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THE PREVENTION, EARLY DIAGNOSIS, TREATMENT AND CURE OF TUBERCULOSIS: A GUIDE AND RECOMMENDATIONS FOR TAC, GOVERNMENT AND CIVIL SOCIETY

This guide and its recommendations are based on the work of many nurses, doctors, community health workers, researchers and TAC members. The Tuberculosis Strategic Plan for South Africa, 2007-2011 by the Department of Health is a step forward but not enough. In this policy brief, the Treatment Action Campaign addresses the need to improve the commitment of government, civil society, communities and TB patients. The recommendations examine:

- **Intensified Case-Finding**
- **Infection Control**
- **Integrating HIV/TB services, and**
- **INH TB prevention for people living with HIV/AIDS**
- **Prevention and Treatment of Drug Resistant TB**

TUBERCULOSIS IN SOUTH AFRICA: A CRISIS THAT NEEDS TO BE ADDRESSED URGENTLY¹

1. TB has historically been a health crisis in South Africa, especially in settings such as mines and the poorest communities. This has been further exacerbated by the HIV epidemic. HIV-related TB is the leading cause of death in South Africa.² Recorded TB deaths have increased from 25,640 in 1997 to 73,903 in 2005.³ Of particular concern is drug-resistant TB. The recorded number of multi-drug resistant TB (MDR TB) cases has grown from 3,278 in 2004 to 6,716 in 2006, with an additional 2,140 cases in the first

¹ This paper was written by Lesley Odendal of the Treatment Action Campaign with comment from Nathan Geffen, Paula Akugizibwe, Gregg Gonsalves, Hannan Braun and Zackie Achmat. It is largely based on the recommendations made in the following documents; *TB: Confronting the Crisis of TB and HIV in Southern Africa, An Advocacy Agenda for governments, health care workers, researchers, civil society, regional and international agencies*. ARASA, TAC and SATAMO. 2007. Available at http://www.arasa.info/files/tb_summit_report.pdf and *Steering the Storm: TB and HIV in South Africa*. Achmat, Z. and Roberts, R. 2005. Available at <http://www.tac.org.za/Documents/TBPaperForConference-1.pdf>. Thanks to Paula Akugizibwe and Nathan Ford for their assistance.

² Mortality and causes of death in South Africa, 2005: Findings from death notification. P0309.3. Available at <http://www.statssa.gov.za/publications/P03093/P030932005.pdf>

³ Mortality and causes of death in South Africa, 1997- 2003: Findings from death notification. P0309.3. Available at <http://www.statssa.gov.za/publications/P03093/P03093.pdf>

quarter of 2007 alone.⁴ The number of extensively drug-resistant TB (XDR TB) cases has grown from 74 to 419 cases in the same period, with 221 cases in the first quarter of 2007 alone.⁵ The lack of capacity and infrastructure to diagnose and treat MDR and XDR-TB and the extremely high mortality rates associated with these strains of tuberculosis, mean that this has become a health emergency.

2. Yet, the response to the epidemic by the state and civil society remains weak. It will take substantially more commitment including increased expenditure and action from government, the private sector and civil society to reduce TB rates to manageable levels. The importance of Treatment Literacy support for TB patients and community involvement in TB programmes cannot be overstressed to assist in treatment adherence.
3. Collectively, all stakeholders, including government, communities, patients, the private sector and civil society must play their part in combating this disease.

In this document, we provide an overview of the TB epidemic in South Africa and make recommendations to address it.

4. TAC's involvement in combating TB is not new. TAC has been involved in addressing TB in the following ways:
 - Education for TAC members since 1999 on prevention and treatment of TB.
 - Systematic policy research since 2004.
 - Through conducting workshops and door-to-door campaigns, Treatment Literacy Practitioners work in communities to educate people on symptoms and treatment of TB and Drug-Resistant TB, the importance of early testing and infection control measures.
 - Pamphlets and posters about TB in 6 languages have been distributed nationally.
 - A special edition of TAC's magazine, *Equal Treatment*, focused on TB and a follow-up edition is planned for later this year.
 - TAC, with the AIDS and Rights Alliance for Southern Africa (ARASA) and The Southern African Treatment Access Movement (SATAMO) held a Emergency Southern African Advocacy Summit on TB and HIV.
 - A satellite conference was held at the 38th Union World Conference on Lung Health (2007) in Cape Town to train people on TB and community mobilisation.
 - On the evening of 8 November 2007, about 5,000 people marched through the streets of Cape Town at the onset of the 38th Annual Union World Conference on Lung Health to demand better TB education, prevention, treatments and cures. A global call was handed over to the organisers of the conference.⁶
 - TAC addressed the open plenary of the 37th Annual Union World Conference on Lung Health on lessons learnt from HIV Community mobilisation and presented at the following congresses in Paris and Cape Town.
 - Participated in World Health Organisation's (WHO) 3 Is meeting in Geneva
 - Made representations to government at national and provincial level.
5. The community level impact of TAC work with, MSF the City of Cape Town's Health Department and the Western Cape DoH through increased cure rates can be seen in the table below. This is the model for collaboration across the country.

