HEALTH & DISEASE

T.3

1993

TB at 'highest level ever — still rising'

(91) CT 28/1/93

By BARRY STREEK
Political Staff

THE incidence of TB among coloured people is at its highest level ever and is still rising, the Department of National Health said.

"In a nutshell, the results (of a study) point to an alarming situation," Dr H G V Kustner, editor of the department's journal, Epidemiological Comments, wrote in the latest issue.

Previous studies have shown that most TB-infected coloured people live in the Western Cape.

The Democratic Party's health spokesman, Mr Mike Ellis, said the survey results — taken from analyses of 300 000 TB patients — were "so sad, because TB is controllable.

"It means the whole primary health care system is just not in place."

The department said the level of reported incidence among black people, 200 per 100 000 people, was far from satisfactory but at least rates were not rising.

'SO SAD' ... Mike Ellis

The rising trend among coloured people was evident in all age groups of males and among younger males the slope of the tracings was particularly steep between 1986 and 1991.

"This suggests that far from improving, the situation has grown worse," the department said.

"Furthermore, the rates that are reached by these younger cohorts are well over 800/100 000, some are even over 1 000/100 000, and as such worse than any other groups recorded.

"These findings are ominous indeed and reinforce the urgent need for renewed control efforts in this group," it said.

Coloured females showed a very similar pattern and the younger age groups demonstrated high and rising trends.

"This looks like an emergency situation," the department said.

The rate among Asians was slightly higher among males than females and although it was declining, it was still at levels that could be improved, the department said.

The reported incidence among whites showed significant declines, it said.

Creche not a haven for TB — nurse

City Press 17/1/93

By BERENG MTIMKULU

AN East Rand creche has dismissed as "nothing but a cruel joke" a scary rumour that it runs a TB-infested operation which has put the lives of more than 69 toddlers in danger.

The creche's principal, Pauline Ngcatshe, 62, denied the rumours, which she said surprised her.

Infected

The story was doing the rounds that 69 toddlers had been infected with TB at her Zamani Pre-school in KwaThema.

Only four children had been diagnosed as having the TB virus, Ngcatshe said.

She could not say how the four toddlers had become infected, although she said her 35-year-old son, Patrick Ngcatshe, had suffered from TB, but was now cured.

Angry

Angry at the allegations, a KwaThema Clinic nursing sister who wanted to be known only as Sister Debra, stressed: "Zamani Pre-school and Creche is rated the highest in adhering to hygiene principles compared with its 22 counterparts in KwaThema."

She said the four children were undergoing a three-month immunisation treatment following last year's routine check at the creche.

A "concerned parent" who asked for anonymity contacted City Press this week and claimed that the kindergarten in 74 Marule Street was not fit for children's day care.

Sister Debra said the "concerned parent" who made the allegation could be a jealous rival.

Disease spreading 'like wildfire'

ARGUS 19/2/93

The Argus Correspondent

91

JOHANNESBURG. — Drug-resistant strains of tuberculosis which are "spreading like wildfire" throughout the world, are causing renewed concern in South Africa, where TB already tops the list as the number one infectious disease.

South African National Tuberculosis Association (Santa) director of community TB education Dr Theo Collins said the drug-resistant strains were not new: "What's happening now is that they are spreading like wildfire."

Dr Collins said there had been under-reporting of drug-resistant strains as many centres did not test specifically for them.

"In Santa's 22 centres there are 75 patients with this condition. Although this is a small number, there is also under-reporting of drug-resistance."

Dr Collins said the drug-resistant strains were brought about by irregular or inadequate treatments which allowed drug resistance to take over.

There was particular concern in the United States, where health workers had died as a result of the strain, which was passed on in the same way other strains.

"I'm afraid we're in for a bit of a catastrophe especially in Africa, South America and the Far East," said Dr Collins.

The emphasis was now on prevention and, from this year, a new reporting system would allow for a register of drug-resistant strains.

"Anyone diagnosed as suffering from TB must have treatment under supervision," said Dr Collins.

"A few lapses or failure to take the treatment could lead to the emergence of drug resistance."

Dr Collins said it cost R16 000 to treat someone with the drug-resistant strain — while it normally cost one-sixth of that to treat TB.

11 500 new TB cases last year

(91) CT 2/2/93

By PETER DENNEHY

FRIGHTENING new statistics were released yesterday on the incidence of pulmonary tuberculosis (TB) in the Western Cape, indicating that the disease is continuing to spread.

Over 11 500 new cases were reported to Cape Town municipal and Western Cape Regional Services Council health authorities last year.

RSC Medical Officer of Health Dr Stuart Fisher said last year's six percent increase in notifications in his area, from 6 242 cases to 6 613, was "very frightening because already we (in the Western Cape) are sitting with the highest incidence rate in the country and possibly the world".

Figures released yesterday by the Cape Town City Council show that in its municipal area there were 4 919 cases reported in 1992, nine percent up on the previous year.

Dr Michael Popkiss, the city council's medical officer of health, said the high TB incidence in the Western Cape had not been satisfactorily explained, but one possible factor was that the Western Cape had at one stage (in the 1970s or early '80s) had proportionally five times fewer hospital beds for TB patients than the national average. More beds had since been provided.

Clinics in the Western Cape had treatment-compliance rates that were among the best in the country. They also had among the highest rates of contacts with, and tracings of, TB patients and those likely to have been infected by them.

Yet there were still several TB sufferers who took their treatment intermittently, and thereby unwittingly helped resistant strains to develop.

"Now the community has been seeded," Dr Popkiss said. "Once children have been infected, they recover from TB but break down again when they get stressed."

BCG vaccinations against TB were 80% effective for infants, and 20 000 of these were administered a year. About 4 000 children a year therefore remained susceptible, and it was interesting that the number of new TB cases a year was also of that order.

Dr Popkiss said he had reported to his council the disappointing news that allocations of funds from the government for community health services "will not be made in excess of the Consumer Price Index, and will not keep pace with it". Earlier, the government had made promising statements about diverting more resources to primary health.

"We got a five percent increase in a year of 15% inflation, and we have been told we will get the same proportion this year," he said.

● About half the TB patients in the Western Cape are coloured and most of the rest are black.

Children never stood a chance

SOUTH 13/2 - 17/2/93. (91)

WITH 27 people crowded into a two-roomed house in Uitsig, Mr Michael Hendricks' four children didn't stand a chance.

All have tuberculosis.

Their house provided by the Regional ServicesCouncil has no ceilings, air vents or bedrooms.

The 16 children living there sleep mostly on the floor. Besides breathing problems, most have sores on their bodies.

"The doctors at the hospital said there are too many people living in the house and that this is unhealthy," said Hendricks, who has given shelter to his three brothers, their wives and children.

"But I can't kick them out. They lived in the bush and the children were even more sick then."

Despite their predicament, the Hendricks' family is still fortunate to have secure accommodation.

Mr John Sauls, his wife and two sons all have tuberculosis. They have been sleeping on the floor of a home in Uitsig for over five years.

He has been on the RSC's waiting list for a house for years and believed a letter written by an RSC social worker was his only hope of getting a house. Now he knows he doesn't have a chance.

"This man is a TB patient. He receives daily anti-TB therapy. Both his children are also on TB treatment. Please assist him with housing as a matter of urgency," the social worker wrote.

"I took the letter to the housing office," Sauls said. "They told me the waiting list was closed and that I should come back in two years'.

"Nothing can help me now. The owner of the house where I am living threw my things into the street. I will have to sleep outside soon."

Another tragic case is that of Mrs Hendricka Manuel, 46, who had a stroke four years ago and is trapped in a wheelchair and a tiny zinc shack she shares with 10 people.

Manuel is paralysed and cannot speak. Her daughter, Marilyn, cares for her.

When the weather is good, Manuel spends her days in her wheelchair outside the shack, but in cold, wet weather she is confined to the shack for days.

There are only two single beds in the one-roomed shack and the family sleeps like sardines on the floor.

"In winter, my mother spends a lot of time in hospital. She needs proper housing, but the RSC just doesn't care."

VICTIM: Hendricka Manuel, 46, who was paralysed four years ago and now lives in a wheelchair in a zinc shack she shares with 10 other people

Raid drives TB family into toilet

SOUTH 13/2 - 17/2/93.

By Rehana Rossouw

A MOTHER and her two children were forced to sleep in a toilet in Uitsig this week when Regional Services Council (RSC) officials confiscated a tent that gave them temporary shelter.

Mrs Joan Pienaar is among a group of about 40 families the RSC has hounded out of the backyards of the filthy northern suburbs township and left in the open.

Infected with tuberculosis, the group lost their homes, food, clothing and bedding when council officials confiscated their belongings.

Their plight has outraged a social worker employed by the RSC who said she was prepared to break council regulations and speak to the press about her "frustration" at their lack of sympathy for people in the area.

"I keep writing letters to the housing department, begging them to give these people, especially those with tuberculosis, a home," she said.

"I feel so frustrated; these people come to me for help, but I know they will find little sympathy with the housing officials."

The social worker said the community had among the highest tuberculosis statistics in the Cape and she was convinced the causes were socio-economic.

The families lived in shacks in the backyards of Aster Avenue until last month. The tenants evicted them when they allegedly received letters from the RSC.

The letters apparently threatened to replace the legal tenants with the squatter. However, the squatters deny they have informed the RSC they are prepared to pay the rent.

The families moved onto a litter-filled field, where they re-erected shacks. RSC officials demolished the shacks and confiscated the building materials.

The Uitsig United Residents Front civic organisation intervened and hired tents for the destitute families. Last Friday morning, the field was raided at dawn and the tents and the families' possessions confiscated.

"All I have left are two blankets and a foam mattress," said Pienaar, who was given shelter in a stinking outside toilet about three metres long and a metre wide.

She is sleeping in the toilet with two children aged seven and one year. Her 11-year-old son sleeps on the floor of a shack nearby.

"I have tuberculosis, my sons have tuberculosis and I am waiting for the results of my baby's X-ray," said Pienaar.

"The council wants us to live like animals. I am sure their white officials won't even let their dogs sleep in a filthy toilet."

Uitsig United Residents Front spokesperson Mrs Anne Jacobs said the RSC broke an agreement it had with her organisation to provide shelter for the families.

"We met the RSC on January 27 and they agreed the people could live on the field temporarily," Jacobs said.Jacobs said she was concerned about the families as winter was approaching and they needed shelter before then.

"The RSC is heartless. They have absolutely no shame. But we will stop them, even if we have to go to the highest court in the land," she vowed.

● A spokesperson for the RSC, Mr Norman Carpenter, denied that they gave the Uitsig United Residents Front permission to erect structures on land for the shack dwellers.

"The minutes of the meeting will show that it was agreed that tenants in Uitsig will be requested not to allow the erection of additional shacks," he said.

"No agreement was made with the squatters to pay rent as they are regarded as unauthorised sub-tenants. It is not known why the legal tenants evicted the sub-tenants as no threats or letters were sent."

Carpenter said in spite of what was agreed to at the meeting, the United Front "wilfully" allowed two families to erect illegal structures in Aster Avenue.

He confirmed the structures were demolished on February 2 and the tents subsequently erected removed last Friday at the request of the House of Representatives.

Carpenter said the council had established a working group to identify land to establish an informal housing project where families could be rehoused, but did not say when housing would be available.

CASE

Miss Charmaine Davids lost her clothing, blankets and food in the council raid. She slept in the open on the field on Monday night with her six-month-old baby with two blankets donated by the Red Cross for shelter.

"I had to borrow clothes from friends for myself and my children," said Davids.

"I could hardly sleep on Monday night. The gangsters are terrible in this area and I was in the field with no protection but one blanket.

"The police are quick to protect the council officials when they attack us, but they are never here to protect us from the gangsters."

HIV-related TB greatest health threat

Star 17/2/93

(91)

By Paula Fray
Medical Reporter

The incidence of tuberculosis, which already kills 36 people in South Africa each day, is expected to escalate as a result of Aids and HIV.

HIV-related TB is the world's biggest health threat since the bubonic plague, according to the head of the Department of Microbiology at London University's National Heart and Lung Institute, Dr John Grange.

Concern

Grange, an international authority on TB, was recently in South Africa to address the Tuberculosis Update conference in the Cape as a guest lecturer of the Department of Paediatrics and Child Health Care at Tygerberg Hospital.

His concern echoed that of Health Minister Dr Rina Venter, who has said TB remains one of South Africa's major health problems.

"The prevalence will increase even more as HIV infection increases," said Venter, naming TB and Aids as her department's major priorities for 1993/94.

"Ironically, the advent of HIV-related TB has resulted in a reawakening of interest in TB," said Grange.

"People who have been infected with tubercle bacilli are highly prone to developing reactivation tuberculosis.

"Once infected by tubercle bacillus, the patient has a one percent or less chance of developing active TB every year. But, if infected with HIV and tuberculosis, the chance of developing TB rises to about 10 percent.

"There are currently about 4 million infected people worldwide — 3 million or more of them in Africa," he said.

According to the South African National Tuberculosis Association (Santa), TB is still the major infectious disease in South Africa.

"One South African dies every 40 minutes as a result of TB," said Santa public relations officer Julia van Heerden. "We already have people in our hospitals with TB and Aids."

According to Santa, there were more than 80 000 notified cases of TB last year.

Latest Department of National Health and Population Development statistics showed that the number of notified cases of TB in South Africa rose from 51 874 in 1971 to 77 652 in 1991.

