ANNUAL MEETING OF THE CHILD AND ADOLESCENT TB WORKING GROUP
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The implementation of the new WHO recommendations on the management of TB in children and adolescents

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The Talk

World Health Organization

END TB

- Purpose is to:
  - ✓ share experience-based common civil society considerations
- Purpose is NOT to:
  - ✓ share any advanced systematic-review on any scientific argument
  - ✓ draw conclusions relevant for any one or more healthcare setting(s)
- Implementation of new recommendations: Four key components
  - ✓ Bring services closer to children and families
  - ✓ Scaled implementation of new diagnostic technologies
  - ✓ New shorter regimen for non-severe DS-TB and TBM
  - ✓ All oral DR-TB regimen for children (all ages)

BRING SERVICES CLOSER TO CHILDREN AND FAMILIES

- Currently child TB care is mostly at secondary hospitals – limited coverage at primary level healthcare settings
- Considerations:
  - ✓Is primary health (PHC) infrastructure & performance - suitable for child TB care?
  - ✓Is this affordable/ feasible for the program to scale child TB care at PHC level?
  - ✓Do programs have "ability" to adapt treatment decision algorithms for PHC setting?
  - ✓Any ongoing mechanism(s) to engage families in responsive child TB care?
  - ✓Any implementation research to address child care delivery/ quality challenges?

SCALED IMPLEMENTATION OF NEW DIAGNOSTIC TECHNOLOGIES: XPERT ULTRA ON STOOL SPECIMENS

- Methodological challenge:
  - ✓Lack of standardized protocols to prepare and test stool samples
- Effectiveness (scaled implementation in program context):
  - ✓additional diagnosis and incremental cost-effectiveness ratio
- Feasibility of scaled implementation:
  - ✓requirements: laboratory biosafety (level-2) and skilled personnel
  - ✓capital and recurrent cost – shorter and longer term perspectives
  - ✓competing allocation healthcare priorities in low resource settings
- Other considerations:
  - ✓requirements limits the prospects of decentralized testing at PHC level
  - ✓limited knowledge on health workers' acceptability and feasibility

NEW SHORTER REGIMENS FOR NON-SEVERE DS-TB AND TBM

- New shorter treatment regimen includes:
  - ✓Shorter 4-month (instead of current 6-month) regimen for non-severe DS-TB children
  - ✓Intensive 6-month (instead of current 12-month) regimen for TB Meningitis in children

  BUT

  - ✓child TB care has weak integration with other programs and services
  - ✓diagnostic challenges continues to limit the potential benefits of better/shorter treatment
  - ✓pricing/ access to child friendly TB drug formulations remains a challenge for many programs
  - ✓need program-level evidence and advocacy on treatment & implementation outcomes of the two shorter regimen (short and medium term)

ALL ORAL DR-TB REGIMENS FOR CHILDREN (ALL AGES)

- New recommendations for MDRR/RR TB of all ages:
  - ✓Use Bedaquiline as part of shorter or longer Bedaquiline-containing regimen
  - ✓Use Delamanid as part of longer DR-TB treatment regimen

  BUT

  - ✓pricing, access and formulation of drugs for all oral DR-TB (Bedaquiline and Delamanid containing) regimen
  - ✓linking DR-TB care and child-TB care – currently offered at different levels of hospital settings
  - ✓need program-level evidence and advocacy on treatment & implementation outcomes of all-oral DR-TB treatment in children (short and medium term)

CONCLUSION

- WHO updated recommendations: a step towards making child TB care simpler and cost-effective

BUT

- Implementation protocols and challenges need in-time attention of the programs and partners - for optimal gains across varied settings.
- Continued "learning-by-doing" and "sharing" for an informed scaling across countries and regions.

THANK YOU

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