⁴ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 15

⁵ Ibid, p.16

⁶ See <http://www.tac.org.za/community/node/2126>

6. The TAC Khayelitsha model district pioneered TB work at community level. This was led by Treatment Literacy and Organizing. In 2005, TAC Khayelitsha's TB cure rate for TB was one of the lowest in the Cape Town Metro. And, Site B one of TAC's strongest branches had the lowest TB cure rate in the Metro.

7. TAC was approached by the City and MSF to help mobilize because the ARV adherence rate was over 90% at that stage. Co-infection data demonstrated that 68% of TB patients in Khayelitsha had HIV. The outcomes based on work by TAC, MSF, the City and Provincial Clinics all demonstrated that the TAC model of patient autonomy and community education works better than the official old DOTS model of patient observation.

Year	New City of Cape Town TB patients	New TB patients Khayelitsha	City of Cape Town Cure Rate	Khayelitsha Cure Rate	Site B Cure Rate
2005			73%	44%	32%
2007	28 000	5900	78%	72%	68%

Source: City of Cape Town Health Department (2007)

Overview

Tuberculosis

8. The WHO ranked South Africa forth among the world's 22 high-burden TB countries in terms of absolute numbers of TB cases.⁷ The number of people diagnosed with TB is escalating, with approximately 341,000 cases being diagnosed in 2006 in the public health system alone. Between 1996 and 2006, there has been a dramatic increase in incidence from 269 to 720 cases per 100,000 population according to the Department of Health.⁸ The World Health Organisation (WHO) however, estimates a much higher incidence rate of 940 cases of TB per 100 000 population in 2006.⁹

9. The cure rate for new smear positive pulmonary TB (PTB) patients was 58% for 2005.¹⁰ Although this is an improvement from previous years (51% in 2004),¹¹ because severely immune-compromised patients are likely not to be smear-positive at baseline, smear positivity is an increasingly inappropriate measure for determining cure rates.

TB and HIV co-infection

1. The percentage of people infected with TB who are also HIV-positive is estimated to be around 53%¹², although it is as high as 80% in some communities.¹³ The risk of

⁷ WHO report 2008 Global tuberculosis control - surveillance, planning, financing. Available at http://www.who.int/tb/publications/global_report/2008/key_points/en/index.html

⁸ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 10. These figures are taken from the public health sector and may be underestimated. It is important that we take these into account as they reflect what the extent of the problem that the Department of Health *knows of*, which should be matched by action and commitment.

⁹ Country Profile, South Africa, World Health Organisation, Available at http://www.who.int/globalatlas/predefinedReports/TB/PDF_Files/zaf.pdf

¹⁰ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 12

¹¹ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 12

developing active TB is increased tenfold by HIV.¹⁴ TB constitutes a serious health risk for people living with HIV because the weakened immune system increases the risk of people infected with latent TB developing active TB and also increases the risk of extra-pulmonary TB infection. In turn, TB infection in people living with HIV causes the immune system to further weaken. Given the HIV-prevalence rates in South Africa, it is paramount that TB and HIV be addressed using integrated strategies.

TB cases reported from 1996 to 2006				
Years	All TB cases	Pulmonary TB cases	New Smear positive PTB cases	Certified TB deaths
1996	109 328	92 380	42 163	Not available
1997	125 913	104 141	54 073	22 071
1998	142 281	115 537	66 047	28 532
1999	148 164	118 686	72 098	34 250
2000	151 239	120 075	75 967	42 246
2001	188 695	144 910	83 808	51 098
2002	224 420	182 583	98 800	60 311
2003	255 422	215 154	116 337	67 609
2004	279 260	234 213	117 971	70 355
2005	302 467	257 604	125 460	73 903
2006	342 315	287 440	131 618	Not available

- The average incidence for South Africa is not the whole picture. Poor and working class communities face much higher rate of TB infection that the average middle class person in South Africa. People who are HIV-positive face in poor and working class have the highest burden of TB disease.

