

**THE LEGAL AND ETHICAL IMPLICATIONS OF INVOLUNTARY DETENTION OF DRUG-RESISTANT
TUBERCULOSIS (DR-TB) PATIENTS IN SOUTH AFRICA.**

A DISSERTATION PRESENTED

BY

IFEANYICHUKWU OFUNNE

TO

COLLEGE OF LAW AND MANAGEMENT STUDIES

THE SCHOOL OF LAW

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTERS OF LAWS

IN MEDICAL LAW

UNIVERSITY OF KWAZULU-NATAL

DECEMBER 2017

DECLARATION

I, **IFEANYICHUKWU OFUNNE**, declare that:

- (i) The research reported in this dissertation, except where otherwise indicated, is my original work.
- (ii) This dissertation has not been submitted for any degree or examination at any other university.
- (iii) This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
- (iv) This dissertation does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
 - (a) Their words have been re-written but the general information attributed to them has been referenced;
 - (b) Where exact words have been used, their writing has been placed inside quotation marks, and referenced.
- (v) This dissertation does not contain text, graphs or tables copied and pasted from the internet, unless specifically acknowledged, and the source being detailed in this dissertation and in the reference sections.

.....
IFEANYICHUKWU OFUNNE

DATE: December 9, 2017.

ABSTRACT

With South Africa battling a TB/HIV epidemic that is one of the highest in the world, drug-resistant tuberculosis (DR-TB) has been an issue of concern lately, due to its virulence and potential fatality.

DR-TB is usually as a result of poorly controlled/treated TB and when persons with this deadly strain of TB do not take precautions to prevent infecting others, certain stringent measures should be adopted.

Involuntary Detention (ID) has been introduced in certain quarters, and this paper attempts to analyse the ethico-legal implications of such an action in South Africa.

It is submitted, ab-initio that ID has been a part of the South African legal landscape since 2010, but lacunae exist in terms of its enforceability and dissemination of knowledge vis a vis its application. It is hoped that the recommendations offered here will help in no small measure towards bridging these gaps.

ACKNOWLEDGEMENTS

Thank you Lord Jesus for the strength, determination and blessings way too numerous to mention.

Codi-Ryan Ofunne, son, this is for you again! Bless you for choosing me to be your dad. I am immensely proud of you.

Prof Yusuf Vawda, I thank you for believing in me. You gave a medical doctor a chance to study law at Masters' degree level. This is also for you. Thank you sir.

Prof DJ Mcquoid-Mason, you simplified the law. Your teaching is exemplary. You are indeed a blessing to the law department.

Prof JA Singh, you set the fire of ethics in me. Hope to continue the fire burning. See you soon for PhD. You are a beacon of knowledge. Bless you too.

Ms Sheetal Soni, my supervisor, I apologise for all the trouble. It was a pleasure learning the law from you. Ditto Profs Strode and Bosch.

Mr Pradeep Ramsewak, you are the best Faculty Officer EVER. Thank you.

My Mum. I Thank you for a solid foundation and good genes of course. I would not have done these without your good genes. May God keep you strong for many more years. And Dad too. I miss you still. Thanks for them genes also.

My siblings, particularly Uche Ofunne-Ojiakor. You are a second mother like none other. I thank you.

Celimpilo Baloyi, you were a friend during the study year. I promised to say thanks. Heregoes. Thanks for them notes. You kind soul (sometimes).

Dr Jenny Maharaj your notes were very helpful too. Goodluck with the rest of the programme.

Jolandi Seibes, you doll. Baie Dankie

Mme Grace Mdhladhla, I thank you for everything. You know what.

Luthando Ngema, you also were and always will be a star. Mwah.

Now all those I did not mention, it is simply because you are very dear in my heart. Nothing else, stru. You know yourselves though....Cheers, sharp sharp (and in Marawa's voice).....' *gqim shelele!*

List of Tables and Figures

Figure 1

page 9

Table 1

page 48

TABLE OF CONTENTS

	Page
Outline of chapters	8
<u>CHAPTER 1-Introduction of Key Concepts</u>	
1.1 Introduction	9
1.2 Rights: Human v Legal Rights	10
1.3 Public Health issues relating to the management of DR-TB in SA	12
1.4 The Legal framework for managing infectious health conditions in SA	20
1.5 The Ethical framework for managing infectious health conditions in SA	23
1.6 The Siracusa Principles	28
1.7 Conclusion	32
<u>CHAPTER 2- The Ethical Implications</u>	
2.1 Introduction	33
2.2 The Facts	33
2.3 The Ethical Issues	34
2.4 The Relevant Rules	34
2.5 Conclusion	50
<u>CHAPTER 3- The Legal Implications</u>	
3.1 Introduction	51
3.2 The Factual problem	53
3.3 The Legal Issues	54

3.4 The Relevant Rules of Law	54
3.5 Conclusion	66
<u>CHAPTER 4- Summary, Recommendations and Conclusions</u>	
4.1 Summary	67
4.2 Recommendations	68
4.3 Conclusion	74
BIBLIOGRAPHY	77
ANNEXURES	82

OUTLINE OF CHAPTERS

The first chapter served as the introduction to the medical, legal and ethical foundations on which the various chapters were based on. In this introductory/first chapter, it was salient to discuss from the beginning, the scientific, medical and socio-economic aspects of TB, as well as a broad introduction to the concepts of legal and human rights, and also a focus on the South African Constitution. Also discussed were the relevant legislature that govern healthcare, especially where TB is concerned. Finally, the broad ethical basis for the topic was also introduced which served as the foundation on which the clinical and pertinent public health ethical theories in chapter 2 were discussed.

In the second chapter, the necessary public health ethical theories were identified, especially the confluence between the ethical and legal basis for involuntary detention as evidenced by the law of justification of necessity. Using a weighted reflection, all the ethical theories and principles were then analysed into a cohesive whole, with the net result seen to be in favour of the involuntary detention of DR-TB patients.

In the third chapter, the various South African and international justificatory basis for such detention were analysed and public health, among others, was identified as one of the bases for enforcing it.

In the fourth chapter, the various recommendations were discussed and the need for their adoption was emphasized. It is expected that adoption of these, going forward, will serve to contribute to terminating the present scourge that is TB, as well as its drug-resistant form (DR-TB).

Chapter 1

INTRODUCTION OF KEY CONCEPTS

1.1. Introduction

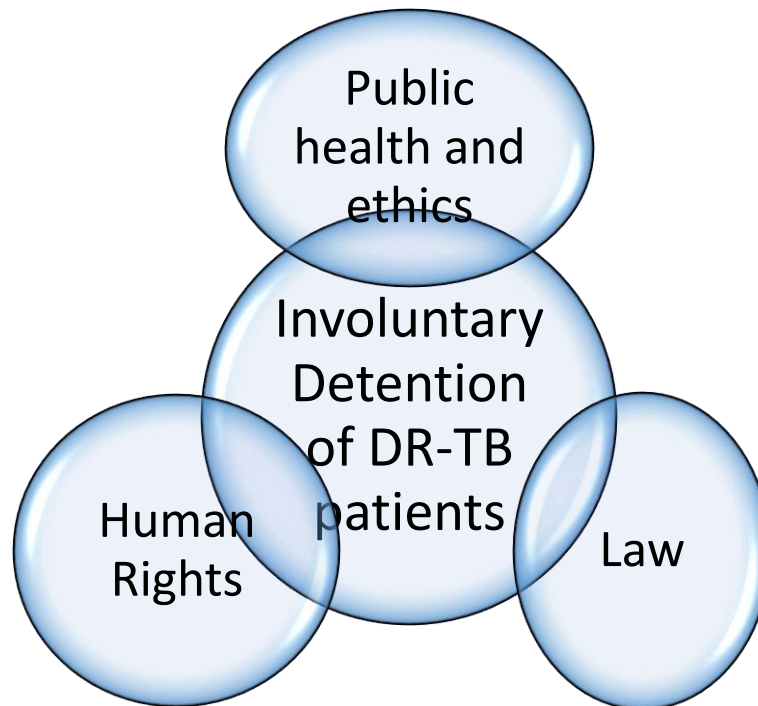


Fig 1: The relationship between involuntary detention, public health and the law

The above diagram captures the very essence of this paper which is an analysis of a contemporary problem and the related public health, ethical and legal ramifications aimed at controlling it. Drug resistant tuberculosis (DR-TB) has become a South African (and indeed global) problem, not least of all due to its virulence, associations with HIV/AIDS, and of course its potential for being difficult or nigh impossible to treat. At the center of it all, the topic of discussion will involve denying certain rights (such as freedom of movement and equality) to persons with DR-TB. The analysis of these will have legal (including rights-based), ethical as well as clinical perspectives all with a view to finding a solution.

The question therefore will be “is there legal or ethical basis for limiting the rights of persons with contagious disease conditions”?. This paper will attempt to analyze all the aforementioned issues with a bid to answering the aforementioned question.

Ab-initio, from a prima facie human rights perspective, the concept of involuntary detention of anyone without some justification will be a straightforward case of rights violation. From a public health angle, however, such seems plausible in order to protect the health and wellbeing of the general public, especially as a form of disease prevention. It goes without saying that a critical analysis will therefore be imperative involving public health (and its ethics), community oriented care, legal, human rights and social considerations also at play. Whilst some argue that for the greater good, sequestration of such patients is indicated, another school, of thought will argue as to the fundamental human rights (of the patients). One other important factor at play here will include the concept of vulnerability. This sentiment is succinctly captured in the following statement.... ”ultimately the question under consideration is whether the public’s rights to be protected from potentially dangerous diseases constitutionally trumps the rights of an individual sufferer to bodily integrity”¹

At this juncture, it becomes pertinent to introduce some of the core concepts that will be discussed in detail, going forward:

1.2. Rights: Human v Legal rights

Simply put, in my words, the difference between a human and civil (or legal) right has to do with necessity. Human rights arise simply by being a human being. The recognition of personhood, regardless of geographic location confers on anyone his/her human rights, whilst Civil rights, on the other hand, arise only by citizenship, and or encoded in a constitution of a country.

Specific to South Africa, the 1996 Constitution of the Republic of South Africa² (hereafter referred to as the Constitution) in chapter 2, ss7-39, introduces the Bill of Rights³. This Bill of rights captures the legal or civil

¹ P Carstens ‘The involuntary detention and isolation of patients infected with extreme resistant tuberculosis (XDR-TB): The implications for public health, human rights and informed consent’ (2009) *Obiter* 420.

² The 1996 Constitution of the Republic of South Africa

³ *Ibid*, ss7-39

rights of all South African citizens and can be looked upon as an explicit agreement between a nation, state and citizens being governed.

Elaborating further, “human rights are generally thought of as the most fundamental rights. They include the right to life, education, protection from torture, free expression, and fair trial. Many of these rights bleed into civil rights, but they are considered to be necessities of the human existence. As a concept, human rights were conceived shortly after World War II, particularly in regard to the treatment of Jews and other groups by the Nazis. In 1948, the United Nations General Assembly adopted the Universal Declaration of Human Rights, cementing their foundation in international law and policy”⁴. According to the Universal Declaration of Human Rights (UDHR)⁵ there are 30 basic human rights (see Annexure A for full list) to which everyone regardless of nationality, religion or creed should be accorded.

The International Covenant on Civil and Political Rights⁶ (ICCPR) was adopted by the UN general assembly on 16 December 1966 and came into effect in 1976 after gaining a sizeable number of treaty member states. Its aim is to further enhance the civil and political rights as encoded in the UDHR introduced above. An executive summary of the ICCPR will read as follows:

“Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the [Universal Declaration of Human Rights](#), the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights,

Considering the obligation of States under the [Charter of the United Nations](#) to promote universal respect for and observance of, human rights and freedoms,

⁴ ‘What is the Difference Between a Human Right and a Civil Right’? Available at <http://www.hg.org/article.asp?id=31546> , Assessed on December 1, 2017

⁵ The United Nations (General Assembly resolution 217 A) *Universal Declaration of Human Rights* (1948)

⁶ International Covenant on Civil and Political Rights available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx>

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant⁷

In summary, human rights are therefore protected by international agencies and are supposedly universal. Civil rights are country specific and can be found in respective constitutions. They can however, also blend into human rights, for example the Bill of Rights⁸ speaks to freedom of expression and right to life (among others) which are expressed as fundamental human rights. It is therefore worth mentioning that the decision to detain persons with DR-TB in South Africa may seem to be a prima facie case of denying them their human rights to free movement, unfair detainment and non-discrimination (to mention a few). The same goes for their civil rights to equality, dignity and privacy (also to mention a few). This paper will be a systematic analysis of this assertion taking into consideration all of the issues in order to arrive at an informed decision/conclusion.

1.3. Public health issues relating to the management of DR-TB

1.3.1 Tuberculosis

“Tuberculosis (TB) is caused by bacteria (*Mycobacterium tuberculosis*) that most often affect the lungs. Tuberculosis is curable and preventable. TB is spread from person to person through the air. When people with lung TB cough, sneeze or spit, they propel the TB germs into the air. A person needs to inhale only a few of these germs to become infected.

About one-third of the world's population has latent TB, which means people have been infected by TB bacteria but are not (yet) ill with disease and cannot transmit the disease. People infected with TB bacteria have a lifetime risk of falling ill with TB of 10%. However persons with compromised immune systems, such as people living with HIV, malnutrition or diabetes, or people who use tobacco, have a much higher risk of falling ill.

When a person develops active TB (disease), the symptoms (cough, fever, night sweats, weight loss etc.) may be mild for many months. This can lead to delays in seeking care, and results in

⁷ ibid

⁸ Note 3 above

transmission of the bacteria to others. People ill with TB can infect up to 10-15 other people through close contact over the course of a year. Without proper treatment up to two thirds of people ill with TB will die.

Since 2000 more than 49 million lives have been saved through effective diagnosis and treatment. Active, drug-sensitive TB disease is treated with a standard 6-month course of 4 antimicrobial drugs that are provided with information, supervision and support to the patient by a health worker or trained volunteer. The vast majority of TB cases can be cured when medicines are provided and taken properly⁹

1.3.2 What is Drug Resistant (DR) Tuberculosis?

DR TB, is “a type of tuberculosis (TB) caused by a bacterium (*Mycobacterium tuberculosis*) that has developed a genetic mutation(s) such that a particular drug (or drugs) is no longer effective against the bacteria”¹⁰. Elaborating further, the following terminologies are introduced:

1. “Mono-resistance- resistance to one first-line anti-TB drug other than isoniazid and rifampicin¹¹
2. Poly-resistance- resistance to more than one first-line anti-TB drug other than isoniazid and rifampicin¹²
3. Multidrug resistance (MDR)-resistance to at least isoniazid and rifampicin, the two most potent anti-TB drugs¹³
4. Rifampicin resistance (RR)-resistance to rifampicin, either in isolation, or as MDR or polyresistance¹⁴
5. Extensive drug resistance (XDR)-MDR plus resistance to at least two (one from either class) of second-line TB drugs¹⁵

⁹ ‘What is TB? How is it treated?’ available at <http://www.who.int/features/qa/08/en/>, accessed on 15 August 2017.

¹⁰ Partners in Health *The PIH Guide to the medical management of multidrug-resistant tuberculosis* 2013 (16).

¹¹ *ibid*

¹² *ibid*

¹³ *ibid*

¹⁴ *ibid*

¹⁵ *ibid*

6. 'Pre-XDR'-not a WHO officially accepted terminology, but refers to resistance to either one of the two classes referred to in (6) above¹⁶
7. Totally drug resistant-also not officially recognized as a classification by the WHO, but it refers to resistance to ALL testable anti-TB drugs¹⁷

It is worth pointing out at this juncture that the first-line TB drugs being referred to are: Rifampicin, Isoniazid, Ethambutol and Pyrazinamide. The second line drugs involve, among others, the fluoroquinolones (an example is moxifloxacin) and injectables (for example capreomycin). Newer more potent drugs such as bedaquiline¹⁸ are currently being introduced.

It is also worth noting that although most of the sourced literature speak about XDR-TB when they reference DR-TB, I will choose to class both MDR and XDR as DR-TB, except otherwise stated, during the course of this paper. This is due to the following reasons:

- Causality: Both MDR and XDR-TB are usually caused by poor adherence to TB treatment. With a progression from Drug-Sensitive TB (DS-TB) to MDR-TB. Consequently, most XDR-TB cases arise from poor MDR-TB management¹⁹
- Record keeping: DR-TB registers should be kept at the MDR-TB hospitals and all centres that will be initiating MDR and XDR-TB treatment updated regularly²⁰
- Virulence: They are both responsible for high TB-associated fatality rates, although XDR, more so than MDR-TB.
- Notifiability: The National Health Act of 2003²¹ (Act 61 of 2003, hereafter known as the Act), which had a drafted regulation in 2010²² stipulates that both XDR- and MDR-TB are communicable diseases/conditions reportable within 24hours of laboratory confirmation.

