



GAY COMMUNITY TO TEST HIV PREVENTION PILL



The local principal investigator of the PreP study, Professor Linda-Gail Bekker.

The recruiting of 200 HIV-negative Capetonian men who have sex with men (MSM) has begun for a (unique in Africa) clinical trial of a once-daily pre-exposure prophylactic ARV pill.

The 'proof of concept' study which kicked off locally in August this year, is part of a 2-year global study of 3 000 high-risk volunteers that hopes to add the 'HIV prevention pill' as a potent weapon to the woefully inadequate traditional prevention arsenal. The multicentre international study has already commenced in South and North America.

Actuarial figures suggest six new infections for every person started on therapy.

There were an estimated 4.3 million new HIV infections world-wide last year, more than half of which were in sub-Saharan Africa. Some 700 000 people around the globe were started on ART in 2006, an estimated 28% of those in need. Actuarial figures suggest six new infections for every person started on therapy.

The scientists involved in the latest protective measure, operating under the Desmond Tutu HIV Foundation (DTHF) and based at the University of Cape Town, said all volunteers will get extensive safer sex counselling and condoms plus monthly testing for HIV and any other STIs.

The local principal investigator, Professor Linda-Gail Bekker, produced data countering contentions that the trial would encourage further risky sexual behaviour in a group who have an already increased risk of HIV transmission. Speaking at the 22 July study launch, she said most studies so far revealed a decline in high-risk sexual acts following the safer sex counselling and condom use promotion that have accompanied HIV vaccine and post-exposure prophylaxis trials.

More sex, fewer partners...

The only existing PreExposure (PreP) prophylactic trial completed (tenofovir only), of 936 high-risk women in West Africa, shows that the reported mean number of sex acts increased, but the reported number of partners decreased. Condom use increased.

The pilot study (in Cameroon, Ghana and Nigeria) showed a 'trend towards efficacy' but study was under-powered to show significant efficacy.

There were two seroconversions among those using the drug and six among those using the placebo. The two cases occurring in participants who received the drug occurred early in the study and it could not be shown whether infection occurred prior to the study's commencement. There was 'no single *bona fide* case of PreP failure' nor any significant toxicity concerns.

Bekker likened the strategy to oral contraception or malarial prophylaxis. 'By making the pill a daily routine, it becomes unlinked to sex and doesn't require a conscious action to access the treatment after a risky encounter in the

The only existing PreExposure (PreP) prophylactic trial completed (tenofovir only), of 936 high-risk women in West Africa, shows that the reported mean number of sex acts increased, but the reported number of partners decreased. Condom use increased.

way that POST-exposure prophylaxis would,' she said. She also stressed that the key to reducing the risk of sexual disinhibition is participant education and continual counselling. Participants would be constantly reminded that neither the study staff nor the volunteers would know who was receiving the drug and who was receiving the placebo and that the strategy is experimental with, as yet, no proven efficacy.

Any volunteer who became HIV positive would be counselled and managed, which would include including referral for ART when appropriate.

Success in Macaque monkeys

The study drug is Truvada, a mixture of tenofovir (TDF), and emtricitabine (FTC), a combination which has been shown to be 100% protective after repeated rectal exposures to HIV in Macaque monkeys. Both show high concentrations in genital tissues and fluids and, importantly, a long intracellular half-life.

Preliminary studies carried out by Bekker and Programmes Manager of the Mother City Men's Health Project, Earl Burrell, indicate the prevalence of HIV infection in a venue-based study among MSM to be 10% in Cape Town and its suburbs and up to 35% in the townships.

Burrell said one 'surprising' figure to emerge was that in the overall 34.3%



HIV-positive figure among the MSMs tested (HIV prevalence among the general local population is 25%) a full 31.5% were unaware of their status. Just over half of the MSMs surveyed 'always' used condoms, 43.1% were jobless, 26.4% used lubricating gel with condoms and 31.5% had STIs.

The study, done earlier this year, canvassed 542 'self-identified' MSMs at 16 'gay-friendly' venues across the Cape Peninsula. Of these, 57.5% reported unprotected anal intercourse in the previous 12 months with a mean of 2.9 partners and 7.3% reported participating in commercial sex work.

The researchers said this study underscored the need to focus again on the MSM population in Cape Town, a sector largely forgotten since the 1980s. Burrell said the UNAIDS 2006 report suggested that MSMs, prisoners, sex workers and intravenous drug users were among the most vulnerable at-risk populations, and yet had received only a small proportion of prevention efforts in the global fight against HIV/AIDS.

