EDITORIAL

Programmatic management of children with drug-resistant tuberculosis: common sense and social justice

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'There can be no keener revelation of a society's soul than the way in which it treats its children.'

Two years after Nelson Mandela's death, his words of wisdom still resonate when applied to the global multidrug-resistant TB (MDR-TB) pandemic. They call us, whether politicians, activists for human rights or health care providers, to view our successes and failures through a different lens, ultimately asking, 'How do we treat our children affected by MDR-TB?' Today's reality is that children are the most vulnerable and the last in the queue: we treat them poorly or not at all.¹

In our early days of practice, in both central Africa and Peru, it was apparent that children were being left out of global plans to address MDR-TB. Children were deemed 'difficult to diagnose', complicated to manage, and—as children often have smear-negative disease—unlikely to contribute to ongoing transmission, and thus not a priority for a public health intervention. A decade and a half later little has changed, and we continue to face the same problems: diagnostics are limited, child-friendly drugs and regimens are not available, and the small percentage of children that are treated are usually managed at highly specialised centres.² One major barrier to the optimal management of children has been the lack of a systematic approach to paediatric MDR-TB in programmatic settings.³ The article by du Cros et al. in this issue of *Public Health Action* (PHA) reflects the determination of the Tajikistan National TB Programme (NTP) and Médecins Sans Frontières (MSF) to arrest this long-standing and deleterious trend.⁴ The article demonstrates not only that MDR-TB in children should be treated, it also shows how it can be done under programme conditions in a challenging setting.

Success in the management of childhood MDR-TB is an issue not only of clinicians and pills, but also of systems building with the interaction of multiple stakeholders. The authors present useful information on how the Tajikistan NTP, with the support of MSF, kick-started a paediatric MDR-TB programme. While it

is certain that Tajikistan faces a unique set of circumstances, the barriers faced and the solutions implemented will be similar in other settings where MDR-TB is encountered.

The article proposes pragmatic solutions, such as starting MDR-TB treatment based on a clinical diagnosis while waiting for bacteriological confirmation, treatment of children with minimal disease and aggressive management of adverse effects. These interventions will save the lives of countless children if they are applied systematically. The paper also supports the idea that most challenges in childhood MDR-TB can be overcome with improved knowledge, better coordination between stakeholders and a willingness to invest in saving children's lives simply because it is the right thing to do. They are not the only ones: others, such as the Sentinel Project on Pediatric Drug-Resistant TB, a virtual network of stakeholders, believe that children should be prioritised for access to MDR-TB treatment.⁵ Now is the time to show courage, challenge dogmas, and creatively overcome barriers to start treating all children with MDR-TB under programme conditions as an exercise of justice and common sense. The work done by the NTP of Tajikistan and MSF described in this issue of PHA is an excellent model that other programmes can and should follow.

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