Summary of the LeaderNet Seminar:

Where is TB in maternal & child health?

September 7-9, 2016[1]

How can MNCH and TB programs improve the detection and case management of childhood TB? - Conclusions from the Seminar

- Increase awareness and knowledge of TB among health providers at all levels as well as in communities
- Estimate from local data the numbers of children exposed and likely child TB cases; share these numbers and gaps in case detection with providers at all levels
- Institute SIMPLE measures to start finding childhood TB cases
- Follow up all new adult cases at home to identify likely contacts
- Place all child contacts < 5 years on IPT unless they are sick
- Suspect all children with poor weight gain, fever or cough of TB and refer
- Send written referral with suspects to higher levels for diagnosis and treatment initiation if found positive. Provide feedback to referring worker to provide DOTS or preventive therapy
- Record and report TB cases found and treated and give credit to NTP and MNCH programs for dealing with this important problem.

1. Question 1: Is childhood TB viewed as relevant and important by the MNCH community?

Why is childhood TB neglected in the MNCH space? We would like to start by understanding the ongoing neglect of childhood TB as a disease affecting child health and survival and thinking about ways to change that. Currently, childhood TB has gained significant policy attention at the global and national levels, but widespread alignment of field practices among TB and MNCH providers have yet to occur. Major reasons for MNCH practitioners not thinking about TB while assessing a healthy or sick child, at communities and health facilities, can be summarized as:

a. *We erroneously believe that TB is a disease of adolescents and adults, and not of small children.* However, globally around 10% of TB cases worldwide occur before 15 years of age, which can increase to 10-20% among populations with high TB prevalence.

b. *We also erroneously believe that TB can't be diagnosed in small children.* A family history of exposure and the presence of suggestive symptoms (e.g. weight loss, reduced playfulness, cough) can suggest TB disease to an alert MNCH practitioner even at the lowest level of care including the community. This suspicion could trigger the life-saving referral to the closest provider with skills to manage the child.

c. *We don't know what to do (e.g. Refer? Treat?) if we suspect TB in a child.* This is a product of the traditional verticality of MNCH and TB programs where:
   - MNCH providers are seldom trained and encouraged to think of TB as a childhood disease and what to do if we suspect it in a sick child.
   - MNCH and TB providers often have no or limited collaboration for patient consultation and referral.

[1] This online seminar was facilitated by Rudi Thetard (MSH) and Anne Detjen (UNICEF), with the participation of Karen Waltensperger (Save the Children), Jon Rohde (MSH) and Luis Tam (MSH) as technical discussants. 151 people participated in the seminar.

2. Question 2: How do we make an appealing case for childhood TB?

How can we ensure that children affected by TB get the attention and care they deserve? What can we as TB and MNCH community do, at the global, regional, country level? How can we increase leadership and high level commitment, to take action and mobilize much needed resources? What are the arguments that will convince decision makers? What is the data/evidence needed?

To make an appealing case for childhood TB we need to facilitate the cooperation of both the MNCH and TB constituencies, e.g. government, civil society organizations and international donor institutions. Creating *TB-MNCH coalitions* of interested stakeholders, can serve as facilitators of this "merging of minds and hearts",

Maybe the greatest reason for the relative neglect of childhood TB is the *lack of data or even realistic estimates of the real burden of disease*.

Other important pieces of information are the *costs and benefits (economic, social and epidemiological) of doing something (versus doing nothing) for childhood TB*.

To fully *capture the social and emotional costs of childhood TB* is very important. It can be done through personal stories. Death of a child is a devastating loss of a family and society, especially if it could have been prevented by taking simple steps across the chain of health providers at different levels of care.

> Jim Grant, the famous Executive Director of UNICEF, would always ask UNICEF people in every country he visited "How many kids die each year from diarrhea? From measles? From malnutrition?" Estimates were always necessary but he insisted on the NUMBER. Then, in discussions with government – often the Prime Minister or President – you would hear him say "Mr. President, do you realize that some 2,800 kids die in your country EVERY DAY for lack of ORS? And 760 from lack of measles vaccine? ….."
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> *Personal communication. Dr Jon Rohde*