'In Cape Town it's time to recognise that we have multiple vulnerable groups,' he added.

'Complex ethical/moral debate urgently needed'

Dr Francois Venter, President of the SA HIV Clinicians Society, said there were 'precious few interventions that work... we need to explore every one of them'.

However, he added that 'there are complex operation ethical and moral debates that need to occur around

PrEP before it becomes a public health intervention – and these need to be had urgently'.

Bekker concurs: 'The research must happen – we need to know what works, but there is no doubt that it must be stressed this is experimental and we are a long way from any hint of implementation.'

'There are complex operation ethical and moral debates that need to occur around PrEP before it becomes a public health intervention – and these need to be had urgently'.

Burrell said the Medicines Control Council had approved the first version of the MSM trial while a ruling on the most recent amendment of the trial protocol was 'imminent'. No work would begin until all ethical and regulatory approvals were complete. In order to be eligible volunteers have to be born male, willing and able to provide written informed consent, be 18 years or older, HIV-1 uninfected and have taken part in any one of six high-risk behaviours to qualify. These are: (i) no condom use during intercourse with an HIV-positive male partner or (ii) male partner of unknown HIV status during the last 6 months; (iii) anal intercourse with more than 5 male sex partners during the last 6 months; (iv) exchange money, gifts, shelter or drugs for anal sex with a male partner

during the last 6 months; (v) sex with a male partner and STI diagnosis during the last 6 months or at screening; and (vi) sexual partner of an HIV-infected man with whom condoms are not consistently used.

Other criteria include being able to provide a street address of residence for themselves or one personal contact and the ability to understand and speak English, Xhosa or Afrikaans.

Trial 'fully inclusive'

Bekker said consultation with and the participation of local affected communities were a cornerstone in developing the Cape Town PrEP study. A community advisory board consisting of leaders of HIV/AIDS service organisations, lesbian, gay, bi-sexual and transvestite (LGBT) community activists and members of the at-risk community helped develop the study design, the informed consent process and recruitment strategies as well as educate the community about the trial.

Twice weekly 'open house' sessions were being held at the medical school to explain the study. The trial is sponsored by the National Institute of Health with the Bill and Melinda Gates Foundation. The other study sites are in Brazil, Ecuador, Peru, Thailand and the USA.

Bekker said the final outcome would be 2 years after the last study participant is enrolled but 'we want a result by the end of 2010'.

Chris Bateman

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SLOW PROGRESS IN DOCTOR PLACEMENT KICKBACK PROBE



Foreign qualified doctors queue up at the Health Department's Foreign Workforce Management Programme offices in Pretoria in 2006.

An investigator from the police's organised crime branch in Pretoria was last month scouring three provinces, tracing payments allegedly made to a health department deputy director by foreign doctors desperate for hospital placements.

The national health department's director of Labour Relations, Advocate Thomas Ngake, claimed the probe involved 'a web' connecting Home Affairs, the Health Professions Council and his own Foreign Workforce Management Programme (FWMP). He confirmed that the chief suspect was in mid-July being grilled at a separate in-camera internal disciplinary hearing

following a forensic probe 'dating back over several years,' adding that a second suspect, a security officer, was also involved.

Izindaba put it to Ngake that investigators might struggle because they had less knowledge about the systems and procedures than their chief suspect (known to *Izindaba*), a pivotal player and acknowledged expert with strong institutional memory. While admitting that 'the intricacies of this case are very challenging', he said he believed his department had 'done enough', and said: 'I can indicate that we're making quite a good impact in terms of the processes. There's no

reason for us to worry about our ability to make inroads on this. We have substantial evidence so far,' he asserted.

