



XDR TB – HUMANE CONFINEMENT ‘A PRIORITY’



An HIV/TB co-infected end-stage patient under hospice care in the Port Shepstone district.

Super-heated by the HIV/AIDS pandemic, South Africa is ‘sitting on a volcano’ of lethal extreme drug-resistant TB infections with the known XDR TB case load having increased by 41% and direct fatalities by 46% between March and August this year.

The fastest escalation is in the Eastern Cape, which ranks second at 105 cases confirmed and 46 dead (increases of 68% and 89% from March).

The latest national and provincial figures were given to *Izindaba* by national TB chief, Dr Lindiwe Mvusi in mid-September when human rights issues among drug-resistant patients came sharply to the fore amid several XDR patient ‘escapes’ from hospitals.

She and Professor Ames Dhai, Director of the Steve Biko Centre for Bioethics at the University of the Witwatersrand, said that while greater

awareness and better reporting probably contributed to the prevalence spike, it remained ‘deeply worrying’.

The emergence and spread of resistant TB strains mark the extent to which the country’s TB programme has failed. South Africa has one of the highest recorded TB rates per population in the world, with HIV co-infection contributing to extremely high mortality.

With accumulating tallies made on the 20th of each month, the national confirmed XDR TB figure for August stood at 537 with 348 deaths, up from 314 confirmed cases and 185 deaths in March this year (41% and 46% increases respectively). Nationally there were 183 people on treatment, of whom 5 were back home and non-infectious (having tested negative on 4 consecutive cultures). Four patients had defaulted and been lost to follow up.

Every province is reporting XDR TB, with KwaZulu-Natal the worst off at 316 confirmed cases and 271 deaths (increases of 27% and 36% from March).

The fastest escalation is in the Eastern Cape, which ranks second at 105 cases confirmed and 46 dead (increases of 68% and 89% from March). Meanwhile the known overall national TB cure rate increases at a relative snail’s pace – from 50.8% in 2004 to 57.6% in 2005.

Mvusi said the 2006 overall cure rates were expected only early next year because of logistical difficulties in reviewing various treatments.

Drug-resistant patients proving a handful

Professor Dhai was initially approached by *Izindaba* to comment on the court-ordered confinement of dozens of angry MDR and XDR TB patients in Gauteng’s Sizwe Tropical Diseases hospital and their subsequent protests and legal appeal. They claim their constitutional rights are being violated and describe hospital conditions and facilities as ‘worse than prison’ – a claim vigorously denied by the Gauteng health department.

In July the High Court granted the Gauteng health department an urgent interdict enabling it to confine MDR/XDR patients to Sizwe Hospital but ordered that they be provided with lawyers at State expense to ensure their rights were protected. The province has since upped its provision of social workers, counsellors, TV lounges and video equipment, library services, shops, ATM banking and public telephones to Sizwe. In September 4 XDR patients absconded from Cape Town’s Brooklyn Chest Hospital, prompting another court interdict and a multidisciplinary panel of specialist health advisors being hurriedly assembled.

With a 50/50 chance of survival that plummets steeply with HIV-positive co-infection and progression to AIDS, XDR TB patients are faced with radical psychological challenges.



They must prepare themselves and their families for their possible demise and its consequences, plus deal with job, domestic and financial worries. Enforced hospitalisation and isolation hugely aggravate these challenges.

Responding to the latest national XDR TB statistics, Dhai said: 'This is a volcano and we need to address it...it's greater than HIV and we're not seeing it. With XDR there's no cure, you die and the figures are showing it'. She said patients with XDR TB were a 'very real threat to society'.

Section 12 of the Bill of Rights made a compelling argument for everyone's right to bodily integrity, but Section 36 made an even more compelling argument to limit this right from a public health hazard perspective. (Section 36 allows for the limitations of rights, provided the limitations are 'reasonable and justifiable in an open and democratic society'.)

Dhai said of the public discourse on the topic: 'We've heard a lot of "rights" language but we haven't heard a lot in terms of responsibility language'. She pointed to international common law that says 'patient privileges end where public peril begins'.

Humane treatment reduces public peril

Dhai however firmly stressed that the Gauteng Department of Health, on whose TB Expert Advisory Group she sits, had an obligation to ensure all patients under court-ordered 'involuntary admission' were treated holistically and helped with challenges.

The Sizwe XDR TB patients, some of whom could be isolated from their families and community for up to 2 years, have put safe visitation rights from family and friends at the top of their menu of legal demands.

Dhai said that while the Gauteng health department was doing its level best to see to the best interests of the Sizwe patients, it could not tackle

the issue alone and needed 'strong support' from the Department of Social Welfare. 'These kinds of patients need recreational facilities, help with employer liaison, social grants, group counselling, constant contact with the situation at home – can you imagine their state of mind when some or all of this is absent?'