TB incidence per 100 000 of the population in peri-urban township¹⁵

	South Africa	Township	HIV negative	HIV positive
1996	269	580	--	---
2004	720	1468	656	4381

¹² Profile, South Africa, World Health Organisation, Available at http://www.who.int/globalatlas/predefinedReports/TB/PDF_Files/zaf.pdf

¹³ Gandhi, N.R; Moll, A.; Pawinski, R.; Sturm, A.W.; Laloo, U.; Zeller, K.; Andrews, J.; Friedland, J.; High Prevalence and Mortality from Extensively-Drug Resistant (XDR) TB in TB/HIV Coinfected Patients in Rural South Africa, XVI International AIDS Conference, Toronto Canada. Available at <http://www.aids2006.org/PAG/Abstracts.aspx?AID=51350>

¹⁴ World Health Organization. TB/HIV: A Clinical Manual. (2nd Edition) Geneva: WHO; 2004., p.37. Available at <http://libdoc.who.int/publications/2004/9241546344.pdf>

¹⁵ Lawn S, Bekker L-G, Middelkoop K, Myer L and Wood, R. "Impact of HIV Infection of the Epidemiology of Tuberculosis in a Peri-Urban Community in South Africa: The Need for Age-Specific Interventions." *Clinical Infectious Diseases*, 2006;42:1040-7

- The results from this study¹⁶ which examined the impact of HIV infection on TB in a peri-urban community in South Africa, clearly illustrated the high levels of co-infection as well as the correlation between levels of HIV infection and TB notification in specific age groups, with the highest increases in the TB notification rate correlated with the age groups where HIV infection rates are highest in South Africa, namely the 20 – 39 year groups.

Age based TB notification rate per 100,000 persons in a peri-urban township

Age	1996-1997	2003-2004
0-9	582	731
10-19	0	436
20-29	245	1369
30-39	706	2599
40-49	1405	2824
50-59	1708	1856

MDR AND XDR TB

- We are facing a TB crisis in South Africa, especially given the rising number of drug resistant cases of TB in South Africa. According to the Department’s own admission drug resistant TB has arisen as a result of the failures of the health system to adequately deal with patients who have TB.¹⁷ As the Department itself states, “In order to reduce and prevent further spread and development of MDR and XDR-TB cases, the TB programme needs to be strengthened.”¹⁸ However, there are concerns among clinicians that an increasing number of drug resistant TB cases are not due to a lack of adherence but that drug resistant TB strains are now being increasingly transmitted directly from person to person. Additional factors that have contributed to the spread and development of drug resistant TB are:
 - Drug stock outs caused by failing supply chain management systems in health facilities
 - The lack of transport for patients who have to travel long distances to access their medication, often on a daily basis under the DOTS system
 - The fact that there is not a clear policy and programme with adequate financial resources for adherence education (such as that of the ARV model). The lack of education and adherence support for substance abusers especially alcohol users.

Even if 100% adherence with optimal regimens and no breakdowns in medicine supply were to be ensured now with all patients, drug resistant TB would still continue to be a problem for the public health system. The spread and treatment of MDR and XDR TB poses grave public health threats and must be addressed urgently.

- As of the first quarter of 2007, there were 2,140 known cases of MDR TB and 898 of XDR TB in South Africa. However, this is an underestimated figure of infected patients due to a lack of laboratory capacity in the public sector to diagnose cases of DR TB and due to the fact that South Africa is not using active case finding to identify patients who are infected with drug resistant TB.

¹⁶ Lawn S, Bekker L-G, Middelkoop K, Myer L and Wood, R. “Impact of HIV Infection of the Epidemiology of Tuberculosis in a Peri-Urban Community in South Africa: The Need for Age-Specific Interventions.” Clinical Infectious Diseases, 2006;42:1040-7

¹⁷ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 15

¹⁸ Ibid, p. 16

6. While norms and standards must be sustained in the public sector, given the emergency of TB in the context of drug resistant TB, it is critical that the underutilisation of the private sector is evaluated to supplement the public sectors efforts to address TB.

