

BMJ Open Impact of prolonged isolation on adolescents with drug-susceptible tuberculosis in Lima, Peru: a qualitative study

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ABSTRACT

Objectives Patients with tuberculosis (TB) generally are instructed to isolate at the beginning of treatment in order to prevent disease transmission. The duration of isolation varies and may be prolonged (ie, lasting 1 month or more). Few studies have examined the impact of isolation during TB treatment on adolescents, who may be more vulnerable to its negative effects.

Methods This study took place from 2018 through 2019 in Lima, Peru, where the Ministry of Health mandates the exclusion of patients with TB from educational institutions for at least 2 months. Using semi-structured guides, we conducted individual in-depth interviews with adolescents who received treatment for drug-susceptible TB, their primary caregivers and health providers. We performed thematic analysis of the transcribed interviews.

Results We interviewed 85 participants: 34 adolescents, 36 caregivers and 15 healthcare workers. At the time of their TB diagnoses, 28 adolescents were in secondary, postsecondary, vocational or military school. Adolescents with drug-susceptible TB were prescribed home isolation usually for 2 (and occasionally for 1) months. Consequently, they could neither attend school nor socialise with family members or friends. Two primary themes emerged from the interviews. First, as a result of their exclusion from school, most adolescents fell behind academically and had to repeat a semester or academic year. Second, absence from school, separation from friends and loved ones, and reinforcement of TB-related stigma (arising from fear of TB transmission) harmed adolescents' mental health.

Conclusion Prolonged isolation led to educational setbacks and emotional trauma among adolescents with TB. Prolonged isolation is not supported by current evidence on TB transmission and is problematic from a human rights perspective, as it violates adolescents' rights to education and freedom of movement. Isolation recommendations should be re-evaluated to align with data on TB transmission and the principles of patient-centred care.

BACKGROUND

Globally, an estimated 850 000 adolescents, defined by the WHO as individuals

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This qualitative study had a robust sample size (n=85) and included perspectives from adolescents, their primary caregivers and health providers.
- ⇒ The analysis incorporated both data and investigator triangulation.
- ⇒ A Community Advisory Committee provided input on the interview guides.
- ⇒ Because this is a secondary analysis, we may not have captured all impacts of prolonged isolation and may not have reached data saturation with respect to this topic.
- ⇒ There may have been selection bias, as adolescents who were not enrolled may have had different experiences than those who participated in the study.

10–19 years old, become ill with tuberculosis (TB) each year.¹ In general, patients being treated for pulmonary TB are instructed to isolate to prevent airborne transmission of *Mycobacterium tuberculosis*. Guidelines for the discontinuation of isolation vary across settings.² Some Ministries of Health (MOHs) allow discontinuation of isolation after 2 weeks as long as the patient is adherent to and tolerating appropriate treatment. Other MOHs require longer isolation periods and/or multiple sputum smears that are negative for acid-fast bacilli (AFB).² In most settings, isolation occurs at home, while in former Soviet republics, patients with TB disease are isolated in TB hospitals.^{3–5}

Few reports have described the impact of prolonged isolation, which we define as lasting 1 month or more, on adolescents with TB.⁶ Adolescents may be particularly vulnerable to the negative effects of prolonged isolation. During adolescence, increased social interaction, particularly with peers, contributes to psychological and social development.⁷ During the COVID-19 pandemic,

school closures, isolation and quarantine were associated with depression and anxiety in adolescents.⁸ Absence from secondary, postsecondary or vocational school may lead to worse educational outcomes and lower future earnings.⁹

The TB guidelines of the Peruvian MOH lack detailed recommendations for isolation, stating only that patients should be informed about the potential need for isolation.¹⁰ However, according to national policy, patients with TB cannot attend school for at least the first 2 months of treatment; they can return to school only if they have AFB-negative sputum samples at the end of the first and second months of treatment, even if their pretreatment sputum was smear-negative.¹¹

We conducted a qualitative study in Lima, Peru to better understand barriers to treatment adherence among adolescents treated for drug-susceptible pulmonary TB, as well as other challenges faced by adolescents with TB. In this paper, we report on a critical theme that emerged from the data: prolonged isolation during TB treatment and its impact on adolescent well-being.