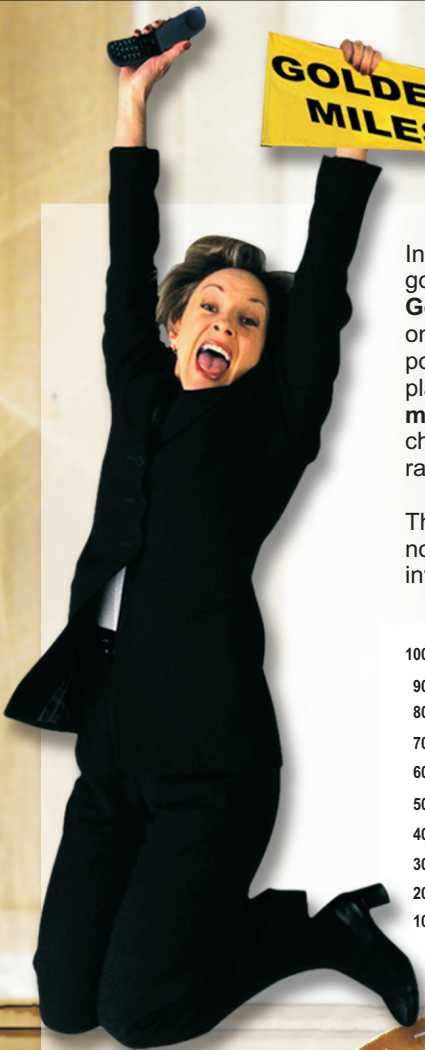
Ironically, the deputy director being investigated is highly regarded by private recruiters, one of whom summed up industry sentiment by calling him 'an angel who cuts red tape and makes things happen in a bureaucracy otherwise gone dilly'. The scandal has shocked this small, tightly knit recruitment community that daily struggles to overcome procedural hurdles to address the growing public sector health care staffing crisis, now aggravated by the capacity implications of the probe.

An award-winning 2006 *Izindaba* feature story¹ predicted a rural health care delivery crisis this year and exposed a short-staffed and overworked staff cadre at the FWMP's Pretoria headquarters, where a handful of staff try to help hospital managements desperate for doctors.

The doctor shortage crisis has hit rural hospitals hardest this year because of the new 2-year internship training having reduced available community service conscripts by 78%. Any further bottlenecks in processing legitimate foreign doctor applications, the other mainstay of public sector rural hospital staffing, will deeply aggravate matters.

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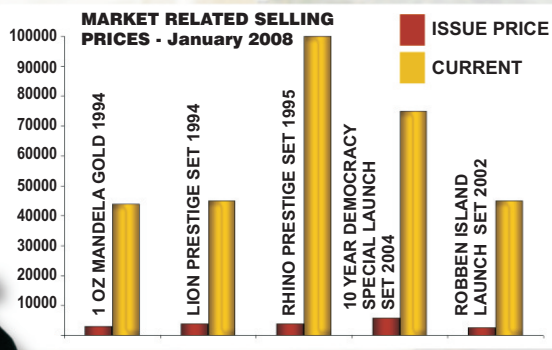


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Disciplinary hearing well underway

Izindaba learnt that there had already been several days of the internal disciplinary hearing by late July when Pretoria's Organised Crime Unit was due to dispatch the investigating officer to Cape Town, the Eastern Cape and Free State to follow leads. At least one foreign doctor allegedly wrote out a cheque for R1 000 to the deputy director, 'plus other amounts before that', while providing 'gifts like wrist watches and cell phones', *Izindaba* was told by organised crime unit sources.

South Africa's painfully slow placement procedures (and this includes the SA Nursing Council) have resulted in substantial losses of foreign doctors and nurses keen to work in rural areas, where the doctor-to-patient ratio can be as low as 3 to 100 000.

The probe reportedly began when a foreign doctor, angered at not getting the post he claimed he was promised for bribes allegedly paid, reported the deputy director to a senior official in his department. At the time of writing no charges were imminent, but the investigating officer said he would be handing evidence over to the Directorate of Public Prosecutions 'for a decision'.

A spokesman for the Department of Health, Ms Charity Bhengu, said: 'The department is not in a position to comment, the hearing is still ongoing'. In May this year a health department spokesman, Sibani Mngadi, told *Izindaba* that the suspect was suspended on full pay early in April. He was unable to say how many posts were allegedly fraudulently allocated. 'We're looking at registration and allocation, the HPCSA is looking at their side of the issue to see if they went through the registration process correctly and we've asked Home Affairs to look at the migration

status of the doctors, plus those normally accredited to practise locally as part of their study requirements,' he said.

Corrupt precedents

Just over 3 years ago an HPCSA official responsible for registering foreign qualified doctors was convicted of fraud for accepting cash for improper registrations. According to HPCSA spokesman Tendai Dliwayo 'about 11' foreign doctors were immediately struck off the roll as a result.

Around 15% of doctors currently working in South Africa are foreign qualified, many of them working in terms of unwieldy country-to-country agreements. The global average of foreign qualified doctors in developed countries is around 25%. South Africa's human resource plan has set a target of 5% while the country stubbornly maintains a policy of not employing foreign qualified doctors from other African countries, despite the fact that they are already here, some working as car guards.

Health department director general Thami Mseleku told Durban's July tuberculosis conference during an open floor debate that the health ministers from the DRC and Zambia were 'begging him' to send their doctors home and not to employ them. 'What must I do? How can we tell the UK not to recruit our doctors if we do the same?' he asked.