As more XDR patients were identified and confined with widely varying degrees of efficiency across the country, headlines portrayed clumsy official responses and outraged patient protests, most sparked by fear and misunderstanding.

Viewed more broadly, however, the priority public health issue remained patient confinement, 'while we work on the other issues'. 'It would be pointless allowing patients the rights to freedom of movement and activity while we work on the other issues and then find we have a dead society!' she added.

Commenting on the latest figures, Professor Yosuf Veriava, Head of Internal Medicine at the University of the Witwatersrand and chair of Gauteng's expert advisory committee on TB, said that while there was 'reason for concern, we shouldn't panic. We must get on with looking at our TB programmes'.

Lab result turnaround times slashed

He said his committee ran a pilot drug resistance testing programme using PCR methodology that showed that the current 8-week laboratory turnaround times could be reduced to 48 hours. This is vital for treatment efficacy and infection control and will be expanded as the National Health Laboratory Service adjusts for capacity. Since his expert committee was set up 6 months ago, it had run urgent

educational workshops for health staff, drafted administrative and treatment guidelines, boosted hospital infection control measures and increased mask and respirator availability.

Veriava said rapid diagnosis of ordinary TB (within 6 hours) was crucial so that the 'essential question' of whether there was also resistance could be answered. He said all Gauteng health staff were also told that any patient who had interrupted their TB treatment, been in contact with a TB-resistant person, not been given their medicines or had TB in the past was an automatic suspect for MDR/XDR.

'These patients must be sent straight to an ordinary TB hospital so their sputum can be sent for resistance testing. If confirmed they go straight to Sizwe'. He said complaints by Sizwe patients of not seeing doctors regularly were 'totally valid'. Proper ward rounds had since been instituted and 5 medical officers supplemented with 2 medical registrars, plus the rotation of a senior medical registrar. Members of his committee also now regularly led Sizwe ward rounds, and from 1 January a full-time physician would be posted there.

Since the unique initial 2005 discovery of widespread XDR TB among ART-unresponsive patients at the deep rural Church of Scotland Hospital (Tugela Ferry, KwaZulu-Natal) by its chief medical officer, Tony Moll, surveillance nation-wide has 'hit the ground running', as one TB chief put it.

Spate of unruly patient incidents

As more XDR patients were identified and confined with widely varying degrees of efficiency across the country, headlines portrayed clumsy official responses and outraged patient protests, most sparked by fear and misunderstanding.

One of the more recent incidents (July this year) involved 50 MDR TB patients blockading, for the second time, the entrance to Sizwe Hospital, demanding better treatment and an end to 'prison-



like' conditions which some of them had endured for over a year, allegedly without any visible improvement in their health. Others included:

- November last year: Protests at Port Elizabeth's Jose Pearson TB hospital (MDR TB patients), where 9 patients were found to be XDR and moved to isolation wards. When new MDR patients were brought in to occupy the vacated beds, their skittish MDR colleagues assumed they were also XDR.

- January this year: Violent confrontation between 21 Sizwe patients and masked and gloved police called in to end an 8-hour barricade of the hospital gates and shut-out of medical staff, patients and food. The protestors, who claimed they had not seen a doctor for over 2 months, were frog-marched to police vehicles and temporarily housed at the Pretoria West Hospital while Sizwe beefed up its security measures.

- March this year: Gauteng brought its first interim court order against 13 XDR patients who forced their way out of the Pretoria West Hospital before catching a taxi to Sizwe, where they demanded to be treated as outpatients.

They had previously received treatment at Sizwe.

- Terrified 'ordinary' TB patients fleeing the Fort Grey Hospital in East London after seeing paramedics wearing full-length protection suits bringing in XDR patients for isolation.

Mvusi admitted that there were 'some problems with patients', adding that in most cases these were caused by 'major family issues'. 'They're also worried about work but once you give them the commitment to try and address the problems it gets easier.'

Patients sometimes smuggled drugs or liquor into hospital and then became violent and abusive. Counselling was provided 'whenever possible'. She said the priority was to strengthen ordinary TB programmes so that patients were cured 'first time around', deal with infection control in all facilities and educate the public at home and work 'or any places of congregation'.

Improved drug compliance measures were vital while providing sufficient MDR and XDR beds was 'getting harder all the time – we need a longer term plan'.

Each province was currently identifying new treatment sites and projecting needs over the next 5 years, based on renovation of existing (often ill-suited) buildings and new construction. Costing on boosting infection controls and staffing requirements was also being done. 'Recruiting people to these areas is a problem,' she admitted. The national treasury was treating her requests 'as an urgent matter'.

There are 40 TB hospitals across the country, 9 of which handle MDR/XDR patients. Many of them are prison-like apartheid-era structures that need structural modification to improve infection control and to simplify isolation measures. Mvusi admitted that inter-departmental co-operation around nutrition, food supplements, access to social welfare grants, poverty alleviation, sick leave and sheltered employment or redeployment at work needed urgent improvement.

Chris Bateman

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