METHODS

Setting

Peru has a population of 33 million people and an estimated TB incidence of 116 per 100 000 per year.¹² Lima, the densely populated capital, accounts for 54% of the country's TB cases.¹³ In 2015, the largest proportion of new TB cases in Peru was among young people aged 15–24 years, accounting for 29% of all new cases.¹³ In Peru, over 70% of patients with TB receive care at public health facilities run by the MOH.¹⁴ Patients receive in-person directly observed therapy (DOT) for TB at the health centre closest to their home. Nurses and nurse technicians (licensed vocational nurses) supervise DOT. Treatment of drug-susceptible TB typically consists of a 2-month intensive phase with four medications given daily, followed by a 4-month continuation phase with two medications given three times per week. All study participants received TB treatment before the COVID-19 pandemic.

Inclusion and exclusion criteria

We recruited three groups of study participants: adolescents, their primary caregivers and health providers. We included adolescents who (1) were diagnosed with drug-susceptible pulmonary TB; (2) were between the ages of 10–19 years at treatment initiation; (3) received DOT at a health centre run by the MOH; and (4) in the preceding 12 months, either completed TB therapy or were lost to follow-up from TB treatment. We excluded adolescents who had extrapulmonary TB or who received any second-line TB drugs. Each adolescent identified the adult whom they considered their primary caregiver during their TB illness; we excluded adolescents whose primary caregivers did not agree to participate in a separate interview. Caregivers without legal guardianship of minors could participate as long as informed consent was obtained from

the adolescent's legal guardian. For the health provider group, we included nurses and nurse technicians who had supervised DOT at an MOH facility for at least 6 months.

Sample size and recruitment

We estimated a priori that a sample size of 30–45 adolescent-caregiver dyads and 10–15 healthcare providers would be sufficient to reach thematic saturation for our primary objective of identifying barriers to treatment adherence. We aimed to include adolescents from three age strata: 10–13 years old, 14–16 years old and 17–19 years old. We further aimed to achieve gender balance among the adolescents, but expected caregivers and health providers to be predominantly women.^{15 16}

Study personnel identified eligible adolescents from TB treatment rosters at health centres in Lima. Health centre staff called consecutive eligible adolescents—or their parent/guardian if they were a minor—to obtain permission for study personnel to contact them directly. Study personnel then called, or visited, potential participants to describe the study and invite them to participate. We enrolled a purposeful sample of 15 nurses and nurse technicians who worked in health centres with high volumes of patients with TB.

Data collection

We developed and piloted semi-structured individual interview guides with open-ended questions (see online supplemental material). Because the primary objective of the study was to identify barriers to treatment adherence, the interview guides did not include direct questions about isolation. They did, however, include questions about missing school and other activities, and, in line with standard semi-structured interview methodology, probed for details about patients' isolation experiences, when appropriate.

Three Peruvian investigators (MW, EA, LS), who had prior training and/or experience conducting interviews and were employed by Partners In Health-Peru (PIH-Peru), conducted interviews in Spanish from August 2018 to May 2019. The interviewers had no prior relationships with adolescent and caregiver participants, but had professional relationships with some of the health providers who participated in the study. Interviews with adolescents and caregivers took place privately in the participants' home. Health worker interviews took place in a closed room at their workplace. Two interviewers were present whenever possible to allow the second interviewer to take notes and ask clarifying questions as needed. Interviews lasted 45–60 min and were audio-recorded and transcribed verbatim. Participants were reimbursed with grocery gift cards valued at 45 Peruvian *soles* (approximately US\$13).

Patient and public involvement

The Community Advisory Committee (CAC) of PIH-Peru is an independent group of nine volunteers who ensure that research studies respond to the needs of the community. The CAC approved this study and provided input on

the interview guides. Additionally, we piloted and refined the interview guides in response to feedback from the first several participants in each participant group. The results of our study will be shared with the CAC and the Peruvian MOH.

