# TB or Not TB: Drug-Resistant Tuberculosis in South Africa and the Legal Implications of Forced Detainment

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## I. INTRODUCTION

In July 2008, the High Court of South Africa delivered a profound and controversial ruling on a fundamental constitutional matter in the struggle between individual liberty and general public welfare.[1] The

* © 2009 Lance Simon. J.D. candidate 2010, Tulane University School of Law; B.A. 2006, *magna cum laude*, University of Georgia. This Comment is dedicated to the attorneys of the Legal Aid Board in Cape Town, South Africa, who first introduced me to this important issue when I was an intern in 2008 and whose unyielding commitment to justice and the rule of law continues to inspire me.

1. *See Minister of Health of the W. Cape v. Goliath*, No. 13741/07, para. 43 (S. Afr. July 28, 2008), *available at* http://www.alp.org.za/pdf/PressReleases/TBCase_WCMinHealthWCvGoliath.pdf.

court ordered patients with extensive drug-resistant tuberculosis (XDR-TB), a highly contagious and deadly strain of TB, into forced hospitalization.[2] In a nation already plagued by HIV/AIDS,[3] this matter raises important human rights issues within the public health framework. This is particularly relevant in South Africa because, while the State holds itself out as a protector of civil rights and individual liberties,[4] it is still considered an immature democratic society because it has been less than twenty years since the abolition of apartheid.[5]

This Comment explores the legal ramifications of forced quarantine in light of the alarming outbreak in South Africa of drug-resistant TB that threatens to cripple the nation and has the potential to wreak havoc across sub-Saharan Africa.[6] Part II of this Comment provides a brief overview of South Africa's constitutional development, followed by Part III, which presents general background on TB and the emergence of drug-resistant strains. Part IV delves deeper into the recent outbreak of drug-resistant TB, which has the potential to become a global pandemic, and Part V examines the judiciary's approach to the issue of forced detainment. Finally, Part VI posits that the South African judiciary is dealing with this health care crisis in the wrong way and discusses the constitutional implications that forced detainment may have on the South African judicial system, health care regime, and population at large. Part VII concludes.

## II. TOWARD DEMOCRATIZATION

### *A. Repealing Apartheid*

Facing insurmountable international pressure after forty years of government-sponsored racial segregation, the South African apartheid government officially ended the ban on political organizations on February 2, 1990.[7] Just over a week later, Nelson Mandela, the symbolic

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2. *Id.* paras. 10, 43.

3. THE HIV PANDEMIC: LOCAL AND GLOBAL IMPLICATIONS 246 (Eduard J. Beck et al. eds., 2006). South Africa has more people living with HIV than any other country, and approximately 25% of all deaths in South Africa are attributed to AIDS. *Id.*

4. *See, e.g.*, S. AFR. CONST. 1996 ch. 2 (Bill of Rights).

5. *See* JAMES L. GIBSON & AMANDA GOUWS, OVERCOMING INTOLERANCE IN SOUTH AFRICA 17 (2003).

6. *See* Michael Wines, *Virulent TB in South Africa May Imperil Millions*, N.Y. TIMES, Jan. 28, 2007, *available at* http://www.nytimes.com/2007/01/28/world/africa/28tuberculosis.html. Epidemiologists and TB experts have predicted that the drug-resistant strain that originated in South Africa has probably spread to neighboring countries that share a migrant work force with South Africa. *Id.*

7. GIBSON, *supra* note 5, at 16-17. As a result of international criticism and worldwide divestment, South Africa was faced with an economic crisis that directly prompted the South

figure of racial equality, was released after twenty-seven years' imprisonment.[8] This marked the repeal of South Africa's apartheid system and the beginning of a new movement toward reconciliation and democratization.[9]

In 1993, the interim South African government drafted a transitional constitution.[10] Although the transitional constitution was thereafter replaced by a formal constitution,[11] it served a fundamental purpose in laying the groundwork for South Africa's new liberal democracy.[12] Enshrined in the transitional constitution were the ideals of constitutionalism, respect for freedom and equality, and judicial autonomy.[13] As one scholar points out, "[t]he context for the 1993 constitution, both internationally and domestically, effectively excluded the possibility of parties drawing up any document that was not committed to a liberal democratic agenda."[14] While the transitional constitution was only in place for two years, it paved the way for a sustainable democratic system of governance in a political climate strained by distrust and dissent.[15]

The transitional period saw the establishment of a Constitutional Court, which remains the highest in the land.[16] According to the transitional constitution, the Court had jurisdiction over all constitutional matters arising between organs of the state at all governmental levels.[17] Despite the overwhelming mistrust of the South African judiciary resulting from its role in propagating apartheid, the transitional phase infused the judicial branch with a renewed sense of authority.[18]

The South African citizenry took to the polls in 1994, electing Nelson Mandela, of the African National Congress (ANC), President of the new Republic of South Africa.[19] This first universal-suffrage election

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African government to dismantle its policies of racial segregation, which now came at too high a price. *Id.*

8. *Id.* at 17.
9. *See id.*
10. HEATHER DEEGAN, SOUTH AFRICA REBORN: BUILDING A NEW DEMOCRACY 15 (1999).
11. *Id.* at 15-16.
12. *Id.* at 17.
13. *Id.*
14. *Id.*
15. *Id.* at 16.
16. *Id.* at 17-18.
17. *Id.* at 18.
18. *See id.*
19. *See* Roger Southall, *The Contested State of Democracy in South Africa*, *in* POLITICAL LIBERALIZATION AND DEMOCRATIZATION IN AFRICA 277, 280 (Julius Omozuanvbo Ihonvbere & John Mukum Mbaku eds., 2003).

galvanized a new way forward,[20] and a Constitutional Assembly was created and charged with the duty of drawing up a permanent constitution.[21] Inviting the public to be a part of the drafting process, the Assembly received approximately 1.9 million submissions from a largely disenfranchised population eager to be a part of the political process.[22] After two years of consultation, negotiation, and drafting among the political parties and the citizenry at large, the Constitution of the Republic of South Africa was formally adopted on May 8, 1996,[23] and entered into force in 1997.[24]

### *B. Recognizing Civil Liberties and Human Rights*

Composed of fourteen chapters and seven schedules,[25] the South African Constitution is widely recognized as "one of the most advanced liberal democratic instruments in the world."[26] The preamble sets the tone for the Constitution, which focuses in large part on fundamental human rights and social justice.[27] Chapter two of the Constitution lays out the Bill of Rights, which dubs itself "a cornerstone of democracy in South Africa" and guarantees "the democratic values of human dignity, equality and freedom."[28] In addition to the detailed political rights[29] and human rights,[30] the Bill also guarantees socioeconomic rights.[31] These rights include, inter alia, the right of access to health care services,[32] the

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20. *Id.*

21. DEEGAN, *supra* note 10, at 19. The Constitutional Assembly also performed a more general role as South Africa's new democratic parliament. 2 HUMAN RIGHTS LAW IN AFRICA 1506 (Christof Heyns ed., 2004).

