzania</b>	<ul style="list-style-type: none"> <li>• Numerous children were initiated on TB treatment.</li> </ul>
<b>Uganda</b>	<ul style="list-style-type: none"> <li>• Number of people coming in for treatment improved.</li> </ul>
<b>Zimbabwe</b>	<ul style="list-style-type: none"> <li>• One parent said that their child would have died without the referral by the community health agent and that the community health agents had instilled positive health-seeking behaviour in their children.</li> </ul>

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