¹⁶ ibid

¹⁷ ibid

¹⁸ Bedaquiline discovery and use are elaborated on in Chapter 4, section 4.2.7 (conclusions and recommendations)

¹⁹ South African National Department of Health *Management of Drug-resistant Tuberculosis: Policy Guidelines* (2013) 4

²⁰ ibid

²¹ The National Health Act of 2003 (Act 61 of 2003)

²² The National Health Act of 2003; regulation No. R. 287

- Management: In terms of duration and protocol, they both are treated for a minimum of 18-24 months, using a combination of injections and oral medications. Indeed, “management of these cases (XDR-TB) should be prioritized using the same basic principles as those for MDR-TB. XDR-TB patients must be hospitalized, preferably at the MDR-TB referral centres, where additional infection control measures such as isolation facilities should be provided”²³

Regardless of the technical or pharmaceutical description, however, what is fundamental here will be the progression from TB to DR TB (MDR or XDR). MDR-TB, as seen, arises as a result of poor management of TB patients and most cases of XDR-TB arise as a result of poor MDR-TB management. Prevention, diagnosis and effective treatment are therefore key to effective control of DR-TB. This view is echoed in the foregoing quote “if we don’t do something about it now, MDR-TB is going to become XDR-TB. If we don’t start focusing on how we treat XDR-TB properly as well, we’re just going to drive further and further resistance as we go”²⁴.

These views are further elaborated by Singh, when he contends that although there is a dire need to isolate (X) DR-TB patients in order to forestall a public health crisis of global proportions, countries are reluctant (or ill-equipped) to do so. He (Singh) further gives a historic account of XDR-TB in Tugela Ferry (Kwazulu-Natal, South Africa), the highest recorded in one place with figures put at 53 people in 2006, and mean survival time from diagnosis being 16 days. He goes further to highlight the reluctance of the South African government to mandatorily isolate such patients with the resultant risk of infecting family, and indeed anyone who come in contact, due to its extreme virulence. Whilst contending that resources and logistics may be lacking in sub-Saharan countries, South Africa inclusive, he highlighted a case in the USA of a DR-TB patient who was allowed to board a flight, putting not only fellow passengers at risk, but also potentially spreading the disease across geographical barriers²⁵.

Although a federal order has been used to enforce isolation of this (and future other cases in the USA) since 1963, poorer/developing countries in sub-Saharan Africa are yet to learn from and/or implement such. Apart from tackling stigma and discrimination that would result from the identification and isolation of such

²³ Carstens (note 1 above; 422).

²⁴ B Bosworth ‘South Africa battles drug-resistant TB’ *Inter Press Agency Online* 12 March 2014, available at <http://www.ipsnews.net/2014/03/south-africa-battles-drug-resistant-tb/>, accessed on 7 February 2017.

²⁵ JA Singh ‘Isolating TB patients: prevention is better than cure’ (2007) *Journal of Science and Development Network* available at <http://www.scidev.net/en/opinions/isolating-tb-patients-prevention-better-than-cure.html>, accessed on 24 June 2017

cases, he concludes that it would be “better to have dedicated community-based isolation units, where XDR-TB patients can be treated without putting other members of the local community at risk”²⁶. This issue of community-based intervention units will be visited again in the chapter dealing with recommendations²⁷

1.3.3 Diagnosis of TB and Sputum Response

TB is usually diagnosed with sputum or radiologically (X-rays). A patient suspected to be having TB will either report or be noted to be having one or all of the following symptoms:

- Fever²⁸
- Cough (usually productive of sputum, but not always) lasting over 2 weeks²⁹
- Weight loss which is usually unexplained³⁰
- Night sweats (often described as drenching sweats which makes the beddings wet)³¹
- Other constitutional symptoms like body aches³²

Patients with these complaints are asked to produce sputum under controlled situations and these sputa samples are either examined microscopically for Mycobacterium Tuberculosis or cultured for same. In certain instances, an X-ray (as already noted) may also be used for the diagnosis.

In Drug-sensitive TB, it is expected that after two months of treatment, the positive sputa cultures will have converted to negative and continuously so for the duration of treatment (usually 6months). After two months, sputa that fail to convert are usually suspected to be DR-TB and further confirmation will be required³³. If confirmed, appropriate therapy in line with guidelines, as above, will be instituted and the monthly sputum tests will continue. Even for DR-TB management, “sputum conversion from positive to negative in (X) DR-TB patients is regarded as an indication of successful treatment. Once sputum culture

²⁶ *ibid*

²⁷ Chapter 4 below

²⁸ Section 1.3.1 above

²⁹ *ibid*

³⁰ *ibid*

³¹ *ibid*

³² *ibid*

³³ ‘sputum collection during TB treatment’ available at <https://www.dhs.wisconsin.gov/publications/p4/p47131.pdf>, accessed on 11 December 2017.

conversion has occurred for three consecutive cultures, taken at monthly intervals, the patient is at minimal risk of transporting the disease, and the disease can be managed on an outpatient basis”³⁴. In a nutshell, as soon as there is documented and scientific evidence that the patients are no longer infectious (or contagious), they can be allowed back home and into the society (my words).

1.3.4 The threat of DR-TB

“MDR-TB bacteria aren’t affected by the first-choice TB treatments that have saved tens of millions of lives over the past 15 years. Extensively drug-resistant TB (XDR-TB) is impervious to nearly all antibiotics. WHO estimates that there were nearly 500,000 MDR-TB cases and approximately 50,000 cases of XDR-TB globally last year. More than 190,000 people die each year from drug-resistant TB. We must take action now to stop this completely preventable disease.

Imagine for a moment you have MDR-TB. You face two years of treatment and will need to see a health provider nearly every day. You’ll receive 250 injections and 15,000 pills. The drugs most likely to cure you can have long-term side effects such as hearing loss and liver damage, and there’s a very real chance that even this exhausting treatment regimen won’t cure you. And treating MDR-TB patients in the United States is expensive, costing about \$150,000. Treating XDR-TB is even more expensive – nearly half a million dollars, about 30 times more than the \$17,000 it costs to treat regular, drug-susceptible TB”³⁵.

The above excerpt captures the health economics aspect of DR-TB. Imagine the impact on the health budget of developing countries, especially in sub-Saharan Africa if proactive utilitarian measures are not put in place for DR-TB care and prevention!

1.3.5 Vulnerability (A note on the social and economic determinants of TB)

When one looks at the concept of DR TB, certain factors spring to mind. Not least of these are the concept of vulnerability, capacity, as well as human rights (already introduced above). Capturing the former

³⁴ Note 1 above; 422

³⁵ T Frieden ‘world must act now to stop drug-resistant TB’ 2016 *Fox News*. Available at <http://www.foxnews.com/opinion/2016/01/07/cdc-chief-frieden-world-must-act-now-to-stop-drug-resistant-tb.html>, accessed on 5 March 2017.

concept was aptly done by the following excerpt from the the international Federation of Red Cross and Red Crescent societies

“Vulnerability in this context can be defined as the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard. The concept is relative and dynamic. Vulnerability is most often associated with poverty, but it can also arise when people are isolated, insecure and defenseless in the face of risk, shock or stress.

People differ in their exposure to risk as a result of their social group, gender, ethnic or other identity, age and other factors. Vulnerability may also vary in its forms: poverty, for example, may mean that housing is unable to withstand an earthquake or a hurricane, or lack of preparedness may result in a slower response to a disaster, leading to greater loss of life or prolonged suffering.

The reverse side of the coin is capacity, which can be described as the resources available to individuals, households and communities to cope with a threat or to resist the impact of a hazard. Such resources can be physical or material, but they can also be found in the way a community is organized or in the skills or attributes of individuals and/or organizations in the community.

Counteracting vulnerability requires:

- reducing the impact of the hazard itself where possible (through mitigation, prediction and warning, preparedness);
- building capacities to withstand and cope with hazards
- tackling the root causes of vulnerability, such as poverty, poor governance, discrimination, inequality and inadequate access to resources and livelihoods.

Physical, economic, social and political factors determine people’s level of vulnerability and the extent of their capacity to resist, cope with and recover from hazards. Clearly, poverty is a major contributor to vulnerability. Poor people are more likely to live and work in areas exposed to potential hazards, while they are less likely to have the resources to cope when a disaster strikes.

In richer countries, people usually have a greater capacity to resist the impact of a hazard. They tend to be better protected from hazards and have preparedness systems in place. Secure livelihoods and higher incomes increase resilience and enable people to recover more quickly from a hazard”³⁶.

Specifically speaking though, patients with infectious and contagious diseases (such as DR-TB), are vulnerable because as seen, they may have a reduced capacity to withstand the effects of the disease, both financial and biomedical. This vulnerability is exponentially increased when they are low income earners (see below), are being sequestered from society, with a risk of nil protection of their rights. Also, their vulnerability can be obvious when they do not have a say as regards their detention (hence nil autonomy). They may also be exploited by the responsible healthcare workers who may provide substandard care or living conditions.

Furthermore, TB/DR-TB as a chronic debilitating condition affects income, livelihood, social cohesions and more, with severe psycho-social impacts. That it affects predominantly poor people is not only a fact, but further exemplifies their vulnerability.

“Tuberculosis has historically been associated with poverty. A number of studies indicate that two broad mechanisms explain the relationship between poverty and TB incidence: the likelihood of being exposed to the disease and the immunological status of the individual....Descriptive analysis shows that those in the poorest quintile are 9 times more likely to report that they are suffering from TB or associated symptoms than those in the top quintile.

Regression analysis shows that TB prevalence has a positive and significant association with urban location, age, being black or Coloured, living in the Eastern Cape, Free State, KwaZulu-Natal or Northwest province (compared to the base case which is the Western Cape) and overcrowded living conditions. More education, being female and living in Limpopo (rather than the Western Cape) significantly reduce the likelihood of having TB. The addition of these intermediary factors significantly reduces the coefficient on poverty and provides preliminary evidence to show that policies targeting these specific transmission channels may significantly reduce the vulnerability of the poor to this disease. We find no evidence of significant differences in access to care and also no

³⁶ ‘What is vulnerability?’ *International federation of red cross and red crescent societies (IFRC)* available at <http://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/what-is-vulnerability/>, accessed on 2 February 2017.

significant patterns in the reported levels of satisfaction across poverty quintiles for TB sufferers. TB sufferers from poor households are less likely to consult doctors and to utilize private care”³⁷

It should be noted at this point that *capacity* referred to here is different from mental capacity or competence which Moodley describes as clinical judgement of an individual’s ability to agree to or decline a treatment or course of action³⁸. The legal interpretation of this capacity is however, is referred to as competence.³⁹

1.4. The legal framework for managing infectious health conditions in South Africa

1.4.1. (a) *Protecting the health rights of persons – international standards*

Health as a right means that everyone is entitled to the highest attainable standard of physical and mental health within available resources⁴⁰. This ‘highest attainable standard of care’ which includes access to all medical services, good sanitation, adequate food, decent housing, healthy working conditions, and a clean and safe environment, is enforced by the International Covenant on Economic Social and Cultural Rights (ICESCR)⁴¹. Accordingly, this covenant ensures a systems that supports the notion that everyone has the right to the health care they need, and to living conditions that enable us to be healthy, such as adequate food, housing, and a healthy environment. And also, health care must be provided as a public good for all, financed publicly and equitably⁴².

³⁷ R Burger & E Moses ‘TB and Poverty’ 2013 RESEP. Available at <http://resep.sun.ac.za/index.php/research-areas/tb-screening-and-treatment/tb-and-poverty/>

³⁸ K Moodley ‘Law and the health professional in South Africa’ in K Moodley (ed) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 44.

³⁹ Ibid.

⁴⁰ General Comment No. 14: The Right to the Highest Attainable Standard of Health - UN Committee on Economic, Social and Cultural Rights

⁴¹ The International Covenant on Economic, Social and Cultural Rights (ICESCR) is a multilateral treaty adopted by the United Nations General Assembly on 16 December 1966, and in force from 3 January 1976. The Covenant is monitored by the UN Committee on Economic, Social and Cultural Rights and forms a part of the International Bill of Human Rights, along with the Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR), including the latter’s first and second Optional Protocols. South Africa formally ratified the ICESCR in January 18, 2015 (after having signed it in 1994) therefore making it legally binding within her political landscape. In a nutshell, the international Bill of Human Rights has as its arms, the UDHR, the ICCPR, and the ICESCR

⁴² Ibid, Article 12

Furthermore, this human right to health care means that hospitals, clinics, medicines, and doctors' services must be accessible, available, acceptable, and of good quality for everyone, on an equitable basis, where and when needed⁴³.

1.4.2. The Constitution of the Republic of South Africa

The Constitution⁴⁴ 'is generally regarded as the most liberal and progressive national constitution in the world'⁴⁵, and it serves like all other constitutions, to set the limits on the exercise of state power. A Constitution should give the government enough power to govern but should not allow it to abuse that power⁴⁶. The concept of abuse and need for protection of human rights deserves special mention especially with the pre-1994 apartheid history of South Africa. The need for protection of any rights serves to underscore the propensity for abuse of same and as rightly asserted, "The Bill of Rights is arguably the part of the constitution that has had the greatest impact on life in this country.... reaffirming the democratic values of human dignity, equality and freedom"⁴⁷

Noting the history of South Africa, the liberal nature of the Constitution, *vis a vis* the Bill of Rights and equality, the following statement will indeed be appropriate:

Our Constitution entrenches both civil and political rights and social and economic rights. All the rights in our Bill of Rights are interrelated and mutually supporting. There can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied those who have no food, clothing or shelter. Affording socio-economic rights to all people therefore enables them to enjoy the other rights enshrined in Chapter 2 (of the Constitution – the Bill of Rights). The realization of these rights is also key to the advancement of race and gender equality and the evolution of a society in which men and women are equally able to achieve their full potential⁴⁸

⁴³ 'what-is-the-human-right-to-health-and-health-care' available at <https://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care>, accessed on 7 March 2017.

⁴⁴ Note 2 above

⁴⁵ JA Singh 'Law and the health professional in South Africa' in K Moodley (ed) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 112.

⁴⁶ DLA Cliffe Dekker Hofmeyr *Rights For All: The Bill of Rights in all Official Languages* (2013) xiii.

⁴⁷ Ibid

⁴⁸ Justice Yacoob in *Government of the Republic of South Africa & Others v Grootboom & Others* (11) BCLR 1169 (CC)

1.4.3. The Bill of Rights (BOR)⁴⁹

Sections 7, 8 and 39 of the Constitution will be elaborated upon here:

Section 7 of the bill of the Constitution identifies the Bill of Rights as the cornerstone of South African democracy. It expresses the rights of people in the country as well as the values of human dignity, equality and freedom. It therefore places an obligation on the state to respect, promote and fulfil the rights contained therein, and also provides that the rights may be limited in terms of section 36 or certain other provisions⁵⁰.

Section 8 refers to its application to the extent that is it universal and binding to the all arms of government- the Executive, Judiciary and legislature and every other organ of state. Where it concerns a juristic person, the person is entitled to rights that to the extent that concerns not only their nature, but the nature of the rights in question and therefore any limitation thereof must be read inter alia with the provisions as stipulated in section 39 of the Constitution⁵¹.

Concerning its interpretation, and the necessary authority for it, this must be done in such a manner that is based on human dignity, equality and freedom, and that are found in any democratic society. International legal instruments should be considered and any applicable foreign law may also be read as well⁵².

This section on interpretation is particularly relevant, as will be seen in subsequent chapters how international law was compulsorily considered to “promote the spirit, purport and objects of the Bill of Rights”⁵³.

1.4.4. (c) The Statutory framework

Assented to in 2004, the Act⁵⁴ exists “to provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith”⁵⁵. It takes cognizance of the fact that there were injustices of the past in the Republic

⁴⁹ Note 3 above

⁵⁰ Note 2 above, section 7

⁵¹ Note 2 above, section 36

⁵² Note 2 above section 39

⁵³ *ibid*

⁵⁴ Note 21 above

⁵⁵ *Ibid*

(of South Africa), and in the present democratic dispensation, heal the rifts, improve the quality of life and respect fundamental human rights of all⁵⁶.

The relevant portions of the Constitution⁵⁷ that empower the Act⁵⁸ include:

The State must, in compliance with section 7(2) of the Constitution, respect, protect, promote and fulfil the rights enshrined in the Bill of Rights, which is a cornerstone of democracy in South Africa. In terms of section 27(2) of the Constitution the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services, including reproductive health care. Section 27(3) of the Constitution provides that no one may be refused emergency medical treatment; whilst in terms of section 28(l) (c) of the Constitution every child has the right to basic health care services and in terms of section 24(a) of the Constitution everyone has the right to an environment that is not harmful to their health or well-being.

Although the legislature is responsible for statutory laws, and the Executive arm of government for governance as well as drafting and amending state policy, “most statutes also confer the right on relevant cabinet ministers to make regulations in connection therewith. Regulations are sometimes referred to as subordinate legislation, and are equally as legally binding as the principal legislation under which they are passed”⁵⁹. The 2010 regulation of The Act⁶⁰ regulation gives the minister of health provision (after consultation with the National Health Council) to make certain changes, especially as it concerns communicable diseases including DR-TB. These will be discussed in detail in chapter 3.