Data analysis

We performed thematic analysis, which summarises textual data by identifying themes that extend across interviews.¹⁷ First, three authors (SDR, JC, SC) listened to 10 interviews to immerse themselves in the data. Then, they created two initial codebooks: one corresponding to the adolescent and caregiver interviews, and the other to the health provider interviews. The analysis was not informed by any theoretical frameworks; rather, we used an inductive approach, in which our codebook was informed by repeated readings of the transcripts and contained only themes that emerged from the data. The three authors individually coded a subset of the interviews, compared their coding, resolved discrepancies through group discussion, and refined the codebooks accordingly. They repeated this process until they agreed on codebooks that captured all interview content. Next, five authors (VEOR, CBB, SDR, JC, SC) applied the final codebooks to all interviews using NVivo V.12 (QSR International, Cambridge, USA). Eight (9.6%) interviews were independently coded by two authors; inter-rater agreement was >90%. Remaining interviews were coded by one author.

We performed data triangulation by comparing general findings between all three groups and participant-specific details between adolescent-caregiver pairs. VEOR and SC independently reviewed the codes to identify emergent themes related to isolation practices and their impacts, developed a conceptual framework, and identified and

translated illustrative quotes. All reported findings were verified by multiple sources.

This study has been reported in accordance with the Consolidated Criteria for Reporting Qualitative Research checklist (online supplemental material).¹⁸

RESULTS

This analysis includes 85 interviews: 34 adolescent-caregiver dyads (68 interviews), 15 healthcare workers and 2 additional caregiver interviews without accompanying adolescent interviews. [Figure 1](#) shows the number of individuals who were invited to participate, enrolled and interviewed. [Table 1](#) describes the characteristics of the study participants.

At the time of their TB diagnoses, all but six adolescents in this study were in secondary, postsecondary, vocational or military school. Two adolescents had full-time jobs at the time of treatment initiation.

Isolation practices

All participants reported having been instructed to isolate and refrain from activities outside the home, other than medical appointments. Most adolescents and health providers reported the duration of isolation to be a minimum of 2 months, consistent with the previously mentioned policy, while a few reported 1 month. When asked why they were instructed to isolate, participants most commonly reported it was to prevent disease transmission.

... they told me that [in] the first phase [of treatment] I was contagious and that I had to be in my house ... And so, for two months I had to be [in my

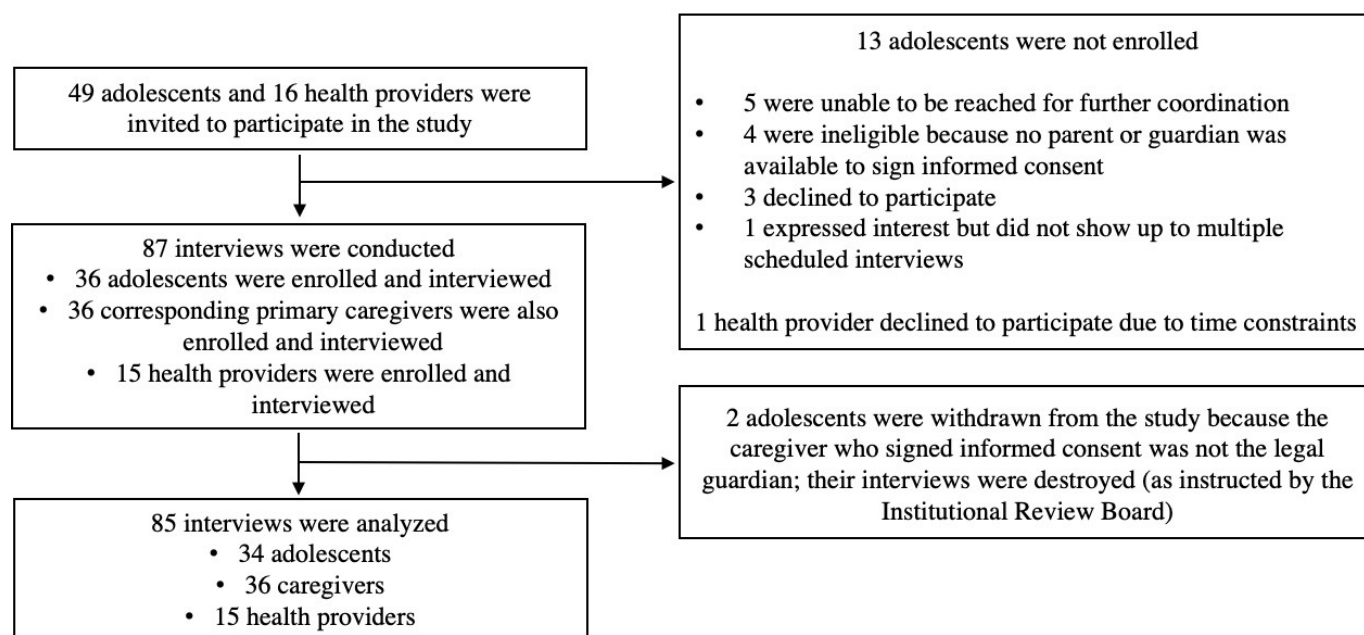


Figure 1 Flowchart of participant recruitment and enrolment.

