

Main Problems	Adverse Consequences	Suggested Policy Changes	Collaboration
<p>Epidemiology: Limited surveillance data on DR-TB in children (misconceptions about DR-TB: “rare”, “not contagious”, “not virulent”, “secondary/acquired”) --Detection among younger children appears low and suggests underdetection and/or under-reporting</p>	<p>TB control strategy—at least as focused by the WHO—has not adequately addressed children as a vulnerable subgroup... “limited data must mean limited problem” --post-mortem examinations finding 25-50% of cases to be due to TB</p>	<ul style="list-style-type: none"> • Data collection in separate age groups (e.g., 0-4; 5-9; 10-14). • Including children w/o bacteriological conf. of DR-TB, but who are clinically diagnosed based on risk factors (and who then may have Tx response) • Developing a case definition in children that however imperfect, can at least serve as surrogate epidemiologic indicator • Setting targets for detection (as is done for other program reference indicators) 	<p>Open access to epidemiologic surveillance databases</p>

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Diagnosis: <ul style="list-style-type: none"> • Clinical Dx limited by access to imaging studies & immunol. test • Microbiologic confirmation still dependent on smears 	<ul style="list-style-type: none"> • Under-diagnosis & underreporting of TB & DR-TB • Denial of Tx w/o microbiological evidence of disease 	Building human & lab capacity to assure: <ul style="list-style-type: none"> • CXR quality & reading • Immunol. test • Specimen collection in all children • Universal access bacteriologic confirm. & [direct] DST by culture +/- NAAT 	<ul style="list-style-type: none"> • Collaboration in the development and validation of new diagnostics and prognostic biomarkers through multi-center studies • Exchange of experts for training of TB control program personnel

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Treatment: <ul style="list-style-type: none"> • Limited availability of high quality 2nd-line drugs • Medication regimens, based on adults (not validated in children), w/o pediatric formulations 	<ul style="list-style-type: none"> • Increased morbidity & mortality; • Risk for DR amplification 	<ul style="list-style-type: none"> • Uninterrupted availability of quality assured (QA) pediatric formulations for optimal dosing • Early inclusion of children in clinical trials • For high-risk exposures to DR-TB, especially in young children: seriously consider “window” prophylaxis • For DR-LTBI, appropriate prophylaxis 	<p>Collaboration in multi-center clinical trials of new therapeutics for chemoprophylaxis and treatment (e.g., study being proposed by MSF in Armenia for Pediatric contacts of MDR-TB adults)</p>

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Socio-Economic Aspects: Stigma of TB	<ul style="list-style-type: none"> • Social isolation & educational limitation (if unnecessary hospitalization) 	<ul style="list-style-type: none"> • Social support • Limit hospital isolation to strictly necessary time period, and transfer to ambulatory care/management • Support for TB patient groups • Publicity campaign to de-stigmatize TB (following example of HIV community) • De-emphasize TB as a social disease, and emphasize TB as a medical disease with social determinants 	Collaboration with international organizations such as Treatment Action Group and other patient advocacy organizations