1.5. The ethical framework for managing infectious health conditions in South Africa

Public health aims to understand and ameliorate the causes of disease and disability in a population⁶¹. As against the one on one relationship in a clinical/medical setting, it involves interactions and relationships with many community members, professionals, governments and non-government agencies. Consisting of

⁵⁶ *ibid*

⁵⁷ Note 2 above

⁵⁸ Note 21 above

⁵⁹ J Singh ‘Law and the Health professional in South Africa’ in K Moodley (ed) *Medical Ethics Law and Human Rights: A south African perspective* (2011) 110

⁶⁰ Note 22 above

⁶¹ JF Childress, RR Faden, RD Gaare; et al ‘Public health ethics: Mapping the terrain’ (2002) 30 *Journal of Law, Medicine & Ethics* 170.

laws, actions, policies and interventions thatare concerned with the health of the entire population, rather than individuals. Its features include amongst others, health promotion, disease prevention, collection and use of epidemiological data, population surveillance, knowledge of health determinants and factors involved in effective health interventions⁶²

The key words from this description set the tone for protecting the general population from being infected with a highly contagious disease agent (DR-TB), getting reliable information from regular screening and relying on case reports for necessary interventions. It follows therefore that such complex interactions involving patients, communities and government will result in a different set of ethics that is not normally seen in a 'routine doctor-patient' clinical setting. We will therefore need to understand the differential dynamics of public health ethics.

Van Niekerk⁶³ introduces the four ethical principles which mainly govern clinical settings (autonomy, beneficence, non-maleficence and justice) and whilst this paper will focus on public health ethics, these principles will also be used inter-alia with boni mores (together known as general moral considerations) in determining to what extent interventions will be instituted in public health.

Childress et al⁶⁴ introduce three dimensions involved in public health ethics. The first is in the definition of public to include a numerical public or target population. This numerical public is utilitarian, with each person counting as a unit. In other words, the numerical public is everyone (including DR-TB patients), with the net happiness being derived from the total number of people protected by the sequestration of DR-TB patients. This net happiness is underscored by the fact that more people will be protected by isolating the fewer DR-TB patients, who have a potential to infect more people.

The second dimension is the 'political public'. Simply referring to the role of government and public agencies in protecting health. Governments are mandated to act affirmatively in protecting the health of people. Although government cannot arbitrarily invade people's rights in the name of communal good, in liberal, pluralistic democracies, this can be done if there is justification for doing so, especially if they border on the boni mores (see below) of the people being protected.

⁶² ibid

⁶³ AA Van Niekerk 'Ethics theories and the principlist approach in bioethics' in K Moodley (ed) *Medical ethics, law and human rights: A South African perspective* (2011) 37

⁶⁴ Note 61 above, 171

The 'communal public' is the 3rd dimension and refers to non-government participants in public health, who may not necessarily get consent from the political public, but also must not act contra boni mores. Borrowing from the South African context, the Treatment Action Campaign (TAC)⁶⁵ case in spearheading antiretroviral campaigns to treat HIV-positive patients and protect the public is a case of communal public in action. Although in this particular case the Minister for health as appellant was appealing an earlier judgment made in favour of the TAC. The TAC had earlier successfully sued for the administration of Nevirapine (an HIV medication) to pregnant and expectant mothers in South Africa. Nevirapine had been discovered to be effective against transmission of HIV from mothers to their children and would also form part of essential medicines in South Africa. The minister summarily also lost the appeal in this case.

1.5.1. Resolving conflict among general moral considerations in public health ethics

The goal of public health-producing benefits, preventing harms and maximizing utility⁶⁶ will often be met after weighing up different moral considerations to decide on a particular course of action. That said, the rationalization process(es) is based on the following five justificatory conditions or parameters

- Effectiveness: the questions often asked is 'will restricting one or more general considerations be beneficial for public health?' Of what use will the restriction be if public health objectives are not achieved?⁶⁷
- Proportionality: there should be an inverse relationship between the moral consideration denied and the public health objective achieved. The virulence and costs of treating DR-TB (including death and suffering) will far outweigh the restrictions placed on freedom when patients are detained, even involuntarily⁶⁸.
- Least infringement: the least mode of restriction should be sought and applied. That said, if the chosen intervention is restriction of freedom (which is contrary to autonomy as a general moral consideration) the least manner of restriction should be sought. I will attempt a schema to say nil shackles, freedom of movement (within and around the hospice or treatment facility), nil solitary

⁶⁵ *Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC)

⁶⁶ Note 64 above.

⁶⁷ Note 61 above, 173

⁶⁸ *ibid*

confinements, torture and of course, the earliest route back home when patients are no longer infectious⁶⁹.

- Public justification: this simply refers to the political public (and communal public) seeking to get the numerical public's acceptance and buy-in of proposed interventions⁷⁰. Key here will be stakeholder identification and involvement⁷¹. Accountability and boni mores are also ensured through this process (my words and analogy)
- Necessity: Even with proof of effectiveness and proportionality, not all interventions will be deemed necessary⁷². The prima facie case of the law of necessity stipulates utilizing a less morally troubling route. This refers to least morally troubling intervention to achieve an objective, as against least infringement (above) which speaks to course of chosen action and rationalizing the least (and best) manner to achieve same. It is noteworthy to point out that this justificatory condition (necessity) is reflected in the Goliath case⁷³. Here, there was a judgment based on among other things, the common law ground of justification of necessity. This case is further elaborated on in chapter 3.

1.5.2. Other relevant bioethical theories

As already introduced, there are four principlist theories⁷⁴ as well as some other boni mores ideologies/values that help rationalize when and how to institute public health interventions. It is necessary to reflect on these, because although we will mainly deal with a different set of rules (in public health), respect for each individual's autonomy, justice, beneficence and non-maleficence will still be taken into consideration in designing public health policies. Furthermore, the necessity for overriding any of these will be based on to what extent they will impact on the interventions planned to achieve desired results. Simply put, in trying to decide whether to involuntarily detain DR-TB patients from infecting the public, autonomy will easily be relegated in favour of public health.

The general moral considerations include:

⁶⁹ *ibid*

⁷⁰ *ibid*

⁷¹ Stakeholder identification and involvement are elaborated upon in recommendations below (chapter 4)

⁷² Note 70 above

⁷³ *Minister of Health, Western Cape v Goliath* 2009 2 SA 248 (C)

⁷⁴ Note 63 above

- Producing benefits (beneficence)⁷⁵
- Avoiding, preventing and removing harm (non-maleficence)⁷⁶
- Respecting autonomous choices and actions including liberty of action (autonomy)⁷⁷
- Distributing benefits and burdens fairly and ensuring public participation, including the participation of affected parties (distributive and procedural justice, respectively)⁷⁸
- Producing the maximal balance of benefits over harms and other costs (utility)⁷⁹
- Protecting privacy and confidentiality⁸⁰
- Keeping promises and commitments⁸¹
- Transparency⁸²
- Trust (building and maintaining same)⁸³

Furthermore there is the concept of casuistry which also assigns weights to these interventions. Casuistry is “the approach where we learn ethical insights primarily by studying cases”⁸⁴. They (Childress et al) contend that “public health specialists should focus on new situations with relevant similarities to and differences from paradigm or precedent cases that have gained a relatively settled moral consensus”⁸⁵.

Having already noted that the rationalization in public health ethics is different to that in routine clinical/patient milieu, it is imperative to point out that the principles⁸⁶ introduced above, as well as other (biomedical or clinical) ethical theories will still need to be considered when dealing with the public. In a nutshell, as much fit there is as possible to these theories reflects a greater bearing on us as to what we ‘should do’ when confronted with ethical dilemma in actuality.

⁷⁵ Note 61 above, 171

⁷⁶ *ibid*

⁷⁷ *ibid*

⁷⁸ *ibid*

⁷⁹ *ibid*

⁸⁰ *ibid*

⁸¹ *ibid*

⁸² *ibid*

⁸³ *ibid*

⁸⁴ Note 63 above

⁸⁵ *ibid*

⁸⁶ Note 63 above

These ethical theories discussed in the next chapter will include communitarianism, Kantian deontology, ethics of care, virtue ethics, social contract theory, utilitarianism, liberal individualism, casuistry, as well as narrative ethics. There is also the concept of subsidiarity⁸⁷, which although not regarded as a biomedical theory per se, will be deemed useful as it incorporates the tenets of at least two or more of the aforementioned theories in its application. Subsidiarity encourages the tenets of autonomy and communitarianism⁸⁸ to be applied together for each patient encountered.

1.6. The Siracusa Principles⁸⁹

More appropriately known in full as The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, they serve to provide a framework for the legitimate and ethical denial of certain rights derogable and non-derogable (except the entirely non-derogable)⁹⁰. Developed in 1984 by a team of international law experts who met in Siracusa Italy, these principles serve to correct the arbitrary denial of certain rights by historical and contemporary governments. As noted, they came into being because it was noted

....”that one of the main instruments employed by governments to repress and deny the fundamental rights and freedoms of peoples has been the illegal and unwarranted Declaration of Martial Law or a State of Emergency. Very often these measures are taken under the pretext of the existence of a “public emergency which threatens the life of the nation” or “threats to its national security.” The abuse of applicable provisions allowing governments to limit and derogate from certain rights contained in the International Covenant on Civil and Political Rights has resulted in the need for a closer examination of the conditions and grounds for permissible limitations and derogations in order to achieve an effective implementation of the rule of law. The United Nations General Assembly has frequently

⁸⁷ World Health Organization *Guidance on ethics of tuberculosis prevention, care and control* (2010) 7

⁸⁸ Elaborated in chapter 2 (section 2.4).

⁸⁹ United Nations, Economic and Social Council *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, U.N. Doc. E/CN.4/1985/4, Annex (1985).

⁹⁰ Note 2 above, section 37.

emphasized the importance of a uniform interpretation of limitations on rights enunciated in the Covenant⁹¹.

The background to the Siracusa Principles⁹², as noted, is one that allows the denial of certain rights especially as it concerns public health, national security and public safety in a democratic society, as well as maintaining public order, as prescribed by law. Regarding public health, we may be concerned about quarantine/isolation of certain patients with communicable or contagious diseases. This denies them certain rights (freedom and privacy, for instance) in order to protect the general public at large. It is worth noting here that although the aim is to treat, the 'informed consent' parameter of the right to health of patients is lacking, putting this 'right' in question. Ethically speaking, autonomy (and liberal individualism)⁹³ is overcome in favour of utilitarianism⁹⁴ and communitarianism⁹⁵. As stated, "public health may be invoked as a ground for limiting certain rights in order to allow a state to take measures in dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured. Due regard shall be had to the international health regulations of the World Health Organization"⁹⁶

Mburu et al further elaborated on the Siracusa Principles as those "which were adopted by the UN Economic and Social Council allowing for the limitation of individual rights as a means to deal with a serious threat to the health of the population of individual members of the populations"⁹⁷. They further elaborated on the relevant justifications for enforcing these limitations and these include that they (limitations) are:

- Provided for and carried out in accordance with the law⁹⁸
- Directed towards a legitimate objective of general interest⁹⁹

⁹¹ 'The siracusa principles on the limitation and derogation provisions in the International Convention on Civil and Political Rights' *American Association for the international commission of jurists* 1985 available at <https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf> accessed on 17 October 2017

⁹² Note 89 above

⁹³ Note chapter 2 (section 2.4)

⁹⁴ *ibid*

⁹⁵ *ibid*

⁹⁶ Note 91 above, Limitation clauses 25, 26.

⁹⁷ G Mburu, E Restoy, E Kibuchi; et al 'Detention of people lost to follow-up on TB treatment in Kenya: the need for human rights-based alternatives' 2016 *HHR*

⁹⁸ Note 91 above

⁹⁹ *ibid*

- Strictly necessary in a democratic society least intrusive and restrictive in severity and duration to achieve the objective¹⁰⁰
- Based on scientific evidence and neither drafted nor imposed arbitrarily nor in a discriminatory manner¹⁰¹

According to the WHO, this limitation of rights and movements “must be viewed as a last resort and justified only after all voluntary measures to isolate such a patient have failed”.... and “each one of the five criteria must be met, but should be of a limited duration and subject to review and appeal¹⁰²”.

From the above, what can therefore be deduced is 3-fold:

- Public health ethics are founded on the Siracusa Principles
- DR-TB, as already introduced, is a serious public health safety concern and any concomitant detention (especially when involuntary) will raise ethico-legal arguments
- The Siracusa Principles serve to balance all the scenarios-protecting the public (and individual) right to health. This simply means that the principles balance the ethical and legal angles.

1.6.1. Infection control strategies used in the Siracusa Principles

There are four words commonly encountered in infection control strategies and they are often incorrectly used interchangeably. These are isolation, detention, incarceration and quarantine.

- Isolation

This refers to separation of persons who have a specific infectious illness from those who are healthy, and the restriction of the movement of the sick to stop them from spreading the illness¹⁰³. This isolation could either be voluntary or involuntary; solitary or in groups; and in the ‘patients’ homes or in designated healthcare facilities.

¹⁰⁰ *ibid*

¹⁰¹ *ibid*

¹⁰² ‘WHO guidance on human rights and involuntary detention for XDR-TB control’ (2007) *World Health Organization*

¹⁰³ JA Singh ‘Humanitarian work and Infection Control: Legal, Ethical, Human Rights, and Social Considerations’ 2007 *Humanitarian Stakes No1: MSF Switzerland Review on Humanitarian Stakes and Practices*

Voluntary isolation occurs when following appropriate counseling or any other necessary intervention, the 'patient' decides to isolate himself on his own accord/volition, to protect those uninfected, but could be at risk.

- Involuntary detention

Also known as therapeutic detention¹⁰⁴, or in my words, involuntary isolation. This is applied to those who have a propensity to infect others, but have deliberately or inadvertently failed to take precautions to do so. It could also be in isolation or in groups. Whilst solitary confinement is the ideal model, economic and human resource constraints, especially in developing countries make group isolation the norm. Either way, the need for conditions which protect dignity (and other human rights as elaborated above) can never be overemphasized. Whatever the set up, it should always be as a last resort and in line with the Siracusa Principles¹⁰⁵ already introduced above. The role of effective counselling and patient/community education is also salient as a means of informing on TB/DR-TB and of course, the importance of voluntary isolation as a means of prevention.

- Quarantine

This simply refers to the separation and restriction of the movement of persons who, while not yet ill, have been exposed to an infectious agent and therefore may become infectious...."in order to to prevent such a disease from spreading"¹⁰⁶.

- Incarceration

Incarceration is often used as a misnomer for involuntary detention. Singh elucidates on incarceration to mean the "imprisonment of individuals who have been tried and convicted of a crime, or those who violate a court order"¹⁰⁷. Contextually speaking, a convict who has DR-TB, will of course be incarcerated and isolated (preferably solitarily), but this is actually different to detaining non-convicted public citizens who have DR-TB but have not taken precautions to protect the numerical public (involuntary detention as described above). These precautions could either be in the form of voluntary isolation and/or adhering to treatment and other infection control measures.

¹⁰⁴ *ibid*

¹⁰⁵ Note 89, above

¹⁰⁶ Note 103, above

¹⁰⁷ *ibid*

1.7. Conclusion

The Constitution¹⁰⁸ provides for the limitation of certain rights insofar as some conditions are met. Often involuntarily, this detention may be temporary or permanent (seen in incurable XDR-TB, or in cases where patients with more potentially treatable forms of TB, are averse to taking treatment and/or taking necessary precautions not to infect others). Where, there is a need to remove such persons from society, their rights to self-determination and bodily integrity (autonomy) still have to be respected. This simply means although they can be sequestered, they do still retain the rights to refuse or not to be forced to receive treatment. This sentiment is echoed by Singh et al “...we will not argue for forcible treatment of patients with MDR-TB or XDR-TB, simply restriction of mobility rights of such individuals”¹⁰⁹.

Accordingly, from a legislative angle “isolation’ is defined as the separation of persons who are ill or suspected of having a specific infectious disease from those who are healthy, with the objective of preventing transmission of infection and allowing for specialized care”. The procedures for this isolation are those that are “used in nursing care to protect health care workers, patients and other persons against infectious agents transmitted from a patient or patients suffering from a communicable disease”¹¹⁰.

From a public health angle, it would therefore be argued that the consequences of isolating virulently ill people in order to protect the larger public is the right thing to do. Isolating and denying the rights of a few hundred to protect thousands, if not millions nationally, and across borders will obviously result in a positive balance of overall happiness. The relevant statutory frameworks already introduced will be discussed in subsequent chapters and will give a legal backing to such an action.

¹⁰⁸ Note 2, above

¹⁰⁹ JA Singh, R Upshur & N Padayatchi ‘XDR-TB in South Africa: no time for denial or complacency’ (2007) 4 (1) PLoS Medicine 0004.

¹¹⁰ Note 22, above.

CHAPTER 2

THE ETHICAL IMPLICATIONS

2.1. Introduction

As already previously stated, the ethical issue in question relates to that of public health ethics. Therefore, the first issue to note is that the more common biomedical and other ethical theories such as principlism¹¹¹ and communitarianism¹¹², although considered, will be relegated in favour of utilitarian, goal-oriented concerns.

Ab-initio, I submit that ethical scenarios, be they clinical, public health or even regular day-to-day events, are subject to systematic analysis and rationalizations as they are oftentimes not resolved by facts. Moodley concurs when she states that ethics deals with arguments and “real ethical arguments cannot be settled definitively by recourse to facts”¹¹³. In support of this stance, the WHO document on the Guidance on ethics of tuberculosis prevention, care and control¹¹⁴ contends that ethics can give rise to some disagreements or conflicts. These conflicts can however be rationalized through analysis and discussions. In so doing, the differential views can be articulated into a “rough consensus” that takes cognizance of the fact that situations will sometimes arise when some rights and obligations are held to be more salient than others¹¹⁵. Adding to this, London¹¹⁶ also introduces the need for resolving conflicts when he states that different people’s rights may conflict and the state may need to violate someone’s rights in the interest of meeting obligations to fulfil that of others. Key provisions that will be considered here will therefore be the South African Bill of Rights¹¹⁷ and the Siracusa Principles¹¹⁸. The rationalizing of these arguments and conflicts into a cohesive whole will indeed form the core of this chapter.