Table 1 Characteristics of study participants

	Adolescents (n=34)	Caregivers (n=36)	Health providers (n=15)*
Age in years, median (IQR)	17 (14–19)	41 (35–48)	41 (32–49)
Females, n (%)	13 (38)	35 (97)	13 (87)
Relationship to adolescent, n (%)			
Mother	NA	27 (75)	NA
Aunt	NA	3 (8)	NA
Older sister	NA	5 (14)	NA
Father	NA	1 (3)	NA
Number of health centres represented	27	27	14†
Studying full-time, n (%)	29 (85)	NA	NA

*Ten (67%) were nurses, while five (33%) were nurse technicians.
†5 of 14 health centres were not represented among adolescents and caregivers; a total of 32 health centres were represented among all study participants.

house], until after the AFB [smear] found me not to be contagious. (Participant #79, 17 years old male)

... until [the patient's] sputum sample is negative, [which] it would be in a month [after starting treatment] ... they leave their other activities ... that is, school, friendships, because we help them see how many [others] it is that they will infect if they're smear-positive. They are going to infect their best friends, people who are closest to them—right?—and at school, all the people who surround them. (Participant #16, nurse technician, 52 years old female)

A few healthcare providers cited the need for physical rest, as well as time to adapt to treatment side effects as another reason for prolonged isolation and exclusion from regular activities:

No, you have to rest ... for at least two months, because you are in treatment. Plus ... you have a [lung] lesion ... if you exert yourself, well, it will hurt. There may be bleeding, and you are going to harm yourself. (Participant #63, nurse, 52 years old female)

... the doctor recommended to us that [my sister] miss a month [of school] to get used to the adverse reactions that the medications might have—she wanted to be able to continue going to school because she was smear-negative so she wasn't transmitting to anyone—but more than anything, I told my mother that sometimes isoniazid has strong side effects, ethambutol has very strong side effects, it's better that she rest at home a month ... not the two months that the doctor at the health center recommended, but the month that the pulmonologist at [the hospital]

recommended ... (Participant #34, sister of a 15 years old female)

Lived experiences

Isolation meant that adolescents could not attend school, gather with friends or participate in other social events; some even isolated from other household members. The few participants who were employed had to quit their jobs or take a leave of absence. Participants' descriptions of how they experienced isolation were similar:

I literally lived shut in. (Participant #81, 19 years old female)

I did nothing, right? I did not like to be like that: lying, sitting, sleeping. (Participant #60, 19 years old male)

... [The health providers] told me, "You are not going to skate, you are not going to play matches, you are not going to go outside, you are not going to be with your friends. You cannot do anything. You are going to be in your room, in your bed with open windows and open doors. (Participant #66, 16 years old male)

Adolescents complied with home isolation with few exceptions. One adolescent stopped going to school, but continued to spend time with friends (Participant #84, 19 years old male). Two adolescent participants ignored doctors' orders to take a leave of absence from school because they wanted to avoid falling behind in their studies. Another chose to enrol in fewer courses rather than miss the semester:

It is not that I completely missed [the semester], but I did take fewer courses at my university ... I thought about not attending that semester, but I was going to fall very behind. (Participant #47, 19-year-old male)

Impact on education and training

Several participants referred to a national policy that directs educational institutions to facilitate medical leave for students with TB and to provide support so the students do not have to repeat the semester or academic year¹⁹:

[T]hey cannot be discriminated against, they cannot be kicked out, they cannot let them fail the school year, and the educational institution has an obligation to support that tuberculosis patient. How? ... By not making him miss the school year, and through other means, they have to see how to support him so he doesn't miss the school year [such as] through tutoring (Participant #13, nurse, 36 years old female)

Despite this policy, most adolescent participants fell behind in school and had to repeat a semester or academic year.