Educate

"If 10 percent of the TB-infected worldwide go on to develop TB every year, it will place an enormous burden on many countries' health-care resources," Grange warned.

"What is really needed is an international focused public-education programme on the nature of TB and its symptoms, and on the fact that if the condition is diagnosed early, thousands of lives can be saved."

The five-week visit by Grange, associate editor of the international specialist publication Tubercle and Lung Disease, was made possible by a R15 000 grant from Pretoria-based Noristan Holdings Limited.

Resistant TB strains spreading

Star 17/2/93

(91)

By Paula Fray
Medical Reporter

Drug-resistant strains of tuberculosis, which are "spreading like wildfire" throughout the world, are causing concern in South Africa where TB already tops the list as the number one infectious disease.

Dr Theo Collins, director of community TB education of the South African National Tuberculosis Association (Santa), said the drug-resistant strains were not new. "What's happening now is that they are spreading like wildfire."

Collins said there had been under-reporting of drug-resistant strains as many centres did not test specifically for them.

"In Santa's 22 centres there are 75 patients with this condition. Although this is a small number, there is also under-reporting of drug resistance."

Collins said the drug-resistant strains were brought about by irregular or inadequate treatments which allowed drug resistance to take over.

"We have found some of these strains in a couple of families," said Collins, who added that there was particular concern in the US where health workers had died as a result of the strains being passed on.

The emphasis was now on prevention. And, from this year, a new reporting system would allow for a register of drug-resistant strains.

"Anyone diagnosed as suffering from TB must have treatment under supervision," he said. "Lapses could lead to the emergence of drug resistance."

Collins said it cost R16 000 to treat someone with the drug-resistant strain, while it normally cost one-sixth of that to treat ordinary TB.

● HIV-related TB "greatest threat" — Page 9

TB expected to rise due to Aids, HIV

(91) ARG 19/2/93

The Argus Correspondent

JOHANNESBURG. — The incidence of tuberculosis, which already kills 36 people in South Africa each day, is expected to increase as a result of Aids and HIV.

HIV-related TB is the world's biggest health threat since the bubonic plague, according to the head of the department of microbiology at London University's National Heart and Lung Institute, Dr John Grange.

Dr Grange, an international authority on TB, was recently in South Africa to address the Tuberculosis Update conference in the Cape as a guest lecturer in the Department of Paediatrics and Child Healthcare at Tygerberg Hospital.

His concern echoed that of Health Minister Dr Rina Venter, who has said TB remains one of the major health problems of South Africa.

"The prevalence will increase even more as HIV infection increases," said Dr Venter, naming TB and Aids as her department's "major priorities" for 1993/94.

"Ironically, the advent of HIV-related TB has resulted in a reawakening of interest in TB," said Dr Grange.

"People who have been infected with tubercle bacilli are highly prone to developing reactivation tuberculosis.

"Once infected by tubercle bacillus, the patient has a one or less percent chance of developing active TB every year. But, if infected with HIV and tuberculosis, the chance of developing TB rises to about 10 percent.

"There are currently about four-million infected people worldwide — three-million or more of them in Africa," he said.

According to the South African National Tuberculosis Association (Santa), TB is still the major infectious disease in South Africa.

"One South African dies every 40 minutes as a result of TB," said Santa public relations officer Ms Julia van Heerden. "We already have people in our hospitals with TB and Aids."

According to Santa, there were more than 80 000 notified cases of TB last year.

Latest statistics showed that the number of notified cases of TB in South Africa rose from 51 874 in 1971 to 77 652 in 1991.

TB kills 192 in Cape Town

(91) ARG 5/3/93

ANDREA WEISS
Health Reporter

TUBERCULOSIS remains the largest single communicable disease problem in Cape Town.

This is the view of Dr Michael Popkiss, Cape Town medical officer of health, in his annual report.

TB deaths were the 11th principal cause of death in the Cape Town area. Last year 192 people died of TB, including 49 in Langa and 52 in Guguletu due to TB.

Dr Popkiss said the differences in incidences of pulmonary forms of TB between race groups remained "striking". Pulmonary TB was of particular importance because it was infectious.

A drop in tuberculous meningitis, a fatal form of the disease, was due to BCG immunisation.

Last year there were a total of 4 809 notifications of tuberculosis among Cape Town residents — 14,53 percent of whom lived in Langa and 22,1 percent in Guguletu.

● Among the other notifiable diseases Dr Popkiss noted that there were four deaths from meningococcal infection (meningitis) which occurs often in the winter months when there is indoor overcrowding.

There were 103 notifications of measles, making it the fifth most common notifiable condition.

There were 259 cases of viral hepatitis and three deaths. Hepatitis A is spread through food and water supplies while Hepatitis B is spread in ways similar to the Aids virus.

There were also 120 cases of whooping cough, five notified cases of typhoid fever (three imported into Cape Town), five imported cases of malaria, one case of insecticide poisoning, one outbreak of food poisoning (involving four or more people), eight cases of acute rheumatic fever and one case of brucellosis (or milk fever).

TB kills 192 in Cape Town

(91) ARG 5/3/93

ANDREA WEISS
Health Reporter

TUBERCULOSIS remains the largest single communicable disease problem in Cape Town.

This is the view of Dr Michael Popkiss, Cape Town medical officer of health, in his annual report.

TB deaths were the 11th principal cause of death in the Cape Town area. Last year 192 people died of TB, including 49 in Langa and 52 in Guguletu due to TB.

Dr Popkiss said the differences in incidences of pulmonary forms of TB between race groups remained "striking". Pulmonary TB was of particular importance because it was infectious.

A drop in tuberculous meningitis, a fatal form of the disease, was due to BCG immunisation.

Last year there were a total of 4 809 notifications of tuberculosis among Cape Town residents — 14,53 percent of whom lived in Langa and 22,1 percent in Guguletu.

● Among the other notifiable diseases Dr Popkiss noted that there were four deaths from meningococcal infection (meningitis) which occurs often in the winter months when there is indoor overcrowding.

There were 103 notifications of measles, making it the fifth most common notifiable condition.

There were 259 cases of viral hepatitis and three deaths. Hepatitis A is spread through food and water supplies while Hepatitis B is spread in ways similar to the Aids virus.

There were also 120 cases of whooping cough, five notified cases of typhoid fever (three imported into Cape Town), five imported cases of malaria, one case of insecticide poisoning, one outbreak of food poisoning (involving four or more people), eight cases of acute rheumatic fever and one case of brucellosis (or milk fever).

State aid for diseases

ARG 13/3/93

Health Reporter

THE government has set aside R2,3 million for the appointment of specialists to combat infectious diseases — with a strong emphasis on TB.

The new jobs provide for one specialist for each region as well as a new appointment in the head office of the Department of National Health and Population Development to focus on the TB problem.

There were 67 157 new TB cases last year.

against dominant warlord

troop force was sent to Kismayu aboard the USS Wasp as-

later said he had complied.

However, last week Mor-

hamed Siad Barre — Morgan's father-in-law. — Sapa-Reuter.

(91) ARG 27/3/93

New vaccine may spur cure for TB and Aids

BOGOTA. — The leader of a team that developed an effective new anti-malaria vaccine says his work may lead to breakthroughs against other deadly diseases such as tuberculosis and even Aids.

"The malaria vaccine is the world's first chemically produced vaccine and it opens up an immense gateway for the development of new vaccines and the improvement of existing ones," Dr Manuel Elkin Patarroyo said.

He said that "obviously a very good candidate to develop a vaccine using this method is Aids". He gave no details and did not say when new vaccines might be ready to test.

Dr Patarroyo and his team at San Juan de Dios Hospital here reported in the British medical publication The Lancet last week that their vaccine helped prevent the most common and lethal strain of malaria.

The disease is one of the Third World's biggest killers, infecting 300-million people a year and killing more than three million, mostly in Africa.

"We have already vaccinated 41 135 people around the world, mainly in Colombia, Venezuela, Ecuador, Peru and Tanzania," Dr Patarroyo said, adding that there were plans to start inoculating people in Cambodia, Thailand, Gabon, Senegal, Gambia and the Central African Republic.

Even as Dr Patarroyo and his team of 65 researchers refined the vaccine, they were already working on the next step — applying similar techniques to find a vaccine against tuberculosis. — Sapa-Reuter

Star 21/4/93

Tuberculosis in Africa under-reported, says doctor

(91)

Medical Reporter

SUN CITY — There could be little doubt that the tuberculosis problem in Africa, including South Africa, was under-reported, the Medical Research Council's Dr Barnard Fourie said this week.

This came less than a month after the South African National Tuberculosis Association revealed that 36 people die of TB each day.

Fourie was speaking at the 57th Medical Association of South Africa (Masa) congress at Sun City. The Congress is also being attended by delegates from nine African countries.

"Worldwide, there is renewed interest in tubercolosis as an epidemic which has returned in an opportunistic way to once more become a public health threat in the under-privileged communities", said Fourie.

About one third of the world's population was infected with Mycobacterium tubercolosis, he added. In the past decade, an average of 2,5 to 3,2 million cases were notified each year worldwide.

Fourie said the main reasons for the upsurge included the HIV-infection, multidrug-resistant strains of TB and the inability of health services to implement adequate control programmes.

Africa represented only 10 percent of the overall number of notifications to the World Health Orginisation. Of the 47 countries included in the WHO Africa region, 35 reported cases rates of fewer than 100 cases in 100 000 in 1989; seven reported rates of 100-200 and five reported rates of 200 and higher (Botswana, Mauritius, Namibia, South Africa and Zambia).

The conference, which ends today, was opened on Sunday by heart pioneer surgeon Professor Chris Barnard who said three factors made it possible for South Africa to break new medical ground with the first heart transplant operation 25 years ago. These were: excellent training facilities for doctors; good back-up in in blood transfusion and nursing; and a situation where superiors allowed their students to excel.

Preventable TB world's chief killer

Star 24/4/93

(91)

LONDON — The World Health Organisation (WHO) yesterday declared tuberculosis a global emergency, saying the disease will claim more than 30 million lives in the next decade unless immediate action is taken.

"TB today is humanity's greatest killer and it is out of control in many parts of the world," said Arati Kochi, manager of the WHO's TB programme, at a news conference announcing the move and a plan to combat what has been dubbed the "forgotten epidemic".

"The disease, preventable and treatable, has been grossly neglected and no country is immune to it."

Once believed to be under control, TB is spreading worldwide because of the emergence of drug-resistant strains, changing research priorities and a link between TB and Aids.

"TB is an unnecessary tragedy," said Richard Bumgarner, senior programme management officer at WHO's Tuberculosis Unit. "Existing drugs and proven techniques have been shown to be successful — with more than 90 percent cure rates — and inexpensive. The cure of TB, and thereby prevention of it, is one of the most cost-effective health services known."

TUBERCULOSIS has been called the forgotten epidemic, not least because it has been overshadowed in the past decade by Aids.

One-third of the world's population is infected with the disease. Although most cases and more than 95 percent of deaths are in the developing world, the number of cases in Europe and North America has soared in the past five years.

'Emergency'

WHO's move to declare an emergency comes as part of a two-day meeting in London of its tuberculosis programme advisory board, which has been hammering out the steps needed to control the disease. The meeting recommended that about R60 million be spent over the next two years to help WHO member states develop effective schemes to cut the number of TB deaths in half over the next decade and stimulate research.

It says that once this prepartory work is under way another R240 million to R300 million will be needed annually from development banks and others to implement the control programmes.

WHO is also calling for intensified research for new drugs and diagnostic methods. Drugs priorities include new antibiotics to treat drug-resistant strains, as well as reviewing and improving vaccines.

"TB and HIV (the virus leading to Aids) are synergistic," said Bumgarner. "HIV activates TB in people who are TB-infected but whose immune systems successfully suppressed the TB germ until the HIV exposure. Conversely, TB can hasten the progression to Aids in HIV-infected people."

Deaths from tuberculosis are running at 3 million each year or about 9 000 a day. "That's equivalent to 20 jumbo jets crashing each day, with all passengers being killed," said Bumgarner.

"This old disease, which people remember as having been the cause of death of Keats, Chopin and Simon Bolivar, is now the leading cause of death from a single infectious agent." — Sapa-Reuter.

Forgotten slow killer running out of control

(91) ARG 24/4/93

■ Tuberculosis, long thought of as "the forgotten epidemic", is the focus of a major programme to combat this eminently preventable disease.

LONDON. — The World Health Organisation yesterday declared tuberculosis a global emergency, saying the disease would claim more than 30 million lives in the next decade unless immediate action was taken.

A third of the world's population is infected with the disease. Although most cases and more than 95 percent of deaths are in the developing world, the number of cases in Europe and North America has risen to 33 percent in five years.

"Tuberculosis today is humanity's greatest killer and it is out of control in many parts of the world," said Dr Arati Kochi, manager of the WHO's tuberculosis programme, at a news conference announcing a plan to combat what has been dubbed the "forgotten epidemic".

"The disease, preventable and treatable, has been grossly neglected and no country is immune to it."

Once believed to be under control, TB is spreading worldwide because of the emergence of drug-resistant strains, changing research priorities and a link between TB and Aids. "TB is an unnecessary tragedy," said Richard Bumgarner, senior programme management officer at WHO's Tuberculosis Unit.

"Existing drugs and proven techniques have been shown to be successful — with over 90 percent cure-rates — and inexpensive.