2.2. The facts

¹¹¹ Section 2.4 below

¹¹² *ibid*

¹¹³ Note 63 above, page 12

¹¹⁴ Note 87 above, page 5

¹¹⁵ Note 2 above, section 37

¹¹⁶ L London ‘Law and the Health professional in South Africa’ in K Moodley (ed) *Medical Ethics Law and Human Rights: A south African perspective* (2011) 103

¹¹⁷ Note 2 above, ss7-39

¹¹⁸ Note 89 above

The fact to be considered is whether it is ethically valid to detain (or isolate) persons with DR-TB against their will. It has been introduced that this should be done after persons having received adequate counseling and information, still fail to take measures to protect their health and that of the numerical public.

2.3. The ethical issues

The relevant questions to be discussed here will include those that pertain to TB/DR-TB generally; isolation in TB/DR-TB; as well as informed consent to and adherence to TB treatment. Although stated here, the entire analysis in this chapter will attempt to answer these questions:

- Is it ever ethically acceptable to resort to involuntary isolation?
- Under what circumstances can forced isolation or detention be ethically appropriate?
- What are the safeguards to prevent abuse of the practice of involuntary isolation or detention?
- Is it ever appropriate to compel TB patients to undergo treatment over their objection?

2.4. The Relevant Rules

These will be divided into two sections: the ethical and then the legal rulings. The ethical rulings will form the focus of this chapter and the legal rulings, whilst introduced here, will be elaborated upon in the next chapter.

2.4.1. The Ethical rules and Applications

(a) The public ethics dimension

Public health ethical decisions are founded on casuistry¹¹⁹ and utilitarianism¹²⁰ and the rationalization of issues that arise from them consider the following rationales: Public Justification, Least infringement, Effectiveness, Necessity, Proportionality and Necessity. Before delving further, I wish to point that these five public health rationales find their legal basis on the 'law of necessity' or the common law ground of

¹¹⁹ Note section 2.4 below

¹²⁰ ibid

justification of necessity as elaborated upon by Mcquoid-Mason and Dada¹²¹. Although the legal angle will be dealt with in more detail in the succeeding chapters, it is essential to introduce and highlight at this stage, the commonalities between both (ethical and legal) perspectives. The common law ground of justification of necessity highlights is one such example where both the legal and ethical angles are indeed similar. In rationalizing the ethical basis for involuntary detention, this (common law ground of justification) will be seen in all the discussions.

The common law ground of justification of necessity¹²² refers to an act by a person in protecting himself or another from a threat being justified under the following conditions:

- The threat is imminent or has started¹²³
- The person or persons are not obliged to tolerate the threat¹²⁴
- The protective action is proportionate (inversely) to the harm being protected from¹²⁵
- There must be an emergency¹²⁶
- Consent is irrelevant¹²⁷
- Pro boni mores¹²⁸

Rationalizing the ethical basis for involuntary isolation of DR-TB patients:

- Public Justification

This simply refers to the political public¹²⁹ (and communal public¹³⁰) seeking to get the acceptance of the numerical public¹³¹ and their buy-in of proposed interventions. In other words, justifying the infringement/intervention to the public. This is mainly via measures that ensure public/stakeholder participation and of course boni mores. One major way by which this can happen is by correct and adequate information, which will also ensure proper accountability of the entire process. The manner in

¹²¹ D Mcquoid-Mason & M Dada *A-Z of Medical Law* (2011) 291-292

¹²² *ibid*

¹²³ *ibid*

¹²⁴ *ibid*

¹²⁵ *ibid*

¹²⁶ *ibid*

¹²⁷ *ibid*

¹²⁸ *ibid*

¹²⁹ Note section 1.5 above

¹³⁰ *ibid*

¹³¹ *ibid*

which the community is engaged¹³² will determine the acceptance and even the acceptance of the intervention by the 'affected' parties.

That said, the right information in the right amount on DR-TB, via patient and public education will make infective persons in particular, take precautions and prevent spreading the infection to others. The right information in the right amount to the public on the need for involuntary detention (when affected persons who are infective) do not take precautions to protect others will also make the numerical public more amenable to such an intervention. Another way in which information will be properly disseminated to ensure buy-in is in the information on the rights of the affected persons and the information that they can appeal their detention at any time and the fact that they will be released insofar as they are deemed no longer infectious.

- Least infringement

The least mode of restriction should be chosen and applied. That said, if the chosen intervention is restriction of freedom (which is contrary to autonomy¹³³ as a general moral consideration¹³⁴) the least manner of restriction should be sought. I will attempt a schema to say there should be nil shackles, nil restriction of freedom of movement (within and around the hospital or treatment facility), nil solitary confinements, torture and of course, the earliest route back home when patients are no longer infectious. Put in clearer light, the idea here can be seen from the following example: if the intervention, for instance, reduces confidentiality, only that information necessary to achieve the goal should be divulged.

- Effectiveness

The questions often asked is 'will restricting one or more general considerations be beneficial for public health?' Of what use will the restriction be if public health objectives are not achieved?

For the first question, what we want to know is how efficacious is the proposed intervention- limiting the rights to freedom in DR-TB. The answer here can be gleaned from evidence- based practices from scientific and medical research. The route and manner of transmission of TB¹³⁵ will also be taken into account.

¹³² See community engagement in the recommendations chapter (chapter 4)

¹³³ Section 2.4 below

¹³⁴ 1.3.1

¹³⁵ See introduction above (section 1.5.2)

For the second question, the public health objectives of maximizing benefits and protecting the numerical public at large will indeed be met when involuntary isolation is enforced.

- Proportionality

There should be an inverse relationship between the moral consideration denied and the public health objective achieved. The pertinent question here is whether restricting a few people's rights to freedom/autonomy will be deemed superior or inferior to protecting the communal public from a potentially deadly, oftentimes untreatable medical condition? The answer will lie in the rationalization that the virulence and costs of treating DR-TB (including death and suffering) will far outweigh the restrictions placed on freedom when patients are detained, even involuntarily.

- Necessity

Even with proof of effectiveness and proportionality, not all interventions will be deemed necessary. When one analyzes all the contributory factors under law of necessity¹³⁶ described above, this point becomes more lucid. Faced with an impending or ongoing public health crisis in the form of DR-TB, it will therefore be necessary for respective governments to involuntarily detain anyone who poses a threat to others.

In summary, I wish to elaborate on two important concepts: the one is that the five (5) parameters discussed above (justification, least infringement, necessity, public justification and effectiveness) all find their legal basis in the common law ground of justification. This common law ground of justification is not only synchronizing the legal and ethical dimensions of the issue at stake (that of involuntary isolation), it forms the basis in rationalizing the public health ethical considerations in the light of the aforementioned parameters. Furthermore, it can be used inter-alia in interpreting the constitutional provision that speaks about the limitation of rights¹³⁷.

The second and quite relevant to this section is that, it can be seen that involuntary detention in DR-TB, from a public health perspective can be justified, necessary and effective if done in a less restrictive manner which will be more rewarding than the opportunity cost. The opportunity cost being referred to here will be in the form of allowing such infected and contagious persons mix freely without restrictions, to such end that will expose everyone to a potentially untreatable and deadly disease.

¹³⁶ Note 121 above

¹³⁷ Note 2 above, section 36

(b) The bioethical principles

In order to get a more holistic appraisal, the biomedical ethical theories will then be separately applied to the scenario at hand.

- Principlism

Principlism is one of the main biomedical theories seen in clinical practice, with its four major branches as elaborated upon below. Principlism is founded on the premise that moral/ethical problems are resolved by applying one or more of these four principles (or branches)¹³⁸. Two cardinal aspects of principlism must be pointed out. These are:

- It is based on the idea of ‘common morality’¹³⁹. This is elaborated to mean that it is consistent with a ‘pre-theoretic common sense’ that people can relate to and identify with. Simply put, before theories came to be postulated as they are now, justice and ‘doing good’ (beneficence in principlism; see below) have existed among people in civil societies¹⁴⁰.
- Resolving conflicts among the principles is best done via a process of reflective equilibrium, where weights are assigned to each principle until some ‘balance’ is arrived at¹⁴¹.

van Niekerk contends, and I concur, that rationalizations via reflective equilibrium are never absolute, and open to revision, especially in the wake of new/overwhelming information¹⁴². Being able to critically appraise issues through systematic rationalization and reasoning as such, is indeed the hallmark of ethical discussions/arguments. As van Niekerk elaborates “arguments are central exactly because real ethical issues cannot be settled definitively by recourse to facts”....although facts can support or strengthen ethical arguments¹⁴³.

The four principles:

1. Autonomy

¹³⁸ AA van Niekerk ‘Ethics theories and the principlist approach in bioethics’ in K Moodley (ed) *Medical Ethics, Law and Human rights: A South African Perspective* (2011) 37.

¹³⁹ Ibid, page 38

¹⁴⁰ Ibid

¹⁴¹ Ibid, page 39

¹⁴² Ibid

¹⁴³ AA van Niekerk ‘Ethics and Philosophy’ in K Moodley (ed) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 12-13

Also known as 'self-rule', it simply translates into self/first person responsibility and in decisions that affect him/her. It is justified by: truth telling, respect for privacy, protecting confidential information, obtaining informed consent and help in making decisions as requested¹⁴⁴. Autonomy is however, never absolute and can be overridden if it clashes with an equal or stronger rule. Emergency medical care is one instance in which the principle of autonomy becomes relegated and paternalism becomes the norm. Paternalism therefore "occurs where one person overrides the autonomy and right to self-determination of another person for the good of the other person....it is based on the ethical principle of beneficence and conflicts with the ethical principle of patient autonomy"¹⁴⁵. Protection of third parties in danger, such as in public health situations, is another where autonomy may be rendered invalid. By extrapolation, in DR-TB, suspects/patients may be denied their 'self-rule' to protect the public at large. Although it must be reiterated that only freedom of movement need be restricted. DR-TB cases in isolation still have the final say in whether they will take treatment.

2. Beneficence

This simply refers to 'doing good'. In so doing, the rules will be: protecting and defending the rights of others and prevention of harm to them, helping persons with disabilities and rescuing those in danger¹⁴⁶. It is often understood to cover acts of kindness or charity that go beyond strict obligation, for instance helping someone in danger, or those with disabilities¹⁴⁷. Moodley further advises that these rules can best be achieved via clinical competence, a risk-benefit analysis and paternalism¹⁴⁸.

In rationalizing involuntary detention of DR-TB persons through the principle of beneficence, it can be argued that:

- The rights to freedom of the DR-TB cases are presumed subservient to the rights to health and a healthy environment of the numerical public. They (numerical public) will need to be protected from danger by removing such conditions that will cause it, whether the danger is ongoing and/or anticipated.

¹⁴⁴ K Moodley 'Respect for patient autonomy' in K Moodley (ed) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 42

¹⁴⁵ Note 121 above, 314

¹⁴⁶ K Moodley 'Beneficence' in K Moodley (ed) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 57

¹⁴⁷ *ibid*

¹⁴⁸ *ibid*

- When doctors or health workers are clinically competent (also in line with Siracusa Principle of scientific validity), they can best perform a risk v benefit appraisal of the situation and therefore, isolate cases in a paternalistic manner. In summary, when autonomy cannot be guaranteed based on reflective equilibrium, then beneficence can be used to justify the scenario. Beneficence here as has already been noted may take the form of emergency medical care and/or protection of third parties in danger (among others). In doing good ‘over and beyond what is expected’¹⁴⁹, the onus may therefore be on the enforcers of the involuntary detention, the obligation to cater to the needs of the dependents of those being detained.

3. Non-maleficence

Closely linked to beneficence, non-maleficence means ‘do no harm’. Its rules include: do not kill, do not cause pain or suffering to others, do not incapacitate others, do not cause offense to others, do not deprive others of the good life¹⁵⁰. These are all overseen by the delicate balance between risk versus benefit. As put by Moodley, “the risk versus benefit ratio of any treatment or intervention needs to be carefully considered at all times to maintain the delicate balance between beneficence and non-maleficence”¹⁵¹. The Health Professions Council of South Africa (HPCSA) guidelines recognize that oftentimes, acting in a non-maleficent manner will mean that “Health care practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest”¹⁵². In other words, in balancing risk versus benefits in considerations involving patients, from a clinical perspective, the best interest of the patient must always override the personal value system of the attending physician. An analogy to be used here will be a doctor who for personal or religious grounds, ordinarily will not do an abortion, should therefore act in the following manner:

- (a) In an emergency setting, perform the abortion, based on the best interest principle, to save a patient’s life
- (b) In a non-emergency setting, refer the patient to a physician who is amenable to the procedure, without any prejudice, regardless of the index doctor’s personal beliefs or value system.

¹⁴⁹ Note 147 above

¹⁵⁰ K Moodley ‘Non-Maleficence’ in K Moodley (ed) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 63

¹⁵¹ *Ibid*, 70

¹⁵² The Health Professions Council of South Africa *General Ethical Guidelines for The Health Care Professions Booklet 1 2*

In making decisions on involuntary isolation, the benefits of isolating subjects with a potentially untreatable/life threatening condition will far outweigh the risks of not doing so. The benefits of isolating few people who can infect more members of the public because of non-compliance with treatment protocols and/or with an incurable communicable disease can never be overemphasized.

4. Justice

Justice deals with fairness. An injustice is said to occur “when some benefit to which a person is entitled is denied without good reason”¹⁵³. In deciding whether it is fair to isolate DR-TB cases, the main issues to be considered under justice will be legal justice and rights-based justice. The legal and human rights implications of involuntary isolation have already been introduced¹⁵⁴ and will be elaborated upon in the succeeding chapter. The conclusion is that it is indeed egalitarian to detain/isolate DR-TB cases in certain instances when conditions necessitate such actions. These conditions necessitating the involuntary isolation/detention may therefore be said to be the “justification for the injustice (detention) as elucidated above.

(c) The bioethical theories:

- Utilitarianism

Van Niekerk contends that in utilitarianism, a subset of consequentialism, “the consequences of actions are to be taken, and taken exclusively as the only concern in terms of which the moral status (i.e. the moral rightness or wrongness) of an action is to be decided¹⁵⁵. He goes further to discuss that the three primary requirements for utilitarianism will be that:

- Actions are to be judged on the consequences they give, nothing else matters¹⁵⁶
- The amount of happiness created is the only factor in assessing consequences¹⁵⁷
- Each happiness counts as a unit and the net calculated happiness determines the balance of happiness over unhappiness¹⁵⁸

¹⁵³ JA Singh ‘Ethical Decision-making’ In: MA Dada and DJ Mcquoid-Mason (eds.) *Introduction to Medico-Legal Practice* (2001) 37.

¹⁵⁴ Note chapter 1, above

¹⁵⁵ AA van Niekerk ‘Ethics Theories and the Principlist Approach in Bioethics’ in K. Moodley (ed) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 20

¹⁵⁶ *Ibid*, 21

¹⁵⁷ *ibid*

¹⁵⁸ *ibid*

“Utilitarianism has been an extremely influential theory, not only in the history of ethics, but particularly in the sphere of moral deliberation about public policy. Whenever a politician talks about the ‘public interest’ or the ‘greater benefit of society’ when justifying a policy decision, he or she invokes a utilitarian argument of some sort”¹⁵⁹

The role of utilitarianism as a public health pillar can never be overemphasized. As DR-TB is a public health/public health ethics issue, utilitarianism will therefore encourage the involuntary isolation of a few TB patients with a potentially deadly form of the disease, to protect the general (and numerically far superior) public.

- Kantian Deontology

According to deontologists, actions are right only if they conform to a morally acceptable principle, which are similar to the pre-theoretic common sense principles of principlism¹⁶⁰. Thus deontologists firstly determine if their actions will be generally acceptable for everyone to do (after a personal moral evaluation) and if so, then that action is the right one to do¹⁶¹. The prima facie duties inherent in deontology will therefore include: fidelity (truth telling), reparation, gratitude, beneficence, non-maleficence, justice, self – improvement or development¹⁶². It will therefore be noted that there is a strong correlation between principlism (see above) and deontology. The deontological duties as listed and ‘general acceptability’ conform to and are consistent with the pre-theoretic common sense of principlism¹⁶³.