Participant: Yes, halfway through the year they told me that I was sick ... my mother took me out of school ... there were 3 months left to finish [the school year].

Interviewer: And did [the school] support you with your grades or did you lose the year?

Participant: No, I lost the year. (Participant #65, 11 years old male)

I was just a month away from finishing university. So, it was shocking to me because a single month, getting sick and no longer going [to school], shakes you quite a bit ... I missed the semester and had to retake it again this year. (Participant #3, 20 years old male)

The educational setbacks experienced by adolescent participants may alter their prospects for higher education, career trajectory and/or employability. One adolescent, who missed a month of school, risked no longer being competitive for a prestigious government-funded scholarship, Beca 18, which covers university tuition and related expenses for students with high academic achievement and limited financial resources. As the adolescent's sister recounts:

... her grades dropped due to the month that she missed [of school] while on medical leave ... Now she wants to apply for the Beca 18, [but] her final grade is lowered, so she has been put at a disadvantage from that month that she missed ... Supposedly, when one has a medical leave, supposedly, they explained to me that they have to carry over her grades from [the previous term] ... but they didn't do it ... (Participant #34, sister of a 15 years old female)

Participant #45 was training to become a pharmacy technician, but at the time of the interview, conducted 7 months after he began treatment, he had not resumed his programme.

... I felt bad because I was doing fine in everything, grades [and] all that, and to leave all that ... Yes, I lost the [school] year ... I had to leave my vocational [school] and then dedicate myself to the health center. (Participant #45, 17 years old male)

Five other participants (one other vocational school student, two secondary school students and two military trainees) also had not resumed their classes or training at the time of their interviews, which were conducted more than 6 months after their isolation period ended.

While most participants who were studying at the time of their TB diagnosis experienced educational setbacks, there were a few exceptions. As previously mentioned, two adolescents continued to attend school despite instructions to stay home. Additionally, for several adolescents, the first phase of TB treatment coincided with summer break; thus, they missed fewer days of school and did not need to repeat the semester. However, even these participants found themselves struggling academically when they returned:

I stopped going [to school] for a week, and that may have complicated my studies because there were subjects that I was studying, and well, when I returned to

my classes, I did not know where I was, and I tried to catch up, to ask my friends. (Participant #38, 19 years old male)

Many participants commented that even after the home isolation period, the requirement of in-person DOT made going to school challenging, as clinic and school schedules often conflicted.

... when I started studying [again] ... I had to ask permission ... to be late [to school] so that I could, um, go to the [health] center in the morning to be able to take my pills. (Participant #1, 18-year-old female)

Impact on mental health

Home isolation led to emotional distress among adolescents for multiple reasons. First, extended absence from school led to despair, which was related to both missing regular interactions with peers and teachers and anxiety over academic performance.

... He was sad because he doesn't like to miss school, he doesn't like it ... He felt sad, a little depressed because he wanted to go to school, but they forbade him to go to school. (Participant #82, mother of a 14 years old male)

At the beginning [I felt] a little, a little down, like sad ... because all of your progress in your studies stops. You were moving forward, and from one moment to another everything ends. You have to stay away from people because you are infectious to others. (Participant #6, 19 years old male)

Physical separation from family members and friends also affected adolescents' moods:

For the first few months I did feel a bit, like, forgotten, closed off ... from my friends ... I was separated [from them]. (Participant #52, 18 years old male)

The most difficult thing for me is to leave my family and feel alone ... and live alone for a while until I recover ... during those days I felt alone, without even a single family member. (Participant #32, 18 years old male)

[She was] different, depressed. My daughter is [usually] very happy ... She was sad, down ... [for] three months she was like this here at home. (Participant #8, mother of a 12 years old female)

Separation from loved ones exacerbated the difficult emotions that some adolescents experienced in reaction to their TB illness. One participant tearfully recounted how being separated from her daughter for months worsened her depression:

I got more depressed ... I lay in bed ... I wanted to tune everything out ... they told me that [TB] could lead to death. Plus, I was not with my daughter. That time was the worst. (Participant #54, 20-year-old female)

Another adolescent wanted to spend time with her friends to feel better. However, her mother enforced home isolation:

She was too sad, too worried. Basically, after taking her pills, she felt down. She wanted to go out to parties ... I didn't let her because she's sick. [I told her,] "You can't go out at night" ... Well, she would tell me, "Mom, but I feel sad". (Participant #76, mother of a 17-year-old female)

Many adolescent boys identified sports as their primary social activity and described feeling at a loss when they had to stop participating in sports during treatment. The combination of home isolation and beliefs about the dangers of exercise during TB treatment led to adolescents' exclusion from sports. One adolescent, who was told by his doctor to stop skateboarding because his lung could rupture if he fell, explained:

I felt bad because [skateboarding] was what I did ... I have been skateboarding for nine years ... my friend also bought himself [a skateboard] and most of us were [skateboarding] from a young age ... Anyway, in other words, that was my life, skateboarding [and] being with my friends ... until I got sick, and I still do not do it [despite having finished treatment]. I have stopped doing so many things ... (Participant #66, 16 years old male)

Finally, prolonged isolation practices stemmed from and reinforced stigma, which is driven in large part by fear of TB transmission. Because of their TB illness, adolescents and their caregivers experienced anticipated stigma (the belief that others will devalue them), enacted stigma (the experience of being devalued by others) and internalised stigma (the absorption of negative messages about oneself). These stigma experiences led to depression and shame and contributed to the emotional trauma of having TB.

Interviewer: Can you describe Miguel's [pseudonym] emotional state when they told him that he had TB?

Participant: Oh, bad, as if he were going to die. He felt horrible because his friends stayed away, my dad and my mom stayed away, my sister-in-law also kept her baby away ... My mom was weak, she had diabetes, and she had gotten sick, and my older brother told Miguel not to get close to my mom because he might give TB to her ... But Miguel, he felt bad, bad, bad. The whole month at the beginning that he found out, he locked himself in his room, he didn't want to go out, he didn't want to take the pill, he said that he wanted to die. (Participant #67, sister of a 16 years old male)

Adolescents received several forms of emotional support during the home isolation period. Many adolescents were consistently encouraged and reassured by family members, and sometimes health providers. Some

adolescents used social media platforms to stay connected with friends, as well as video and phone calls with family members.

Most adolescents reported improvement in their mood when they were released from home isolation, returned to school and began spending time with family and friends.

Interviewer: [How did you feel] when you isolated yourself from your friends?

Participant: Actually, it did shock me a lot, because that's when I went into depression, I felt a little sadder ...

Interviewer: And how would you describe yourself now?

Participant: Like before, before everything happened, I've gone back to being as cheerful as I was before. (Participant #38, 19 years old male)

DISCUSSION

In this study, we observed that adolescents with drug-susceptible TB were routinely instructed to isolate at home for 1–2 months at the start of treatment. The only policy that explicitly defines the isolation period is limited to school attendance; yet, in practice, health providers extended this restriction to all activities outside the home (other than attending medical appointments). As a result of prolonged isolation, adolescents suffered detrimental effects to their education and mental health.

During adolescence, interactions with the social environment shape the development of cognitive, social and emotional capabilities that serve as the foundation for well-being in adulthood.^{7 20} Our findings suggest several pathways by which prolonged isolation undermines adolescents' ability to thrive and reach their full potential (figure 2).

First, prolonged isolation disrupts education. Of 28 adolescents in our study who were in school or vocational/military training at the time of TB treatment initiation, six still had not resumed their programme more than 6 months after isolation ended. The adolescents in our study experienced educational setbacks despite a national policy that directs schools to support students on TB treatment so that these students do not have to repeat the semester or academic year.¹⁹ The reasons underlying this disconnect between policy and reality were not explored in our interviews; however, schools may lack the resources to help students make up 1–2 months' worth of lessons. Our findings are similar to observations from other settings. According to cost surveys administered by the WHO to families affected by TB in 10 countries, 18.7% (95% CI 8.8% to 28.7%) of households with an adolescent with TB reported educational disruptions.²¹ In South Africa, China, Ukraine and India, adolescents whose schooling was disrupted because of TB reported learning difficulties on resuming classes, anxiety about their academic and professional futures, and altered