South Africa's painfully slow placement procedures (and this includes the SA Nursing Council) have resulted in substantial losses of foreign doctors and nurses keen to work in rural areas, where the doctor-to-patient ratio can be as low as 3 to 100 000. This is compared with ratios of 15 to 100 000 in our public sector urban institutions. The USA has 550 doctors for every 100 000 patients.

One nurse's story epitomises experiences

The local job placement challenges are epitomised by a story related by

a frustrated Canadian management consultant, Andrew Fulton, who is considering packing up his successful business in Cape Town. His wife, Jenna Sue, a cardiothoracic specialist nurse, returned to re-occupy her well-paid job at a top Manhattan hospital last month after 2 fruitless years of applications to the SA Nursing Council.

Jenna Sue Fulton has a Bachelor's degree in nursing science and more than 3 years' experience as a senior staff nurse in the Cardiothoracic Critical Care Telemetry Unit at New York-Presbyterian Hospital. While there she developed a quality assurance programme designed to educate and train nursing staff on the management of sexual assault clients in the emergency department – something that would hardly go amiss in this country's health system.

'It boiled down to an argument with the nursing council official – after we secured the qualifications authority and FWMP approval, who took issue with faxed course descriptions after original transcripts of her university qualifications were rejected as unacceptable', Andrew Fulton said. When his wife queried why she could not 'simply write the exam' she was told that her papers first had to be in order.

Current Nursing Council practice is to authenticate foreign qualifications before the compulsory appropriate ethos and professional practice exam for auxiliary, enrolled or registered nurse is written.

Born of South African parents and thus a full SA citizen, Fulton said he was becoming disillusioned and seriously considering closing his strategy consulting business that employed eight South Africans, and returning to New York 'There's enough going on with crime, corruption and everything else I read about for this event to just tip the scales for me', he said.

When told of the FWMP probe, he immediately responded: 'The guy

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they're probing was the only ray of sunshine for us in the entire 2 years. He was really helpful and took great trouble. I'm amazed. There was no hint of funny business with us.'

Figures from the South African Health Review reveal that 82% of South African citizens rely on the public health sector. Only 27% of general practitioners opt to work for the State. There are currently more South African qualified doctors working abroad than in the local public sector. An *Izindaba* probe in January 2007² revealed that in 2006, eight times as many South African nurses were apparently leaving the

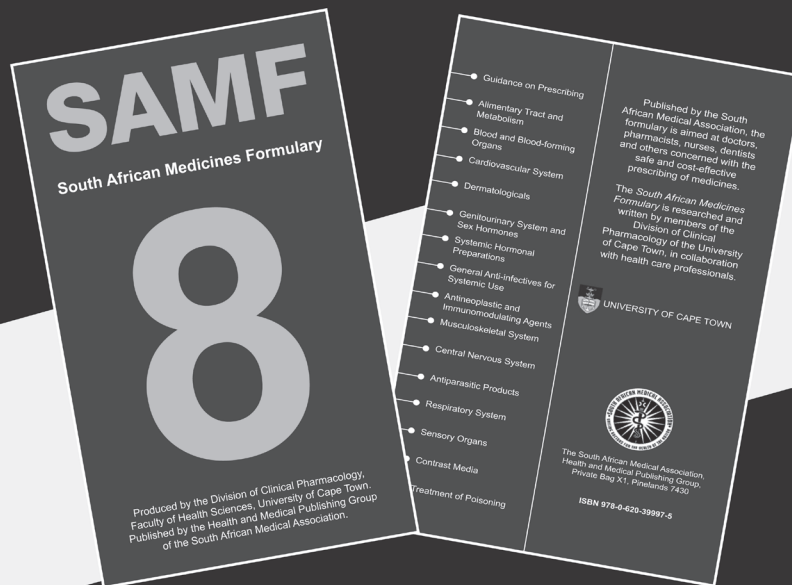
An Izindaba probe in January 2007 revealed that in 2006, eight times as many South African nurses were apparently leaving the country as there were foreign qualified nurses being registered to practise here.

country as there were foreign qualified nurses being registered to practise here. The numbers of foreign qualified nurses registered to practise here dropped steadily from 137 in 2004 to 104 in 2005 to just 78 in 2006.

No response was received to an e-mail requesting the responsible SA Nursing Council official to update these figures. The e-mail, which the SA Nursing Council acknowledged, was sent more than a fortnight before the SAMJ deadline.