In referencing Deontology, where only the ‘actions’ or ‘deeds’ do matter, involuntary isolation will therefore be seen to be unethical. That said, the action of ‘involuntarily detaining/isolating DR-TB patients who have not taken precautions to curb the spread to others’ may not be pursued by a deontologist, for reasons being that not everyone may be amenable to detaining a non-criminal ‘just because he has a disease’ (my quotes for emphasis). This speak to the shortcomings of this moral theory in that consequences cannot be overlooked in the actual world, and in real life, a rigid stance cannot be tolerated in everyday application. This inflexibility in abrogating morality solely to actions, may put everyone at risk of contracting DR-TB,

¹⁵⁹ Ibid, 22

¹⁶⁰ Note 138 above

¹⁶¹ Note 153 above, 38

¹⁶² Note 153 above, 38-39

¹⁶³ Note 138 above

which is very much anti-public health strategies. As van Niekerk¹⁶⁴ rightly contends, Kantianism is “in direct opposition to utilitarianism”

- Virtue Ethics

As opposed to Deontology, Virtue Ethics, is interested not in the actions, or the consequences (utilitarianism), but in the actors themselves¹⁶⁵. Conferring a moral status to the character of the people perpetuating the actions simply means that ‘good people can and should do good things’ (my words). That said, the submission that medical doctors, by training, are supposed to treat and restore sick people to wellness, means that ‘virtually’ all their actions will be deemed morally sound. Therefore, the detention of DR-TB patients, regardless of justification, will be acceptable.

Another angle encouraged by virtue ethicists is that “the knowledge to decide what is best for the patient comes with practice and experience. It can thus be concluded that according to virtue ethicists, morally virtuous people have a good motive and use skills and practice which come with experience when making ethically correct decisions”¹⁶⁶. The same extrapolation can be made of anyone else within the health facility who enforces such isolation (nurses and security personnel). Outside the health establishment, the police officers or correctional officers who detain persons found guilty of criminal acts. Insofar as they are trained law enforcement agents, their actions will be deemed ‘good and moral’. This forms the foundations of virtue ethics.

Although, it is known in actuality that people are oftentimes dissociated from their professions on the basis of character, and this speaks to the shortcomings of this theory. Furthermore, despite skills and experience, healthcare workers are oftentimes faced with unprecedented experiences that may call for deviation from the norm, where experience and skill alone may not result in the right choices being made¹⁶⁷. For the purpose of this paper however, the summary is that based on virtue ethics, DR-TB patients can be detained, as per the hitherto raised point of good people by training, and experience and qualifications will do what is best for their patients.

- Liberal individualism

¹⁶⁴ Note 155 above, 25

¹⁶⁵ Note 155 above 29-30

¹⁶⁶ Note 153 above, 38

¹⁶⁷ *ibid*

Ab-initio, advocating for autonomy, this theory may seem to be wholly against any action that limits the freedom and rights of individuals. However, the fact is that these rights and freedom are only sacrosanct insofar as they do not pose a threat to others¹⁶⁸. This simply means that they are 'relative, not absolute' rights, hence DR-TB patients can be involuntarily detained when they fail to take precautions that will prevent others from contracting the potentially deadly disease. As van Niekerk puts it...."power may only be exerted to curb our freedom when not to do so might bring harm to others"¹⁶⁹. In summary, applying this theory to the issue of involuntary detention will therefore depend on the actions and duties of the persons in question (those with DR-TB). Should they therefore engage in behaviour that does not expose the numerical public to imminent danger (adhering to treatment, possibly also voluntary isolation as examples) then their autonomy will be respected. The reverse will be the case should they fail to adhere to the necessary infection control procedures.

- Communitarianism

In direct contrast to the first part of Liberal Individualism (that of rights and freedoms) this theory encourages the promotion of communal values, beliefs and principles, over that of individuals. In advocating for communal values over individuals, autonomy and informed consent are relegated and communities (or families at a relatively more micro level) make decisions on behalf of individuals. The overwhelming notion here is in decision-making, not necessarily in protecting the communal public as it were. It can therefore be defined as "a model of political organization that stresses ties of affection, kinship, and a sense of common purpose and tradition"¹⁷⁰

It should also be pointed out at this juncture that communitarian decisions will therefore speak to *boni mores*, after a buy-in which will most likely involve community leaders and other stakeholders. In applying this to the issue at hand, involuntary detention *may* only be enforced after community engagement. Hence the need to get the leaders/stakeholders on board through a series of collaborative partnerships and engagements¹⁷¹. This view is best expressed by the following statement "communitarianism promotes

¹⁶⁸ Note 153 above, 35

¹⁶⁹ *ibid*

¹⁷⁰ S Blackburn 'Communitarianism' *Oxford Dictionary of Philosophy* (1996) 63

¹⁷¹ Note section 4.2 below

persuasion rather than coercion in the quest for pro-social behaviour through counselling, conflict resolution, communication, pluralism and consensus through dialogue”¹⁷².

Hence, a failed persuasion, equals failed stakeholder involvement and nil involuntary detention of DR-TB persons. On the other hand, however, the detention may take place when “personal rights such as the right to healthcare are regarded in a communal context”. In so doing, “the right question therefore to ask is “what is most conducive for society, rather than does it violate autonomy”?”¹⁷³

- Social contract theory

The main pillars of social contract theory (SCT) can be summarized to include: Communal arrangement for the benefit of all members of the society; submitting to authority to create law and order; addressing inequalities-both genetic and societal; and finally, accepting these inequalities if they work to everyone’s advantage¹⁷⁴.

In applying these to the issue at hand, DR-TB patients will be isolated if benefits everyone (especially if they are catered for both medically and socio-economically to also redress inequalities), especially if this isolation is codified in law.

- Casuistry

Here, the idea is to build theories from studying cases, comparing similarities and noting differences between them. As van Niekerk puts it, “ethics proceeds best when we start with a case, think about its moral issues and challenges, try to compare aspects of the case with other cases that we might also have encountered, and thus slowly build up a more comprehensive perspective that can assist us in future”¹⁷⁵.

Societies have always ostracized those with communicable diseases to protect the general/communal public. An example of this can be seen in the Biblical case of leprosy, where it was stated “all the days wherein the plague shall be in him he shall be defiled; he is unclean; he shall dwell alone; without the camp

¹⁷² GA Ogunbanjo & D Knapp van Bogaert ‘Communitarianism and Communitarian Bioethics’ (2005) *SA Fam Pract* 47(10) 51

¹⁷³ *Ibid* 53

¹⁷⁴ Note 153 above, 33

¹⁷⁵ Note 153 above, 37

shall his habitation be”¹⁷⁶. The ‘modern plague’¹⁷⁷ two centuries ago and a more contemporary issue as seen in the Goliath case¹⁷⁸, offer further examples. Casuistry has proof of not only the boni mores application of isolation, but also has exposed some ethical concerns in its application.

The one overwhelming concern, however, will not be in the fact that it shows acceptable proof in the utility and purpose of isolation in the wake of communicable diseases, but of course in preventing discrimination and prejudice. For instance, in New York, USA, the “use of isolation orders for tuberculosis in the 1990s show that more than 90% of the people detained were non-white and more than 60% were homeless”¹⁷⁹. From a casuistic angle, this historical perspective of potential for discrimination will serve to prevent same from happening in contemporary times.

It may also not be entirely out of context to further advocate the need for treatment in addition to isolation, under casuistry. Whilst noting the autonomous angle where patients cannot be forced to take treatment after been involuntarily detained, it must be emphasized that there is evidence to show that patients become less infective, within a few days of initiating treatment for TB¹⁸⁰. Ongoing didactic counselling in addition to detention is the ideal and this can and should be advocated (see Recommendations below).

- The ethics of care

Based on feminist bioethics¹⁸¹, ethics of care concerns itself with being flexible and open to totality of care¹⁸² that is not as ‘authoritarian’ in enforcement as utilitarianism for example. A good analogy will be seen in the case of a mother who may love and protect her child no matter what and/or a propensity to overindulge, as against a more ‘paternalistic or strict disciplinarian’ approach (which utilitarianism¹⁸³ or principlism¹⁸⁴ will seemingly allow). That said, this theory, may by extrapolation, be against isolating DR-TB patients as it seemingly is contrary to the notion of caring for the sick that is not dictated by authority or stipulations.

¹⁷⁶ Leviticus Chapter 13 verse 46, *The Holy Bible, King James Version*

¹⁷⁷ ‘Plague’ available at <https://www.cdc.gov/plague/history/index.html> accessed on 31 October 2017.

¹⁷⁸ Note 73 above

¹⁷⁹ WE Parmet ‘Legal Power and Legal Rights-Isolation and Quarantine in the case of Drug-Resistant Tuberculosis’ (2007) 357 (5) *New England Journal of Medicine* 434.

¹⁸⁰ Note Chapter 1 above, section 1.3.3

¹⁸¹ Note 185 below

¹⁸² Note 155 above, 36

¹⁸³ Note 155 above

¹⁸⁴ Note 138 above

- Narrative Ethics

As the name implies, narrative ethics (NE) involves getting the person's story, 'narrative' or perspective and taking same into consideration in arriving at decisions that concern them. The person's (or patient's in the clinical setting) perspective enables the service provider (through empathy) to better plan interventions that will not only be holistic, but shared, in terms of decision-making.

Narrative theorists believe that the narrative approach brings out the details of cases which may be lost if a rigid approach to decision-making is adopted. Narrative theorists believe that health workers must appreciate, understand and be interested in the story of the patient, and then help the patient or the patient's family to interpret the narrative in order to make an appropriate decision¹⁸⁵

In the clinical setting, autonomy is reflected in NE, whilst in the public health setting, NE may make non-autonomous interventions to be more acceptable and effective. A simple way to look at NE (in public health settings) insofar as involuntary isolation refers, is in perhaps devising a means of catering to the financial and other needs of dependents of isolated persons and/or where applicable, isolating them in close proximity to their families where supervised visits and other forms of psycho-social care can be provided. The only way of knowing about dependents, if any, is by taking a proper detailed history (the narrative) of the patient.

In a nutshell, Narrative Ethics will not be against involuntary detention, but rather encourage it, taking contextual factors from the patient into consideration. This contextual angle will be more holistic in outlook, ensuring maximal care for the persons concerned, and pro boni mores for the numerical public perspective.

- Feminist bioethics

Given the historical male dominance in social and medical issues, feminism and more specifically feminist bioethics concerns itself with addressing these inequalities. As such, we may define feminist bioethics as that which concerns itself with analyzing and challenging (female) oppression¹⁸⁶. Some have argued that feminist bioethics involve analyzing and challenging oppression, generally¹⁸⁷. For the purpose of this paper,

¹⁸⁵ Note 153 above

¹⁸⁶ SM Wolf 'Introduction: gender and feminism in bioethics'. In SM Wolf (ed) *Feminism and Bioethics: Beyond Reproduction* (1996) 8

¹⁸⁷ Ibid 10

we will focus on the ethical concerns regarding females (biologically) who have DR-TB, and need to be involuntarily detained as a result.

Here, special attention, amongst others, must be paid to the differentials in dynamics from males. Concerns such as sanitary pads and sanitation needs, the possibility for sexual oppression and dominance from male attendants who may enforce the detention/isolation and the issue of children and families dependent on the females' caregiving roles. Women usually play caregiving roles at the home front, mainly¹⁸⁸ and there may also be issues of caring for children. These speak to the concept of the ethics of care¹⁸⁹, narrative ethics¹⁹⁰, boni mores and community stakeholder involvement¹⁹¹. The historical and contemporary issues of women and vulnerability must also be factored here¹⁹², especially taking into consideration the issues of sexual harassment being allegedly propagated in Europe and America presently, as exemplified by the Weinstein situation¹⁹³.

That said, for these women, it would be ethical to involuntarily detain them (if they fail to comply with best practices on infection control). Especially noted here will be narrative ethics¹⁹⁴ as elucidated above, ethics of care¹⁹⁵, and also from a utilitarian perspective¹⁹⁶. These perspectives will ensure that all stakeholders¹⁹⁷ including the children that the females take care of will need to be protected from a potentially deadly and untreatable medical condition.

- Subsidiarity

Not exactly an ethical theory, this concept is added here because it seems to draw upon at least three (3) of the aforementioned theories, viz, liberal individualism, communitarianism and narrative ethics. It is described as a value that "promotes the idea that decisions should be made as close to the individual and

¹⁸⁸ I Ofunne *An Assessment of the Knowledge, Attitudes and Practices of Caregivers of HIV Positive Children in Pretoria, South Africa: A case Study of Out-patients in Kalafong Hospital, Pretoria* (unpublished MPhil Thesis, University of Stellenbosch, 2014) 25

¹⁸⁹ Note 181 above

¹⁹⁰ Note 184 above

¹⁹¹ Note Chapter 4, section 4.2

¹⁹² Note Chapter 1 above, section 1.3.5

¹⁹³ 'Harvey Weinstein' *The Guardian Online* December 2017 available at <https://www.theguardian.com/film/harvey-weinstein>, accessed on 14 December 2017.

¹⁹⁴ Note 184 above

¹⁹⁵ Note 182 above

¹⁹⁶ Note 155 above

¹⁹⁷ Note 87 above, 7

communities at local level as possible. The idea is that this ought to result in decisions reflecting local interests, concerns and beliefs, and ensure the highest possible involvement by the public”¹⁹⁸

The summary and conclusion of this chapter can be done from a strategic rationalization where points are awarded each theory or argument presented. Using an equality not equity format (where each argument scores the same point as the next) the following summation is seen:

Public health rationalization	In favour of involuntary isolation Y/N
JUSTIFICATION	Y
NECESSITY	Y
LEAST INFRINGEMENT	Y
PROPORTIONALITY	Y
EFFECTIVENESS	Y

Bioethical theory (principlism)	Y/N
Autonomy	N
Beneficence	Y
Non-maleficence	Y
Justice	Y

Other Bioethical Theories	Y/N
Utilitarianism	Y
Kantian Deontology	N
Virtue ethics	Y
Liberal individualism	Y/N
Communitarianism	Y/N
Social contract theory	Y/N

¹⁹⁸ WHO Guidance on ethics of tuberculosis prevention, care and control page 7, Geneva Switzerland.

Casuistry	Y
Ethics of care	N
Narrative ethics	Y/N
Subsidiarity	Y/N
Feminist bioethics	Y

Table 1: Public health rationale, Ethical principles and biomethical theories

The summary is that although it is indeed ethical and appropriate to detain certain persons with DR-TB, against their wish, it is always advisable if the ethical actions are not contra boni mores to the societal values and expectations.

2.5. Conclusion

In conclusion from the foregoing, it is indeed ethical and permissible to isolate certain persons with DR-TB. Each case should however be assessed on its merit and after ALL less restrictive means like didactic counselling and community/person education have been exhausted. This is particularly important, as evidence, as seen, shows that patients cease to be infectious within a few weeks of initiating treatment¹⁹⁹. Less restrictive means to get patients to comply with therapy and as such be less contagious are indeed always desirable and should be vigorously advocated.

For those (hopefully rare) cases where involuntary detention may have to be enforced, the onus is on the authorities and enforcers to employ the detention with the ethical backgrounds discussed herein. The government and other ethico-legal structures which are liable for the public health guidance and protection, based on a sense of duty, can take such a stance.

The next chapter will analyze the legal angle of involuntary detention, its applicability in South Africa and what, if any, legal authorities will be used to encourage or deter the action.

¹⁹⁹ Note 180

Chapter 3

THE LEGAL IMPLICATIONS

3.1. Introduction

From the introduction, that South Africa has one of the highest DR-TB prevalence in the world is a known fact²⁰⁰. That the burden of HIV and the significant socio-economic burden of the epidemic takes a significant toll on the priority setting decisions of the National Government has already been stated (introduction above)²⁰¹. Furthermore, in the preceding chapter, we argued as to the ethical acceptability of detaining persons with DR-TB, especially when they (affected persons) fail to take precautions not to infect the numerical public. This chapter will analyze the legal provisions under which involuntary detention may take place.

From a South African perspective, what is indeed noteworthy is that prior to 2010, there was no effective legislative framework put in place to tackle the DR-TB scourge, further placing more burdens on the government's responsibility to provide for the rights to health, as enshrined in the Constitution²⁰². The Act²⁰³ dealt with issues of treatment without consent, but was silent on the issue of mandatory isolation, especially in the outbreak of Infectious diseases with severe public health sequelae.

Besides (and perhaps linked to) the hitherto dearth of legal frameworks to tackle the disease, healthcare establishments, particularly in the public health sector have faced logistic challenges in containing the disease. According to Carstens:

“Ultimately these health-care providers/services have been challenged, not only in the diagnosis and treatment of XDR-TB patients, but specifically to control and curtail the spread thereof by effectively managing sufferers by way of forced isolation and monitoring to ensure that they abide by the rules and strict treatment regime related to XDR-TB. The said challenge has become exacerbated specifically in public health-care facilities where patients suffering from XDR-TB fail to abide by the treatment regime and regularly abscond from follow-up appointments, posing a real threat of infection to the community at large”²⁰⁴

²⁰⁰ Note Chapter 1, section 1.1

²⁰¹ Note Chapter 1, section 1.3

²⁰² Note 2 above, Section 27

²⁰³ Note 21 above

²⁰⁴ Note 1 above, 420

These logistic inadequacies were again elaborated upon in the case of *Dudley Lee v Minister of Correctional services*²⁰⁵, hereafter referred to as the Dudley Lee case. The facts of which are as follows: The applicant, Mr Lee, was detained at Pollsmoor Maximum Security Prison from 1999 to 2004. The respondent is the Minister for Correctional Services (Minister) and the Treatment Action Campaign, Wits Justice Project and Center for Applied Legal Studies, were admitted as amici curiae. Mr Lee contracted tuberculosis (TB) while in prison. He sued the Minister for damages on the basis that the poor prison health management resulted in his becoming infected. The High Court upheld the claim on the basis that the prison authorities had failed to take reasonable steps to prevent Lee from contracting TB. This same poor standards existed in many correctional facilities nationwide and fell short of what should reasonably be the norm.