22. DEEGAN, *supra* note 10, at 19.

23. *See id.* at 31. The process of drafting the constitution marks "the largest public participation programme ever carried out in the country." *Id.*

24. *Id.*

25. *Id.*

26. Southall, *supra* note 19, at 277.

27. Christof Heyns & Danie Brand, *Socio-Economic Rights and the Transition*, *in* ON BECOMING A DEMOCRACY 25, 28 (N. Chabani Manganyi ed., 2004). The preamble of the South African Constitution provides: "We, the people of South Africa, . . . adopt this Constitution as the supreme law of the Republic so as to—Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights . . . ." S. AFR. CONST. 1996 pmbl.

28. S. AFR. CONST. 1996 ch. 2, § 7.

29. *Id.* ch. 2, § 19. Political rights include, inter alia, the right to make political choices, form political parties, participate in free, fair and regular elections, and to stand for public office. *Id.*

30. *Id.* ch. 2, §§ 14-16, 18, 21. Human rights include, inter alia, the right to privacy; freedom of religion, belief, and opinion; freedom of movement; freedom of expression; and freedom of association. *Id.*

31. *Id.* ch. 2, §§ 27, 29, 35.

32. *Id.* ch. 2, § 27.

right to education,[33] the right not to be refused emergency medical treatment,[34] and the right of detained persons to receive adequate accommodation, nutrition, reading material, and medical treatment.[35] Focused heavily on human rights and civil liberties, "[c]lauses on the protection of human dignity, the freedom and security of the person, the right to life and to privacy, the outlawing of slavery, servitude and forced labour are resonant with images of the past."[36] The Constitution's detailed emphasis on human rights was undoubtedly premised on the fresh memory of apartheid.[37]

In order to foster and protect this new conception of human rights in South Africa, the government established commissions, including the Human Rights Commission; the Commission for the Protection and Promotion of the Rights of Cultural, Religious, and Linguistic Communities; and the Truth and Reconciliation Commission.[38] Additionally, South Africa adopted various United Nations treaties, including the International Convention on Civil and Political Rights and the Covenant on Economic, Social, and Cultural Rights.[39] It also ratified the African Charter on Human and Peoples' Rights (African Charter).[40] In fact, it is generally recognized that the inclusion of universal human rights in the Constitution's Bill of Rights is in large part modeled after these various international conventions.[41]

In its human rights jurisprudence, the South African judiciary has often relied on international conventions.[42] In the years following the dismantling of apartheid, the courts frequently turned to the African Charter, even before its official accession.[43] However, as one scholar points out, "[s]ince South Africa became a state party to the Charter, this tendency has changed very gradually," and the African Charter currently

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33. *Id.* ch. 2, § 29.
34. *Id.* ch. 2, § 27.
35. *Id.* ch. 2, § 35.
36. DEEGAN, *supra* note 10, at 33.
37. *See* S. AFR. CONST. 1996 pmbl. ("We, the people of South Africa, [r]ecognise the injustices of our past [and h]onour those who suffered for justice and freedom in our land . . . .").
38. Vincent Saldhana, *NGOs and the Promotion of Human Rights in South Africa*, *in* HUMAN RIGHTS, THE RULE OF LAW, AND DEVELOPMENT IN AFRICA 209, 212 (Paul Tiyambe Zezela & Philip J. McConnaughay eds., 2004).
39. *Id.*
40. *Id.*
41. *Id.* at 211.
42. *See, e.g.*, FRANS VILJOEN, INTERNATIONAL HUMAN RIGHTS LAW IN AFRICA 556 (2007). For instance, in declaring capital punishment unconstitutional, the Constitutional Court referenced the African Charter in its judgment, underscoring the fact that the Charter "prohibits the arbitrary deprivation of life." *Id.*
43. *Id.*

plays only a minimal role in judicial decision making.[44] Nevertheless, other African Union and United Nations treaties continue to enjoy widespread influence, especially in cases of first impression.[45] In addition, with its limited postapartheid human rights jurisprudence, the South African courts commonly turn to the United Nations and other regional human rights bodies,[46] as well as Canadian, American, and European case law, to aid in interpreting the South African Constitution.[47] Given South Africa's political and judicial past, reaching beyond South Africa's borders to build "an independent, credible, and legitimate judiciary . . . is an essential task in the enterprise of establishing the rule of law and giving substantive content and meaning to the rights contained in the constitution."[48] Accordingly, South African courts enjoy widespread autonomy in invoking legal principles from international charters and treaties, as well as foreign statutes and case law, at their discretion.

## III. BACKGROUND ON TUBERCULOSIS

### *A. General Facts and Figures*

Tuberculosis is often discussed in the context of reemerging infectious disease.[49] Its roots can be traced back at least seven thousand years, and in the past two hundred years alone it has killed over two billion people.[50] Responsible for approximately 5000 deaths per day, TB is as relevant now as it has ever been.[51] On a global level, TB is the most common infectious disease to cause death in adults and is the second leading cause of death in children after acute respiratory and diarrheal disease.[52]

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44. *Id.* at 557-58.

45. *See id.* at 559. For example, the South African Constitutional Court invoked the Convention on the Rights of the Child and the International Convention on Civil and Political Rights when invalidating the role of male primogeniture with respect to the customary law of inheritance in Africa. *Id.*

46. *Id.* at 559-60.

47. *Id.* at 557.

48. Saldhana, *supra* note 38, at 212.

49. BARRY E. ZIMMERMAN & DAVID J. ZIMMERMAN, KILLER GERMS: MICROBES AND DISEASES THAT THREATEN HUMANITY 81 (2003).

50. *Id.* at 59. It was first identified by Robert Koch as the cause of the white death in 1882, at which time the disease killed one in seven people and was far more fatal than cholera or the bubonic plague. *Id.* at 62.

51. *See* CHARLOTTE A. ROBERTS & JANE E. BUIKSTRA, THE BIOARCHAEOLOGY OF TUBERCULOSIS: A GLOBAL VIEW ON A REEMERGING DISEASE 1 (2003).

52. *Id.*

Tuberculosis is caused by a bacterium called *Mycobacterium tuberculosis* and usually attacks the lungs.[53] It is easily spread through the air when a person with an active respiratory infection coughs, sneezes, speaks, or sings.[54] When a victim aspirates the TB microbe, the bacteria usually begin to multiply in the lungs; however, it can then spread to other parts of the body, such as the brain, kidney, or spine.[55]

Most people who breathe in the TB bacteria are able to fight the bacteria and prevent it from becoming active.[56] Thus the bacteria remain alive but inactive in the body, unable to reproduce and cause TB.[57] Commonly referred to as latent TB infection, many people who inhale the TB bacteria never develop active TB disease, are not able to spread the disease, and remain unharmed for the duration of their lifetimes.[58] Individuals who have weak immune systems, however, such as those infected by Human Immunodeficiency Virus (HIV), are unable to keep the bacteria from reproducing, thus resulting in active TB.[59] Accordingly, it is widely accepted that those who are especially susceptible to the disease include the young and the old, and that factors such as "poor environmental living conditions, high population density, certain occupations, . . . and the lack, or crumbling of, public health infra-structures" contribute to the widespread occurrence.[60]

Nowadays, TB is highly treatable.[61] So why is it still one of the leading infectious diseases in the world? Unfortunately, adequate treatment is often unavailable in developing countries, and those who need it most cannot afford the six-month course of treatment.[62] Moreover, since the 1980s, there has been an increasing rate of TB that is resistant to the antibiotics now available.[63]

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53. CDC, Questions and Answers About TB, http://www.cdc.gov/tb/publications/faqs/qa_introduction.htm (last visited Sept. 4, 2009).