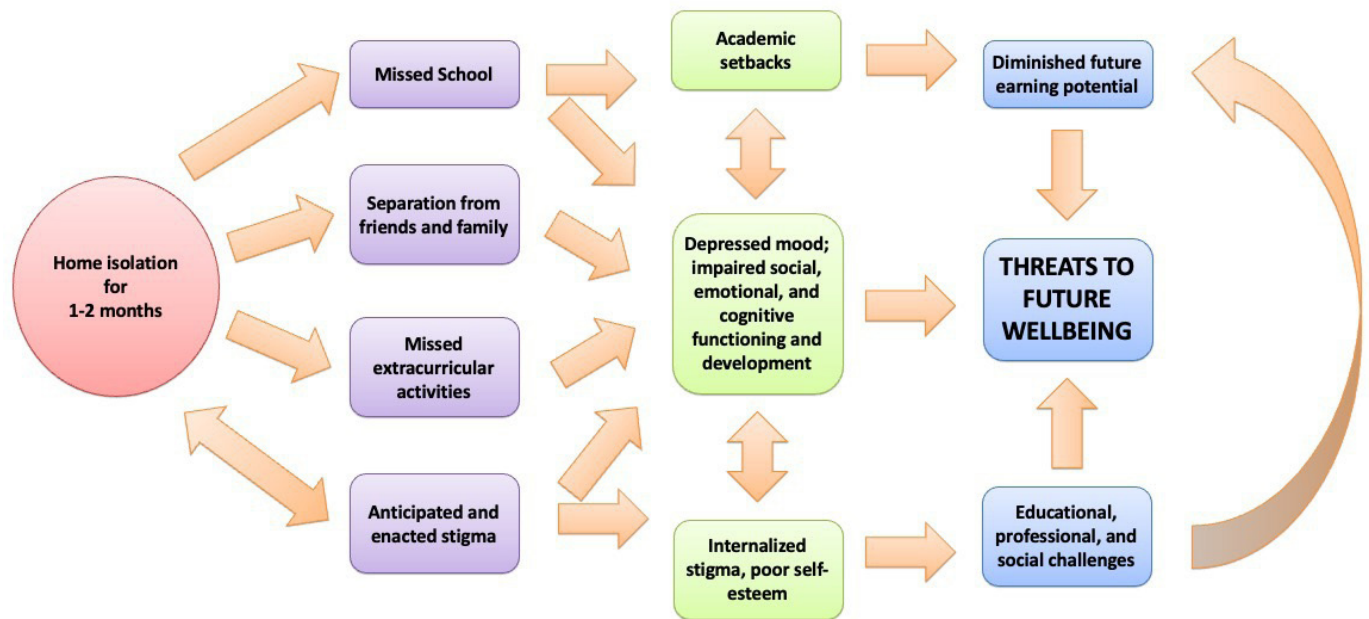


Figure 2 Pathways between prolonged home isolation and threats to adolescents' future well-being.

career trajectories.^{5 22–24} Educational setbacks impede adolescents' ability to transition into the workforce. Because adolescents with TB tend to come from families with fewer socioeconomic resources, educational attainment may be even more crucial for securing future earning potential.

Second, prolonged isolation may interfere with adolescents' social and cognitive development. Adolescents' frequent peer interactions, which are often facilitated through school, support the development of self-identity, empathy and the skills to understand and navigate social situations.^{4 7 25} Moreover, social deprivation during adolescence may result in increased aggression and diminished performance on tasks that require learning and attention.^{7 26}

Third, poor mental health in adolescence may extend to adulthood, impairing physical and psychosocial well-being and limiting professional and personal opportunities.²⁷ Positive interpersonal relationships and participation in school and other group activities are associated with improved adolescent mental health.^{27 28} In contrast, in our study, adolescents who were physically isolated because they had TB—and thus excluded from school and other activities—experienced loneliness and depression. These findings are similar to those of other qualitative studies of children and adolescents with TB in South Africa, Russia, Ukraine, and India.^{4 5 22 24}

Fourth, stigma arising from fear of TB transmission underlies prolonged isolation practices, which, in turn, reinforce stigma against patients with TB. Among our participants, being subjected to TB-related discrimination exacerbated the emotional trauma of the illness. As shown in other qualitative studies of children and adolescents with TB, adolescents are particularly vulnerable to internalised stigma, which may lead to low self-esteem

and its sequelae, including psychological, educational, professional, and social challenges.^{22 24 29}