In noting the recommendations that should be adopted, Bateman²⁰⁶ noted that supervision and assistance from the National Department of Health, as well as the promulgation of effective communicable disease laws²⁰⁷, would be the way forward. This position and solution was aptly summarized by Professor Orsini-Duse²⁰⁸ then Chair Chief Specialist Department of Clinical Microbiology and Infectious Diseases School of Pathology of the NHLS & University of the Witwatersrand, Johannesburg, South Africa. He summarized that:

- State required ethically and by law to protect communities from being exposed to, and acquiring, potentially dangerous Infectious Diseases (IDs)²⁰⁹.
- Health Act ‘empowers’ Public Health (PH) authorities to implement interventions to contain those IDs that are a PH threat BUT these must be carefully balanced with rights of the patient as an individual. Furthermore, in SA Constitution, provision is made for restriction of individual rights under strict circumstances²¹⁰.

²⁰⁵ *Dudley Lee v Minister of Correctional Services* (2012) CCT 20/12

²⁰⁶ C Bateman ‘Breaching the chasm between what’s law and what’s done’ (2014) *S Afr Med J* 104 (9) 601

²⁰⁷ Note 22 above

²⁰⁸ AG Orsini-Duse M/XDR-TB and the Law: South African Context (2007) available at http://www.who.int/tb/events/archive/icmeeting_oct07/03_duse.pdf, accessed on 5 June 2017

²⁰⁹ *ibid*

²¹⁰ *ibid*

- Constitutionally, however, all South Africans are entitled to a safe and healthy environment, including right to be protected from infection²¹¹.
- Public Health interventions for IDs, with aim to contain infection, that have to resort to quarantine or detention of affected individuals will come at a cost of individual rights (particularly those concerning freedom and privacy)²¹².
- Violations of individual patient rights include violation of rights to: (i) freedom & security of person, (ii) life, (iii) healthcare services & emergency medical treatment, (iv) privacy, (v) justice, and (vi) those that, consequent to enforced hospitalization and isolation, impact on human dignity, freedom of movement & residence, and freedom of trade, occupation and from enforced detention.²¹³

With the Act²¹⁴ already introduced (chapter 1) as catering to the right to health in the Constitution²¹⁵ and the obligation it imposes on the respective government levels be they national, provincial or local, the regulations to the Act²¹⁶, specifically address the issue of communicable disease legislation. Concerning communicable diseases, chapter 4 (of the regulations) specifically discusses the mandatory medical examination, isolation and quarantine of persons diagnosed with MDR or XDR-TB.

As a summary, patients with DR-TB should ideally be isolated (voluntarily) after appropriate/adequate counselling. This counselling will take the form of both scientific, medical and social implications of the disease and it is supported by the regulations to the Act²¹⁷. If the patient refuses voluntary isolation and poses a risk to the public either by deliberate or non-deliberate actions (my words) then Involuntary isolation will be instituted.

3.2. The factual problem

The fact to be considered simply refers to that of detaining persons with DR-TB against their will. More specifically, the legal implications of involuntarily detaining (or isolating) persons with DR-TB.

²¹¹ *ibid*

²¹² *ibid*

²¹³ *ibid*

²¹⁴ Note 21 above

²¹⁵ Note 2 above

²¹⁶ Note 22 above

²¹⁷ *ibid*

3.3. The Legal Issues

The legal questions which should be deliberated upon here, will include:

1. Is the detention legal? Or in other words, can this detention be termed arbitrary or justifiable?
2. Who qualifies for such detention?
3. Can the detained persons challenge the detention? In other words, a counter application, and do the detained persons still retain any of their rights after the detention?
4. On what legal basis can the respondents state their claim that they were unlawfully detained? In other words, what is the statutory basis for the 'arrest and detention'?
5. The evidence necessary for (and duration of) involuntary isolation.
6. Under what conditions and where must be detention be carried out?
7. Who enforces the detention of these persons with DR-TB?

3.4. The Relevant Rules of Law

In analyzing the relevant rules of law, the following factors would be considered based on the sources of law in South Africa and beyond:

- The Constitution
- Statutory Provisions
- Common Law (South African)
- Applicable foreign law
- International legal frameworks

3.4.1. *The Constitution*

With the Constitution²¹⁸ and the Bill of Rights²¹⁹ (BOR) already introduced in chapter one, this section will deal specifically with the limitations of rights and the conditions under which it can be done. Although the Constitution²²⁰, as previously noted (chapter 1) provides a prima facie case against the involuntary isolation of DR-TB persons, based on certain rights they possess²²¹, these rights can be limited under certain conditions itemized in section 36²²². Before discussing the limitations of these rights, it is therefore pertinent to elaborate on some of the rights that the involuntary detention of DR-TB persons will infringe upon. The BOR²²³ introduces the following rights:

- Equality

This speaks to the fact that all are equal and enjoy the same rights to protection and other benefits of the law. As all are equal, any discrimination that is based on race, gender, sex, marital status, ethnicity, colour, age, religion, culture, language is deemed unfair and such discrimination is only held valid if can be proven that it is indeed fair. Appropriate national legislation must be put in place to evaluate and prevent any unfair discrimination along any of such discriminatory grounds as elucidated above²²⁴

- Human dignity

Human dignity is an inherent trait and such must be protected as well as respected²²⁵

- Freedom and security of the person

Freedom and security as rights cannot be denied arbitrarily, such that detention without trial torture and any form of violence and or cruel, inhuman treatment will be deemed unlawful. Autonomous decisions such as those concerning informed consent especially as it pertains to the medical sciences must always be respected²²⁶

- Freedom of movement and residence

²¹⁸ Note 2 above

²¹⁹ Ibid, sections 7-39

²²⁰ Note 2 above

²²¹ Note 219 above

²²² Note 2 above section 36

²²³ Note 2 above, section 7-39

²²⁴ Note 2 above Section 9

²²⁵ Ibid, section 10

²²⁶ Ibid, Section 12

Here, the freedom of movement both within and outside the Republic of South Africa is a right which must be respected²²⁷

- Environment

A safe and healthy environment remains the right of everyone²²⁸

- Healthcare, food, water and social security

The rights to health, which also includes emergency care and reproductive health must be respected. Sufficient access to food and water must be ensured and for those unable to provide, adequate support for such persons and their dependents in the form of social security must be guaranteed by government. All these must be done within the resources at the disposal of the state²²⁹.

- Access to courts

The right to a fair public trial remains the rights of everyone²³⁰

- Arrested, detained or accused persons

Anyone who is arrested or detained must be told the reason(s) for the arrest or detention, and to have prompt access to a legal practitioner. If a legal practitioner cannot be afforded, one must be provided at state's expense. Detained persons retain a right to challenge their detention and should be released if it can be proved that such a detention is illegal. Whenever detention is enforced, such must be done in a manner that is in line with human dignity. The conditions that must be fulfilled if dignity is maintained include adequate accommodation, food and access to medical care. Furthermore access to family and chosen religious personnel must be respected. All these must be done at state's expense and any information so disseminated here, must be done in a language the person understands²³¹

Limitation of Rights

As previously stated, there is a prima facie case against the detention of persons with DR-TB and based on the above from the BOR²³², the respective rights that will be affected have been discussed. For those rights

²²⁷ Ibid, section 21

²²⁸ Ibid, section 24 (a)

²²⁹ Ibid, section 27

²³⁰ Ibid, section 34

²³¹ Ibid, section 35

²³² Note 219 above

that are limited, the onus is on the government to provide some form of justification. Specifically section 36 of the Constitution²³³ becomes relevant here. Section 36 (1) specifically states that these rights may only be limited based on the law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into consideration all relevant factors, including:

- The nature of the right²³⁴
- The importance of the purpose of the limitation²³⁵
- The nature and extent of the limitation²³⁶
- The relation between the limitation and its purpose²³⁷
- Less restrictive means to achieve the purpose²³⁸

Therefore involuntary detention, which restricts the aforementioned rights of persons with DR-TB, is necessitated by the need to protect the numerical public from exposure to deadly/contagious diseases. This restriction will be in place until tests and clinical analysis can confirm that they (persons with DR-TB) are no longer infectious as determined clinically and from laboratory tests and provided that they would have been isolated in designated specialized health facilities for the purpose of treatment (ideally). This isolation will be deemed necessary especially after they have failed to voluntarily take precautions to protect the public, following counselling and voluntary isolation.

On the other issue which speaks to the grounds for challenging the detention, the Constitution²³⁹ furthermore offers some guidance here. Section 38 specifically talks about the enforcement of rights. It states that:

²³³ Note 2 above

²³⁴ Ibid section 36

²³⁵ Ibid

²³⁶ Ibid

²³⁷ Ibid

²³⁸ Ibid

²³⁹ Note 2 above

Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights. The persons who may approach a court are -

- a. anyone acting in their own interest²⁴⁰;
- b. anyone acting on behalf of another person who cannot act in their own name²⁴¹;
- c. anyone acting as a member of, or in the interest of, a group or class of persons²⁴²;
- d. anyone acting in the public interest²⁴³; and
- e. an association acting in the interest of its members²⁴⁴.

For persons who feel their rights have been infringed upon due to DR-TB, they retain the right to “challenge the lawfulness of the detention in person before a court and, if the detention is unlawful, to be released”²⁴⁵.

3.4.2. Statutory Provision

The Act²⁴⁶ as well as the 2010 regulations of the same Act²⁴⁷ will be discussed here. For the Act²⁴⁸, relevant portions of sections 7, 21 and 25 will be summarized:

Concerning consent, the relevant portions of the Act²⁴⁹ allow for service provision without consent when such is authorized by a court order or when failure to treat the user in question, will result in serious threat to public health.²⁵⁰

²⁴⁰ Note 2 above, section 38

²⁴¹ *ibid*

²⁴² *ibid*

²⁴³ *ibid*

²⁴⁴ *ibid*

²⁴⁵ Note 2 above, section 35 (2) (d)

²⁴⁶ Note 21 above

²⁴⁷ Note 22 above

²⁴⁸ Note 21 above

²⁴⁹ *ibid*

²⁵⁰ *Ibid*, section 7

Elaborating further, service here may or may not include treatment (although this is desirable from a clinical perspective), but the involuntary isolation of the DR-TB patients as shown, is ratified by legislative authority (my words)

Section 21 introduces the duties of the National Department of Health, specifically the Director General (DG). Accordingly, these duties will include: development and implementation of the National Health policy, liaising with international health authorities on best practices, as well as with provincial health systems on improving health standards.

From the provincial health unit, section 25 offers guidance, in that the Member of the Executive Council (MEC)²⁵¹ responsible for health, is tasked with the implementation of policies and programmes in conformity with the National Health policy

The regulations to the Act²⁵² read *mutatis mutandis* with the Act²⁵³ sets to further clarify the statutory provisions in terms of communicable diseases. Sub-regulations 18 through 21 speak primarily to the responsible officers charged with enforcing involuntary detention of DR-TB patients, the conditions necessary to be met for such a detention, as well as the duration of and possible extension of such. Lastly, it states that such detention, when reasonably suspected based on the criteria as will be seen, must be enforced pending the outcome of the court order.

Elaborating further, for the heads of establishments and or institutions a knowledge, or even suspicion that someone suffers from a communicable disease or has been in contact with another who suffers from such a disease requires them to notify such. This notification just be done either verbally or in writing to the local or regional government and must be accompanied by quarantine or isolation of such person(s) until informed otherwise by a relevant health authority²⁵⁴. Within a health establishment, a health care provider is to apply for a court order to compel a known case or susceptible contact of MDR or XDR-TB to be admitted to a health facility for isolation and or treatment, also to be examined and biological samples taken for laboratory analyses. This court order is especially indicated when the aforementioned contact or confirmed case refuses to voluntarily consent to the medical interventions so itemized²⁵⁵.

²⁵¹ Note 21 above, section 25

²⁵² Note 22 above

²⁵³ *ibid*

²⁵⁴ *Ibid*, sub-regulation 18 (1)

²⁵⁵ *Ibid*, sub-regulation 21 (1)

The conditions that must be fulfilled before such isolation is carried out are spelt out in sub-regulation 21(3). They include:

- It must be a confirmed communicable disease that poses a health risk²⁵⁶
- Other less restrictive measures which may prevent the occurrence or spread of the disease have been tried and failed²⁵⁷
- An overall evaluation must have been made to the effect that this is clearly the most justifiable course of action in relation to the risk of the disease being transmitted and to stress what the compulsory measure is likely to entail²⁵⁸; and
- It is highly probable that other persons will otherwise be infected²⁵⁹.

An order of the court contemplated when all the aforementioned criteria are fulfilled shall be valid for a period not exceeding six months and wherever an extension of this period is necessitated, a new court order must be duly sought²⁶⁰. Whenever a court order is sought either ab-initio or as an extension, any appropriate medical action or intervention (including of course, involuntary detention) can still be enforced whilst the outcome of the court order is being awaited²⁶¹.

In summary, once DR-TB is suspected in a person (even before confirmation) the head of the institution where the person is located is empowered to quarantine the suspected case, pending medical intervention or confirmation. When the person refuses isolation, even after appropriate counselling, a healthcare provider is empowered to approach a high court for a court order²⁶² to enforce the isolation. The court order is only granted based on the aforementioned conditions in sub-regulation 21 (3), and when granted is valid for 6 months. If the person is confirmed non contagious before the expiration of the 6month order, he may be released back into society, but if still contagious, a renewal of the order for a further 6months will be sought. It is noteworthy that even before the court order is granted, 'appropriate action to protect public health' must still be enforced. In other words, it is not illegal to still involuntarily detain persons with suspected or confirmed cases of DR-TB, pending the process and granting of a court order. As it is noted

²⁵⁶ Note 22 above, sub-regulation 21 (3)

²⁵⁷ *ibid*

²⁵⁸ *ibid*

²⁵⁹ *ibid*

²⁶⁰ Note 22 above, sub-regulation 21 (6)

²⁶¹ Note 22 above, sub-regulation 21 (8)

²⁶² Note 21 above, section 7 (c)

that only health care providers can approach the courts for a detention order, the onus is on them (providers) to be kept abreast with modern diagnostic and treatment approaches, especially as it concerns DR-TB. This last point is further buttressed by the fact that diagnosis of DR-TB is a stipulated requirement for granting the court order.

3.4.3. Common Law

In the Goliath case²⁶³, the lawsuit was initiated by the then Minister for Health (hereafter known as the Applicant) in the Western Cape Province of The Republic of South Africa. The Respondents were a group of four (4) XDR-TB patients who despite appropriate counselling, still posed a risk to society due to their actions. The first respondent, for instance, according to court records, was reportedly disruptive, violent and disrespectful, also he engaged in illicit drug use such as cannabis and metamphetamine. The fourth respondent also reportedly regularly absconded from the facility, interrupting his treatment. These actions not only had the potential to cause further harm to themselves, but also to infect other people with deadly TB strains.

The applicant therefore applied to the court for an order that they should remain in hospital, essentially quarantined until such a time when they are no longer infectious and/or at risk to the general public. As was noted in papers filed, they still persisted in 'risky' behavior, whilst involuntarily kept in the hospital as per the court order. They were also allowed to apply for a counter-order challenging their involuntary stay in the hospital. This was in line with the Constitution²⁶⁴, regulations to the Act²⁶⁵ and Siracusa Principles²⁶⁶ and other relevant international legal frameworks. This Goliath case therefore became a landmark case in the development of the South African common law which speaks to common law of justification of necessity²⁶⁷.

As this case represented a landmark turning point in the South African judicial milieu, the bulk of the discussion here will be incorporating issues from applicable foreign law and legally binding international conventions and covenants.

²⁶³ Note 73 above

²⁶⁴ Note 231 above

²⁶⁵ Note 21 above, section 21 (9)

²⁶⁶ Note 89 above

²⁶⁷ Note 121 above

3.4.4. *Applicable Foreign law*

- *Andrew Speaker vs CDC*²⁶⁸ (hereafter known as the Speaker case):

The facts of this case highlight the arguments raised for involuntary isolation of DR-TB patients and supported by legislative arguments in the USA. Speaker was diagnosed with DR-TB, ignored a restriction of movement order and flew on public commercial flights, further endangering people from diverse international areas. This propensity to cause harm across borders underscores the analogy made by a legislator, where DR-TB is likened to terrorism, which can threaten a nation's existence, and so "must be thwarted by enhanced security measures, including the vigorous application of isolation and quarantine"²⁶⁹.

In the lawsuit, it is imperative to note that the contentious issue was breaching of privacy and confidentiality. It should be noted that Andrew Speaker did not challenge the decision to detain him, which is in line with the Public Health Service Act²⁷⁰, but argued about his right to privacy and confidentiality which he alleged was infringed upon based on the publicity the process of his detention had generated. Although highlighted here, this case however, was one that did not raise any issues as regards involuntary detention per se (which the plaintiff did not object to) but that of confidentiality. Three issues worth noting at this juncture are that the above legislature is in line with the regulations to the Act²⁷¹ and also, the Promotion of Access to Information Act (Act 2 of 2002)²⁷². Lastly, respective government authorities will do well to adopt the South African and American legislatures, which serve to show how involuntary detention can be carried out where communicable diseases like DR-TB are concerned.