Chris Bateman

1. Bateman C. Rural health care delivery set to collapse, *S Afr Med J* 2008; 96: 1219-1226.
2. Bateman C. Foreign nurses 'trickle in' – eight times slower than locals leaving, *S Afr Med J* 2007; 97: 82-85.



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RUNAWAY TB EPIDEMIC – CAN WE CATCH UP?



Professor Anton Stoltz, chief of the Foundation for Professional Development's (FPD) Infectious Diseases Unit and founder of the equivalent facility at Pretoria Academic Hospital.

South Africa is doing 'some things right' in combatting a runaway TB epidemic that may be 10 times greater than government estimates, but dismal infection control at health care facilities and inadequate basic directly observed treatment short-course strategy (DOTS) need emergency attention.

This was the warning sounded by Professor Anton Stoltz, chief of the Foundation for Professional Development's (FPD) Infectious Diseases Unit and founder of the equivalent facility at Pretoria Academic Hospital.

Addressing the opening session of the country's first TB conference in Durban in July, Stoltz said the impression he got from feedback received from FPD mentors sent to 37 government facilities was that there 'is virtually no infection control'.

'It seems that there's no proper infection control anywhere. It's a real problem. We don't have places that have negative pressure that you can put the patient in. It's blowing all over the hospital. We're sitting on a time bomb. If health care workers start getting ill from MDR, as some are, what are we going to do, given our human resources situation?' he asked.

The FPD allocates one or two doctors plus a data capturer and mentor to each of the 37 government HIV and/or TB clinics and hospitals, so Stoltz, who pores over their detailed reports, is not grasping his claims out of thin air, so to speak.

Scary number crunching

In an interview with *Izindaba* after the TB conference, Stoltz anxiously queried the official government TB statistics of 7 000 MDR TB sufferers, saying the World Health Organization (WHO) TB Partnership put this at 10 000.

'But what worries me far more is this global study that shows that 20% of all TB going into the labs is now MDR. If you do your arithmetic based on 1 in every 100 South Africans having TB, that's 90 000 MDR patients, over 10 times the official estimate!'

Stoltz emphasised that 'we just don't know the figures, but only certain people are being tested for MDR and XDR, so we're missing a huge number of these folk walking among us. That's very frightening to me'.

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South Africa was spending generously on its TB control programme with 70% of the budget going to MDR and XDR TB. However, only around 20% of the budget was being dedicated to the DOTS, aimed at ensuring that people with TB complete their treatment, thus reducing the chances of developing MDR TB.

It cost around R377 to treat (and cure) TB, compared with around R50 000 to cure MDR TB, if the patient survives.

A potent contributor to the high costs of treating TB is the difficulty in diagnosing it in people infected with HIV. 'We struggle to find TB in people with HIV and it's expensive,' Stoltz said.

South Africa's TB cure rate stands at about 57%. This would have to be improved 'dramatically' if the country wanted to make any meaningful impact on the epidemic.

Stoltz identified three priorities: increase the basic TB cure rate, rethink the DOTS strategy and dramatically increase infection control. He said that on the government's own admission there are no data on 27% of people who go through its TB clinics. 'They could be dead, cured or defaulting, but they could also have MDR TB!' he warned.

Monitoring and evaluation needed urgent improvement.

'Get the basics right'

'If I could send out one message it would be prevent, prevent and prevent ordinary TB. Then you don't have to spend so much money on MDR/XDR'.

He highlighted a recent probe by the Medical Research Council (MRC) into the main reasons people defaulted on their TB treatment which cited the attitude of health care workers. Patients were reluctant to return to the clinic and face widespread demeaning and/or dismissive attitudes.



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Stoltz also recommended staggering clinic appointment times and improving 'down referrals' to avoid scores or hundreds of people sitting and standing around all day in often dark, unventilated waiting areas.

'We have over six million HIV-positive people – so we initiate treatment and within a month the person is back, adding to the others there for the first time. All our clinics just overflow, get clogged.'

'We have limitless resources of wind and sunshine in this country, I really don't understand why we're not using them,' he said.

Another largely underreported phenomenon impacting on DOTS and DOTS-plus was the large population of patients with HIV dementia which resulted in them simply not taking their pills.

What Government is doing right...

Some of the things the government was doing right included working with all medical schools to put final-year students into clinics to mitigate the staffing crisis, giving the FPD about R15 million over the past 18 months to educate TB, STI and ART clinic workers and committing to making the new rapid test for MDR TB available within the next few months. The WHO-approved test will enable laboratories to diagnose MDR TB within a day, and not the 2 - 3 months as was the case previously.