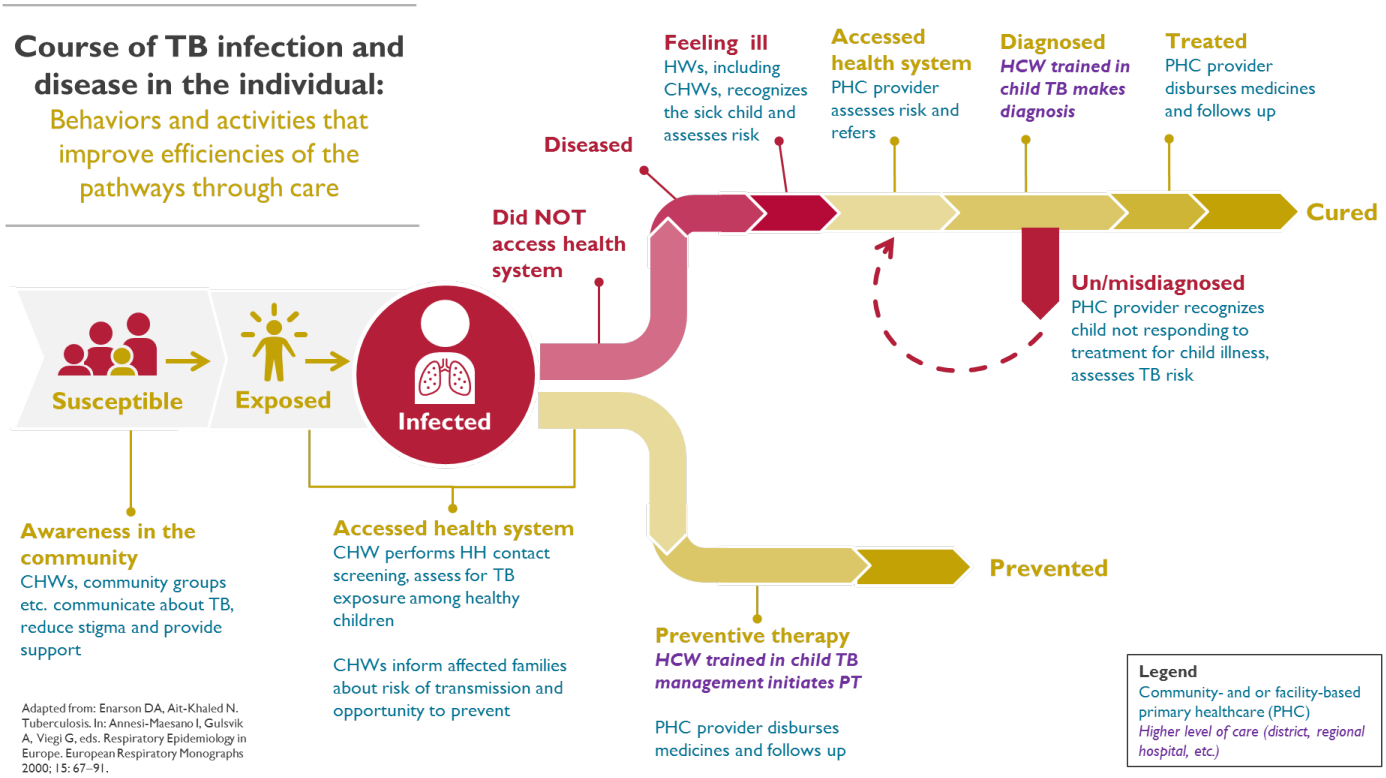
With all this information, *TB-MNCH coalitions can ask for increased policy attention and resources* for childhood TB among domestic and external donors, national and sub-national governments, civil society and academia.

The media can be a powerful ally, both in disseminating hard evidence but also personal stories. These efforts need to be followed by engagement with political and professional leaders, with technical staff and those managing the purse of a government, corporation or international development organization.

Even as we seek to increase high-level leadership and commitment, we also need to consider how to *stimulate demand among users of services*, particularly in settings where HIV and TB rates are high. As we implement community-based SBCC interventions, we must raise awareness of childhood TB risk.