GUIDE FOR TAC, CIVIL SOCIETY and GOVERNMENT:

TAC recommends that the following steps need to be taken in order to strengthen the National TB Control Programme:

Improved and intensified testing and diagnosis of TB:

7. A key problem is that a large proportion of people who are infected with active TB are not diagnosed. Undiagnosed patients are unknowingly spreading TB in their communities and are dying unnecessarily because they are not accessing treatment.
8. In order to make TB diagnosis more accessible, access to sputum testing needs be expanded. Smear microscopy of sputum is the main test for TB as it is inexpensive and widely available. However, access to sputum testing needs to be further expanded and decentralised so that people do not have to travel to clinics to deposit sputum samples. This can be done by making places such as schools, churches and community organisations fast-track sputum collecting points. The speed of results can also be improved by SMS-ing positive results back to clinics within 48 hours with paper copies of results following later. Government must work with communities to establish sputum collection services in rural areas and other places where the distance to, and opening hours of clinics provide a barrier to diagnosis. Sputum testing in congregated settings such as prisons and mines needs to be scaled up.
9. The Department of Health is also failing to implement proper tracing of patients once they have been initiated on treatment. The number of defaulters and patients not completing treatment is unnecessarily high. Community Health Workers should be more effectively utilised in this regard. However, the working conditions and salaries for these essential staff members must be improved.
10. Many people living with HIV present as smear negative even though they are infected with active TB. Access to X-ray facilities and TB culture testing, which are more accurate and sensitive, must be scaled up in primary healthcare facilities. Individuals who are smear-negative but have symptoms of TB or a compatible chest X-ray should be treated for TB presumptively.
11. Laboratory services need to be strengthened in order to increase quality and to be able to cope with increased sample loads that need to be tested due to the increasing case load. Up until recently, South Africa had only one reference lab. This has increased to two, but this is still not enough to address the demand for testing and laboratory services. In order to address this, skilled labour, equipment, infrastructure and human resources to increase South Africa's laboratory capacity are necessary.
12. Large-scale community education programmes need to be implemented to educate communities and health care workers on the symptoms of TB and the need for early testing. While government may not have the capacity to do this alone due to human

resource shortages, partnerships need to be established and better funding and resources need to be made available to organisations which can do this.

13. A total of R39 million has been earmarked by National Treasury for improving TB control and management over the next three years. While it is noted that this is a conditional grant and that additional funding for TB will come out of the provincial Health Department's budgets, as noted in the Tuberculosis Strategic Plan for South Africa 2007-11 (the Plan)¹⁹, it is not clear from provincial budget documents how much funding each province will allocate to the issue of TB. These figures must be made publicly available. In order for the Plan to be successfully implemented and the goals therein to be reached, government must ensure that the required R23 billion costed in the Plan is available.²⁰ Government must allocate additional resources for TB immediately and should consider applying to the Global Fund to Fight AIDS TB, and Malaria Round 8 to apply for additional funds specifically earmarked for TB.
14. More funding and research into anti-TB drugs is necessary to reduce the treatment duration and improve completion rates. Government, with the assistance of civil society, must put pressure on the pharmaceutical industry to assist in this.

Infection Control:

15. Proper infection control measures are critical. Implementing infection control measures should be prioritised as it reduces the number of cases of TB that will have to be treated. In many cases, people are being infected with TB at health facilities due to poor infection control. A recent study showed that a relatively low number of South Africa's health facilities pass international infection control norms and standards. Although the Department of Health has an Infection Control policy²¹, the proper implementation of this policy needs to occur in all health facilities and must be monitored. This policy, which is based on the WHO's infection control policy needs to be adapted to the South African-specific context and specific plans also need to be developed for congregated settings such as prisons, mines, schools and detention centres.
16. Health care workers, as well as patients, should be educated on infection control policies, on the occupational risk of TB and on how to protect themselves from exposure. This should be expanded to congregated settings such as prisons, detention centres, mines and factories. In addition, all people who are working in these setting, including administrative staff, security guards and cleaning staff should be educated on infection control measures.
17. One of the challenges is the human resources required to implement the infection control plan effectively.²² This must be addressed and given high priority. Government must monitor and evaluate healthcare facilities for compliance with infection-control policies. The proper implementation of infection control policies is critical given the devastating effect that inadequate infection control has where TB (including drug-resistant TB) is being transmitted amongst patients in healthcare facilities.