"At $3,00 (R9,00) a year to save a human life, the cure of TB, and thereby prevention of it, is one of the most cost-effective health services known."

The WHO's move to declare an emergency comes as part of a two-day meeting in London of its tuberculosis programme advisory board, which has been hammering out the steps needed to control the disease.

The meeting recommended about $20 million (R60 million) be spent over the next two years to help WHO member-states develop effective schemes to cut the number of TB deaths by half over the next decade and to stimulate research.

It says once this prepartory work is under way another $80- to $100 million (R24- to R30 million) would be needed annually from development banks and others to implement the control programmes.

The WHO is also calling for intensified research for new drugs and diagnostic methods.

TB has been called the forgotten epidemic, not least because it has been overshadowed in the past decade by AIDS, with which there is a link.

"TB and HIV are synergistic," said Bumgarner.

"HIV activates TB in people who are TB-infected, but whose immune systems successfully suppressed the TB germ until the HIV exposure.

"Conversely, TB can hasten the progression to AIDS in HIV-infected people." — Sapa-Reuter.

TB now world emergency

(91) CT 24/4/93

One third of globe has disease

LONDON. — The World Health Organisation (WHO) has declared tuberculosis a global emergency, saying the disease will claim more than 30 million lives in the next decade unless immediate action is taken.

One third of the world's population has the disease with 9 000 dying each day. Although most cases and more than 95% of deaths are in the developing world, the number of cases in Europe and North America has risen to 33% in the past five years.

And TB and HIV (the virus leading to Aids) are synergistic, a WHO spokesman said. "HIV activates TB in people who are TB-infected but whose immune systems successfully suppressed the TB germ until the HIV exposure. Conversely, TB can hasten the progression to Aids in HIV-infected people."

In the Western Cape, TB has reached epidemic proportions. More than 11 500 new cases were reported to Cape Town municipal and Western Cape Regional Services Council health authorities last year, according to recent reports.

More than a third had occurred in the Western Cape. One hundred and ninety-two people died of TB in Cape Town last year.

Cape Town medical officer of health Dr Michael Popkiss said TB remained the largest single communicable disease in the City.

"Tuberculosis today is humanity's greatest killer and it is out of control in many parts of the world," said Mr Arati Kochi, manager of the WHO's tuberculosis programme at a news conference announcing the "global emergency" declaration and a plan to combat what has been dubbed the "forgotten epidemic".

"The disease, preventable and treatable, has been grossly neglected and no country is immune to it," he said.

Once believed to be under control, TB is spreading worldwide because of the emergence of drug-resistant strains, changing research priorities and a link between TB and Aids. — Sapa-Reuter, Staff Reporter

11 500 new cases as TB reaches 'epidemic'

(91) ARG 27/4/93

CLIVE SAWYER
Municipal Reporter

Cape Flats worst-hit area

TUBERCULOSIS has reached epidemic proportions in the Western Cape where drug-resistant strains have been diagnosed.

More than 11 500 new cases were reported in the Cape Town City Council and Western Cape RSC areas last year — just under half the 24 000 cases reported in the whole Western Cape. Figures have been rising about 8 percent annually for the past 15 years.

TB cases in the region account for about a third of those reported countrywide, according to the Department of National Health.

While there was a 95 percent cure rate among patients who kept to their treatments, there had been cases of drug-resistant strains developing among those who did not take medication regularly, or who stopped taking it.

This strain was being passed on to the community.

RSC medical officer of health Dr Stuart Fisher said the steady annual growth rate of the disease meant it had to be classified as an epidemic.

"About 30 percent of the population has been exposed to TB, which does not mean they have it, but they are at risk if their resistance weakens," he said.

Worst-hit areas were the Cape Flats, in particular Elsies River, Ravensmead, Uitsig and Khayelitsha.

While bringing people closer to health care facilities, urbanisation also led to overcrowding in which the disease could flourish.

"Our main message must be that TB can be cured, but only if employers and the community are ready to play a large role.

"The worst thing an employer can do is fire somebody who has TB, because that person is pitched into a vicious cycle of poverty and even if he or she gets another job, might try to conceal the problem," Dr Fisher said.

Patients given a few weeks' sick leave could return "non-infectious" as long as they had taken their medication regularly.

Firing an employee with TB was shutting the door after the horse had bolted, because by then it was probable the patient was past the infectious stage.

In the long term, a socio-economic solution had to be found, because poverty and high unemployment were spurs to poor diet, alcoholism and bad living habits.

In the short term, health services had to concentrate on reducing the pool of infected people. This could be done successfully only with early diagnosis and adequate treatment, and by reducing the stigma attached to the disease.

Dr Fisher said only 20 percent of patients needed hospital treatment. Supervisors could be trained to help patients at school or work and, in some cases, patients were allowed to supervise their own treatment.

While medication was expensive, with some ingredients imported from overseas, treatment at clinics and medication were free.

Reacting to the World Health Organisation's labelling of TB as a "forgotten disease," Dr Fisher said that in the Western Cape it was everything but forgotten. "It has been the major focus of our health services for some time."

In his annual report, city council medical officer of health Dr Michael Popkiss said TB deaths were the eleventh principal cause of death in the municipal area.

Dr Popkiss said clinics in the Western Cape had treatment-compliance rates that were among the highest in the country and there had been considerable success in keeping contact with TB patients and those likely to have been infected.

About 20 000 vaccinations against TB were given a year.

Those who took their treatment intermittently had "seeded" the community.

Dr Popkiss said government allocations for community health services last year did not match inflation and this trend was expected to continue.

Move to ward off TB 'holocaust'

B/Day 28/4/93

KATHRYN STRACHAN (71)

THE SA National Tuberculosis Association (Santa) launched a major drive yesterday to spread awareness of the threat of TB, which is rated as the No 1 killer among infectious diseases in the country.

One South African dies of TB every 40 minutes, and half the adult population has the potential to contract the disease.

Dormant, harmless TB infections are often broken down into a dangerous disease by the HIV virus. Santa has predicted a "TB holocaust" as the AIDS statistics spiral and trigger an explosion in the incidence of TB.

Santa spokesman Julia van Heerden said yesterday one of the biggest obstacles in the control and prevention of TB was the fragmented health services in SA.

The slashing of provincial administrations' health budgets also meant that TB services would be pared down at a time when more facilities were desperately needed, Van Heerden said.

Medical expert Theo Collins said the greatest danger in the fight against TB was multiple drug resistance, which developed when sufferers take medication irregularly. Secondary medication for the highly resistant strain of TB was available, he said, but it was expensive and toxic. He said resources were being strained by the large number of people developing the resistant variety. Introducing more powerful drugs would only heighten resistance.

NEWS 100 000 are infected every year ● End of road for Nkosinathi

TB kills 36 every day

Sowetan 28/4/93

By Musa Zondi
Medical Reporter

(91)

■ Awareness campaign to combat the disease is launched:

ABOUT 36 people die of tuberculosis (TB) in South Africa every day.

This was disclosed by the South African National Tuberculosis Association yesterday at the launching of an awareness campaign.

The campaign, which will go on until the end of October, is aimed at:

- Addressing the disease;
- Santa's efforts in combating the disease; and
- Pinpointing the role of the individual and encouraging voluntary participation.

"Our ultimate objective is to place the people of South Africa in a position where they can take the required action and assume responsibility in the fight against tuberculosis," the association said.

Seven major target groups have been identified. These are teachers, youth, employees, nurses, traditional healers and women's groups.

The main reason for the difficulty experienced in eradicating the disease stems from social problems such as "poverty, overcrowding, ignorance and the survival characteristics of this organism with its ability to lie dormant for long periods in the human body".

While reliable figures were not available, Santa estimates that at least 100 000 people in the country become victims of the disease annually.

"These estimates in themselves are frightening but the situation becomes much worse when account is taken of the disability resulting from permanent damage to lungs or other organs and the observed, but not documented, increase in drug-resistant forms of the disease promoted by various factors, among them the inadequate treatment in some instances of the most serious infectious disease in South Africa," says Santa.

But the biggest danger is the link between HIV — the Aids virus — and TB. Santa says in recent years HIV has emerged as a strong factor in the flare-up of dormant TB infections into an active disease. "At least half of the population is already infected with TB and with at least 400 cases of HIV infection reported every day, we are facing a time bomb," says Santa.

Hani funeral boy dies of head wounds

By Ruth Bhengu

■ He never recovered from coma:

THE 15-year-old boy who was in a coma for five days following an injury while travelling to Mr Chris Hani's funeral died in the Johannesburg Hospital on Saturday.

Nkosinathi Mngoma, of Tsakane in Brakpan, fell off a bus that was ferrying mourners after he was allegedly hit on the head with a stone thrown by a white person on Monday April 19.

Apparently Nkosinathi, who was a Standard 6 pupil at the Retlhokofaditswe Secondary School, was one of several youths riding on the roofs of buses carrying thousands of mourners from all over the country.

"I am heartbroken," said Mrs Nomvula Mngoma, Nkosinathi's mother. "It is difficult to accept that I now have only one child when a month ago I had two.

"I was left with Nkosinathi and his younger brother Mandla, who is six years old. Now there is only Mandla," she said.

Mngoma said Nkosinathi died while his father and grandfather were visiting him. The family had taken turns visiting Nkosinathi, who never regained consciousness from the time he was injured on Monday.

Santa mounts drive against killer TB

(91) CT 28/4/93

JOHANNESBURG. — The South African National Tuberculosis Association (Santa) yesterday launched a six-month campaign to spread awareness of the threat of tuberculosis, which is the biggest killer among infectious diseases in South Africa.

One South African dies of TB every 40 minutes and half the adult population has the potential to contract TB.

Expert Dr Theo Collins said the greatest danger in the fight against TB was multiple drug resistance which developed when sufferers took medication irregularly.

Secondary medication for the highly resistant strain of TB was available, but was expensive and toxic. He said resources were also being strained by the large number of people developing the resistant variety.

These TB sufferers were again sources of infection who passed on the highly resistant TB organism.

Introducing more powerful drugs into South Africa would only worsen the problem and heighten resistance, he said.

The World Health Organisation warned last week that TB would claim more than 30 million lives in the next decade unless immediate action was taken.

Although most cases and 95% of the deaths occur in the developing world the number of cases in North America and Europe has risen 33%. — Sapa

TB 'must be tackled now'

ct 18/5/93 (91)

Staff Reporter

THE tuberculosis epidemic in South Africa must be tackled now as the risk of a TB sufferer becoming HIV infected is six times that of a non-TB sufferer, warned one of the world's top TB researchers at a Medical Research Council seminar this week.

According to researcher Professor Stefan Gryzbowski, a former consultant to the World Health Organisation on TB and Aids, the two diseases compound each other's effects.

While the world's spotlight has fallen on Aids, TB has become the "forgotton epidemic", with one South African dying of TB every 40 minutes.

The Western Cape is the worst hit area with 42% of the country's total number of cases.

● The Pharmaceutical Society of South Africa on Thursday resolved at a conference in Durban to pursue a system for community pharmacists to distribute free syringes, needles and condoms to drug-users so that addicts did not share infected syringes and thereby increase their chances of contracting Aids.

HIV infection adds to TB misery

ABOUT one in five tuberculosis patients admitted to hospitals in SA were HIV positive, says the Department of National Health. Cities 5/9/93

The TB epidemic had greatly increased in Africa as a result of the Aids plague, putting increased pressure on health care services, the Department said this week. (91)

At least 80 000 new TB cases were notified annually. Between 24 and 36 people died daily because of the disease, the statement said.

Russian scientists link genes to TB risk

MOSCOW. — Russian scientists have proven that some people may be genetically at risk of contracting tuberculosis (TB). (91) CT 17/5/93

Mr. Alexei Primak, head of the Tuberculosis Research Institute in Moscow, said his institute had developed a way of establishing if a person's genes contained antibodies liable to encourage the development of the disease.

Those with active antibodies, as opposed to passive, were at risk, and their parents either had tuberculosis or were harbouring the disease.

The institute's specialists said each new-born baby should have a "genetic passport" indicating whether vaccination was necessary. — Sapa-AFP

Central Economic Advisory Service

Capacity	*Number of retrenched public servants*	*Number of retired public servants*
State Accountant		1
Total		1

South African Communication Service

Capacity	*Number of retrenched public servants*	*Number of retired public servants*
Principal Communication Officer		1
Industrial Technician	1	
Total	1	1

Schools: number of classrooms

323. Mr R M BURROWS asked the Minister of Education and Training:

(a) What is the (i) total number of classrooms in (aa) primary and (bb) secondary schools administered by his Department and (ii) average number of classrooms in each case and (b) in respect of what date is this information furnished? B744E

The MINISTER OF EDUCATION AND TRAINING:

(a) (i) (aa) 43 509.

(bb) 14 849.

(ii) (aa) 5,8.

(bb) 23,2.

(b) 3 March 1992.