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.* Individuals with latent TB do not experience any tuberculosis symptoms and cannot spread TB to others, unless the disease becomes active at a later time. *Id.* These individuals will still generally have a positive return on a skin test reaction or blood test. *Id.*

59. *Id.*

60. ROBERTS & BUIKSTRA, *supra* note 51, at 11.

61. *Id.* at 31.

62. *Id.* at 32. Other factors that contribute to an increased likelihood of death from TB include lack of information on treatment, social stigma associated with the disease, inferior social status, and poverty. *Id.* at 33.

63. *Id.* at 35.

### *B. Drug-Resistant TB*

Multidrug-resistant TB (MDR-TB) is generally resistant to what is considered the first line of drugs used to treat patients with tuberculosis,[64] and extensively drug-resistant tuberculosis (XDR-TB) is resistant to both the first-line and second-line drugs, leaving patients with few, if any, treatment options.[65] Drug-resistant TB occurs when treatment regimens are not properly followed.[66] This includes, for instance, "when patients do not complete their full course of treatment; when healthcare providers prescribe the wrong treatment, the wrong dose, or length of time for taking the drugs; when the supply of drugs is not always available; or when the drugs are of poor quality."[67] It is also possible to acquire MDR- or XDR-TB from an individual already infected with the drug-resistant strain through the same airborne vector by which drug-susceptible TB is transmitted.[68] Therefore, one of the most important ways to prevent the spread of drug-resistant TB is for infected individuals to take all of their medications as prescribed in order to prevent the bacteria from becoming resistant to the drugs.[69]

The World Health Organization (WHO) estimates that approximately one-third of the global population is currently infected with TB, causing approximately 1.7 million deaths annually.[70] Drug-resistant TB is on the rise in Eastern Europe, Latin America, Asia, and Africa.[71] Twenty-two "high-burden countries" (HBCs) account for approximately 80% of the TB cases around the world.[72] Not surprisingly, TB is most prevalent in developing countries,[73] and according to WHO

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64. *See* CDC, Multidrug-Resistant Tuberculosis (MDR-TB) Fact Sheet, http://www.cdc.gov/tb/publications/factsheets/drtb/mdrtb.htm (last visited Sept. 4, 2009). First-line drugs are used to treat all those infected with TB, and include isoniazid and rifampicin, two of the most effective anti-TB drugs. *Id.*

65. *See* CDC, Extensively Drug-Resistant Tuberculosis (XDR-TB) Fact Sheet, http://www.cdc.gov/tb/publications/factsheets/drtb/xdrtb.htm (last visited Sept. 4, 2009). Second-line drugs include fluoroquinolones and three injectable drugs: amikacin, kanamycin, and capreomycin. *Id.* While XDR-TB is highly resistant to drug treatment, the Centers for Disease Control reports that some TB control programs estimate that 30% of those affected by the strain can still be cured. *Id.*

66. CDC, *supra* note 64.

67. *Id.*

68. *See* ROBERTS & BUIKSTRA, *supra* note 51, at 35.

69. CDC, *supra* note 65.

70. WHO, MDR-TB Frequently Asked Questions, http://www.who.int/tb/challenges/mdr/faqs/en/index.html (last visited Sept. 4, 2009).

71. *Id.*

72. WORLD HEALTH ORG. [WHO], GLOBAL TUBERCULOSIS CONTROL 2008: SURVEILLANCE, PLANNING, FINANCING 17 (2008).

73. *See* JOAN R. CALLAHAN, BIOLOGICAL HAZARDS 67 tbl.4.3 (2002).

data from 2006, Africa has the highest incidence rate per capita—363 cases per 100,000.[74] Furthermore, South Africa has the second-highest TB rate among all African countries,[75] and according to the WHO, ranks fourth in the world in terms of absolute numbers of TB cases (approximately 940 people out of every 100,000 are infected).[76] The WHO's 2008 *Global Tuberculosis Control* report points out that "[t]he high incidence rates estimated for the African countries . . . are partly explained by the relatively high rates of HIV coinfection."[77] With approximately 20% of its adult population infected with HIV/AIDS, South Africa has one of the highest HIV/AIDS prevalence rates in the world.[78] It was estimated that, as of 2005, approximately 5.5 million South Africans were living with HIV/AIDS.[79] One African news source reported that approximately 44% of South Africans living with TB are also HIV positive.[80] Accordingly, South Africa has become a hotbed for tuberculosis, which takes host in the vast number of South Africa's immune-suppressed, HIV-positive citizens.[81] Even more alarming, however, has been the recent outbreak of drug-resistant TB in South Africa, especially among HIV/AIDS patients.[82]

## IV. THE EMERGENCE OF MDR- AND XDR-TB IN SOUTH AFRICA

On September 1, 2006, the WHO announced that an overwhelming number of MDR-TB cases, many of which were also XDR cases, had been identified in Tugela Ferry, "a rural town in the South African

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74. WHO, *supra* note 72, at 3. Of the fifteen countries with the highest incidence rates, thirteen are African nations. *See id.* at 21 fig.1.4.

75. *Id.*

76. *Id.* at 145.

77. *Id.* at 20.

78. JEREMY R. YOUDE, AIDS, SOUTH AFRICA, AND THE POLITICS OF KNOWLEDGE 1 (2007).

79. *Id.*

80. Kerry Cullinan, *South Africa: Country Has Worst TB Prevalence in the World—Report*, ALLAFRICA.COM, Mar. 19, 2008, http://allafrica.com/stories/printable/200803190364.html (pointing out that this figure could, in fact, be an underestimation, because the study only tested one in five TB patients for HIV).