South Africa's top researchers, policy makers, managers and providers have meanwhile released the outcome of a round-table discussion last year where they grappled with ARV access and the health system's capacity to cope with burgeoning demand.

The report, authored by Helen Schneider, Dingie van Rensburg

and David Coetzee, contains the key findings and policy recommendations from the meeting which they hope will feed into the country's National Strategic Plan. One of the main insights was that most of the existing programmes are still to a large extent doctor and pharmacy dependent.

Participants felt strongly that integrating ART with HIV-related primary health care services, particularly with TB, the prevention of mother-to-child transmission and maternal and child health services within a district health system, remains critical.

Most of the existing programmes are still to a large extent doctor and pharmacy dependent.

Stoltz said he understood the necessity for streamlining HIV and TB treatment on the grounds of efficacy but unless a grip was obtained on infection control, putting patients suffering from both diseases in one room was 'asking for trouble'.

Nine key lessons

In summary, nine key overall lessons and recommendations for policy arose from evidence presented at last year's think-tank:

1. Shift the focus of ART implementation from ART sites to district/sub-district-based approaches.
2. Mobilise and strengthen the existing PHC system by reviewing the composition, staffing and support systems of PHC teams.
3. Integrate HIV and TB care, and provide both as one service within PHC settings.

4. Focus on PMTCT, and integrate the programme into the treatment of children and pregnant women.
5. Address loss to follow-up by introducing services more widely spread across the system and by strengthening systems for tracing dropouts.
6. Build trust in the public health system, by seeing the system from the household and patient's perspective so as to better understand barriers to use of services.
7. Simplify and standardise approaches to implementation for patients, programme governors and local providers to promote better access and enhanced quality.
8. Strengthen prevention and the health system response to other diseases and build the PHC and district health system.
9. Improve dialogue among researchers, policy makers and service providers to promote the transfer of lessons, and to harmonise and simplify approaches.

The chair of the Durban TB conference and former head of TB control in the health department, Dr Refiloe Matji, said for too long stakeholders have been working in silos with the impact on the TB epidemic fragmented. 'We need to build one team, follow up with one plan, towards one goal,' he said.

Perhaps the mounting crisis will galvanise role players into transforming think-tanks into battle tanks in a consolidated push to gain ascendancy over the twin epidemics.

Chris Bateman



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ALP-HEALTH DEPT TB SKIRMISH TO BEAR FRUIT?



Mark Heywood (right), chair of the AIDS Law Project with Dr Francois Venter, chairperson of the SA HIV Clinicians Society at the last AIDS conference in Durban.

A heated public spat in the longstanding feud between the national Health Department and the AIDS Law Project (ALP) at the Durban TB conference in July may yet lead to a healthier working tension between government and civil society.

The ALP chief, Treatment Action Campaign (TAC) treasurer and deputy chair of the South African National AIDS Council (SANAC) Mark Heywood, has since accompanied David Mametja, the health department's new (March this year) TB cluster manager on two new MDR/XDR TB site inspections. This followed a heated invitation made at the Durban TB conference.

Built with the first R400 million budgeted exclusively for TB drug-resistant patients last year (this year's budget is R289 million, rising to an expected R940 million next year), the sites are among the first three due to come on line in Kimberley, Klerksdorp and Fort Grey near East London. They will feature exclusive facilities for MDR and XDR patients, UV lights, extractor fans and open recreational spaces

'to make life as normal as possible for patients', says Mametja. He says Heywood taking him up on his offer and joining him on visits to Klerksdorp and Kimberley was 'a sign that the ground is fertile for fruit to come out'.

The ALP has been at the forefront of speeding up the government's rollout of ART and prevention of mother-to-child HIV transmission drug therapy, successfully using the courts or the threat of court action to enable public access to proven therapy over the last decade. These bruising encounters have alienated top state officials with a low-scale 'war' involving Western versus traditional medicine constantly in the news.

Mametja confessed to *Izindaba* that Heywood's public skewering of government at the Durban July conference and constant references to 'negligence and the government killing people' became a 'bit rich' for his blood. He devoted an entire conference plenary report-back to rebutting Heywood, ignoring conference protocol and outraging ALP-aligned delegates.

Mametja co-chaired the TB conference track on 'Patient and Civil Society' and said Heywood had the previous day 'gone to town outlining a non-caring attitude by the department, leading to lives being lost due to negligence and all sorts of things. Our DG (Thami Mseleku) tried to respond off the floor and it got quite heated. My difficulty was: do we let that go or find a way to respond to it? What fuelled my unhappiness was that in November last year they (the ALP/TAC) helped us put together the very strategic TB plan that Heywood was vilifying'.