Notifiable diseases in each race group

331. Mr M J ELLIS asked the Minister for National Health and Welfare:

How many cases of each notifiable disease were notified in respect of each race group in 1992? B745E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

Disease	*Population Group*					
	Unknown	*Asian*	*Black*	*Coloured*	*White*	*Total*
Brucellosis	1	1	6	7	24	39
Cholera	1	0	13	0	0	14
Congenital syphilis	83	0	423	288	1	795
Congo fever	0	0	7	0	2	9
Diphtheria	0	0	2	0	0	2
Food poisoning	2	7	21	51	1	82
Lead poisoning	0	0	1	0	1	2
Legionellosis	0	0	1	0	1	2
Leprosy	2	0	69	1	0	72
Malaria	42	2	2 540	5	188	2 777

Disease	*Population Group*					
	Unknown	*Asian*	*Black*	*Coloured*	*White*	*Total*
Measles	910	340	12 677	2 117	4 304	20 348
Meningococcal infection	9	3	258	291	32	593
Pesticidal poisoning	3	1	68	50	20	142
Rabies	0	0	15	2	10	27
Rheumatic fever	0	2	15	12	1	30
TB bones & joints	0	3	99	34	6	142
TB genito-urinary system	0	0	34	13	20	67
TB intestines	0	3	50	8	5	66
TB meninges, CNS	3	5	237	98	14	357
TB miliary	1	1	117	48	7	174
TB other organs	34	17	1 653	354	97	2 155
TB other respiratory	0	2	476	373	33	884
TB primary infection	1	1	1 892	2 705	31	4 630
TB pulmonary	247	506	47 608	19 054	782	68 197
Tetanus	1	1	74	2	4	82
Tetanus neonatorum	0	0	15	1	0	16
Trachoma	0	0	7	0	0	7
Typhoid fever	10	8	1 084	8	37	1 147
Viral hepatitis A	138	40	164	215	825	1 382
Viral hepatitis B	27	36	330	175	52	620
Viral hepatitis non-A, B	1	0	25	0	9	35
Viral hepatitis unspecified	0	5	212	56	38	311

Deadly duo can be held in check

(91)

ARG 22/5/93

Aids and tuberculosis make a deadly duo in South Africa as epidemics sweep the country. Two experts suggest ways of coping. These reports by ANDREA WEISS, Health Reporter.

BY the turn of the century Aids will be the leading cause of death among adults in South Africa — but predictions that the disease would decimate the population are unfounded.

This is the view of Metropolitan Life actuary Mr Peter Doyle, whose forecasts regarding HIV and Aids are remarkably similar to recent figures released by the Department of National Health and Population Development.

"Aids is not going to wipe out the population, reduce the labour force to zero or collapse the economy, but it is going to be enough of a problem to affect us severely," he says.

Mr Doyle and colleague Mr Tjaart Esterhuyse have estimated that there are about 300 000 people infected with HIV in this country, including the TBVC states. They expect a further 200 000 people to become infected this year with about 550 new infections a day.

And they estimate that up to 7 000 people will become Aids sick this year.

These predictions overturn earlier views that the doubling time for HIV infection would get shorter and the disease would engulf the population.

On the contrary, Mr Doyle and his colleague say that as HIV spreads across the total adult population the doubling time will in fact begin to lengthen. But even though the total spread of infection will take longer than 12 months to double in size, total HIV infections could still number about 500 000 at the beginning of 1994.

"The figures show that not millions of people will be infected by the year 2 000, but the number is still disconcertingly large."

Mr Doyle says South Africa probably has the best national data available in Africa — drawing from surveillance projects at ante-natal clinics throughout the country and in Johannesburg, Natal and KwaZulu.

The graph for HIV infection differs from other epidemics largely because the disease has a very different pattern to other diseases. The virus is not as virulent and has an extremely long incubation period, possibly 10 years or longer.

He thinks the disease should really be viewed as a series of epidemics taking hold of different groups at different times.

If HIV infection levels off, as most epidemics do, this does not mean it will then decline because the infected population would live on for a number of years while a new generation would become infected.

In Africa, it was thought that people with HIV would not live very long — probably no more than five to seven years. But Mr Doyle says more recent studies show that people infected at a younger age tended to live longer.

Because infections in Africa tended to occur in the early 20s, those affected might live for 10 to 15 years. Estimates were that only 30 percent of people would be Aids sick in 10 years. Aids deaths would consequently occur when people were in their most economically active period in the age-group 30 to 40.

Ironically, intervention in the progress of HIV was currently aimed at prolonging life, which in itself prolonged the epidemic. In other words, the longer people stayed healthy, the more time they had to infect others.

But why did Mr Doyle feel it necessary to challenge the "doom and gloom" predictions of the early days of the epidemic?

Mr Doyle believes that accurate predictions are important for two reasons. Firstly, they are needed to inform policy decisions. If people, for instance, imagined that the housing crisis or population explosion would be nullified by Aids, they needed to be put right. Secondly, a "doomsday" scenario had the effect of paralysing people into inaction.

"People are inclined to throw up their hands and say: 'We can't do anything'."

Also, the business of predictions was rather like the politics of South Africa. "When you're planning, you'll either say that everything will be hunky dory or it will be a total disaster, but you know neither is true."

And he points out that whatever the graphs may show, the chart they plot is not necessarily inevitable.

Tune to TB — get real! SA told

(91) ARG 22/5/93

EVERY TB patient who keeps taking tablets long enough to be cured should be rewarded with a gift such as a transistor radio, says an international TB expert.

Professor Stefan Grzybowski, a World Health Organisation consultant on TB who received the Order of Canada for his pioneering work in controlling TB among theEskimos, has been visiting South Africa as a guest of the Medical Research Council to help review research strategies.

He said the tuberculosis epidemic in the Western Cape had not yet peaked and health authorities would have to employ imaginative strategies if inroads were to be made.

While socio-economic conditions were a factor, a real change could be made if health authorities concentrated on curing every case of TB diagnosed, and on encouraging people to stick to their treatment.

This could be done by providing them with incentives such as a transistor radios or food parcels.

At present lack of compliance is a major headache because people with TB have to take drugs on a daily basis for six months. This also increases the incidence of drug-resistant TB.

He said the fact that people got a disability pension while they were sick could work as a "disincentive", encouraging them to stay sick longer. Extend the pension for six months after they were cured, he suggested.

He also thought current treatment could be modified to a twice-weekly dose of drugs rather than the daily regime which many people find difficult.

"If a tremendous effort were made in diagnosing all the infectious cases and making them non-infectious by treating them, then you could probably control the epidemic and bring rates down.

"But it would be a tremendous task because the population here is very large. The Eskimo population is only 100 000," he said.

Professor Grzybowski believes that South Africa's health-care system is too hospital-based.

Huge amounts of money will be spent hospitalising a patient coughing blood, but the clinics outside the hospital where that patient should have been treated before he became seriously ill are "cash-starved".

Also, while South Africa has bought an "expensive combination of drugs" to control TB, bacteriological tests were carried out infrequently which meant the treatment was not well documented.

Why exactly the "coloured" population of the Western Cape is particularly susceptible to TB is a mystery to researchers.

Professor Grzybowski points out that socio-economic factors such as overcrowding, malnutrition and alcohol abuse may not be the only causes.

Improved living conditions would be helpful but "not enough to turn the tide". He likened the epidemic here to England of the early 1800s.

He said when the Labour Corps of "Cape (coloured) boys" went to France in 1917-18, there were 182 TB deaths among 11 000 men.

Compare this to the 165 TB deaths among 1,5 million British troops, he added.

"The problem with TB is it is such a slow disease. What happens now may only show up in 50 years," Professor Grzybowski said.

People with AIDS

Percentage of HIV-positive

Health chiefs unveil battle plan to curb soaring cases of TB

(91) ARG 3/6/93

□ W Cape is world crisis spot

ANDREA WEISS
Health Reporter

THE government announced a national tuberculosis control programme today in an effort to stem the disease, which is rampant in South Africa.

Dr Coen Slabber, director general of the Department of National Health and Population Development, told a news conference in Cape Town that the incidence rate of TB had risen by 27 percent since 1988, with about 80 000 new cases notified each year.

In the Western Cape the incidence of TB was among the highest in the world.

The new control programme included the creation of special posts in nine regions.

Professors of community health departments meet next week to discuss the role the new staff will play in a joint academic and health department effort.

Professor Eric Glathaar, chairman of the TB Advisory Group, said the group had identified five major goals, the first to reduce the infectious pool of TB victims by curing every case.

Only 75 percent of cases were being cured at present because successful treatment depended on daily doses for six months, which was not followed by sufferers.

Professor Glathaar said the group was looking at other treatments, given only two or three times a week.

The Community Health Association of South Africa was also investigating offering incentives to patients and their supervisors. These could be food or housing relief.

Dr Michael Popkiss, Cape Town medical officer of health, said one should guard against making TB attractive.

His colleague, Dr Stewart Fisher of the Western Cape Regional Services Council, said in some cases people deliberately remained sick to draw their welfare grants.

The campaign will also focus on research, disease surveillance, immunisation, community participation and the training of health care workers.

Professor Glathaar said the TB control programme brought South Africa into line with practice throughout the world.

Goals were attainable and a high premium was placed on evaluation and the implementation of corrective measures.

Technical sub committees had been appointed to implement the programme, which Professor Glathaar described as a "milestone in the control of this formidable disease".

W Cape TB 'highest in world'

CT 4/6/93

(91)

Staff Reporter

THE Western Cape has the highest reported rate of tuberculosis in the world, health authorities disclosed at a launch of the SA Tuberculosis Control Programme in Cape Town yesterday.

Dr Coen Slabber, director general of the Department of National Health, said the incidence of TB in the country had risen by 27% since 1988 with about 80 000 new cases notified each year.

During 1992 a total of 9 250 cases of TB were reported in the WCRSC area, representing about 12% of all notifications in the country.

Health authorities said the reason why the Western Cape had the highest incidence of TB was not clear although the rapid rate of urbanisation and socio-economic circumstances played a significant role.

Professor Eric Glatthaar, head of the Department of Community Health of Pretoria University, said the TB campaign's first goal was to reduce the infectious pool of victims.

It will also focus on community participation, research, disease surveillance, immunisation and the training and support of health care workers.

Officials said only 75% of TB cases were being cured at present because patients did not adhere to taking daily doses for six months.

health

South 12/6 - 16/6/93.

TB: A disease which thrives in poverty

TB is one of the world's biggest killers. To tackle it, the first task is to find a cure for poverty. JUSTIN PEARCE reports:

TUBERCULOSIS (TB) is a disease of the poor. Of the two billion people infected with TB today, 95 percent are in the developing world.

TB came to South Africa with sufferers from Europe who thought that the warm climate would help their recovery. The epidemic exploded when mining companies brought migrant workers together from the entire subcontinent, crowded them together into unhealthy living quarters, and sent them home when they developed TB — to pass the disease on to those who lived around them.

In developed countries, the disease declined steadily from the 1830s to the 1980s. The decline began before the TB germ was identified in the 1880s, and before vaccination began in the 1950s.

The drop in TB cases relates not to these medical breakthroughs, but to the steady increase in living standards in developed countries.

"This shows the importance of quality of life over medical intervention says a doctor.

Malnutrition weakens the immune system, leaving the body vulnerable to TB. Crowded, badly ventilated living conditions — typical of townships and squatter camps — increase the chance of the disease being passed on. The lack of a comprehensive health service makes it difficult to identify and treat TB.

This explains why most of the world's TB cases are in developing countries. It also explains why those developing countries which have been most successful in controlling the epidemic are those which do not treat disease in isolation, but which actively address the causes of TB.

Last week the Department of National Health and Population Development launched a Tuberculosis Control Programme, which emphasises the need for education about TB, and for state health workers to work with community organisations and non-governmental organisations to fight the disease.

"You can't create community inolvement in Pretoria or (in the CPA offices) in Wale Street," says National Health director general Dr Coen Slabber. "Local authorities are in a unique position in combatting TB."

But, says Dr Louis Reynolds of the Progressive Primary Health Care Network, primary health care means more than medicine. Primary health care must include the provision of proper nutrition, an adequate supply of safe water and proper sanitation.

At present, health authorities in South Africa have no control over drains being laid, houses being built or jobs being created.

"The principle of primary health care is an intersectoral approach," Reynolds says. "It's not only the responsibility of the Department of Health. We need a national political decision that tells the health, education, housing, agricultural and other sectors that we need a scheme of healthy development."

Fighting the roots of TB

South 12/6 - 16/6/93

By Mluleki Gantsho

SANTA Sunshine creche in Elsies river has become a beacon of hope for children suffering from tuberculosis.

It is a community-based project for children who suffer from TB and those who are at risk.

"This is a unique creche in South Africa that deals with children who come from deprived families or whose parents are alcoholics," said Mrs Dulcie Erasmus, community project manager.

There are also programmes which involve parents, like gardening skills. Parents are also given food parcels.

"We recruit members from the community to be trained as community health workers. Their tasks are to supervise and support TB patients and to encourage them to take treatment regularly," said Erasmus.

The recruits also assist in finding new patients and refer them to the clinic. Sometimes they have to treat patients in their homes.

Erasmus said TB is curable but because of ignorance and the stigma attached to it — it is seen as a poor person's disease — it becomes difficult.

(91)

"TB can be cured in less than six months if people take treatment regularly, and if one suspects that he or she has TB they should visit the nearest clinic immediately."

People should take note of these signs and symptoms: coughing for more than three weeks; loss of appetite and weight; shortness of breath; tiredness; sweating at night; and coughing blood.

Erasmus said anyone with any of these symptoms should visit a clinic for a check up.

"You may not be suffering from TB but remember an early diagnosis means an early recovery," she said.

The Sunshine Creche is one of the community health projects run by the South African National Tuberculosis Association (Santa), a non-governmental organisation which has been combatting TB since 1947.