81. *See* WHO, *supra* note 72, at 21 ("[T]he annual change in TB incidence runs almost parallel with the change in HIV prevalence in the general population."). As one expert points out, TB is an "opportunistic disease" in the sense that it may infect but remain dormant until one's immune system is compromised. David Rochkind, *The Tuberculosis Epidemic in the South African Gold Mines*, INT'L REPORTING PROJECT, Oct. 13, 2008, http://www.internationalreportingproject.org/stories/detail/1090/. Therefore, "[a]s a result of the rise of the HIV epidemic[,] people had compromised immune systems[,] so the TB that was already there became more active and TB rates shot up." *Id.*

82. *See* Detaining Patients Is Justified To Contain Deadly TB Strain in South Africa Say Experts (Jan. 25, 2007), http://www.medicalnewstoday.com/printerfriendlynews.php?newsid=61383.

province of KwaZulu-Natal, the epicentre of South Africa's HIV/AIDS epidemic."[83] According to the study, which was conducted in 2005, of the 544 TB patients studied in the area, 221 were diagnosed with MDR-TB; of those 221 cases, 53 were infected with a new, deadly form of XDR-TB.[84] The strain was so lethal that all but one of the 53 patients died within a median of 16 days from the time of testing.[85] Of particular importance is the fact that 44 of the XDR-TB patients were tested for HIV, and all were found to be HIV positive.[86]

In 2007, the *New York Times* reported that the deadly strain of XDR-TB had been found in over forty hospitals in each of South Africa's nine provinces.[87] The media outlet announced that "[t]he World Health Organization calls the extremely drug-resistant form 'a grave public health threat' because of its potential explosiveness among the millions of H.I.V.-infected people in poor countries."[88] One expert at the WHO, Dr. Paul Nunn, further underscored the global threat of XDR-TB, reporting in early 2007 that one or more cases had been found in at least twenty-eight countries.[89] Although the WHO reported that two-thirds of the XDR-TB cases were from outside of South Africa—many of which are in China, India, and Russia[90]—South Africa's XDR-TB outbreak is considered "far more alarming."[91] This is because South Africa's absolute number of XDR-TB cases is significantly higher than any other single nation; more importantly, the outbreak has erupted "at the center of the world's H.I.V. pandemic."[92]

Given the fact that this particular strain of XDR-TB killed all but one of its HIV-positive victims within just a few weeks of diagnosis, it has the potential to inflict devastation among South Africa's 5.5 million HIV-positive individuals.[93] Beyond South Africa's borders, should the disease find a foothold in the HIV-positive population, tens of millions of

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83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.*
87. Lawrence K. Altman, *Rise of a Deadly TB Reveals a Global System in Crisis*, N.Y. TIMES, Mar. 20, 2007, *available at* http://www.nytimes.com/2007/03/20/health/20docs.html?fta=y&pagewanted=print. Experts also predicted that the extreme drug-resistant strain had spread into neighboring countries such as Lesotho, Swaziland, and Mozambique—all of which share a significant migrant workforce with South Africa. *See* Wines, *supra* note 6.
88. Altman, *supra* note 87.
89. *Id.*
90. *Id.*
91. Wines, *supra* note 6.
92. *Id.*
93. *Id.*

individuals infected by HIV/AIDS across sub-Saharan Africa would also be at risk.[94]

In the face of this imminent epidemic, two researchers at the Centre for AIDS Programme of Research in South Africa (CAPRISA), Jerome Singh and Nesri Padayatchi, in conjunction with Ross Upshur of the Department of Family and Community Medicine and Joint Centre for Bioethics at the University of Toronto in Canada, published a position paper on the drug-resistant TB outbreak in South Africa.[95] They attribute the outbreak of MDR-TB and XDR-TB to a variety of factors, including "inappropriate treatment regimens[,] . . . irregular drug supply, incompetent health personnel [and] poor adherence."[96] They also point out that poverty has fueled the outbreak in sub-Saharan Africa, and that South Africa's TB cure rate is comparatively much lower than that of the rest of the world.[97]

Given the fact that TB is a disease that preys on poverty-stricken communities, the authors argue that the South African government is mishandling the epidemic.[98] Approximately ten million South Africans receive some form of social welfare; this accounts for approximately one-fourth of the population in a country where the estimated unemployment rate is at twenty-seven percent.[99] While South Africa does not have a formal universal health care system, most of those who require medical attention are treated free of charge at the government's expense.[100] In return, however, "those who are hospitalised at state expense lose their social welfare benefits for the duration of their hospitalisation."[101] Therefore, the authors point out that when individuals are faced with the choice between being hospitalized for the required eighteen to twenty-four months to treat the drug-resistant TB, or continuing to work or receive welfare benefits (which in many cases serve as a family's sole source of income), many TB patients choose the latter and inadvertently continue to infect their families and communities

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94. *Id.*

95. *See* Jerome Amir Singh et al., *XDR-TB in South Africa: No Time for Denial or Complacency*, PLOS MED., Jan. 2007, at 19.

96. *Id.* at 20.

97. *Id.* According to South Africa's Medical Research Council, approximately half of the adults in South Africa with active TB are cured annually, compared with 80% in countries that are better equipped to ensure that TB patients are medicated to fruition. *Id.* In South Africa, "about 15% of patients default on the first-line six-month treatment, while almost a third of patients default on second-line treatment." *Id.*

98. *See id.*

99. *Id.*

100. *Id.*

101. *Id.*

with the deadly disease.[102] Accordingly, the authors argue that South Africa should rethink its suspension of welfare benefits for MDR-TB and XDR-TB patients during their hospital stays in order to encourage infected individuals to consent to full treatment.[103]

Although the policy paper critiques the government's generally nonchalant attitude in the wake of the most recent XDR-TB outbreak, it also makes several institutional recommendations. Most significantly, the authors recommend forced detention of those infected with XDR-TB.[104] They posit that "[t]he use of involuntary detention may legitimately be countenanced as a means to assure isolation and prevent infected individuals [from] possibly spreading [the] infection to others."[105] They argue that although South Africa's Bill of Rights is highly protective of individual human rights, these rights can be restricted under circumstances that are reasonable and justifiable.[106] Putting forth a utilitarian argument, the authors submit that involuntary quarantine is in the public interest, and thus the resulting human rights infringements would be justified in a time of public health crisis.[107] In the concluding section of the policy paper, the authors state that "if necessary, the government must adopt a more robust approach towards uncooperative patients with MDR-TB and XDR-TB, which might necessitate favouring the interests of the wider public over that of the patient."[108]

### *A. The Government's Response*

The South African Department of Health (DOH) reported that in the period between January 2004 and April 2007, there were over 11,000 confirmed cases of MDR-TB and over 800 cases of XDR-TB, which was rising rapidly.[109] Recognizing the serious public health consequences for South Africa, the Department of Health developed the Tuberculosis

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102. *See id.* at 20-21. By consenting to hospitalization, individuals also give up the prospect of employment—another reason that the authors support the contention that the government should not take away welfare benefits during hospitalization. *Id.*

103. *Id.* at 21.

104. *See id.*

105. *Id.* at 21.

106. *Id.*

107. *Id.* at 24. The authors substantiate their position by invoking jurisprudence from the European Court of Human Rights, drawing on international human rights doctrines, and juxtaposing past instances of forced quarantine in other countries. *Id.* at 22-23. These aspects are discussed *infra* Part V.B.

108. Singh et al., *supra* note 95, at 24.

109. S. AFR. DEP'T OF HEALTH [DOH], DRAFT—TUBERCULOSIS STRATEGIC PLAN FOR SOUTH AFRICA, 2007-2011, at 15-16 (2007), *available at* http://www.doh.gov.za/docs/tb2-f.html.