Heywood accused government of allowing the TB epidemic to grow at a staggering rate while 'squabbling over human rights and other issues around HIV', citing statistics dating back to 1999 to illustrate how TB had burgeoned. He spoke of 'frank discussions' with former Health Director General Dr Ayanda Ntsaluba and former HIV/AIDS Directorate Chief Dr Nono Simelela as far back as 2002 when they 'admitted MDR TB was tipping to epidemic proportions'.

The ALP and TAC condemned Mametja's 'abuse' of his conference track chairmanship and accepted protocol. They described his behaviour as 'contemptuous of all those who presented and participated in the track'.

We acknowledge there are huge challenges, but we're not sitting here doing nothing. The TB caseload has dropped from 340 000 in 2006 to 333 000 last year and the defaulter rate has come down. We've also brought in the TB rapid diagnostic tools (3 - 7 days)...,' he added.



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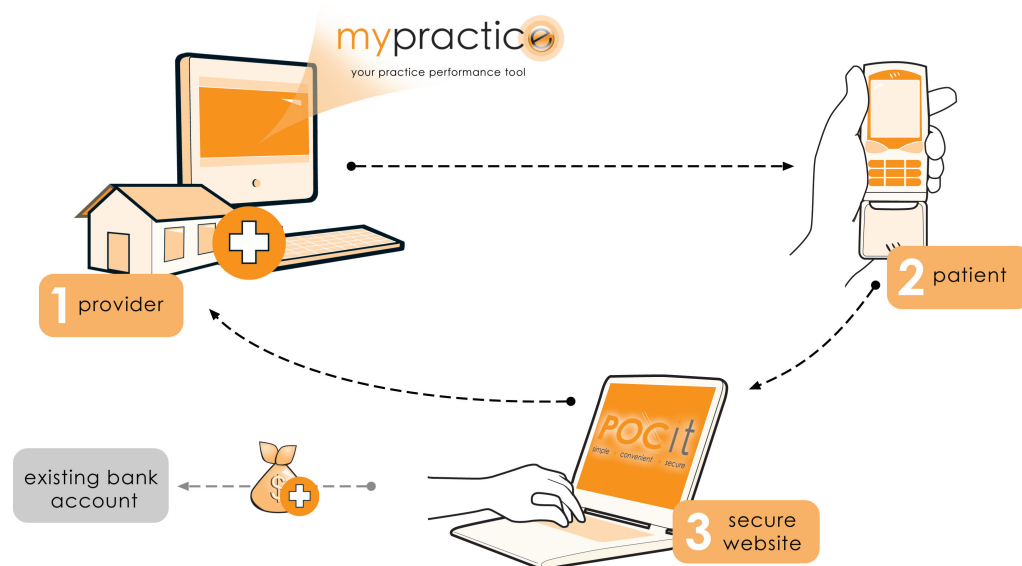
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Mametja's enthusiasm in taking to the trenches in his new job led to him inviting Heywood to join the health department on an inspection of multidrug-resistant sites in KwaZulu-Natal, which was immediately accepted, albeit conditionally.

Into the fray...

Mametja's enthusiasm in taking to the trenches in his new job led to him inviting Heywood to join the health department on an inspection of multidrug-resistant sites in KwaZulu-Natal, which was immediately accepted, albeit conditionally.

The ALP wanted a national inspection of MDR TB hospitals, linked to a departmental commitment to finalise a 'clear national policy on MDR/XDR isolation'. This follows ongoing drama at several MDR TB hospitals with patient breakouts, demonstrations and provincially launched public health restraining court orders amid a human rights outcry over inpatient conditions. The latest ruling was by the Cape High Court (29 July), which ordered the legal detention of two Brooklyn Chest Hospital XDR patients until their sputum tests negative for 3 consecutive months.

The ALP called for the immediate rectification of all deficiencies identified at the MDR/XDR sites and the finalisation of regulations that allow for isolation of drug-resistant TB patients 'based on principles of justice and fairness'. This last topic drew heated debate when Mseleku confronted Heywood from the conference floor, accusing him of 'changing the words of an old HIV presentation'.

To howls from delegates, Mseleku claimed 'human rights do not work in reality', and that his department had 'mulled over' the decision to isolate drug-resistant patients.

He said human rights were not relevant to considerations of health policy in a developmental state. 'These are yesterday's debates', Mseleku added.