Santa is committed to a community-based approach to fighting TB, says community services and planning manager, Ms Louise Remmers.

"Previously the community has been seen as recipients rather than participants, and it is going to take a while to switch that perception."

"The emphasis in South Africa has been on curative medicine," adds Santa public relations manager, Ms Julia van Heerden.

"We want to change that attitude but it doesn't happen overnight. And major problems lie in the fragmentation of the health services."

The creche, started in 1978, now has 80 volunteers, nine health advisors and 13 staff members paid by santa.

Organisations like the Christmas Stamp Fund and private donors contribute to its existence. Food is subsidised by the goverment.

"We are very thankful to the community of Elsies River for their support. If it was not for them things would have been very difficult," Erasmus says.

This page was made possible with the support of Warner-Lambert

From a cough to a coffin

Sowetan 12/6 - 16/6/93 (91)

By Justin Pearce

IT STARTS with coughing — and can end in a coffin.

Tuberculosis is usually transmitted when an infected person coughs, sending droplets of infected saliva into the air.

Inhaling infected material does not always mean you will develop TB — the development of the disease depends on a balance between the presence of the TB bacillus, and the body's immune system.

If your immune system is working well you can carry the infection and be none the worse for it.

Not getting a proper diet affects the immune system, which is why TB spreads quickly in malnourished communities.

Stress also weakens the immune system, hastening the onset of TB.

For the same reason, people with Aids or HIV infection are at risk.

However, while the Western Cape has a low HIV infection rate compared with the rest of South Africa, it has the highest incidence of TB in the country — so it's wrong to assume the TB explosion is solely the result of the Aids pandemic.

Vaccination against TB is one of the most important medical steps that can be taken against the disease, and should be performed as soon as possible after birth.

Although TB can affect different regions of the body, it is most commonly found in the lungs, as this is where the germ first enters the body. From the lungs it can get into the bloodstream and be carried to other parts of the body. It is most serious when it infects the membranes around the brain, as this infection can result in brain damage.

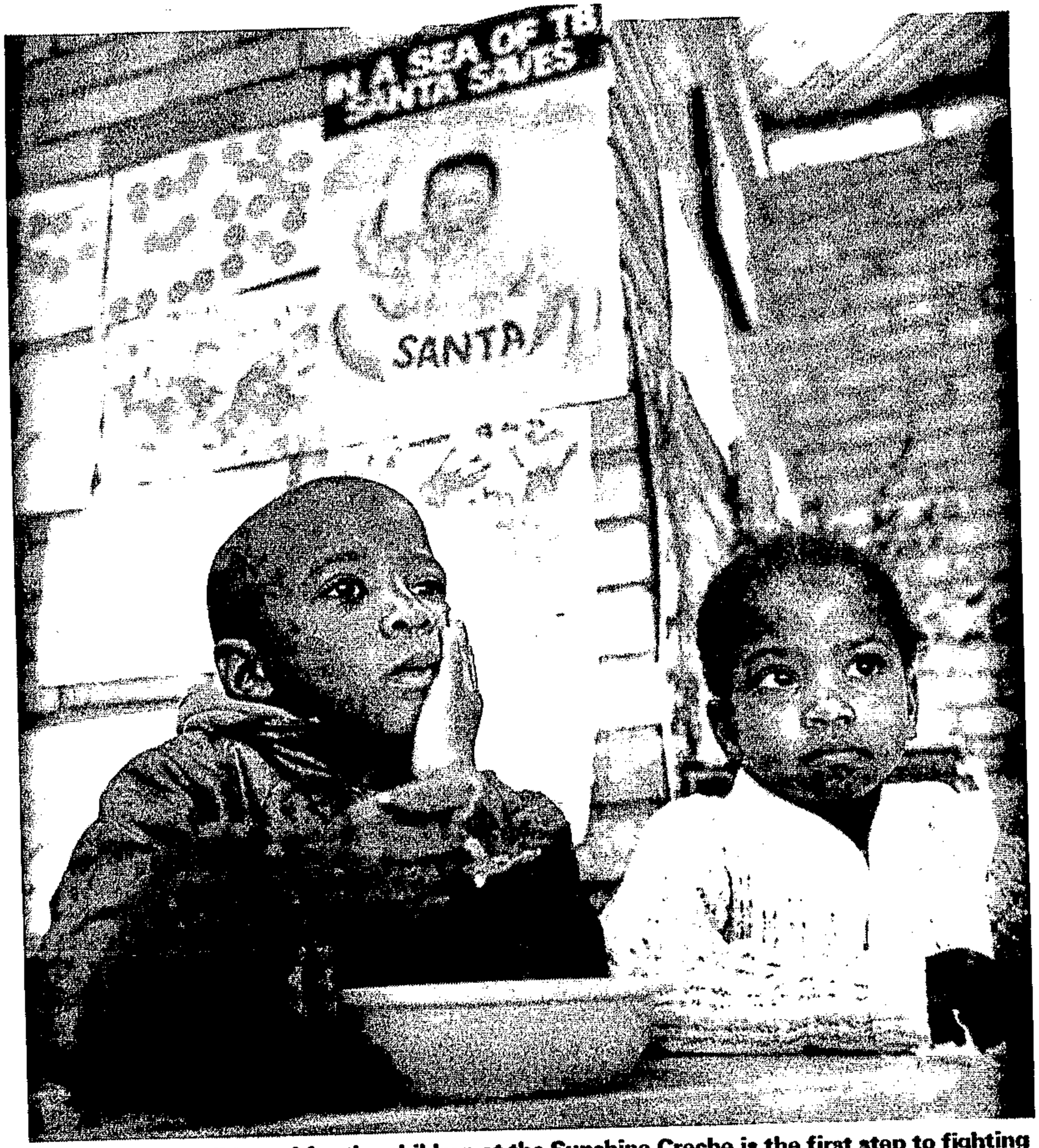
But most sufferers develop symptoms without realising what they mean, and take no precautions against passing the disease on.

They also do not report for treatment until the disease is well advanced.

When people report for treatment, health care staff have problems persuading them to complete their medication. While TB symptoms can clear up fairly soon after the patient takes the first drugs, the medication is not effective unless taken weekly for six months.

There is talk of offering incentives — a patient who turns up at the clinic regularly might be awarded a prize such as a radio. But, as Cape Town City Council Medical Officer of Health Dr Michael Popkiss warns, one must not allow a scheme like this to make TB seem desirable.

"If there is an incentive, it must be correct for that community," he says, emphasising that people close to the communities must decide how to spend whatever money is



MEALTIME: A solid meal for the children at the Sunshine Creche is the first step to fighting off tuberculosis

Photo: Yunus Mohamed

R50m to fight TB sweeping the world

S/Times [C/Metro] 13/6/93

(91)

By PETA KROST

HORRIFYING new statistics which show that tuberculosis is prevalent throughout the world and not just in under-developed countries have prompted an international drug company to pour almost R50 million into TB research in Britain and South Africa.

The research in South Africa will be concentrated at UCT, although the University of Pretoria, Stellenbosch University and the University of the Witwatersrand will also be involved in the research project.

Without this grant UCT would not be able to carry out the research because "the Medical Research Council simply doesn't have the money necessary for it".

The UCT team will be led by Professor Mario Ehlers, head of UCT's Medical Biochemistry department.

There are 10 million new cases of TB reported worldwide every year, resulting in at least 3 million deaths — but Western interest was only rekindled at the end of last year when it was realised that TB was not only "a Third World problem".

Wiped out

"Western governments suddenly sat up and realised that TB was not over by a long shot," Prof Ehlers said this week.

The disease has ravaged communities in Africa, Asia and South America, but now it is also attacking Europeans and Americans at a reported rate of 20 000 people a year.

Despite this, very little is known about the disease.

South African universities — and especially UCT — have been chosen because of the high incidence of TB in this country and their extensive hands-on experience of treating it.

Last year there were 80 000 reported cases of TB in South Africa, a figure which Professor Ehlers says is grossly underestimated.

In Cape Town the disease is so prevalent, especially among children, that it has been described as an epidemic.

TB has also been linked to Aids as it seems to recur in people whose immune systems are weakened.

Another frightening new revelation is that the TB bacteria is becoming resistent to antibiotics, making the disease incurable in some cases.

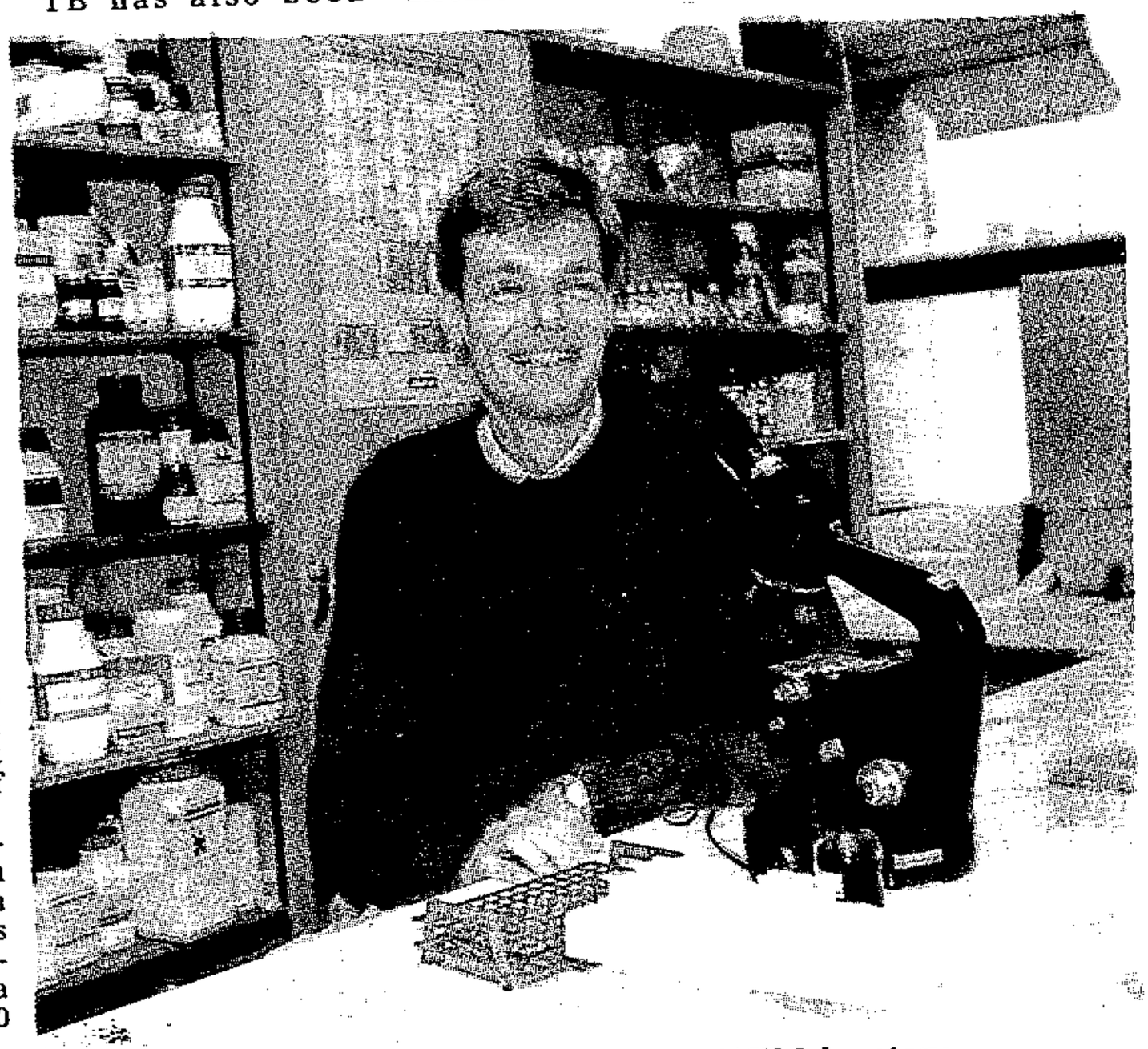
Professor Ehlers said a number of American doctors who had contracted TB while working with Aids patients had died because the medication did not work.

The consequences of a TB epidemic of this resistent strain are "horrific" because the disease is so contagious it can be spread by simply breathing in the bacteria.

One third of the world population is already infected with the TB bacteria, which remains dormant in the body even if they do not develop symptoms.

A serious threat exists, he said, that the strain of TB at present curable by antibiotics, could become impossible to treat.

The professor explained that the obligatory TB vaccine with which all South African children are innoculated, has proved not to be effective enough.



AT WORK ... Professor Mario Ehlers in his UCT laboratory
Picture: JACK LESTRADE

world drive needs SA

Star 1/7/93

(91)

n have since been ab-
ıed into senior positions in
organisations but others
be found among the rank
file, and even among civic
ctures.

eturned exiles: They spent
rs outside the country wag-
a relentless war against
toria, and today happily
shoulders with former
F/MDM colleagues in the
lership. Others, however,
among the rank and file,
are struggling to get jobs.

ıuth African Communist
ty: For years in a rock-
d alliance with the ANC
ıre, during and after its
ning, the SACP will most
ly want as deputy presi-
t somebody with whom it
good relations. Mbeki, a
ner SACP politburo mem-
, might get the nod from
group, but this is by no
ans guaranteed.

ongress of South African
de Unions: A third — but
less important — member
the tripartite alliance, Co-
u might prefer Ramapho-
who was a respected trade
onist before beating ther
umbent Alfred Nzo at the
y 1991 congress in Durban
ecome ANC secretary-gen-
l.

ivic structures such as
ses Mayekiso's South Afri-
National Civic Organisa-
ns (Sanco). Although osten-
ly non-political and non-
tarian, Sanco has strong
s with the ANC-SACP-Co-
u alliance, with some of its
ders holding senior posi-
ns in the tripartite alliance.