Strategic Plan for South Africa, 2007-2011.[110] The government laid out its objectives as follows: "To strengthen the implementation of the DOTS strategy[111]; To address TB and HIV, MDR and XDR-TB; To contribute to health systems strengthening; To work collaboratively with all care providers; To empower people with TB as well as communities; To coordinate and implement TB research[; and] To strengthen infection control."[112] The plan endorsed an educational and directly observed therapy (DOTS) approach in combating the drug-resistant TB outbreak; there was no mention of forced quarantine.[113] At most, the report stated that "[a]ll confirmed XDR-TB patients would be referred to the MDR-TB Unit for hospitalisation for a period of at least six months and thereafter discharged for ambulatory care at the nearest health facility[,] with ongoing treatment and psychosocial support provided."[114] Although the DOH recognized the need to increase hospital bed capacity, update hospital ventilation systems to reduce the risk of spreading the disease within the facility, and recruit and train staff to accommodate the increasing incidence of drug-resistant strains, the government was simply not willing to endorse a policy that forcibly detained MDR- and XDR-TB patients.[115]

In June 2007, the Department of Health updated its 1999 *Management of Drug-Resistant Tuberculosis in South Africa: Policy Guidelines*.[116] Once again taking an evasive position on the human rights implications of forced quarantine, in its opening remarks, the DOH stated that "[l]egal issues around the management of M(X)DR tuberculosis in South Africa are complex and have been addressed in separate documents, guided by rapidly evolving health legislation and the Constitution of South Africa."[117] Although the DOH stipulates that

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110. *Id.* at 4.

111. *Id.* at 21. The "DOTS strategy" denotes treatment by directly observed therapy. ROBERTS & BUIKSTRA, *supra* note 51, at 36. It is particularly endorsed by the WHO as a control strategy in treating tuberculosis and has been around for a long time. *Id.* The strategy involves providing medication to patients and directly observing their compliance with the prescribed medical dose. *Id.* Here, "[t]he onus is . . . on the health care system rather than the patient to achieve a cure." *Id.* See WHO, *supra* note 72, at 28-30, for statistics and global success rates under the DOTS program.

112. DOH, *supra* note 109, at 21.

113. *See id.* at 24.

114. *Id.*

115. *See id.* at 24-25.

116. *See* S. AFR. DEP'T OF HEALTH [DOH], MANAGEMENT OF DRUG-RESISTANT TUBERCULOSIS IN SOUTH AFRICA: POLICY GUIDELINES acknowledgements (June 2007), http://familymedicine.ukzn.ac.za/Uploads/f7019647-dc62-49b6-902f-c48c28e14221/MDR%20TB%20Guidelines2007.doc.

117. *Id.*

"XDR-TB patients *must* be hospitalized," the report highlighted that there is no international consensus with respect to the specific amount of time that XDR-TB patients should be hospitalized during treatment.[118] The DOH recognized that MDR- and XDR-TB are not only far more fatal than drug-susceptible TB, but also that, because MDR- and XDR-TB patients often respond to treatments at slower rates, they are more prone to infect others.[119] Therefore, the treatment regimen for drug-resistant TB is longer, more stressful for the patient, and oftentimes more complex.[120] Yet in spite of the recognized global implications of a drug-resistant outbreak, the DOH's "[r]ecommendations for infection control to prevent M(X)DR-TB are essentially the same as those to prevent the spread of drug susceptible TB, with only minor differences in emphasis."[121] Hence, it is clear that in 2007, the South African government was unwilling to endorse Singh and associates' justification for forced detainment as part of its official drug-resistant TB treatment plan.

### *B. The Hospitals Take Action*

The manner in which some South African hospitals responded to the drug-resistant TB outbreak was markedly different. While the DOH remained silent on the detainment issue, various hospitals around the country began forcibly detaining XDR-TB patients. In March 2008, the *New York Times* reported that the Jose Pearson TB Hospital in Port Elizabeth had erected electric and razor wire fences around the premises and quadrupled the number of guards in order to prevent XDR-TB patients from escaping.[122] And at the Brooklyn Chest Hospital in Cape Town, a six-and-a-half-foot fence was erected around the XDR-TB ward "in a bid to dissuade anyone from fleeing the hospital, even as doctors lack the legal tools to forcibly confine patients or compel them to take medication."[123] Nevertheless, in a desperate attempt to spend the Christmas and Easter holidays with their families, several patients cut

118. *Id.* § 8.1, at 28.
119. *Id.* § 18.1, at 86.
120. *Id.*
121. *Id.*
122. Celia W. Dugger, *TB Patients Chafe Under Lockdown in South Africa*, N.Y. TIMES, Mar. 25, 2008, *available at* http://www.nytimes.com/2008/03/25/world/africa/25safrica.html.
123. Agence France-Presse (AFP), Rights Dilemma as South Africa Faces Drug Resistant TB Epidemic (Jan 27, 2008), http://afp.google.com/article/ALeqM5jxwLa1Lr6VCEZOE4BCsuu9gTD5SA.

holes in the fence and fled the hospital grounds in Port Elizabeth.[124] In response, several hospitals in the Eastern and Western Cape "sought court orders to compel the return of runaways."[125]

## V. *MINISTER OF HEALTH OF THE WESTERN CAPE V. GOLIATH & OTHERS*

### *A. Background*

On September 28, 2007, the Provincial Minister of Health of the Western Cape brought an application before the High Court of South Africa, Cape of Good Hope Provincial Division, to compel the forced hospitalization and isolation of four XDR-TB patients who repeatedly fled Brooklyn Chest Hospital grounds.[126] The court issued a rule *nisi*,[127] granting the order and placing the burden on the respondents to demonstrate why the order should not be granted.[128] According to the order, the respondents were to be admitted to the Brooklyn Chest Hospital and could only be discharged once they had tested negative for three consecutive months.[129] Moreover, the court authorized "the Sheriff, if necessary, to request members of the South African Police Service to assist him in ensuring that the respondents are admitted to Brooklyn

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124. Dugger, *supra* note 122. Prior to the Easter holiday, there was a demonstration at the Port Elizabeth hospital where sixty patients removed their protective masks and threatened the guards; about half escaped. *See* Joe de Capua, *Quarantined South Africa TB Patients Flee Hospital*, VOICE OF AM., Mar. 27, 2008, http://www.voanews.com/english/archive/2008-03/2008-03-27-voa27.cfm?moddate=2008-03-27.

125. Dugger, *supra* note 122. In other provinces, local hospitals took different policy approaches in determining how long to treat XDR-TB patients. For instance, in KwaZulu-Natal, where the XDR-TB outbreak was first discovered, hospitals were discharging patients after six months, whether or not they were still infected with the disease, in order to accommodate new patients who may have a better chance of cure. *Id.* Given the limited resources, the chief medical officer of one hospital stated, "We know we're putting out patients who are a risk to the public, but we don't have an alternative." *Id.*

126. *Minister of Health of the W. Cape v. Goliath*, No. 13741/07, paras. 1-2 (S. Afr. July 28, 2008), *available at* http://www.alp.org.za/pdf/PressReleases/TBCase_WCMinHealthWCv Goliath.pdf; *see also* AFP, *supra* note 123 (media outlet reporting on the court's holding). The High Court of South Africa has jurisdiction over the geographical area in which it is situated. The Courts in South Africa, http://www.capegateway.gov.za/afr/pubs/public_info/C/32303/E (last visited Sept. 4, 2009). Currently, there are ten provincial divisions across South Africa. *Id.* Above the High Court sits the Supreme Court of Appeal, which is the court of last resort save for cases regarding constitutional matters, which can be appealed to the Constitutional Court. *Id.* As a practical matter, the High Courts generally only hear civil matters in excess of R100,000, as well as serious criminal matters. *Id.* They also serve as appellate courts, hearing cases from the magistrates' courts below. *Id.*

127. *Decree nisi*: "A court's decree that will become absolute unless the adversely affected party shows the court, within a specified time, why it should be set aside." BLACK'S LAW DICTIONARY 472 (9th ed. 2009).