3. Question 3: Are current MNCH tools and approaches robust enough to incorporate TB?

Are iCCM and IMCI approaches appropriately structured and deployed to detect children at risk of or with TB? Can our services cope with the demand of identifying children with TB? If not – what can we do about this situation? Do strategic opportunities exist within delivery models to improve the prevention, detection and management of TB? The figure below, an adaptation from an earlier version used for the seminar, summarizes the course of TB infection and disease in an individual. Within these pathways, currently available MNCH tools and approaches have the potential to identify possible cases of TB if providers are enabled to incorporate behaviors and activities outlined in the figure. We need to address the following in our own work settings for effective implementation:



a. *What are the important behaviors that a MNCH provider must practice to incorporate TB into his/her practice?*
   - Ask the caretakers of sick or healthy children for household or close contacts who are TB patients or chronic coughers.
   - Consider TB as a potential cause of illness among children who don't respond to usual treatment of common childhood conditions (e.g. malnutrition, pneumonia).

b. *What are the important MNCH activities and which TB-related behaviors can be promoted in each of them?*
   - During child immunizations, well child visits and growth monitoring events, i.e. *MNCH events with healthy children.*
   - *During the case management of sick children* including Integrated Management of Childhood Illness (IMCI) and Integrated Community Case Management (iCCM) – malnutrition, pneumonia, pediatric HIV, meningitis either in hospital, outpatient or community settings. Sick child events are likely to lead to higher yields of suspect cases than healthy child events.

A major limitation for including TB screening questions relates to the current workload of HWs. To address this, we have to start by 1) making things **simple** and 2) ensuring a **written record**. A positive (yes) response at the initial contact to the question "Is this child exposed to any adult with a chronic cough and/or with TB?" needs to be written down and followed up. For instance, a CHW needs to initiate a referral **with a written slip explaining why!**

4. Question 4: How can TB programs capitalize on existing community systems?

Much of TB management is dependent on community outreach systems for key elements of TB program delivery such as household contact screening and support for community-based treatment. A lot of effort

by the MNCH community is currently going into the strengthening of community systems, so how can TB programs become part of that effort?

a. *Using existing community system to improve active case finding among household and close contacts of an index TB patient.* This activity is key for identifying children with TB disease or at risk of it.

b. *Use the existing community and facility MNCH providers to administer DOTS and/or IPT* (as it is currently happening in Brazil/Parana, Ethiopia and Afghanistan).

c. *Adapt the MNCH experience of community-based peer support groups* (e.g. for safe motherhood) to implement similar initiatives to adhere to TB treatment. In Afghanistan, Cured TB Patients Councils and Family Health Action Groups promote referrals of suspected TB cases.

d. Depending on country and context, we can *engage existing community platforms such as care groups, women's groups, safe motherhood action groups, youth & adolescent peer groups and others to disseminate appropriate messages and raise awareness of childhood TB* and its relationship to common illnesses and HIV infection.

5. Question 5: Do we have functioning referral systems?

Children identified at the primary community or facility level need to be referred for diagnosis and treatment initiation. Are existing referral systems between primary care and higher levels functioning? Are referral sites ready to manage these children?

In many settings the referral systems are not functioning well. Issues that come to mind:

- Documentation: simple referral forms that include critical information (including TB contact or need for TB evaluation) in tick-format.
- Back-referral slips (should include what was done, the diagnosis made, follow-up needed, and encouragement to the primary health worker who made the referral
- "Facilitated referrals", whereby a pregnant woman, or a child, or a mother-baby pair would be accompanied by a CHW to the receiving facility, or would receive a voucher for transport.

6. Question 6: How can we bridge service delivery realities & disease control expectations?

Who are key stakeholders that need to become part of this conversation – and who is responsible for initiating and managing it? What advice should be provided to participants involved in this conversation, and what factors should be considered?

Commitment from policy makers, managers and providers to address the problem of childhood TB and to assign the needed resources is critical. Alignment with key stakeholders, as we all agree, is important. But who are these key stakeholders? Each country has to do a thorough analysis to find out who can help or hinder progress.

To engage MNCH and TB programs and providers in a win-win collaboration and is key to bridge gaps. In Afghanistan, MSH works closely with NTP and MNCH department of MoPH to address TB among mothers and children. In Brazil, a group of pediatricians and TB experts elaborated a hands-on training course on childhood TB lasting 16 hours.

Conclusion

There was no questioning of the role of TB in affecting child health during the three days of discussions, and many opportunities for linkages between TB and MNCH at all levels were identified. Especially the primary care platform (at community and facility level) is ideally placed to address key steps along the pathway of care. Champions are needed to drive the process, at global as well as country level.