¹⁹ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 38

²⁰ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 39

²¹ The National Infection Prevention and Control Policy for TB, MDRTB and XDRTB, April 2007, Department of Health

²² The human resource shortage in the public health sector needs to be addressed immediately. This will require massive commitment and engagement, including rethinking the way our health system is structured, task-shifting, the pooling of resources and working with partner organisations. In this regard see <http://www.tac.org.za/documents/AnnexureALP2HRHsubmission.pdf>

18. However, it must be noted that infection control in health care facilities could be improved by educating people on, and promoting, simple low-cost measures such as improving natural ventilation and screening and triaging coughing patients. These measures are not being implemented at scale. Community education is critical to proper infection control, and government needs to collaborate with Civil Society Organisations (CSOs) which can educate communities on how to implement infection control measures in community settings such as homes, schools, taxis etc.
19. The Ubuntu Clinic in Khayelitsha's waiting room is a model for improving infection control in all waiting rooms at health facilities in South Africa. There is 100 percent natural ventilation as the waiting room is outdoors with heaters, blankets and a roof to protect patients from the elements.

Integration of HIV and TB services:

20. Although South Africa has a national policy of counselling and testing TB patients for HIV, this is not being implemented successfully with only one third of TB patients tested for HIV in 2006.²³ Of those TB patients tested for HIV, 53% tested positive.²⁴ Individuals affected by both diseases often have to attend different clinics on different days for each disease, which may well be far from each other and their homes or places of work. Despite the potential gains from the integration of HIV and TB services, there is inadequate political commitment to a joint approach. In the Plan, it states that collaborative activities between TB and HIV have not been fully realised because there is a "lack of written formal guidelines on this collaboration" and there is "inadequate detail on how collaboration is to be achieved at facility and district levels".²⁵ The integration of TB/HIV services is critical given the high level of co-infection in South Africa. In this regard we recommend the following:
 21. Culture testing is critical and needs to be scaled up dramatically in South Africa, given the high numbers of sputum smear negative and extra-pulmonary TB cases found in regions with high HIV prevalence rates. While TAC recognises and supports the fact that the Plan states that culture diagnosis will be conducted for all people living with HIV/AIDS when they first present with TB symptoms,²⁶ for this to be successfully implemented, laboratory capacity will have to be strengthened in South Africa. This is a critical aspect of combating TB in South Africa and the implementation of this must be scaled up and closely monitored in all health care facilities.
 22. Expand integration of TB and HIV services at the primary health care level by establishing one-stop facilities in communities. As results from the Khayelitsha Ubuntu Clinic show (the TB cure rate rose from 26% in 2004 to 67% in 2006)²⁷, the potential to prevent transmission of both TB and HIV via the integration of services is significant. The integration of services will also reduce the workload for health workers. This is a difficult but necessary task.

²³ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 17

²⁴ Country Profile, South Africa, World Health Organisation, Available at http://www.who.int/globalatlas/predefinedReports/TB/PDF_Files/zaf.pdf

²⁵ Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa, p. 17

²⁶ Ibid, p. 21

²⁷ Report on the Integration of TB and HIV Services in Ubuntu clinic (Site B), Khayelitsha, 2007, City of Cape Town, University of Cape Town and Medicines Sans Frontieres. Available at <http://www.msf.org.za/docs/Khayelitsha%20TB-HIV%20Report%20November%202007.pdf>

23. Such one-stop facilities (such as the Khayelitsha Ubuntu Clinic) must include the following:
- Increasing Voluntary Counselling and Testing (VCT) for HIV amongst TB patients who have not been tested recently
 - Systematic TB screening for HIV-positive patients
 - The provision of treatment for both TB and HIV in one facility.
- The benefits of this will be:
- Improving cure rates for both co-infected and TB patients through a more patient-centered approach to adherence.
 - Increasing service efficiency through more rational staff deployment.
24. The World Health Organisation's Directly Observed Therapy Short-course (DOTS) strategy must be adapted in South Africa to include a patient-centered approach with increased treatment literacy and support groups. The DOTS approach to TB control is not adequate in areas with high TB and HIV prevalence. Patients should be empowered to care for themselves, following the ARV model.
25. Training of health workers and diagnostics tools for extra-pulmonary TB must be prioritised.
26. Collaboration with traditional healers is necessary to create a referral process with the public health system. The focus should especially be on training traditional healers to identify symptoms relating to HIV and TB and referring patients and also ensuring they comply with infection control standards.

Isoniazid preventive therapy (IPT)²⁸

27. Isoniazid preventive therapy (IPT) is safe and effective for people living with HIV, and it should be part of the standard of care administered to people with HIV in South Africa to reduce the burden of TB in HIV-positive people. This must be done after clinically ruling out active TB. The treatment, which is a six- to nine-month regimen, greatly reduces the risk of developing active TB and thus has the potential to save lives. Currently, IPT implementation has been very low, despite being one of the key recommendations to reduce the burden of TB in people living with HIV. South Africa must evaluate its progress in implementing IPT and devise clear guidelines and scale up treatment.²⁹

Preventing and Treating Drug Resistant TB:³⁰

The emergency of MDR and XDR TB needs to be addressed urgently. We recommend the following:

28. Information about the extent of XDR and MDR TB in each province must be collected, including data on HIV and MDR TB co-infection.
29. MDR and XDR TB hotspots must be identified.

