EDITORIAL

Tuberculosis in children: getting started on the road to zero

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In 2011, of the 8.7 million new tuberculosis cases in the world, approximately 0.5 million occurred in children, representing at least 6% of the global burden.¹ But do we truly know the child tuberculosis burden? Is a global tuberculosis death rate of 71 000 children per year¹ accurate when these data do not include the tuberculosis-related deaths that are classified as due to human immunodeficiency virus (HIV) infection, pneumonia or malnutrition? Childhood tuberculosis is receiving much needed attention of late as we gear up to reaching Millennium Development Goal Number 5 (to reduce child mortality) and the new ambitious World Health Organization (WHO) post-2015 targets for tuberculosis prevention, treatment and care.

In this issue of the *Journal*, Dendup et al. present child tuberculosis data from Bhutan, representing 14% of the total burden.² Bhutan is a small South-East Asian country with a free national health care system and no private practitioners. This is an example of child tuberculosis care integration into the mainstream health system, leading to better health care provider awareness and hundred per cent case notification. These findings are similar to national data reported from Malawi, where all children access the same health care system and registration with the National Tuberculosis Programme (NTP) is required to receive treatment.³

Another study in this issue, by Ade, compares child tuberculosis data from a general hospital with data from basic health units in Cotonou, Benin, a small West African country.⁴ This study highlights issues such as underreporting of children with tuberculosis from the hospital, lack of age-disaggregated data, poor access to HIV testing in the hospital for children with tuberculosis, and lack of training in child tuberculosis for health workers, leading to missed opportunities in case detection. Similar issues are echoed in other studies, such as underreporting of childhood tuberculosis in East Java,⁵ enhanced child TB case detection following private practitioner involvement in Karachi⁶ and following health worker training in Bangladesh.⁷

The WHO post-2015 tuberculosis strategy highlights

the information gap that child tuberculosis needs to fill and the difficulty in setting targets in the absence of baseline data. Despite existing NTP policies, national child tuberculosis guidelines and efforts to decentralise care, a policy-practice gap exists in most high-burden countries. Child contact management and active case finding are policies that are rarely implemented. Recent efforts to include child tuberculosis in NTP reviews and to provide technical assistance and training in child tuberculosis, with a push towards its integration with existing child care services, are a step in the right direction. Efforts to engage the community, civil society and the private sector with a strong focus on a family-centred approach and prevention will cast a wider net for early detection of child tuberculosis. Filling research gaps in child tuberculosis, along with the development of a point-of-care diagnostic test, child-friendly drugs and vaccines, urgently demands attention.

The Bhutan study is an example of how, with additional training in diagnosis and management, good child tuberculosis care is possible under programmatic conditions in high burden settings.

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