Sanco and the Civic Asso-
tions of Southern Transvaal,
now led by Winnie Man-
a — have maintained their
ependence from the ANC
d have at times embraced
ws that the ANC-led alli-
ce's leadership has found
barrassing.

Who their choice for the
NC's deputy presidency
uld be is hard to say. □

ı scien-
't of a
world-
h pro-
vel and
ent and
rge was
al pub-
by the
n, after
the dis-
th toll
around
nually
e infec-
them in
Africa
national
use we
ction of
valence
n a pop-
e (new
d.
in cer-
ulation.
asing in
ns, and
he Col-
Western
nic.
cidence
decade
000 to
ofessor
he de-
chem-
f Cape
and a
nal re-
d to be
he dis-
k are:
an im-
(HIV)
unode-
of the
TB —
osis;
lth ser-
ation of
ve the
10 per-

Many parts of body may be attacked

Tuberculosis (TB) is a bacterial infection that can attack many parts of the body including the brain (tuberculosis meningitis), bone and joints; but it most often affects the lungs.

The disease is transmitted largely by inhaling invisible droplets of sputum, containing the bacterium, Mycobacterium tuberculosis. So the infection tends to be passed among people living or working together.

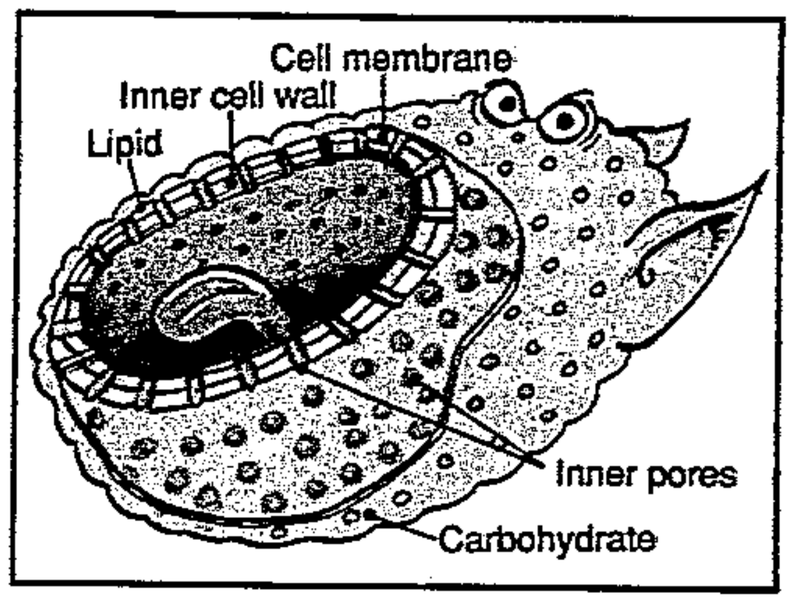
Infected droplets get into the small air sacs of the lungs (alveoli) and the bacterium replicates. Immune cells called macrophages may ingest the organism, but unless they have been activated by previous exposure to the organism that causes tuberculosis, they do not kill it. Instead, they carry the infection to other parts of the lung and elsewhere in the body.

This leads to acute infection, but mostly in only about 5 percent of people.

The rest are usually unaware that they have been infected, and the bacterium lies dormant. Over the course of their lives, these people will have a 10 percent chance of recurrent infection, when the immune system is weakened from situations such as malnutrition, old age, or other diseases such as Aids and cancer.

Symptoms of TB include tiredness, fever, weight loss and, when the lungs are infected, an insidious, nagging cough, in which blood is brought up.

If TB is not treated, the tuberculosis bacteria will gradually eat away surrounding tissue.



Mycobacterium Tuberculosis

- □ Cell wall resists host defence mechanisms and antibiotics.
- □ Forms clumps of bacilli — hard to work with.
- □ Grows very slowly, hinders research progress.
- □ Highly infectious — needs special laboratories.
- □ Survives in host immune cells — they normally destroy bacteria.

cent chance of developing TB in their lifetime, says Ehlers. People with the HIV virus face a risk as high as 8 percent per year of developing the disease, he says.

TB also tends to progress more quickly in HIV-infected people than in those who are not HIV-infected.

Added to this, drug-resistant strains of the disease have emerged; the main reason is almost certainly poor patient compliance in completing the course of treatment, says Ehlers. TB treatment normally spans six to nine months of multiple drugs.

In the United States, especially New York, the emergence of multiple-drug resistent (MDR) TB strain is at its most serious in the world, around three times as common as in South Africa. MDR TB is most common in Aids patients, who are the people who are getting TB in this new epidemic.

Action TB in South Africa will be managed overall by the Medical Research Council.

The academic research in South Africa will identify novel drug targets by looking at what it is about this bacterium and how it causes disease that can be exploited; what is unique about its structure or metabolism that can be interfered with by a drug, says Ehlers. After that, it will be left to the pharmaceutical company funding the programme to develop new cost-effective medicines and vaccines against the disease.

The council has formed three research groups drawn from a variety of South African institutions, including medical schools at the unversities of Stellenbosh, Cape Town, Pretoria and the Witwatersrand, and the SA Institute of Medical Research.

Action TB is funded by Glaxo, the international pharmaceutical company, over an initial five-year period, with a total investment of £10 million.

R30 m injected into search for TB vaccine

(91) ARG 3/7/93

DALE KNEEN
Weekend Argus Reporter

SCIENTISTS in South Africa will be playing a major role in a massive international research initiative to find a vaccine for tuberculosis.

The project was made possible with a R30 million grant from pharmaceutical giant Glaxo which was secured by the SA Medical Research Council.

Called Action TB, the project is likely to generate 30 jobs for South African researchers over the next five years.

The South African input into the project will be managed by the MRC, which will co-ordinate research in South Africa with that done in Britain.

The research in South Africa will be done by scientists from the MRC, the South African Institute for Medical Research and three universities.

The British team is from the London School of Hygiene and Tropical Medicine, St Mary's Hospital School, Birmingham University and Glaxo Group Research.

The researchers in both hemispheres will attempt to develop new antibiotics to combat resistant strains of TB and vaccines to prevent infection.

The MRS's group executive technology development and transfer, Dr Roger Steward, said the project heralded a "new direction" in research.

"Government funding has not been able to keep pace with research and so we have had to co-operate with industry where our interests are compatible.

TB is the leading infectious cause of death in the world, claiming about three million lives annually.

Over 80 000 cases were notified in South Africa last year, although there could be as many as 10 million sufferers in the country and TBVC states.

The MRC has formed three research groups, drawing expertise from various South African institutions.

The first group is under the leadership of Dr Paul van Helden, who is the director of the MRC's Centre for Molecular and Cellular Biology at the University of Stellenbosch.

This group will concentrate on molecular genetics and drug resistance.

The other principal investigators in this group are Dr Valerie Mizrahi at the South African Institute for Medical Research and Professor Lafras Steyn of the Department of Medical Biochemistry at UCT's Medical School.

Group Two is chaired by Professor Mario Ehlers, head of the department of Medical Biochemistry at UCT Medical School.

The group will look at virulence determinants and host cell interaction, and immunology and T-lymphocyte research.

Other researchers in this group include Professor Enid Shephard, Dr Stan Ress and Dr Pauline Lukey of UCT's Medical School, Professor Ahmed Wadee of SAIMR, Professor Albertus Beyers of the University of Stellenbosch Medical Faculty, and Professor Ron Anderson of the Institute of Pathology at the University of Pretoria.

The MRC's Dr Bernard Fourie, leader of the National TB Research Programme, will chair Group Three, which will provide bulk mycobacterial organisms for South Africa and the United Kingdom and will maintain a collection of mycobacterial strains.

Also working in this group will be Professor Hendrik Koornhof, formerly of SAIMR and previous director of Emergent Pathogen Research Unit and now consultant to Dr Fourie's programme.

Professor Peter Donald of the Department of Paediatrics at the University of Stellenbosch Medical Faculty and Tygerberg Hospital will also collaborate with this group and provide clinical material.

Draft legislation sparks TB debate

Star 5/7/93

(91)

Draft legislation now before Parliament could change the way that mining diseases in South Africa are compensated, dramatically affecting the lives of thousands of miners each year. Health Writer DAVID ROBBINS reports.

Change ahead . . . White miners have been entitled to 10 times the compensation paid to black miners. Now there is hope of a new dispensation.

IN ATTEMPTING to deracialise the law governing compensation for mining diseases without unduly increasing the overall cost of compensation, the State has started a debate about tuberculosis which will have far-reaching consequences.

The central question is: Is tuberculosis an occupational disease in mines or isn't it?

It always has been. Tens of thousands of miners with TB have been compensated over the decades in terms of the Occupational Diseases in Mines and Works Act (ODMWA). But the Act ensures that white miners have been entitled to 10 times more compensation than their black counterparts.

This blatantly discriminatory law is at last being overhauled. According to the ODMW Amendment Bill before Parliament, parity of compensation is set at two-thirds the old white rate.

At the same time, tuberculosis is broken down into curable and incurable categories, with only the latter qualifying for compensation.

But there are dissenting voices.

"There is no medical evidence to support the contention that TB is curable," says the National Union of Mineworkers (NUM). "On the contrary, TB is a progressive disease, the progress of which can be arrested by medication, and appropriate changes in working and living conditions."

Rationale for this alteration in the status of TB appears to many to be economic. The mining houses (via penalties for excessive dust levels at individual mines) and the State jointly finance the compensation system, which, at the moment, costs between R40 million and R50 million a year.

NUM researchers have calculated that racial parity of lump sum compensation payouts would cost at least R250 million more, and that if pensions were given to disabled black miners as they are to whites, the annual bill would leap to R847 million.

The researchers conclude: "The Compensation Fund for Occupational Diseases is extremely short of money. This underfunding is a legacy of apartheid which cannot be rectified easily."

In view of all this, the status of TB on the mines becomes pivotal. Can it be compensated or not? What are the medical arguments?

There's no doubt that silica dust, particularly in the gold mines, leads directly to the development of silicosis, and that advanced silicosis can lead to TB. But what of TB in gold miners who haven't got silicosis?

There were more than 4 500 of them diagnosed during 1992 and they received more than 50 percent of the compensation payouts.

The case against TB as a mining-related disease goes something like this: The mines alone cannot be held responsible for the high incidence of the disease among miners. Although TB is a complication of severe silicosis, silica dust does not directly cause TB and should therefore not be considered an occupational disease.

This argument is three-pronged. First, South Africa is the only country in the world to compensate for TB in miners. Second, experiments conducted by Dr Robert Cowie on the Free State goldfields in the '80s indicated that it was not necessary to keep miners suffering from TB on the surface. Returning infected miners underground within a week after starting treatment made no difference to their relapse rate.

The third prong of the argument concerns the incidence of the disease beyond the mines. Although the rate of TB on the mines (1 105/100 000 in 1990) is nearly five times higher than in South Africa generally, the mining houses have several explanations for this. One cogent cause, they argue, is that a superior surveillance and reporting system exists on the mines.

Other causes are persuasively expressed by Cowie.

"The major stumbling block in the control of TB in gold miners is the inability to influence the large infective pool (of TB carriers) that is known to exist in the remote home areas of this working population," he says. Rural poverty and the migrant labour system ensure that TB flourishes on the mines.

But the NUM says that according to figures from the Medical Bureau for Occupational Diseases, the average time it takes a black miner to contract TB is around 10 years of risk work (invariably underground), while the average number for serious silicosis, of which TB is often a complication, is 16 to 17 years.

The relationship between silicosis and TB is medically established; it is the relationship between silica dust to pulmonary TB which is still moot.

While some argue that rural conditions and migrant labour account for the high incidences of TB among miners who have not yet developed silicosis, the union says that dust is at least partially the cause. There's also the high stress levels associated with mining, and the overcrowding in the hostels, but dust is the main culprit.

Compare, for example, the TB rates of white miners without silicosis to white rates in general, and in particular to adult males. Under-reporting in the white population is far less likely and less prevalent than among the subcontinent's millions of rural blacks. Neverthless, white miners are also showing an incidence up to five times higher than their counterparts in the general population.

Now take the rates for various mining jobs. Drillers would be among those most subject to silica dust, whereas surface workers would be least subject.

In recent tests drillers weighed in with a TB rate of 1 552/100 000, while no category of surface worker exceeded 600/100 000.

All this ties in with evidence from Europe. A long-term study on foundry workers in Denmark established once again the increased TB risk associated with silicosis, but also suggests "that silica (dust) exposure may cause an increased pulmonary TB risk among foundry workers" not suffering from silicosis.

How much silica dust are South African gold miners subjected to? In terms of the old Mines and Works Act the legal maximum was more than three times higher than the international standard.

The new Minerals Act advises the international standard but leaves it up to companies to negotiate codes of practice with mining inspectors, with unions consulted.

In spite of considerable secrecy surrounding dust level data, it is known that levels are still high in spite of overall improvements. In 1965, as many as 18 000 miners were working in dust levels six times the international limit. By the end of the '80s, this number had dropped to just below 7 000.