128. *Goliath*, No. 13741/07 para. 2.

129. *Id.* paras. 2.1, 2.4.

Chest Hospital and remain there until their compliance" when the three-month stipulation was met.[130]

Soon after the respondents were readmitted to Brooklyn Chest Hospital, two of the four respondents died from the disease.[131] Represented by the Legal Aid Board, the remaining two patients submitted a counter-application seeking "an order declaring their detention to be inconsistent with their right to personal freedom as enshrined in s 12 of the Constitution."[132]

### *B. The High Court's Decision*

As a result of the respondents' repeated refusal to voluntarily consent to hospitalization and treatment, the issue before the court was whether they could be lawfully detained against their wills on the basis that they posed a significant public health risk in spreading XDR-TB to others.[133] Faced with the constitutional question of restricting individual civil liberties, it was incumbent upon the court to determine whether forced quarantine was "arbitrary" or "without just cause" pursuant to Article 12 of the Constitution.[134]

The court stated that "isolation of patients with infectious disease is universally recognised in open and democratic societies as a measure that is justifiable in the protection and preservation of the health of citizens."[135] Citing article 12 of the UN International Covenant on Civil and Political Rights (ICCPR), the court submitted that when public health is at stake, limiting an individual's freedom of movement is justified.[136] The court went on to cite the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, the European Convention on Human Rights, the Ontario Health Protection and Promotion Act, and the 1992 Constitution of Ghana, all of which stipulate that public health provides sufficient grounds to limit individuals' rights and liberties.[137] More than

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130. *Id.* para. 2.2.

131. *Id.*

132. *Id.* More specifically, the respondents argued that their detention at Brooklyn Chest Hospital was inconsistent with Article 12(1) of the Constitution, which provides that "[e]veryone has the right to freedom and security of the person, which includes the right—*(a)* not to be deprived of freedom arbitrarily or without just cause . . . ." S. AFR. CONST. 1996, § 12; *Goliath*, No. 13741/07 para. 18.

133. *Goliath*, No. 13741/07 paras. 1, 14-16.

134. *Id.* para. 19.

135. *Id.*

136. *Id.*

137. *Id.*

any other authority, however, the court cited the Singh article.[138] On Singh's proposition that involuntary detention may be necessary to prevent spreading XDR-TB to others, the court held that "the limitation on the freedom of movement of patients with infectious diseases is reasonable and justifiable in 'an open and democratic society based on human dignity, equality and freedom', as contemplated by s 36(1) of the Constitution."[139]

Having established that the forced detainment was justifiable in light of the grave public health threat, the court next took up the issue of declaratory relief sought by the respondents with respect to the conditions under which they were being isolated.[140] The court recognized that, on average, treatment for XDR-TB lasts between eighteen and twenty-four months.[141] Therefore, as per the declaratory relief sought by the respondents in the event that they would be forcibly detained at Brooklyn Chest, the court turned its attention to Article 35(2)(e) of the South African Constitution, which provides that "[e]veryone who is detained, including every sentenced prisoner, has the right . . . to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment."[142] The Minister of Health for the Western Cape argued that the hospital conditions met and exceeded the requirements in section 35(2)(e), and, therefore, there was no need for the court to grant the respondents any further visitation, recreation, or communication rights.[143] Specifically, the minister contended that patients received adequate counseling by social workers; that newspapers and other reading materials were made available; and that plans for the construction of a visitation room where family, friends, religious counselors, and legal practitioners could meet with patients were being developed.[144]

The court refused to grant the relief sought on the basis that other patients being treated in Brooklyn Chest Hospital would have a "substantial interest in the relief claimed."[145] The court reasoned that

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138. *Id.* para. 20.

139. *Id.* paras. 20-21 (citing S. AFR. CONST. 1996 § 36(1) ("The rights in the Bill of Rights may be limited only in terms of 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 account all relevant factors . . . .")).

140. *Id.* paras. 21, 34.

141. *Id.* para. 12.

142. S. AFR. CONST. 1996 § 35(2)(e); *Goliath*, No. 13741/07 para. 34.

143. *Goliath*, No. 13741/07 para. 38.

144. *Id.* paras. 35-37.

145. *Id.* para. 41.

because the other patients did not have an opportunity to be heard in this case, and because "[t]he present respondents do not purport to bring a 'class action' on behalf of those patients, or indeed on behalf of any other interested parties," declaratory relief was inappropriate at the particular juncture in time.[146] Accordingly, on July 28, 2008, the High Court upheld the order, compelling the respondents to remain at Brooklyn Chest Hospital, where they would be detained until they were determined to be XDR-TB free.[147]

### *C. Analysis*

The High Court's decision is not the first of its kind, as nations have, from time to time, been confronted with critical choices between public health and civil liberties. While forced quarantine is not a novel concept in the context of public health crises, this decision sets a fundamental precedent in South Africa's relatively immature democratic system. Faced with core constitutional questions of individual rights and civil liberties, the court relied almost exclusively on one section of the Constitution—Section 12.[148] This section provides all citizens with "the right to freedom and security of the person, which includes the right . . . not to be deprived of freedom arbitrarily or without just cause."[149] Interestingly, in substantiating its present holding, the court neglected to cite South African case law under which individuals' freedom of movement had been constitutionally restricted on the basis of justifiable and nonarbitrary grounds.[150] Rather, it turned only superficially to international conventions and principles, as well as to national legislation of other countries (e.g., Canada), in support of the proposition that forced isolation within the context of an infectious disease outbreak is justified in protecting and preserving the health of the citizenry.[151] The legislation and principles cited, however, only reinforce the court's ultimate conclusion—that there is a public health threat, and therefore, forced quarantine is justified and not arbitrary.[152]

The court does not purport to articulate any governmental limitation with respect to its holding, nor does it establish an objective test with respect to what is "arbitrary" or what constitutes "just cause." While the

146. *Id.*
147. *Id.* at 43.
148. *See id.* paras. 18-19.
149. *See* S. AFR. CONST. 1996, § 12(1)(a).
150. *Goliath*, No. 13741/07 para. 19.
151. *Id.*
152. *Id.* para. 31.

court found that the provincial minister of health "made out a sufficient case for the granting of a final order," it failed to articulate the standards and expectations that are required for the minister to meet such a burden.[153] Accordingly, it seems that as long as the government, health care scholars (i.e., Singh et al.), and the court can articulate a rational basis for the restriction of fundamental civil liberties protected under Section 12, the action is constitutional.