- *The Ghanaian and Nigerian Constitutions*

The Constitution of the Republic of Ghana²⁷³ read together with the Constitution of the Federal Republic of Nigeria²⁷⁴ in sections 14 (1) (d) and 35 (1) (e) respectively contend that although the right to personal liberty is a guaranteed entitlement, such freedom may be restricted in instances when a person suffers from a

²⁶⁸ *Speaker vs. HHS and CDC* 680 F.Supp.2d 1359, 1369-70 (N.D.Ga.2009)

²⁶⁹ Note 179 above

²⁷⁰ The Public Health Service Act is a [United States federal law](#) enacted in 1944. The full act is captured under [Title 42 of the United States Code](#) (The Public Health and Welfare), Chapter 6A ([Public Health Service](#)). It is an Act to consolidate and revise the laws pertaining to the Public Health Service and for other purposes. Enacted by the 78th United States Congress, available at <https://www.ssa.gov/policy/docs/sb/v7n8/v7n8p15.pdf>

²⁷¹ Note 22 above

²⁷² The Promotion of Access to Information Act (Act 2 of 2002), section 14 (2)

²⁷³ The 1992 Constitution of the Republic of Ghana

²⁷⁴ The 1999 Constitution of the Federal Republic of Nigeria

communicable disease, or is intoxicated, or mentally unstable, insofar as he possess a risk to himself or to the community at large.

- *The United States Public Health Service Act*²⁷⁵

In this legislature, Part G which deals with quarantine and inspection with respect to communicable diseases states that:

“ (a) The Surgeon General, with the approval of the Secretary is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession. For purposes of carrying out and enforcing such regulations, the Surgeon General may provide for such inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings, and other measures, as in his judgment may be necessary. (b) Regulations prescribed under this section shall not provide for the apprehension, detention, or conditional release of individuals except for the purpose of preventing the introduction, transmission, or spread of such communicable diseases as may be specified from time to time in Executive orders of the President upon the recommendation of the Secretary, in consultation with the Surgeon General”²⁷⁶.

3.4.5. International legal Frameworks

It is imperative next to consider international legal frameworks which can be relied upon to further buttress the fact that isolation/detention of persons with DR-TB is permissible when certain criteria are met. These criteria and isolation policies are universal in application despite recognized geographical differences. The frameworks to consider will include:

- *Article 12 of the UN International Covenant on Civil and Political Rights (ICCPR)*²⁷⁷

The ICCPR was introduced in chapter 1 above and it is one of the two conventions that determine how human rights codified in the Universal Declaration of Human Rights²⁷⁸ (UDHR) should be monitored and

²⁷⁵ Note 270 above

²⁷⁶ *ibid*

²⁷⁷ Note 6 above

²⁷⁸ Note 5 above

implemented. The ICCPR (along with its sister monitoring and implementation rights commission-the International Convention on Civil and Economic, Social and Cultural Rights (ICESCR)²⁷⁹ was established in 1966.

Specifically section 3 of the ICCPR states that:

“The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (*ordre public*), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant”²⁸⁰.

- *The Siracusa Principles*²⁸¹

The Siracusa Principles, already introduced above calls upon respective states to deal with public health emergencies by restricting certain rights, insofar as the restrictive means serve to prevent disease, injury and/or take care of the infirm²⁸²

- *The African Charter on Human and People’s Rights*²⁸³

The African Charter on Human and Peoples' Rights (also known as the Banjul Charter) is an international human rights instrument that is intended to promote and protect human rights and basic freedoms in the African continent. It states that:

“Every individual shall have the right to assemble freely with others. The exercise of this right shall be subject only to necessary restrictions provided for by law in particular those enacted in the interest of national security, the safety, health, ethics and rights and freedoms of others”²⁸⁴.

Regarding the issue of the counter-application, Section 5 affirms the rights (including freedom) which every individual should have. Section 6 gives reasons for any deprivation of same, whilst section 7(1) discusses the rights to appeal. It specifically states that:

²⁷⁹ Note 41 above

²⁸⁰ Note 6 above, Article 12 section 3

²⁸¹ Note 91 above

²⁸² Ibid, Article 25

²⁸³ African (Banjul) Charter on Human and People’s Rights (Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986)

²⁸⁴ Ibid, Article 11

“Every individual shall have the right to have his cause heard. This comprises: (a) the right to an appeal to competent national organs against acts of violating his fundamental rights as recognized and guaranteed by conventions, laws, regulations and customs in force; (b) the right to be presumed innocent until proved guilty by a competent court or tribunal; (c) the right to defense, including the right to be defended by counsel of his choice; (d) the right to be tried within a reasonable time by an impartial court or tribunal”²⁸⁵.

- *The European Convention on Human Rights (ECHR)*²⁸⁶

The ECHR expresses the rights of freedom of movement and residence for those residing within a country and also those expressing a desire to leave any country. These rights may only be limited when national security or public health and safety are being considered. When for any reason this limitation is considered, it must be done in accordance with the law in a democratic society²⁸⁷

Furthermore, concerning the rights to liberty and security, the ECHR expresses that this is a guaranteed right except for the purpose of preventing the spread of infectious diseases. For non-infectious disease conditions, those of unsound mind, alcoholics, drug addicts or vagrants may have this right restricted (especially if they have a tendency to cause harm to themselves or the general public)²⁸⁸. (my words in parenthesis).

On the other issue which speaks to the rights to counter application, the following quote will be considered;

“Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful”²⁸⁹.

²⁸⁵ *Banjul Charter supra*, 7 (1)

²⁸⁶ The European Convention on Human Rights (ECHR) (formally the Convention for the Protection of Human Rights and Fundamental Freedoms) is an international treaty to protect human rights and fundamental freedoms in Europe. Drafted in 1950 by the then newly formed Council of Europe, the convention entered into force on 3 September 1953. All Council of Europe member states are party to the Convention and new members are expected to ratify the convention at the earliest opportunity.

The Convention established the European Court of Human Rights (ECtHR). Any person who feels his or her rights have been violated under the Convention by a state party can take a case to the Court. Judgments finding violations are binding on the States concerned and they are obliged to execute them. Available from https://en.wikipedia.org/wiki/European_Convention_on_Human_Rights#cite_note-Council_of_Europe-1

²⁸⁷ *Ibid* Article 2, protocol 4

²⁸⁸ *ECHR supra* section 1, article 5 (1)

²⁸⁹ *ECHR supra*, Article 5 section 4

In furtherance to this, anyone who has been proven to have been arbitrarily detained or arrested shall retain the rights to appropriate compensation²⁹⁰.

3.5. Conclusion

In conclusion, this chapter has followed up on the legal provisions introduced in chapter one. The human and civil rights angles of equality and non-discrimination and equality provisions of the Constitution²⁹¹ duly noted in chapter one, here, the argument is on the limitation of freedom of certain persons with communicable diseases and the conditions under which that can happen. The Constitution²⁹² and its provisions on limitation of the aforementioned rights have been elaborated upon here. Under common law, the law of justification of necessity has been discussed (chapters 1 and 3), where involuntary detention of DR-TB persons has been argued insofar as they are contagious and pose a threat to person or society. The international statutory frameworks supporting same, in line with the Siracusa Principles²⁹³ have also been highlighted. Comparable foreign laws and relevant international frameworks have equally been analyzed and the conclusion is not only on the legality of denying affected persons of their rights to freedom, but that of making sure it is done in a manner that not only meets international standards, and is also acceptable to the local communities in which they are practiced (*boni mores*)

It is also noteworthy at this juncture that although we have shown that under certain conditions, the involuntary detention of persons with DR-TB is legal and ethical (chapter 2), the onus is also on making sure that in line with the Siracusa Principles²⁹⁴, it is the ultimate last resort²⁹⁵. This is where feasible, practical, as well as innovative recommendations should be considered. The next chapter will attempt to introduce some of these recommendations, with the hope of finding a way forward in other to ending the scourge of the DR-TB (and of course, TB) pandemic.

²⁹⁰ *ECHR supra*, Article 5 section 5

²⁹¹ Note 2 above

²⁹² *ibid*

²⁹³ Note 89 above

²⁹⁴ *ibid*

²⁹⁵ *Ibid*, provision 5

CHAPTER 4

SUMMARY, RECOMMENDATIONS AND CONCLUSION

4.1. Summary

The entire paper can be summarized to state that involuntary Isolation/detention is ethical from a public health ethics perspective insofar as it is effective, necessary and done in a least infringing and proportionate manner which can be justified by and to the public.

From a legal perspective, in terms of section 36 of the Constitution²⁹⁶, rights may be limited in accordance with certain conditions necessary for the limitation of such rights²⁹⁷. Furthermore, from a statutory perspective, it is not illegal to isolate persons with DR-TB ,as the relevant statutory frameworks in South Africa allow for involuntary detention with certain admissible conditions (sections 7,21 and 25 of the Act²⁹⁸, read with s18(1) and s 21(1) of the regulated Act²⁹⁹).

From the foregoing, it can be reasonably concluded that since 2010, Involuntary Detention has been part of the South African legal and public health landscape. Indeed, Amon et al states that “under South African law, authorities may detain an individual suffering from an infectious disease until the disease ceases to present a public health risk; draft government policy guidelines call for the isolation of all MDR- and XDR-TB patients in a specialist facility for a minimum of six months. This authority has been used to isolate individuals with drug resistant TB for as long as two years, often in conditions resembling prisons”³⁰⁰.

That said, it must be noted that even when it is ethical and legal as shown, it must therefore also speak to the good morals of the society, in other words, be pro *boni mores*. The ideal will obviously be an intervention that is pro boni mores as it is ethico-legal. This is where community buy-in will become relevant and should be recommended (see elaboration below). This dimension (boni mores) again, seemingly tends to unite both the ethical and the legal arguments of this paper and can be interpreted to be one of the lacunae that need to be filled to ensure adequate uptake and utilization of involuntary isolation/detention of DR-TB persons who meet the stipulated requirements for isolation.

²⁹⁶ Note 2 above

²⁹⁷ Ibid, section 36

²⁹⁸ Note 21 above

²⁹⁹ Note 22 above

³⁰⁰ JJ Amon, F Girard, S Keshavjee’ Limitations on human rights in the context of drug-resistant tuberculosis: A reply to Boggio et al’ 2009 *Health and Human Rights Journal*.

Other gaps that must be addressed will be those due to logistics and implementation, patients not adhering to treatment, absconding patients, poor facilities which will include diagnostic and adequate buildings for the proper housing of those with DR-TB, poorly trained staff, attrition from staff due to low morale and poor equipment, poor implementation of interventions, among others.

The solutions can be found in the Siracusa Principles³⁰¹, which was discussed in the previous chapters. Forming a benchmark for the ethical and legal application of involuntary isolation of persons with communicable diseases, it elaborates on training and education, scientific knowledge and ethical implementation.

4.2. Recommendations

4.2.1. Enhanced community interventions

This point draws inferences from the ethics of communitarianism, social contract theory and 'subsidiarity'³⁰². Simply put, getting communities to understand, buy-in and participate in decisions to isolate certain members with communicable diseases is an endeavor whose success is dependent on stakeholder involvement. The stakeholders being parties who will be affected by anticipated interventions. For interventions which will see involuntary isolation of DR-TB being successful, the stakeholders will include the DR-TB persons themselves, their families and dependents, their extended communities and friends, work colleagues, community leaders, health care workers, indeed everyone directly or indirectly affected.

Elaborating on 'stakeholders', the following excerpt will be appropriate: "Think of stakeholders as *strategic partners*. They may be key decision-makers, implementers, or customers of your services and activities. They include those who have a stake in the issue you are tackling, those who could be important contributors to solutions and facilitators of change, or those who could potentially block action in certain areas. In selecting and assembling stakeholders, it is important to be inclusive, while balancing the principle of inclusion with the practicality of having a manageable and effective group.... it is essential that the

³⁰¹ Note 91 above

³⁰² Note 87 above

stakeholder group be engaged, actively participate, feel ownership over the process and outcomes, and lead the team—in agreement with the decisions made and actions taken³⁰³”.

Effective stakeholder-targeting will include identifying key gatekeepers like community leaders, elders, religious leaders, and any mentor(s) that the society will look up to. Educating the stakeholders on the risk of TB/DR-TB transmission and the need to isolate persons who do not take precautions to avoid infecting others, especially from a utilitarian³⁰⁴ perspective will help in no small way towards ensuring success. Getting a buy-in from these group of persons will ensure not only a communitarian angle, but also that the isolation of persons becomes pro boni mores.

It should be pointed out that at this juncture that part of the recommendations may also include community interventions that do not necessarily warrant involuntary detention (ID). This is where the Lesotho model becomes relevant. As has already been introduced, ID should always be a last resort³⁰⁵ and I wish to draw upon experiences in Peru and Lesotho using community interventions in the treatment of DR-TB. This model has proven to be effective and can be utilized in similar communities with hard to contain communicable diseases like DR-TB. According to Amon et al ...”programs in Lesotho and elsewhere have demonstrated that community-based treatment models that respect rights can provide clinically effective and cost-effective care”, and as such....”greater emphasis must be put on ensuring access to effective, sustainable, and rights-respecting community based treatment when responding to MDR-and XDR-TB”³⁰⁶.

This community-based approach was pioneered in Peru and involved training community health workers to administer pills and injections to patients, as well as education on infection control. This emphasis on community rather than hospital care is based on Directly Observed Therapy (DOTS)-plus approach, “which included training and hiring people from the community to accompany patients during up to two years of MDR-TB treatment. They achieved very high cure rates of around 83% among those who completed at least four months of treatment in the initial report³⁰⁷. Since that time, the strategy has been expanded to deliver MDR-TB care and treatment throughout Peru. A subsequent report from the country has reported cure rates of 66.3% (out of 400 patients who initiated treatment), and relatively high cure rates for XDR-TB

³⁰³ ‘Optimizing performance and quality’ Available at <https://www.intrahealth.org/opq/stages/stage-2/#stage-content> accessed on 23 September 2017.

³⁰⁴ Note 155 above

³⁰⁵ Note 102 above

³⁰⁶ Note 300 above

³⁰⁷ *ibid*

(60.4%)”³⁰⁸. This is also in line with the WHO document, which asserts that community based care from trained community health workers not only is efficacious, but has been shown to be cost-effective, especially for resource-deficient settings³⁰⁹.

4.2.2. Improve HIV/TB Management

DR-TB and HIV are interrelated. The HIV epidemic in South Africa has especially been implicated in the TB, and by default, the DR-TB spread. As noted, “not only does HIV/AIDS fuel the spread of tuberculosis, but infection with both HIV/AIDS and XDR-TB means an almost certain death. Weak African health systems lack the means to treat XDR-TB patients, for whom the only drugs that might work are much more expensive than regular TB drugs³¹⁰”

It goes without saying that the DR-TB fight is intertwined with HIV fight. Improving health education, scale-up of ART as well as drug availability and adverse drug reactions surveillance should be paired with similar TB programs. Patients who test for HIV, regardless of the outcomes, should also be routinely screened for TB. A high index of suspicion for TB disease is imperative. Accordingly, the WHO ethical guidance summarizes this point succinctly when it states that “for now, TB incidence and mortality in people with HIV can be reduced through early testing of TB patients (and) high quality TB screening in people with HIV, increased use of antiretroviral therapy (ART) and isoniazid preventive therapy (IPT), proper infection control and scale-up of TB diagnostic capacity³¹¹”. For emphasis, IPT is the giving of isoniazid (one of the TB drugs as discussed in chapter one above) to HIV positive patients (who are obviously at risk for TB, but not with active TB disease) with a view to preventing the onset of active TB. It has been shown to reduce the incidence of TB in these patients by at least 60% and in combination with ART, the risk reduction exceeds 80%³¹². As a further note, the role of prompt and effective diagnosis of DR-TB can never be

³⁰⁸ T Smart ‘Decentralised, patient-centred models of delivering treatment and palliative care for people with M/XDR-TB’ (2010) 166 *HATIP* available at <https://www.aidsmap.com/Decentralised-patient-centred-models-of-delivering-treatment-and-palliative-care-for-people-with-MXDR-TB/page/1520451/>, accessed on 19 August 2017

³⁰⁹ Note 102 above, 11-12

³¹⁰ ‘Some TB patients could be forcibly quarantined’ *nbcnews online* 22 January 2007, available at http://www.nbcnews.com/id/16756634/ns/health-infectious_diseases/t/some-tb-patients-could-be-forcibly-quarantined/#.WjKQUVWWbIU

³¹¹ Note 87 above

³¹² Namibia Ministry of Health and Social Services *National Guidelines for Antiretroviral Therapy* 5 ed (2016) 44

overemphasized. It will be recalled that positive identification of DR-TB is a requirement for granting a court order for the involuntary detention of confirmed cases³¹³.