Mining — especially gold mining — has been the mainstay of the South African economy since gold was discovered during the last quarter of the 19th century. The human cost has been enormous. Around 66 000 miners dead in accidents; a million injured. To these figures must be added the hundreds of thousands of miners who have died or been permanently disabled by disease.

While the compensation arguments rage, the mines will continue to produce both wealth for the country and risk for the men who work them. □

New TB legislation will hit miners

Star 5/7/93

(91)

By David Robbins
Health Writer

As South Africa braces for a tuberculosis explosion, the Government has introduced legislation which, if passed by Parliament, will affect the lives of thousands of gold miners suffering from the disease.

Amendments to the Occupational Diseases in Mines and Works Act could change the status of tuberculosis, and end the payment of compensation to miners who develop TB.

Santa's director of community TB education, Dr Theo Collins, said there was no doubt that releasing tubercular miners into mostly rural homes had done a great deal to perpetuate the disease in southern Africa.

Under current legislation, black miners are compensated at a rate of one-tenth of that paid to whites. The new legislation attempts to correct this imbalance, but at the expense of compensating for what the new Bill calls "curable" TB. Also, there is generally no provision for treatment after men have left the employment of the mines.

This means that thousands of ill miners could return to their homes each year with neither the meagre compensation currently paid nor any continuing treatment. "This won't help the situation," Collins said. "The reality is that the disease is on the increase, especially multiple drug-resistant TB."

● Draft legislation sparks TB debate — Page 7

S/Times [Buss] 18/7/93

SA joins world drive for new medicines

By CHERILYN IRETON

INTERNATIONAL pharmaceutical groups are breathing fresh purpose into the South African medical research fraternity.

In the past few months millions of rands have been pledged for basic research projects, giving scientists the chance to take part in ground-breaking investigations in the search for new drugs.

Large committments have been secured from two international groups, Glaxo and Burli-Med. Glaxo is looking for ways to combat tuberculosis (TB) and Burli-Med is using SA scientists to try to develop a male contraceptive pill.

The untapped academic expertise available, the relatively sophisticated research facilities and the extremes in society make SA an ideal place for primary research, says Glaxo medical director Peter Moore.

"It is also a good place to get your money's worth," says a researcher from the Medical Research Council.

Glaxo will spend R30-million in the next five years as part of an effort between SA and UK scientists and researchers to combat the growing global problem of TB.

Burli Med has given R1,2-million to the Tygerberg hospital. Chief executive Gert Hoogland says the money is for research on a male contraceptive.

"Tygerberg has a good reputation and in-house experience in this field. It is not a subject that is extensively researched around the world."

Some of the highest rates of TB in the world have been recorded in the Western Cape. But TB is no longer confined to Third World environments. A doctor in Johannesburg's northern suburbs was shocked recently when one of his wealthy white patients contracted the disease.

The World Health Organisation estimates that one in three people is infected with the mycobacterium tuberculosis. Most remain carriers, but an increasing number of people whose immune systems are damaged are contracting the disease.

Dr Moore says: "There is definitely an increasing incidence of TB due to AIDS. TB is the biggest single cause of death among people infected with HIV.

"There is also growing evidence that the disease is spreading among the homeless, elderly and children. Evidence shows an increase in the incidence of TB in the coloured population, where there are rising malnuturition and alcoholism."

One of the factors leading to the resurgence of TB has been the emergence of multi-drug-resistant strains. Doctors believe this is largely due to patients failing to complete courses of treatment.

Glaxo has traditionally been responsible for developing sophisticated, expensive products, such as its its ulcer cure Ranitidine, a top seller in First World countries, and its recently released Sumatriptan migraine treatment.

Dr Moore says the company was concerned about not doing anything for Third World countries. He put the idea of collaborative research into TB to the group's London headquarters a year ago.

Glaxo's budget is £10-million and a third of the research will take place in the UK.

In SA the funds will go to the cost of equipment and the salaries of between 30 and 40 scientists.

The research involves three separate studies. The first group will look at the the molecular biology of the bacillus and the second team will concentrate on immunology and why some people are carriers and not sufferes.

Group three will set up a culture bank in Pretoria at which all known strains of the TB bacillus will be grown. The strains will be used by the UK researchers as well.

Glaxo has invited academic institutions to apply for funding if peripheral research projects dovetail with the main investigation.

The findings will be pooled.

TB can attack many parts of the body, including the brain, bone and joints. Most often it affects the lungs.

It is transmitted by inhaling droplets containing bacteria, so infection tends to spread among people living or working together.

Symptoms of the disease include tiredeness, fever, weight loss and an insidious cough, in which blood is often brought up. Left untreated, the bacteria gradually eat away surrounding tissue.

80 000 TB cases annually

(9) C 22/7/93

PORT ELIZABETH — The scourge of tuberculosis, once thought to be dying out, is back with a vengeance, with more than 80 000 new cases recorded annually in South Africa and one South African dying every 40 minutes.

South African National Tuberculosis Association (Santa) public relations manager Mrs Julia van Heerden said yesterday at least one-third of South Africa's population were infected with the "very virulent" TB germ, which could become active, especially in Aids patients whose immune systems had broken down.

She said a number of people at "executive level" were treated for the disease.

Cape Town has the unenviable record of having the highest incidence of TB in the world.

Since 1987 there has been a marked increase in the disease, specially in the Western Cape.

From January to November 1992, 67 157 TB cases and 1 615 deaths represented 80% of all notified medical conditions in South Africa.

According to experts it will not be possible to wipe out TB completely because the highly infectious disease breeds where poverty is rife.

an 87% subsidy from government for thereafter going to residents and ex-

Dramatic rise in TB cases

Own Correspondent

PORT ELIZABETH — Tuberculosis, once thought to be beaten, is back with 80 000 new cases recorded annually in SA.

The "tragic forecast" resulting from dramatic rises in TB infection was described by South African National Tuberculosis Association (Santa) public relations manager Julia van Heerden yesterday.

Van Heerden said there had been an upsurge in TB worldwide. The disease had been declared a "global emergency" by the World Health Organisation in April.

She said the increase could be ascribed to the link between TB and Aids, as well as to development of a drug-resisant strain.

Van Heerden said at least one-third of SA's population was infected with the "very virulent" TB germ, which could become active. (91)

More than 80 000 new cases of TB were recorded annually in SA, with about 8 000 of those in the Eastern Cape, and about 3 500 in Port Elizabeth, she said.

The increase in TB cases cut across racial boundaries.

With a number of people at "executive level" being treated for the disease, said stress was one of the factors influencing the development of TB. B/Day

Van Heerden appealed to employers to assist Santa in preventing development of the drug-resistant strain of TB by supervising treatment of infected employees.

She said TB patients stopped being infectious about 48 hours after they had started treatment, but if they stopped treatment once they felt better they could develop the fatal drug-resistant strain.

Steps she encouraged employers to take included: 22/7/93

- ☐ Informing employees about signs and symptoms of TB.
- ☐ Encouraging workers to undergo medical tests.
- ☐ Not firing infected employees, because if they were spreading the disease they were doing so before it had been diagnosed.
- ☐ Keeping infected employees' jobs open if they needed to go to hospital.
- ☐ Arranging for local health authorities or Santa advisors to inform employees about TB.

Beeld journalist 'has no privilege'

MARIANNE MERTEN

THE police had the right to obtain all necessary information related to investigations and journalists were not exempt from giving testimony or statements, State advocate G Nel said in the Johannesburg Magistrate's Court yesterday.

Speaking at the trial of Beeld reporter Andries Cornelissen, who is being charged for refusing to make a statement to police concerning ANC Youth League president Peter Mokaba's use of the slogan "kill the Boer, kill the farmer", Nel said there was no privilege in SA allowing journalists to refuse to testify.

Cornelissen, who appeared in court for the second time yesterday, was subpoenaed under Section 205 of the Criminal Procedure Act. The subpoena followed an article in which he reported that Mokaba had chanted the slogan at an SA Students' Congress meeting at Wits University on May 26. B/Day 22/7/93

Nel said Cornelissen's testimony on Tuesday had created the impression that by testifying for the State in this political matter, he would choose sides and possibly endanger his career as a political reporter.

Cornelissen could face up to five years in jail if the magistrate finds he does not have legal reasons for refusing to testify.

Magistrate R G le Roux reserved judgment until August 3.

1 000 die

Resistant TB strains 'a huge threat'

(91) CT 6/9/93

LONDON. — The emergence of resistant strains of tuberculosis could take a generation to bring under control if the health service fails to curb the disease, the British Association has been told.

In the past two years there have been increasing reports of tuberculosis resistant to a spectrum of drugs and "it is difficult to overestimate the threat these organisms pose to our society", said Dr Tim Peto of Oxford University.

"The impact of multi-drug-resistant strains of TB in Britain would be immense," he said.

Dr Peto estimates that tens of thousands of people — notably the homeless — do not have access to proper health care and are consequently at risk from resistant strains, noting that the emergence of the most resistant forms of the disease have occurred among the urban poor in the United States.

These untreatable strains had not yet occurred in Britain, said Dr Peto.

"The control of multi-drug resistant tuberculosis will provide one of the most important tests of the new Health Service in the coming decade," he said.

The total cost of managing a major outbreak would be huge, he said, as it might be necessary to increase the number of isolation beds and even build new units.

Research was needed to develop new anti-TB drugs and to quickly diagnose the disease, which now takes three months. — The Telegraph plc

TB cases worse than reported, experts fear

(91) ARG 6/9/93

ANDREA WEISS
Health Reporter

MORE new cases of tuberculosis are being treated in South Africa than notified, leading experts to believe that the size of the epidemic is hopelessly under-reported.

And the problem is likely to grow as more people become infected with the Aids virus HIV. Because HIV attacks the immune system, infection predisposes people to getting TB.

Experts are also concerned that the advent of drug-resistant TB will mean an increase in deaths from the disease because patients cannot be treated. Drug resistance can happen when patients do not complete the full treatment.

The SA National Tuberculosis Association estimates about 100 000 new cases of tuberculosis occur in South Africa each year.

Santa said notifications from homelands were erratic and under-estimated the situation.

Figures from clinics and hospitals in the seven health regions, which excluded homelands, showed more new cases were put under treatment than the total notifications from all parts of South Africa.

● Cholesterol, blood pressure and weight — these three dietary problems are tackled in three new booklets compiled by the Medical Research Council and Heart Foundations. Cost is R2.50 each.

Two booklets aimed at reducing blood cholesterol and triglyceride levels are available only to doctors or dieticians.

A third, *Slimming*, may be ordered by anybody directly from the MRC's National Research Programme for Nutritional Intervention, PO Box 19070, Tygerberg, 7505.

'10m in SA now have TB'

(91) CT 7/9/93

Staff Reporter

TEN million people — more than one in four in South Africa, including the TBVC states — have tuberculosis and the number is increasing by 100 000 a year, with the Western Cape the worst affected.

These new TB statistics were revealed yesterday at the annual meeting of the South African National Tuberculosis Association (Santa) in the city, where nearly three times as many cases were reported as anywhere else in the country.

For every 100 000 people in South Africa, 235 are infected — 10 times more than in developed countries and 15% above the African average.

In the Western Cape, there are 610 reported cases for every 100 000 people — nearly triple the national average.

Guest speaker Dr Stuart Whittaker, from Stellenbosch University, said the disease spread because the TB germ became drug-resistant when people did not complete their treatment.

The World Health Organisation has reported that a third of the world population has TB.

TB code cracked for sufferers

DNA boffins on track of better cure

(91) ARGT 18/9/93

■ A breakthrough in which scientists at least partially cracked the genetic code of the organism that causes tuberculosis could lead to new and successful treatment of the disease, which is out of control in South Africa with 11 000 new cases reported in the Cape Peninsula alone every year.

LIBBY PEACOCK
Weekend Argus Reporter

ABOUT 10 million people — one third of the South African population — have been infected with TB. But that does not mean that they physically have the disease.

"They may have an infection, or have dormant germs," Santa regional director Dr Stewart Fisher told Weekend Argus this week.

The World Health Organisation estimates that eight million people develop TB annually and three million die each year from the disease.

But only 10 to 15 percent of those who are infected with the organism actually develop TB.

It was reported this week that American molecular epidemiologist Lee Riley said the genetic breakthrough was an important first step toward the possibility of developing a totally new vaccine to prevent transmission of TB and to creating new drugs to treat those who already had it.

Dr Riley spearheaded the research which led to the partial cracking of the genetic code of the TB organism.

The scientists reportedly identified and cloned a segment of DNA, which allows the TB organism to safely invade certain human cells. Called macrophages, these scavenger cells normally circulate through blood and tissue, gobbling up foreign micro-organisms.

In the case of TB, macrophages allow the organism to penetrate their cell walls. The TB organism can sit dormant in these macrophages for years before escaping the cells to invade the host's lungs or other body parts.

Now that researchers have found a genetic organism responsible for TB invasion, they hope to be able to block the micro-organism from entering human cells.

Dr Harold Zappe, of the Department of Medical Micro-biology and Medical Biochemistry at the University of Cape Town, said yesterday the news of the breakthrough was "very exciting".

He was "very interested" to see the full report on the breakthrough and believed the new development could have a bearing on the future treatment of TB in South Africa.

"There is a real possibility that it could lead to new drug treatment."

Dr Fisher told Weekend Argus the TB problem in South Africa was worsening and figures were increasing by about five percent every year.