The High Court does single out one case from the Ontario Court of Justice—*Toronto v. Deakin*.[154] In that case, a patient diagnosed with TB who was "recalcitrant in taking medication as an outpatient" was ordered to four months' detention and treatment in a health care center in Toronto, Canada.[155] In 2002, after fleeing the center on two occasions, he was placed in a magnetically locked room with security guards stationed outside his door to escort him to and from "smoke breaks."[156] Using this case to provide a legal foundation for its holding, the High Court of South Africa highlighted the fact that the Canadian court found it justified to infringe on the patient's rights protected by the Canadian Charter of Rights and Freedoms[157] because the act was not arbitrarily applied.[158]

In a similar analysis to the High Court, the Canadian court engaged in a very brief discussion of individual liberties, reasoning from a conclusion rather than toward one. Beyond holding that the invasion upon an individual's freedom of movement is justified under the circumstances, the court consulted almost no precedent or case law to substantiate its off-the-cuff analysis. Not surprisingly, the High Court of South Africa used this case to its advantage in assessing the facts before it, concluding that the government action was justified, thereby circumventing the need to establish guidelines with respect to when such an invasion into individual privacy and fundamental human rights may or may not be legal.

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153. *Id.*

154. *Id.* paras. 29-30.

155. Basrur v. Deakin, No. 2777, 2002 WL 1604294, para. 7 (Ont. C.J. July 3, 2002). The High Court of South Africa cites this case as "*Toronto v. Deakin*." *Goliath*, No. 13741/07 para. 19 n.8.

156. *Deakin*, 2002 WL 1604294, paras. 19, 21.

157. Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, § 7 ch. 11 (U.K.). Section 7 of the Charter provides: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." *Id.* Here, the High Court states that this section is "equivalent to [§ ]12(1) of [the South African] Constitution." *Goliath*, No. 13741/07 para. 30 (explaining the lower court's holding).

158. *Goliath*, No. 13741/07 para. 30 (quoting the lower court's holding).

The High Court plays a dangerous game in using the Canadian case to establish a legal framework to forcibly detain XDR-TB patients in South Africa. Relying on the Canadian case was unwise for two primary reasons. First, unlike South Africa, Canada was not faced with the threat of a widespread drug-resistant TB pandemic. This was an isolated incident of a patient that repeatedly refused to take his medication, which, at most, could have given rise to a single drug-resistant case of TB.[159] Second, the Canadian court did not need to consider its actions within the context of a country plagued by disease—and that makes all the difference. Relying on the Canadian case, the High Court of South Africa has arguably given the government unfettered discretion to quarantine any of the millions of individuals infected with *drug-susceptible* TB who are obstinate in following the prescribed treatment regimen. By invoking the Canadian case, the High Court sought to establish judicial legitimacy, as Canada is undeniably a fervent protector of human rights. Presumably, the idea is that if such a legal justification is good enough for Canada, it should be good enough for South Africa too. However, the High Court's newly established precedent, in the face of an infectious disease pandemic, has the potential to create widespread human rights violations. Accordingly, the High Court should have applied a far more stringent and rigorous standard of review in laying out its precedential decision.

Had the High Court placed the burden on the state rather than on the respondents whose civil liberties were at stake, the court may have still come out with the same holding, but in the process, would have done so with far more legitimacy. Rather than merely citing international conventions and agreements that in one way or another provide that the state may encroach on individual civil liberties for the benefit of the greater good, the court should also have given effect to the terms "justified" and "arbitrary" by engaging in a thorough constitutional analysis. Especially because this was a case of first impression, the court should have made a fervent effort to establish a test with respect to when it would be permissible and when it would be impermissible for the state to forcibly quarantine individuals in the wake of a public health threat.

The High Court would have done well to adopt a more instructive approach similar to the method used by the United States when it comes to this type of issue. U.S. courts have frequently analogized the permissible mandatory isolation of patients with infectious disease to

159. As previously discussed, drug-resistant TB may develop when patients take their prescribed medications on an irregular basis. CDC, *supra* note 64.

cases in which the mentally ill are involuntarily committed.[160] Thus U.S. courts have generally applied a demanding standard of review, and placed the burden on the government "to demonstrate that there are no less restrictive alternatives to achieve the public health objective."[161] As one author suggests, the government may have to offer directly observed therapy (DOT) as an alternative to confinement.[162] In the United States, the restriction of individual liberty is considered an infringement on a fundamental right.[163] Therefore, the constitutional inquiry triggers a heightened standard of judicial review.[164] Under such a standard, the burden is on the state to show that the quarantine measures are more than rationally related to the state's interest in protecting public health (i.e., intermediate scrutiny).[165]

To a lesser extent, the United States has experienced isolated TB outbreaks throughout the twentieth century.[166] Most recently, there was an MDR-TB outbreak in New York City during the 1990s.[167] Due to the heightened standard of review necessitated by the potential for significant infringement on individual liberty, New York City implemented DOT programs and treated patients on an outpatient basis, forcibly quarantining patients only as a last resort.[168]

## VI. MOVING IN THE WRONG DIRECTION

### *A. Ramifications*

The High Court of South Africa's holding in *Goliath* may cause the opposite effect of what was intended. Cognizant of the fact that the respondents repeatedly fled due to the poor hospital conditions, "as well

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160. *See, e.g.*, Green v. Edwards, 263 S.E.2d 661, 663 (W. Va. 1980) (explaining that the state's "Tuberculosis Control Act and the Act for the Involuntary Hospitalization of the Mentally Ill have like rationales, and [that] involuntary commitment for having communicable tuberculosis impinges upon the right to 'liberty, full and complete liberty' no less than involuntary commitment for being mentally ill").

161. David P. Fidler et al., *Through the Quarantine Looking Glass: Drug-Resistant Tuberculosis and Public Health Governance, Law, and Ethics*, 35 J.L. MED. & ETHICS 616, 622 (2007).

162. *Id.*

163. Rosemary G. Reilly, *Combating the Tuberculosis Epidemic: The Legality of Coercive Treatment Measures*, 27 COLUM. J.L. & SOC. PROBS. 101, 139 (1993).

164. *Id.*

165. *Id.*

166. *See* Dugger, supra note 122. In New York City, for example, "TB patients were confined to North Brother Island in the East River in the early 1900s and to Rikers Island in the 1950s." *Id.*

167. Singh et al., *supra* note 95, at 22.

168. *See* Dugger, *supra* note 122.

as their financial and family responsibilities,"[169] the court does little to placate the respondents' concerns and encourage them to comply voluntarily with the treatment regimen in the hospital. Rather, the court compels the patients to be readmitted by force if necessary. Such an approach is sure to have widespread ramifications across South Africa in deterring MDR- and XDR-TB patients from seeking treatment.