²⁸ A separate TAC policy briefing is available and published with this Policy Brief (01 July 2008)

²⁹ For more information, read this in conjunction with a separate policy brief on Isoniazid Preventative Therapy called *Isoniazid Preventive Therapy in the context of HIV: An intervention that can save lives* that TAC has written.

³⁰ See letter sent by the TAC to then Acting Minister of Health, Mr Jeff Radebe, 2 March 2007, Annexure A.

30. Laboratory capacity needs to be strengthened urgently to ensure the efficient diagnosis of drug-resistant TB in South Africa. One of the reasons for high mortality rates of DR TB is that diagnosis takes so long.
31. Communities and patients in MDR and XDR TB hotspots must be educated about the disease and what steps they can take to get treated, reduce the risk of transmitting it to others and of contracting it.
32. A system must be implemented to ensure all patients in MDR and XDR TB hotspots are traceable and that they adhere to TB treatment regimens. In particular, measures are needed to trace all patients that have been diagnosed and sent to referral hospitals and who have not been admitted but sent back to their clinics.
33. Appropriate medicines and treatment must be made available to MDR and XDR TB patients. Some drugs remain unavailable because of cost. Pressure must be put on drug companies to resolve this.
34. South Africa should apply to be part of the Green Light Committee established by the WHO Stop TB partnership, which ensures access to low-cost, high-quality second line drugs and also provides technical support for systems for the management of DR TB and second line treatment.
35. Many waiting rooms increase the risk of MDR and XDR TB transmission. Infection control measures in all health facilities must be improved so that patients are not infected with MDR or XDR TB strains by people already infected with drug resistant TB. The Department of Health's Infection Control Policy³¹ needs to be implemented properly in all health care facilities. This must be closely monitored by the Department of Health.
36. Measures must be implemented to reduce the possibility of patients needing MDR or XDR TB treatment being waitlisted. The number of TB beds that are available in our hospitals needs to be increased. Some patients have to wait up to 4 months before a bed is available.
37. TB treatment must be decentralised so that more clinics are able to manage TB patients. Centralised MDR and XDR-TB care is not feasible due to infrastructure and staffing constraints. Centralised services that are far away from where patients live are also contributing to high defaulter rates. A new model of community-based drug resistant TB care where treatment centres are decentralised and placed closer to where patients reside needs to be implemented. Initiation of treatment can occur at centralised facilities with rapid transfer to local centres.
38. Greater investment is needed in facilities and human and other resources to properly isolate, treat and diagnose MDR and XDR patients.
39. Any form of isolation must be done in a manner that meets international norms and standards and takes into account constitutional requirements and provisions and takes into account the human rights of patients. These cannot be less than that provided for by section 35 of the Constitution on the rights of arrested, detained and accused persons.

³¹The National Infection Prevention and Control Policy for TB, MDRTB and XDRTB, April 2007, Department of Health

40. Meaningful social grants should be given to those who forced to stay in hospital. This will give patients peace of mind and their families support. The current policy stops social grants for people who accept long-term hospitalisation. The disability grant to desperately poor people with TB assists with transport costs, nutrition and general family support. In addition to protecting essential social security rights for people who cannot support themselves, the disability grant assists in keeping patients with MDR and XDR TB in hospital. Several of the “escapes” from TB facilities have been attributed to lack of family contact and need to access grants. This is a threat to public health.

41. Reading and recreational material must also be made available at all hospitals where patients are being kept for long periods.

In conjunction to these recommendations, the Department of Health must ensure that all the recommendations of the review of the 2000-2005 TB strategy, as outlined in the 2007-2011 TB Strategic Plan are implemented with urgency.³²

Conclusion:

TB is entirely curable and, in a properly functioning system, could be eliminated. However, this will take high-level commitment from government, healthcare workers, the private sector and partners in civil society to address the crisis and implement strategies that will reverse the devastating effect of TB we are seeing in our country.

We must commit ourselves to taking on the challenge of addressing this disease which is causing unnecessary hardship in South Africa and in the region.

01 JULY 2008

³² These can be found on p. 14 of the Tuberculosis Strategic Plan for South Africa, 2007-2011, Department of Health, South Africa