Although quantitative studies would be helpful to further characterise the short-term and long-term sequelae of prolonged isolation on adolescents with TB, the data from this and other studies—which have been conducted in diverse settings—consistently demonstrate the harms of this practice. Furthermore, prolonged isolation in this context is problematic from a human rights perspective, as it violates adolescents' rights to education and to freedom of movement.^{30–32} While governments may limit certain rights for the benefit of public health, these limitations must be based on objective grounds and must not be arbitrary.³³ Yet, the prolonged isolation imposed on adolescents in Peru and other settings do not align with scientific evidence on TB transmission. The US Centers for Disease Control and Prevention, Infectious Diseases Society of America and American Thoracic Society all have adopted the 'two week rule', which considers transmission risk to be eliminated once patients have received adequate treatment for 2 weeks, have demonstrated clinical improvement, and have a negligible risk of MDR-TB.³⁴ The 'two week rule' was derived from expert consensus, though some experts, citing multiple human-to-guinea pig transmission studies, believe that just a few days of effective treatment are sufficient for minimising transmission risk in most cases.³⁵ Moreover, once patients are on effective treatment, sputum smear positivity no longer predicts infectivity.³⁴

To optimise the well-being of adolescents with TB, MOHs must ensure that their TB isolation guidelines are clear, non-arbitrary and in alignment with both existing evidence on disease transmission and the principles of patient-centred care, the latter of which is central to the WHO's End TB Strategy and 'involves systematically

assessing and addressing the needs of patients'.³⁶ In most cases, the isolation period can be safely shortened to 2 weeks, as long as the aforementioned conditions are met.³⁴ While some providers cite the need to rest or adapt to adverse treatment events as rationalisations for prolonged isolation, these reasons are not evidence-based, and providers should evaluate the needs and preferences of adolescents and their caregivers before using these arguments to justify prolonged isolation.

In parallel, adolescents should receive other forms of social support to minimise the harms of isolation. In Russia, adolescents who were hospitalised for TB developed friendships with each other, and this mutual acceptance and understanding helped them feel better about themselves and feel part of a community, despite being separated from their friends and family. Positive relationships with caregivers, and healthcare providers also mitigated the negative impacts of TB-related isolation on adolescent well-being.⁴ Similarly, when asked for recommendations for developing patient-centred care, adolescents with TB in India and their caregivers recommended peer support platforms and outreach to reduce stigma and discrimination within families and communities.²⁴

This study has limitations. Because the primary objective of this study was to identify barriers to treatment adherence, the interview guide did not focus specifically on isolation, so we may not have captured all impacts of prolonged isolation and may not have reached data saturation with respect to this topic. Most adolescent participants were male and older. Although this distribution reflects the higher incidence of TB in this subgroup, the experiences of younger and/or female adolescents may not be fully represented in our dataset. There may have been selection bias, as adolescents who declined to participate or were otherwise unable to be enrolled may have had different experiences than those who participated in the study. Like all qualitative studies that use non-probabilistic sampling, our findings may have limited generalisability to other populations and settings. Nevertheless, the overarching themes that emerged in our study—about the negative impacts of prolonged isolation on adolescents' academic progress and mental health during the treatment and immediate post-treatment periods—align with those of studies from several other diverse settings.^{4 5 21–24} Finally, our study did not include adolescents with drug-resistant TB, who may experience longer isolation periods and, thus, more disruptions to their education and mental health.

CONCLUSIONS

In this study, we observed that adolescents with TB who isolated at home for 1–2 months suffered detrimental educational and mental health consequences. To support the well-being of adolescents with TB, MOHs need to re-evaluate their isolation recommendations and align them with data supporting rapid cessation of

transmissibility after initiation of adequate treatment, as well as the principles of patient-centred care.

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Contributors SSC, LL and JTG designed the study. EA, LS and MW collected the data. SSC, VEOR, CBB, JC and SDR conducted the analyses. All authors interpreted the data and critically reviewed the manuscript. All authors approved the final draft for submission. SSC accepts full responsibility for the work and the conduct of the study; had access to the data; and controlled the decision to publish.

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Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by institutional review boards (IRBs) of Peru's National Institute of Health (OEE-001-18) and Rhode Island Hospital (1122843) approved this study. Written informed consent was obtained from participants 18 years of age and older and the parent or legal guardian of minors. Assent was obtained from participants younger than 18 years.

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