From a public policy standpoint, the legal recourse established by the High Court is counterintuitive and may perpetuate the spread of drug-resistant TB across South Africa. As previously discussed, individuals who are treated at the state's expense may not continue to receive welfare payments.[170] Therefore, by allowing the government to forcibly detain patients and not guarantee their continued welfare benefits, patients are discouraged from coming forward and submitting to treatment. The High Court defers to Singh and his coauthors in defending its decision to forcibly quarantine the respondents.[171] However, the court breezes past the recommendation that the government extend welfare benefits to those who voluntarily admit to hospitalized treatment.[172] The authors point out that "[a]lthough these measures will undoubtedly have cost implications for the government and may not adequately compensate patients for their lost income, they would at least serve as some form of incentive and encouragement for infected individuals to enter and remain in the health system."[173] The fact of the matter is that patients are being forcibly detained under conditions that deprive them of their families and subject them to substandard living conditions. The *International Herald Tribune* quotes one patient's poignant observation of the forced quarantine: "We're being held here like prisoners, but we didn't commit a crime."[174] Because many of the XDR-TB patients are already infected with HIV, the overwhelming majority succumb to the disease in the hospital.[175] This creates the impression that once an individual is hospitalized for XDR-TB, the only way he will be able to leave is in a coffin. It therefore follows that "[l]ocking up the sick until death will . . .

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169. *Minister of Health of the W. Cape v. Goliath*, No. 13741/07, para. 18 (S. Afr. July 28, 2008), *available at* http://www.alp.org.za/pdf/PressReleases/TBCase_WCMinHealthWCvGoliath.pdf.

170. Singh et al., *supra* note 95, at 21.

171. *Goliath*, No. 13741/07 para. 20.

172. Singh et al., *supra* note 95, at 21.

173. *Id.*

174. Celia W. Dugger, *In South Africa, TB Patients Behind Barbed Wire*, INT'L HERALD TRIB., Mar. 24, 2008, http://www.iht.com/articles/2008/03/24/africa/saf.php?page=1.

175. *See id.*

discourage those not yet diagnosed from coming forward, likely driving the epidemic underground."[176]

On the basis of this important recognition, the advantages and disadvantages of forced quarantine must be weighed. While the High Court believes that the best way to protect the public at large is to detain the highly infectious patients, at this point in time, such action is likely to deter individuals from coming forward and seeking the treatment they need. Accordingly, the South African government should act expeditiously in reversing the judicially sanctioned detainment and pursue a public policy-oriented approach that minimizes public health risks, but at the same time encourages infected individuals to seek immediate treatment.

If the South African government's intention is to act in the public's interest and for the greater good, it must chart a new path. The High Court emphasized that XDR-TB poses a global health threat and therefore, "[p]revention and deterrence, rather than treatment after the fact, is . . . of prime importance."[177] To this end, there is much that can be done in order to preempt a widespread epidemic of drug-resistant TB, while at the same time protecting fundamental human rights.

### *B. Alternatives*

From a policy-oriented standpoint, the first issue that must be addressed is how to ensure that those infected with XDR-TB come forward and seek treatment in order to prevent the spread of the disease. Instituting forced quarantine laws where patients are admitted to hospitals that are reminiscent of prisons is likely to drive people underground and stoke the fire. In *Goliath*, the High Court invited an action for declaratory relief, which the court said could only be granted when the individuals affected (those who are being treated in the ward) were included in the claim.[178] This type of relief, however, is a matter of urgency, and in the interest of winning the hearts and minds of the citizenry at large, the government must allocate resources to improve hospital conditions and encourage drug-resistant TB patients to seek the help they need. The South African government, more than any other, knows how to run an effective public relations campaign. After all, the Constitutional Assembly, in drafting the very civil liberties that are now

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176. *Id.*

177. *Minister of Health of the W. Cape v. Goliath*, No. 13741/07, para. 10 (S. Afr. July 28, 2008), *available at* http://www.alp.org.za/pdf/PressReleases/TBCase_WCMinHealthWCvGoliath.pdf.

178. *Id.* paras. 39-41.

at stake, included the general population in the constitution-making process.[179] Funneling resources into education is imperative when it comes to managing a highly infectious disease that preys largely on rural, indigent populations. The government must be on the side of the people if this public relations war is to be won and individuals are to feel safe in coming forward to seek treatment.

The negative perception of South Africa's TB hospitals is contributing to the spread of drug-resistant TB, and within the hospital grounds, the situation is no better. With the overcrowding of TB wards, some public health experts contend that "poorly ventilated hospitals have themselves been a driving force in spreading the disease in South Africa."[180] A revamping of these facilities will require a significant financial undertaking, but more importantly, time—something South Africa does not have. Accordingly, at this juncture, "[t]he public would be safer if patients were treated at home . . . with regular monitoring by health workers"[181] and if the government educational initiatives intended to inform families and friends of the highly infectious nature of the disease were implemented. While not an ideal solution, given the limited resources and the damage that has already been done due to the widespread negative association with South Africa's TB hospitals, a program of home treatment coupled with public education is the only realistic alternative. Without enough room to accommodate patients at the present level, hospitals are already discharging patients after six months of treatment, regardless of whether they are still infected, in order to make room for new patients.[182] Forced quarantine is clearly not a solution to an infectious disease crisis. Recognizing the reality that the South African hospitals are already unable to accommodate the growing number of drug-resistant patients, the government must refocus its approach on eradicating the disease, rather than maintaining the status quo.

Reallocating resources to DOT programs, as originally endorsed by the Department of Health, is the best option at this point.[183] The aforementioned approach does not negate the possibility of forced detainment in the future; it only posits that such an arrangement is premature and counterproductive given the current state of affairs. With the recognition that many patients live in rural communities, additional

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179. *See supra* text accompanying notes 21-24.
180. Dugger, *supra* note 122.
181. *Id.*
182. *Id.*
183. DOH, *supra* note 116, at 66.

healthcare workers must be hired to ensure that individuals are taking their medication.[184] In the alternative, "[w]hen human or financial resources do not permit the use of health care workers, trained community members can serve as effective DOT workers."[185] Accordingly, funds must be channeled into hiring, educating, training, and empowering community members to be proactive participants in eradicating drug-resistant TB in South Africa.[186]

## VII. CONCLUSION

The High Court of South Africa has contributed in a detrimental way to the XDR-TB crisis by granting the government unfettered authority to detain persons that refuse to voluntarily submit to isolation. In the short term, compelling isolation has the potential to deter those affected from seeking treatment and therefore propagate the disease. In the long term, the judiciary has set a dangerous precedent by allowing the government to forcibly detain infirm patients on the basis of a "public health crisis" without articulating clear and specific standards for when such action is constitutional. Given the democratic ideals enshrined in the relatively young South African Constitution, the judiciary has a crucial role to play in interpreting and giving effect to South Africa's broad Constitution. This duty should not have been circumvented.

As the health crisis in South Africa continues to emerge, the judiciary must remain cognizant of its sacrosanct role in upholding the ideals on which the new South Africa has been built. Beyond its borders, "South Africa's fragile young constitutional democracy does not only have modest lessons for Africa[,] . . . [i]t also has important lessons for the developed countries in strengthening their international human rights discourse, culture, and observance."[187] In seeking to eradicate drug-resistant TB, the judiciary must act pragmatically, weighing the realities on the ground with South Africa's constitutional ideals, which are unquestionably grounded in human rights and individual freedom. Finding the proper balance is the challenge that lies ahead.

184. *Id.*
185. *Id.*
186. *See id.*
187. Saldhana, *supra* note 38, at 212-13.