[DOH ADMINISTRATIVE ORDER NO. 2008-0011, May 21, 2008]

REVISED GUIDELINES FOR IMPLEMENTING TUBERCULOSIS CONTROL PROGRAM IN CHILDREN

I. RATIONALE/BACKGROUND

The goal of the National Strategic Plan to Stop TB 2006-2010 and the Western Pacific Regional Strategic Plan 2006-2010, is to reduce the TB prevalence and mortality by half by 2010 (relative to 2000), contributing to the attainment of the Millennium Development Goal (MDG) come 2015. Among the objectives identified in these plans were: to improve detection of all TB cases, adapt DOTS to respond to high-risks population and ensure equitable access to care of international standards for all TB patients. This would an reaching out to all people with TB; adults and children, infectious and non-infectious, or without HIV and with or without drug resistant TB.

To address TB in children, DOH created the Task Force (TF) on Childhood TB in By virtue of Dept Order (DO) 248-H s. 1998 as amended by DO 66-D s. 2001. This TF was composed of experts both from the public and private sector. In 2002, DOTCh (DOT in children) was piloted in these areas. Two years later, the DOH through the TF, released ^ 1st guidelines for TB in children through Administrative Order (AO) 178 s. 2004 which paved the way for the expansion of the program to 16 cities (1 city per region) nationwide.

In 2006, WHO issued the *Guidance for National Tuberculosis Programmes on Management of TB in Children.* Because of this, the DOH deemed it necessary to convene the TF and revise the current national guidelines in accordance with that of the WHO and for consistency with the 2005 Manual of Procedure (MOP) for the National Tuberculosis Control Program (NTP) before embarking on a nationwide implementation of the Childhood TB Program.

II. OBJECTIVES

The objectives of these guidelines are: to provide a standard policy for casefinding; treatment of children with TB; contact tracing of children at risk of developing TB for preventive therapy; and to include all childhood TB cases in the routine NTP recording and reporting activities using the DOT strategy.

III. SCOPE/COVERAGE

These guidelines shall apply to all health facilities, agencies and organizations that will implement Tuberculosis Control Program among children 0-14 years old.

IV. DEFINITION OF TERMS

Contacts for screening- all children - 0-4 years (whether sick or well) and children 5-14 years if symptomatic, who are in close contact with a source case

Close contact - is defined as a person living in the same household as or in frequent contact with a source case.

Isoniazid Preventive Therapy (IPT) - taking a course of isoniazid treatment to individuals who have not been infected in order to prevent development of TB disease.

Source case - a case of pulmonary TB (usually sputum smear-positive) which results in infection or disease among contacts.

TB Diagnostic Committee (TBDC) is a committee established at the province, city or district level that will review the sputum smear-negatives with chest x-ray suggestive of Pulmonary TB. It is composed of the NTP medical/nurse coordinators, radiologist and a clinician (internist or pulmonologist).

V. Statements

1. All children 0-14 years old who come to the health facility with signs and symptoms of TB and/or those who are in close contact with a known TB case (usually an adult) shall be screened for TB.

2. The diagnosis of TB in children depends on careful and thorough history and clinical examination and relevant investigations, e.g. Tuberculin Skin Testing (TST), Direct Sputum Smear Microscopy (DSSM) and Chest x-ray (CXR). Atrial of treatment with anti-TB medicines shall not be used as a method of diagnosing TB in children.

3. When a child is diagnosed with TB, an effort should be made to detect and cure the source case.

4. Treatment of TB disease in children and Isoniazid Preventive Therapy (IPT) shall follow the 2006 WHO guidelines' recommend dosages and regimen.

5. Directly Observed Treatment (DOT) shall be followed for all children undergoing therapy

6. Quarterly reports shall be submitted to the Infectious Disease Office through channels

7. To prevent severe types of TB in children and in accordance with the policies and procedures of the Expanded Program on Immunization (EPI), BCG vaccination shall be given to all infants. However, revaccination of BCG is not recommended.

VI. Implementing Guidelines 1 Case Finding

A. TB in children are reported and identified in two instances:

1. The child sought consultation, was screened and was found to have signs and symp- toms of TB.

2. The child was a close contact of a TB case.

B. Approach to diagnosis:

1. Careful history and clinical examination (including growth assessment)

i. Symptoms - a child shall be considered as a TB symptomatic if with any three (3) of the following signs and symptoms:

- Cough/wheezing of 2 weeks or more.
- Unexplained fever of 2 weeks or more after common causes such as malaria or pneumonia have been excluded.
- Loss of weight/failure to gain weight/weight faltering/loss of appetite.
- Failure to respond to 2 weeks of appropriate antibiotic therapy for lower respiratory tract infection.
- Failure to gain previous state of health 2 weeks after a viral infection or exanthema (e.g. measles).
- Fatigue/reduced playfulness/lethargy.

ii. Physical signs highly suggestive of extrapulmonary TB

- gibbus, especially of recent onset
- non-painful enlarged cervical lymphadenopathy with fistula formation

2 Tuberculin Skin Testing (TST)

i. The Mantoux method of TST is recommended using 2 TU of tuberculin PPDRT 23 or 5TU of tuberculin PPD-S if the former is not available.

ii. A positive TST is an area of induration of the skin with diameter of 10mm or more read between 48 and 72 hours of injection of the tuberculin solution (whether or not they have received BCG vaccination).

iii. Only trained health worker shall do tuberculin testing and reading.

3. Investigations relevant for suspected pulmonary or extrapulmonary TB

i. Diagnosis of Suspected Pulmonary TB:

1. Direct Sputum Smear Microscopy (DSSM) and bacteriologic confirmation whenever possible:

-DSSM shall be performed among:

-younger children (5-9 years old) who can expectorate

-children (10-14) years old who has cough for 2 weeks

- If DSSM turns out positive, treatment shall be started immediately and TST shall no longer be performed.

-Collection, transport, processing and reporting of sputum specimen shall