Heywood responded that while Mseleku conceded that the State's TB response was 'not without serious problems', his primary responsibility remained to the Constitution and not the Minister of Health.

In an obvious reference to imminent political regime change and amid raucous applause, Heywood said Mseleku held a position, 'on which millions of lives depend...I hope the next DG and the next government will be more humane in its approach to health in this country'.

Heywood earlier shared letters sent to him in his capacity as SANAC deputy chairperson in which health workers spoke of their frustration and anger at the lack of action on the part of government, despite several attempts to put the high incidence of TB in their communities on official agendas.

Constructive complaints led to witch-hunts

One wrote: 'If I report problems to the Department of Health, even in a constructive way, the whole thing turns into a witch-hunt and achieves nothing positive.'

On the controversial government MDR TB incarceration, Heywood asked why patients 'feel the need to escape from a hospital'. 'Why are there barbed wire and guards? We need to ask whether we are limiting human rights in a way which is dignified, as there is no legal basis for incarceration.'

He also highlighted the high levels of TB and MDR TB infection in workers at health facilities, questioning government commitment to infection control, which he said needed to be addressed as an emergency measure.

Speaking to *Izindaba* after the conference, Mametja said his first move

upon being appointed to the job was to hold a series of consultative workshops about the 'role clarification of various stakeholders' (April) – which the ALP/TAC spurned. 'For all of that to have happened and for Mark to have the audacity to stand up and accuse us of inaction, was a little too much for me. We acknowledge there are huge challenges, but we're not sitting here doing nothing. The TB caseload has dropped from 340 000 in 2006 to 333 000 last year and the defaulter rate has come down. We've also brought in the TB rapid diagnostic tools (3 - 7 days)...', he added.

Since Heywood's tour with him of two of the budding MDR facilities, Mametja has obviously mellowed. 'We left there recognising that we don't have to turn TB into an area of conflict and tension in the same way that happened for HIV/AIDS. We're open and transparent and willing to acknowledge our limitations. We want to work with others,' he added.

To howls from delegates, Mseleku claimed 'human rights do not work in reality', and that his department had 'mulled over' the decision to isolate drug-resistant patients.

Nobody was asking the ALP/TAC to shed their independence; civil society organisations that spoke independently were crucial, 'but they must be informed by the realities on the ground'. He said nobody had expected to be dealing with a TB epidemic 'of this scale', using an apartheid-era architectural infrastructure that made infection control a nightmare.

He described his approach as 'responding to an emergency', and cited the Fort Grey Hospital near East London as a model new design with bungalows housing four patients each. The CSIR was developing infection control standards and making



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facility design input for the hospital revitalisation programme and the new XDR/MDR wards.

Outside view

In a recent contribution to a global TB cyber forum, Dr Richard Coker, author of *From Chaos to Coercion: Detention and the Control of Tuberculosis*, said he was 'intrigued by the discussions that surround the use of coercive

He said nobody had expected to be dealing with a TB epidemic 'of this scale', using an apartheid-era architectural infrastructure that made infection control a nightmare.

interventions in communicable diseases'.

'The discourse seems to assume an emotional intensity that encourages polemic and positions grounded in the battlefield of personal-public rights and duties'. In his book, based on an examination of New York City's introduction of compulsory isolation of patients during that city's MDR TB epidemic in the late 1980s/early 1990s, Coker concludes that, when it comes to coercive interventions (as opposed to, for example, technological interventions), 'we seem willing to disregard the need to develop an evidence base'.

'And in pursuing coercive policies we may reject or neglect age-old legal traditions that protect some of society's most vulnerable members. The use of

coercion needs to be justified and the burden of justification should reside with the state. Thus an evidence base is required. The Siracusa Principles* demand this'.

Chris Bateman

*A group of 31 experts in international law, convened by the International Commission of Jurists, the International Association of Penal Law, the American Association for the International Commission of Jurists, the Urban Morgan Institute for Human Rights and the International Institute of Higher Studies in Criminal Sciences, met in Siracusa, Sicily, for a week in spring 1984 to consider the limitation and derogation provisions of the International Covenant on Civil and Political Rights. The participants were agreed upon the need for a close examination of the conditions and grounds for permissible limitations and derogations enunciated in the Covenant in order to achieve an effective implementation of the rule of law. As frequently emphasised by the General Assembly of the United Nations, a uniform interpretation of limitations on the rights in the Covenant is of great importance. One of the crucial agreements was that all limitation clauses 'shall be interpreted strictly and in favour of the rights at issue'.