4.2.3. Establishment of DR-TB Committees

Each health establishment where involuntary isolation is to take place must ensure that there is a committee established to analyze cases on its merits and advise accordingly. No two DR-TB cases are exactly the same and each case needs to be assessed individually. Each case marked for involuntary detention comes with its own peculiarities and these should be attended to not only ensure community buy-in but acceptance of the decision from the persons being isolated. The committee members should ideally be from diverse social/demographic backgrounds and even more desirable if they are trained ethicists, and/or people with a knowledge of the law, as well as healthcare workers from the institution concerned. It should be pointed out at this juncture that the committee here encouraged is an 'institution-based' one, and is different to and in addition to that discussed in the 2010 regulations to The Act³¹⁴

Issues that the committee will be empowered to look into will include, but not be limited to:

- Reciprocity: Reciprocity refers to the ethical principle where the onus is on society to provide some form of compensation for individuals who undergo burdens for society³¹⁵. There is therefore a dual perspective here, both to the DR-TB patients who are involuntarily detained and to health care workers. For the former, their deprivation of rights to freedom (and to an extent, autonomy) in order to protect the communal public should be met with either their dependents being taken care of, or perhaps some forms of monetary compensation for time off work. For the latter category (health care workers) the risks they are exposed to when they cater to the needs of persons with potentially deadly diseases. Compensation here could include (but not restricted to) good health insurance packages and/or financially appropriate remuneration, to mention a few.
- Ensure that the process and protocols for isolation are in line with internationally accepted standards and based on the Siracusa Principles³¹⁶.

³¹³ Note 22 above, sub-regulation 21 1

³¹⁴ Note 22 above

³¹⁵ Note 87 above, 10

³¹⁶ Note 89 above

- Institutions earmarked for the purpose of involuntary detention should ideally be those with strict infection control standards and with the personnel skilled in taking care of such patients.

4.2.4. *Enhanced reciprocal obligation to healthcare workers*

Education for health workers across all cadres should focus also on ethico-legal knowledge. Aside from a more holistic perspective to patient care, it also encourages that they (healthcare workers) become agents of change, especially as part of the stakeholder involvement discussed above. When healthcare workers are knowledgeable about the legal aspects of medical practice, the chasm between both professions is bridged. This will be reflected such that cases of malpractice/negligence will be reduced, and from an ethical angle, beneficence is ensured. Elaborating on this beneficence³¹⁷ angle, the rights of patients will indeed be better protected and defending when healthcare workers understand better, what rights are being breached and how best to redress the breach

Other areas in which reciprocal obligations to health workers can be enhanced include but not limited to

- Reciprocity³¹⁸
- Care and support for healthcare workers both in terms of screening for active TB disease and in treatment if identified.
- Appropriate job design and fit for healthcare workers living with HIV. For instance, those living with HIV should not be put in the care of patients with active contagious TB disease

4.2.5. *Making the relevant legislature accessible and encouraging the public to arm themselves with the right legal knowledge/information*

The common law maxim that ‘ignorance is no excuse’ holds true here. Apart from doctors, it behoves the communal public to inform themselves with the appropriate rulings and legislature that concern involuntary detention especially as regards communicable diseases. This knowledge will serve to make such actions (involuntary detention) pro boni mores, as well as ensure persons who may otherwise be detained, take the

³¹⁷ Note 147 above

³¹⁸ Note 87 above, 10

right precautions to avoid that, knowing the outcome should they not comply with such precautionary measures.

4.2.6. Enhanced research

“Bedaquiline is the first drug in a new class of anti-TB medications to be approved in more than 40 years by the US Food and Drug Administration (FDA). It is important to note, however, that owing to the potential for severe adverse events, bedaquiline is not recommended for all patients with MDR TB”³¹⁹. This statement serves to underscore the fact that research into new drug development into the treatment of DR-TB is not only essential but long overdue.

Research into new drug development can take the form of either newer, more efficacious medicines, or off-label use. Off-label use is the prescription of a registered medicine for use that is not included in the product information³²⁰. This is ethical insofar as the use is justified by high-quality evidence, used within a formal research proposal and/or exceptional use justified by individual clinical circumstances (often expert/specialist use). This clinical innovation in the use of registered medicines for which they not initially intended can also include differential dosage, route of administration, or even age range. The justification for off-label use further becomes imperative when one looks at the fact that DR-TB treatment is often between 18-24months and in the case of XDR-TB, potentially untreatable. Newer, less toxic medicine with a shorter duration of treatment is therefore the way to go to reverse the mortality and morbidity from DR-TB. Other areas in which TB research can be done include improved diagnostic and surveillance methods, social and structural determinants of the disease, and non-biomedical interventions³²¹.

4.2.7. General improvement on the social determinants of health

Here, the emphasis will be on correcting the socio-economic conditions that drive TB disease. The cyclical link between TB and poverty has already been introduced in chapter one³²². Poverty alleviation initiatives

³¹⁹ S Mase ‘New Drug Available to Treat Multidrug-Resistant Tuberculosis’ *Medscape online* 31 March 2014, available at <https://www.medscape.com/viewarticle/822098> accessed on 13 October 2107.

³²⁰ M Gazarian, M Kelly, JR Mcphee; et al ‘Off-label use of medicines: consensus recommendations for evaluating appropriateness’ (2006) 185 (10) *MJA* 544

³²¹ Note 87 above, 24

³²² Note 37 above

should be pursued especially in the developing world. Co-operative societies and micro-finance schemes will empower communities in terms of wealth creation and retention. Ongoing financial advice will also be beneficial. Government should seek to provide quality education, good roads and infrastructure, well-staffed health centres to ensure the fulfilments of the right to health. Lastly, provision of quality, affordable housing (or where possible, free) with proper ventilation, will help reduce infection among household contacts³²³.

4.3. Conclusion

That TB or DR-TB is a current and potential public health emergency is no more in contention. That both the rules of law, boni mores and ethical implications impose a bilateral sense of liability both on government and individuals, as has been argued, is no more a matter of conjecture. What is now left is the way forward. Both in America and South Africa, we have seen where judicial rulings have been used to quarantine/sequester patients for the collective good. What is therefore lacking is probably a wider, more generalized international adoption (my words) of the global legislative acts to enforce this, so that the constant, repetitive cycle of abuse (to the persons being isolated, especially where the Siracusa Principles are not upheld) and transmission are eliminated.

Mental health patients can be sequestered based on the mental health care Act³²⁴ and in clinical practice, certain information can be withheld from patients, if such information disclosure may prejudice the patient's recovery from that condition³²⁵, thereby overriding autonomy. It therefore goes without saying that the relevant sections of The Act³²⁶, read with its regulations³²⁷ that speak to communicable diseases and detention of contagious persons until such a time when they are deemed non-infectious and can be re-integrated back to society must be enforced.

³²³ Note 2 above, section 26

³²⁴ The Mental health care Act, Act 17 of 2002, sections 32, 33

³²⁵ Note 112 above, 417 (Therapeutic Privilege)

³²⁶ Note 21 above

³²⁷ Note 22 above

The nisi rule in the Goliath case ³²⁸ is one that further sets the tone for future cases going forward. Evidence from comparable foreign and international laws add evidence to the use of applicable comparable law in the formulation of common law, one of the cornerstones of SA law development.

The costs to both government in terms of providing free treatment for a few, indeed trumps the economic sense (or lack thereof) of providing treatment for more if a check is not made to the spread of DR-TB. Poorly treated DR-TB equals XDR-TB and the effects of an exponential infection of that, on an epidemic scale, is better imagined than experienced. For poorer countries who may battle with costs of free drug provision for infected persons, the multinationals and developed worlds have a huge role to play, not only in this regard, but from a boni mores perspective and a 'self-preservation' angle. With reference to the Speaker case³²⁹, we have seen how DR-TB can be easily spread across borders, making no one country safe or immune from its claws.

The way forward is not just in *nisi rules* applications per se, but as has been shown, the enactment of relevant laws, either constitutionally, or based on the common law of necessity. Adaptation of/from foreign and international laws will also offer guidance in this regard. When the respective national and international health departments have ensured that certain conditions are met (necessity and justification and proportionality to name a few) indeed the public health mandate of protecting the general population in an ethical manner, will always be respected and emphasized.

Ethically, it has been argued over the course of this paper, as to the primacy of utilitarianism³³⁰ and consequentialism³³¹, and also borrowing from virtue ethics³³² and the ethics of care³³³, to mention a few. The overwhelming consensus is in favour of Involuntary Detention (ID). Indeed, the evidence from an 'ethico-legal' angle points towards ID in the care and management of DR-TB patients as a means of controlling the disease, insofar as the infected persons have the propensity to infect others.

From a legal standpoint Singh³³⁴, contends that "in law, there is no liability for an omission (failure to act) unless there is a duty to act or the circumstances are such that society would regard the failure to act as

³²⁸ Note 73 above

³²⁹ Note 268 above

³³⁰ Note 155 above

³³¹ *ibid*

³³² Note 165 above

³³³ Note 181 above

³³⁴ JA Singh 'Law and the health professional in South Africa' in K Moodley (ed) *Medical Ethics, Law and human rights: A South African perspective* (2011) 114

unlawful". In other words, the Government owes a duty to protect the health of its citizens by sequestering (ID) DR-TB patients and this will neither be seen as unlawful nor contra boni mores.

For those who will like to still claim rights and privileges are being denied to such persons, I would like to end with this quote "In our constitution, discrimination is permissible. Unfair discrimination, however, is not. From ethical, legal and Human Rights arguments, the Involuntary Detention of patients with DR-TB is permissible and indeed egalitarian insofar as it is done based on Siracusa Guidelines and must not be contra boni mores"³³⁵.

³³⁵JA Singh, Academic seminar on public health ethics held on 04/04/2017. School of law, Howard College, UKZN

BIBLIOGRAPHY

CASES:

South Africa

- Dudley Lee v Minister of Correctional Services (2012) CCT 20/12
- Minister of Health, Western Cape v Goliath 2009 2 SA 248 (C)
- Government of the Republic of South Africa & Others v Grootboom & Others (11) BCLR 1169 (CC)
- Minister of Health v Treatment Action Campaign (TAC) (2002) 5 SA 721 (CC)

Foreign

- Speaker vs. HHS and CDC 680 F.Supp.2d 1359, 1369-70 (N.D.Ga.2009)

GUIDELINES

- Namibia Ministry of Health and Social Services National Guidelines for Antiretroviral Therapy 5 ed (2016)
- South African National Department of Health Management of Drug-resistant Tuberculosis: Policy Guidelines (2013)
- The Health Professions Council of South Africa General Ethical Guidelines for The Health Care Professions Booklet 1
- WHO guidance on human rights and involuntary detention for XDR-TB control' (2007) World Health Organization

INTERNATIONAL INSTRUMENTS

- African (Banjul) Charter on Human and People's Rights (Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982))
- The European Convention on Human Rights (ECHR)
- The International Covenant on Economic, Social and Cultural Rights (ICESCR)
- The International Covenant on Civil and Political Rights (ICCPR)

- The siracusa principles on the limitation and derogation provisions in the International Convention on Civil and Political Rights
- The United Nations Universal Declaration of Human Rights (1948)

JOURNALS

- C Bateman 'Breaching the chasm between what's law and what's done' (2014) *S Afr Med J* 104 (9)
- JF Childress, RR Faden, RD Gaare; et al 'Public health ethics: Mapping the terrain' (2002) 30 *Journal of Law, Medicine & Ethics*
- GA Ogunbanjo & D Knapp van Bogaert 'Communitarianism and Communitarian Bioethics' (2005) *SA Fam Pract* 47
- JA Singh, R Upshur & N Padayatchi 'XDR-TB in South Africa: no time for denial or complacency' (2007) 4 (1) *PLoS Medicine*
- JJ Amon, F Girard, S Keshavjee' Limitations on human rights in the context of drug-resistant tuberculosis: A reply to Boggio et al' 2009 *Health and Human Rights Journal*
- M Gazarian, M Kelly, JR Mcphee; et al 'Off-label use of medicines: consensus recommendations for evaluating appropriateness' (2006) 185 (10) *MJA*
- G Mburu, E Restoy, E Kibuchi; et al 'Detention of people lost to follow-up on TB treatment in Kenya: the need for human rights-based alternatives' 2016 *HHR*
- P Carstens 'The involuntary detention and isolation of patients infected with extreme resistant tuberculosis (XDR-TB): The implications for public health, human rights and informed consent' (2009) *Obiter*
- WE Parmet 'Legal Power and Legal Rights-Isolation and Quarantine in the case of Drug-Resistant Tuberculosis' (2007) 357 (5) *New England Journal of Medicine*

ONLINE RESOURCES

- AG Orsini-Duse M/XDR-TB and the Law: South African Context (2007) available at http://www.who.int/tb/events/archive/icmeeting_oct07/03_duse.pdf

- B Bosworth 'South Africa battles drug-resistant TB' *Inter Press Agency Online* 12 March 2014, available at <http://www.ipsnews.net/2014/03/south-africa-battles-drug-resistant-tb/>
- 'Harvey Weinstein' *The Guardian Online* December 2017 available at <https://www.theguardian.com/film/harvey-weinstein>
- JA Singh 'Isolating TB patients: prevention is better than cure' (2007) *Journal of Science and Development Network* available at <http://www.scidev.net/en/opinions/isolating-tb-patients-prevention-better-than-cure.html>
- 'Optimizing performance and quality' Available at <https://www.intrahealth.org/opq/stages/stage-2/#stage-content>
- 'Plague' available at <https://www.cdc.gov/plague/history/index.html>
- R Burger & E Moses 'TB and Poverty' 2013 RESEP. Available at <http://resep.sun.ac.za/index.php/research-areas/tb-screening-and-treatment/tb-and-poverty/>
- 'sputum collection during TB treatment' available at <https://www.dhs.wisconsin.gov/publications/p4/p47131.pdf>
- S Mase 'New Drug Available to Treat Multidrug-Resistant Tuberculosis' *Medscape online* 31 March 2014, available at <https://www.medscape.com/viewarticle/822098>
- 'Some TB patients could be forcibly quarantined' *nbcnews online* 22 January 2007, available at http://www.nbcnews.com/id/16756634/ns/health-infectious_diseases/t/some-tb-patients-could-be-forcibly-quarantined/#.WjKQUVWWbIU
- T Frieden 'world must act now to stop drug-resistant TB' 2016 *Fox News*. Available at <http://www.foxnews.com/opinion/2016/01/07/cdc-chief-frieden-world-must-act-now-to-stop-drug-resistant-tb.html>
- T Smart 'Decentralised, patient-centred models of delivering treatment and palliative care for people with M/XDR-TB' (2010) 166 *HATiP* available at <https://www.aidsmap.com/Decentralised-patient-centred-models-of-delivering-treatment-and-palliative-care-for-people-with-MXDR-TB/page/1520451/>
- 'What is TB? How is it treated?' available at <http://www.who.int/features/qa/08/en/>
- 'What is the Difference Between a Human Right and a Civil Right'? Available at <http://www.hq.org/article.asp?id=31546>
- 'what-is-the-human-right-to-health-and-health-care' available at <https://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care>

- 'What is vulnerability?' *International federation of red cross and red crescent societies (IFRC)* available at <http://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/what-is-vulnerability>

STATUTES

South Africa:

- The 1996 Constitution of the Republic of South Africa
- THE Mental Health Care Act, 2002 (Act 2 of 2002)
- The National Health Act, 2003 (Act 61 of 2003)
- The National Health Act, 2003 (Regulation No. R. 287)
- The Promotion of Access to Information Act, 2002 (Act 17 of 2002)

Foreign:

- The 1992 Constitution of the Republic of Ghana
- The 1999 Constitution of the Federal Republic of Nigeria
- The 1944 United States of America Public Service Act

BOOKS

- D Mcquoid-Mason & M Dada *A-Z of Medical Law* (2011). Juta, South Africa
- DLA Cliffe Dekker Hofmeyr *Rights For All: The Bill of Rights in all Official Languages* (2013)
- JA Singh 'Humanitarian work and Infection Control: Legal, Ethical, Human Rights, and Social Considerations' 2007 Humanitarian Stakes No1: MSF Switzerland Review on Humanitarian Stakes and Practices
- JA Singh 'Ethical Decision-making' In: MA Dada and DJ Mcquoid-Mason (eds.) *Introduction to Medico-Legal Practice* (2001)
- K. Moodley (ed.) *Medical Ethics, Law and Human Rights: A South African Perspective* (2011). Van Schaik, Pretoria
- Oxford Dictionary of Philosophy (1996)

- Partners in Health *The PIH Guide to the medical management of multidrug-resistant tuberculosis* 2013
- SM Wolf (ed) *Feminism and Bioethics: Beyond Reproduction* (1996)
- The Holy Bible, King James Version
- World Health Organization *Guidance on ethics of tuberculosis prevention, care and control* (2010)

UNPUBLISHED SOURCES

- I Ofunne 'An Assessment of the Knowledge, Attitudes and Practices of Caregivers of HIV Positive Children in Pretoria, South Africa: A case Study of Out-patients in Kalafong Hospital, Pretoria' (unpublished MPhil Thesis, University of Stellenbosch, 2014). Available at <http://www.scholar.sun.ac.za>

ANNEXURES

ANNEXURE A

Universal Declaration of Human Rights

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people, Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law, Whereas it is essential to promote the development of friendly relations between nations, Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom, Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms, Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge, Now, therefore,

The General Assembly, Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article I

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each State.

2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.

2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.

2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

2. Marriage shall be entered into only with the free and full consent of the intending spouses.

3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.

2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.

2. No one may be compelled to belong to an association.

Article 21

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

2. Everyone has the right to equal access to public service in his country.

3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.

2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

