

Counting children: comparing reporting for paediatric HIV and tuberculosis

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"All women, men and children who need TB diagnosis and care have a right to it – no matter who they are or where they live – and they should be able to access TB services free of charge and in a manner that respects their dignity."¹

Although the World Health Organization's (WHO's) latest report on tuberculosis² provides welcome news on falling numbers of cases, children are still being neglected despite the fact that they represent approximately 15–20% of the global burden of tuberculosis.^{3,4} Indeed, the neglect of mothers and children in tuberculosis initiatives was the topic of a major symposium by WHO's Stop TB department at the recent 42nd Union World Conference on Lung Health.⁵ *The Global Plan to Stop TB 2011–2015*¹ includes the objectives of early diagnosis and treatment of all cases including children. However, current reporting on tuberculosis in children falls far short of what is required to measure and pressure progress. As Director-General of WHO, Margaret Chan, said in her inaugural speech: "what gets measured gets done".⁶

To assess efforts to track progress in scaling-up services for paediatric tuberculosis, we compared reporting against that for another global epidemic for which scaling-up paediatric services is a priority: HIV. We used three indicators – disease burden, treatment and prevention – to compare paediatric data in the tuberculosis report² with those in the *2010 UNAIDS Report on the Global AIDS Epidemic*.⁷ This comparison is summarized at: <http://tinyurl.com/d3o68wa>.

There are many constraints to diagnosing and treating tuberculosis in children. Definitive, simple diagnostic tests do not exist, while treatment is complicated by a lack of appropriate fixed-dose combinations for children.⁸ In contrast with HIV, there is limited reporting of the burden of disease and treatment for paediatric tuberculosis.

Globally, the only indicators for children aged less than 15 years are the number of children orphaned by tuberculosis and the notification of smear-positive cases. This latter indication is of limited value since, except for advanced disease, most tuberculosis in children is smear-negative.⁹ For 22 high-burden countries, 157 135 cases of tuberculosis in children were reported in 2010. These countries have an estimated total prevalence of 9.97 million cases, meaning that at conservative estimates we should expect the number of paediatric cases to range from 498 500 (5%) to 1.49 million (15%). Even at the lowest estimate of 5%, this means that at least 341 365 cases were not diagnosed or reported in these countries.

Within the 22 high-burden countries, the proportion of estimated paediatric cases varies considerably within the same region: in Asia from 0.1% (Viet Nam) to 9.6% (Indonesia) and in Africa from 1.4% (Nigeria) to 15% (South Africa). Other commentators have estimated higher proportions.¹⁰ Without specific paediatric disease estimates, it is hard to interpret whether programmes with low proportions of children are performing well (i.e. early infectious case-finding and treatment) or badly (not including children).

The drive to increase access to treatment and prevention for people living with HIV/AIDS has been supported by clear reporting of need. The "antiretroviral treatment gap" has been the foundation of global advocacy efforts directed at donors to increase funding and countries to increase commitments, both for adults and children,¹¹ and has led to ambitious political commitments to eliminate paediatric HIV by 2015.¹² By contrast, current tuberculosis reporting gives little indication of unmet need and thus there is no way of judging how far we have to go. Better reporting could provide the foundation for a much-needed drive to increase political

commitment to tuberculosis funding mirroring the success of HIV activism.³

The need for special efforts to ensure that children are not neglected in global health efforts has long been recognized. It is essential to include children in outcome indicators of plans and strategies for scaling-up tuberculosis services so as to ensure that paediatric tuberculosis is no longer left behind. ■

References

1. *The global plan to stop TB 2011–2015*. Geneva: World Health Organization; 2011.
2. *Global tuberculosis control 2011*. Geneva: World Health Organization; 2011.
3. Keshavjee S, Harrington M, Gonsalves G, Chesire L, Farmer PE. Time for zero deaths from tuberculosis. *Lancet* 2011;378:1449–50.
4. Marais BJ, Schaaf HS. Childhood tuberculosis: an emerging and previously neglected problem. *Infect Dis Clin North Am* 2010;24:727–49.
5. Meeting the unmet needs of women and children for TB prevention, diagnosis and care: expanding our horizons (Stop TB Symposium). In: *42nd Union World Conference on Lung Health, Lille, 26–30 October 2011*.
6. Chan M. Address to WHO staff. Geneva: World Health Organization; 2007.
7. *Global report: UNAIDS report on the global AIDS epidemic 2010*. Geneva: Joint United Nations Programme on HIV/AIDS; 2010.
8. Shingadia D, Novelli V. Diagnosis and treatment of tuberculosis in children. *Lancet Infect Dis* 2003;3:624–32.
9. Marais BJ, Pai M. New approaches and emerging technologies in the diagnosis of childhood tuberculosis. *Paediatr Respir Rev* 2007;8:124–33.
10. Nelson LJ, Wells CD. Global epidemiology of childhood tuberculosis. *Int J Tuberc Lung Dis* 2004;8:636–47.
11. *No time to quit: HIV/AIDS treatment gap widening in Africa*. Brussels: Médecins Sans Frontières; 2010.
12. *PMTCT strategic vision 2010–2015. Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals. Moving towards the elimination of paediatric HIV*. Geneva: World Health Organization; 2010.

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