TB was going to become an even greater problem because of Aids and multiple drug resistance.

"Under normal circumstances, TB is relatively easy to cure. If you take tablets every day for six months, you should be cured. But over the years people have been taking the tablets irregularly. The bacilis itself becomes resistant."

"Now you get patients infected by TB that is resistant to normal tablets. In about three percent of cases in the Western Cape the bacilis is resistent. Then the patients have to take very toxic drugs and be hospitalised."

Dr Fisher said: "There is a huge stigma to it and you still hear about people getting fired for having TB, but it doesn't have to be a dirty disease, anyone can get it."

He said every year there were about 180 000 new notifications, but there were probably more cases that were not reported.

The overall national average rate is 250 cases per hundred thousand people. In the western Cape the rate is 455 per 100 000.

New tuberculosis breakthrough

(91) CT 21/9/93

Staff Reporter

A BREAKTHROUGH by American scientists studying tuberculosis — of which 11 000 new cases are reported in the Peninsula alone each year — could lead to a new and successful treatment of the disease.

It was recently reported that American molecular epidemiologist Dr Lee Riley's genetic breakthrough was an important first step towards the possibility of developing a totally new vaccine to prevent transmission of TB and to create new drugs to treat sufferers.

Now that researchers have found a genetic organism responsible for TB invasion, they hope to be able to block the micro-organism from entering human cells.

Dr Harold Zappe of the department of medical biology and medical biochemistry at UCT said it was an "exciting breakthrough" and could lead to new drugs and vaccines in the future to treat TB patients in South Africa and the Western Cape.

Santa regional director Dr Steward Fisher said the TB problem in South Africa is worsening — figures were increasing by about 5% a year and TB would become an even greater problem because of Aids and drug resistance.

The national average is 250 cases per 100 000 people, but in the Western Cape the rate is 455 per 100 000.

'Mass action may curb TB'

(91)

CT 19/10/93

Staff Reporter

MASS ACTION is needed to combat the spread of tuberculosis (TB), which has infected an alarming proportion of the population of South Africa, TB expert Dr Theo Collins said yesterday.

Dr Collins, a former director of the South African National Tuberculosis Association (Santa) is retired, and serves as a part-time consultant to the association.

Dr Collins said in an interview that "mass action in the form of pressure on local municipalities, provincial administrations, MPs, and the minister of health — who are after all civil servants," — could be a solution to the creation of more facilities, especially in the Western Cape, which is the worst-affected area in the country.

Pressure on authorities suggested

According to figures released by Santa, for every 100 000 people in the Western Cape, there are 661 with TB, and according to Dr Collins, the Eastern Cape is not far behind.

Dr Collins estimates between one third and one half of South Africa's population is infected with the bacteria.

He said that together with the World Health Organisation data, Santa's own research into the number of schoolchildren, adolescents and mine worker recruits with TB had led him to arrive at the figure.

Dr Collins explained that people merely infected with the disease would not necessarily be ill, but if they contracted the HIV (Aids) virus, the disease would attack the defenceless immune system.

Other conditions such as stress, poor nutrition, the use of immunosupressant drugs — for asthma and arthritis — as well as other diseases such as measles, cancer and diabetes could cause full-blown TB development.

Infants and old people are also at risk as their immune systems are weak, added Dr Collins

The spread of multiple-drug resistant (MDR) TB will "lead to disaster," he said . MDR TB is a result of patients not completing their treatment, or receiving inadequate treatment, and consequently the TB bacteria become resistant to medication.

Urgent action needed to fight TB

ADRIAN HADLAND

PRETORIA — There is a major tuberculosis (TB) epidemic in SA that is claiming the lives of 7 000 people every year, says Pretoria University's professor of community health Eric Glatthar.

About 10-million people in SA had been infected with TB while 150 000 were in the active stage of the disease, he told an SA Institute of International Affairs conference on the politics of health last week. "Very urgent steps are needed now. We are in very serious trouble," he said.

The tragedy of the TB epidemic, which was exploding worldwide and was estimated to have infected a third of the world's population — or 1,7-billion people — was that it was easily curable.

Part of the problem was that people who had TB failed to undergo the full treatment and had periodic relapses. A third of all TB cases in SA were patients who had relapsed.

Other contributing factors to the epidemic included emerging drug resistance, the rise of AIDS, poor management of the disease and harsh socio-economic conditions. B/Day

The worst hit of SA's population were the coloured community of the western Cape, Glatthar said. The prevalence of TB in this sector, which was currently about 600 cases a 100 000 people, was astronomically high and posed a severe problem for health authorities. 9/11/93

The reasons for the sudden outbreak in the western Cape were unknown. Theories of congenital predisposition, increased vulnerability through urbanisation and the varied cycles of the epidemic for different population groups had not been proven, he said. (91)

A new R150m initiative to publicise the prevalence, symptoms and treatment of TB, called the Chasa TB Alliance Project, had recently been started and would soon enjoy a "massive marketing launch".

The World Health Organisation has predicted that 30-million people will die of TB in the next decade unless urgent steps are taken.

TB 'likely to kill 30 million'

CT 16/11/93 (91)

GENEVA. — Tuberculosis is set to kill 30 million people over the next 10 years unless more money is found to prevent its spread, the World Health Organisation (WHO) said yesterday.

In a special report released here the UN health agency said 12m TB deaths could be avoided if aid agencies boosted spending on treatment progammes to $100m (about R340m) a year from some $15m (R51m) a year at present.

TB could become effectively incurable if control efforts were not stepped up, because "multidrug-resistant strains" would continue to multiply if TB programmes in poor countries remained underfunded, the WHO warned.

"Tuberculosis is the world's most neglected health crisis," said Dr Arata Kotchi, head of the WHO Tuberculosis Programme.

"How can we ignore a germ that already infects one in every three people on the planet?" he asked.

The WHO declared TB a global emergency in April, estimating that the disease killed more adults each year than all other infectious diseases combined. — Sapa-Reuter

Aids is adding a dangerous dimension

Star 29/11/93

TB making comeback

(91)

WHEN the incidence of TB went down worldwide, our guard was let down, says an expert

Washington — A contagious disease once all but wiped out worldwide — tuberculosis — is making an alarming return, this time with a dangerous complication, Aids.

The problem, health experts say, is not how to fight TB, which has long been known, but the political will to do it.

In some cases, they say, draconian action may be needed.

That, they say, should include mandatory quarantine for patients who do not take their prescribed medication, and so become potent carriers of new, drug-resistant TB strains.

And money to wage the fight is short.

TB has risen sharply in the past decade mainly because the public health community relaxed when TB seemed conquered.

The World Health Organisation (WHO) says TB is fast becoming the world's most urgent health crisis, and without more funding, could claim 30-million lives in the next 10 years.

Charles Felton, a leading TB specialist who works in the heart of the disease's resurgence in the United States, New York's Harlem, said: "When the incidence of TB went down, our guard was let down."

And Felton, chairman of the pulmonology section at the Harlem Hospital Centre, said TB returned for the same reasons it flourished up to the early 1900s.

This was poverty, homelessness and immigration, but now there is also the link with HIV, the virus that causes Aids.

Felton said TB incidence worsened in the 1980s "with increased poverty and homelessness, together with the advent of HIV".

He and others note clear evidence that infection with HIV activates TB in people whose disease had been inactive and that TB may hasten the progression from HIV to Aids.

Experts say that people with latent TB have a much greater probability of developing active TB if the also harbour HIV.

In America, TB has risen by 18 percent since 1985, with deaths running at about 1 500 a year — low by world standards, but alarming to experts for a disease once all but wiped out.

And the Institute of Allergy and Infectious Diseases says about 15-million people in the United States have latent TB, and so have the chance of developing it during their lives.

Asked if enough effort was going into the fight, Richard Baumgarner, deputy director of WHO's TB programme, said: "Based on results, we cannot be satisfied with what's being done."

He said in an interview that more money was needed in high-risk Africa, where some 3,5 million people are infected with HIV and TB, and Asia, where more than one billion are TB-infected and where Aids is rising swiftly.

As those people emigrate, "this synergistic effect can have a drastic effect in America's cities," Baumgarner said.

US experts warned that it is vital that the high-risk population — immigrants and the poor — be vaccinated.

Experts stress the need to be certain those identified with active TB get the full six-month antibiotic treatment, and not drop out after a week or so when the symptoms are gone. — Sapa-Reuter.

HEALTH *Our rulers urgently need to recognise the link between TB and Aids*

The deadly TB-Aids link

Sowetan 1/12/93 (91)

■ GROWING LINK *Fast becoming the world's most urgent crisis:*

By Mokgadi Pela

ALTHOUGH divided by the Atlantic Ocean, South Africa and the United States have a common concern for the growing link between human immuno-deficiency virus and tuberculosis.

It is a problem South Africa's interim rulers should give urgent attention to if they are to avert a disaster.

This is the message expressed at every turn as the country's politicians deal with an uncertain future.

This link will be talked about at some workshops today and tomorrow as South Africa joins everybody else in marking World Aids Day.

In the squalor of New York's Harlem, Aids has added a dangerous dimension to the community.

Dr Charles Felton, a leading TB specialist in the US, said: "TB returned for the same reasons it flourished up to the early 1900s. This was poverty, homelessness and immigration, but now there is also the link with HIV."

In South Africa the situation is no different. The Western Cape and Hillbrow Hospital's HIV clinic have recently highlighted this worrisome link. Both diseases thrive in poor socio-economic backgrounds where poverty and homelessness are room mates.

Experts say infection with HIV activates TB in people whose disease has been inactive. TB may also hasten the progression from HIV to Aids. They further say people with latent TB have a much greater chance of developing active TB if they also harbour HIV.

Experts also recommend a massive vaccination programme against TB.

The World Health Organisation says TB is fast becoming the world's most urgent health crisis, and without more funding, could claim 30 million lives in the next 10 years.

The WHO further notes that more money is needed in high-risk Africa, where some 3,5 million people are infected; and Asia, where more than 1 billion are TB-positive and where Aids is rising swiftly. While there's hope that TB may be wiped out as it once was, a cure for HIV is at least a decade away. Until then, information and condoms are the only weapons.

On the eve of WAD the director of the National Aids Training and Outreach Programme, Professor Ruben Sher, called on the private sector and the interim government to put more money into Aids education programmes.

"You can't plan anything in this country without taking Aids into account. Therefore, a percentage of any budget should go towards Aids education and prevention," he said.

Educators have major hurdles to deal with, such as changing people's attitudes. During a recent visit to the Hillbrow Hospital's HIV clinic, I was told by Sister Pauline Vunandlala of the infection control unit that many people still refuse to accept Aids as a reality.

She said this in the wake of the clinic's disclosure that it was treating an average of 55 new cases of HIV a month.

The situation in Soweto is no different with between 20 000 and 30 000 women believed to be HIV-positive.

Sowetan further learnt yesterday that three HIV-positive mothers give birth at Baragwanath Hospital daily.

Specialist obstetrician at Bara, Dr James McIntyre, said he would like to see the new government making Aids a priority in the health service.

"But it is up to the community to demand that political parties commit themselves to an Aids programme," McIntyre said. According to the department of National Health and Population Development, about 500 South Africans contract the HI-virus daily. Close to 2 000 people have developed full-blown Aids since the first case was diagnosed in 1982 in the country.

The obvious complacency towards Aids is exactly what the virus needs to thrive. If this attitude does not change the future, in the words of the late President John Vorster will be "too ghastly to contemplate."

"You can't plan anything in this country without taking Aids into account. Therefore, a percentage of any budget should go towards Aids education and prevention"

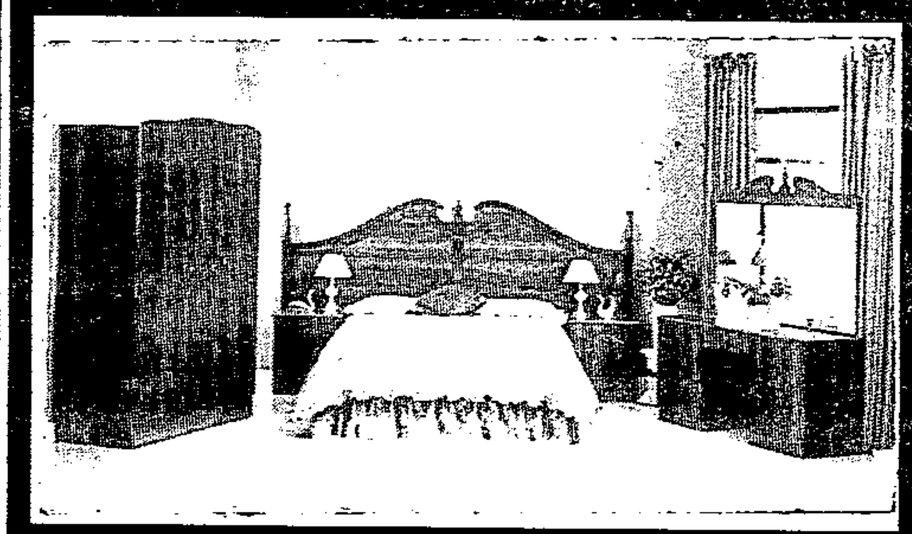
Deadly Facts

THE HI-VIRUS: It causes Aids and destroys the body's immune system, thereby making the patient vulnerable to opportunistic infections. These are diseases which would not normally kill a person but do so because of one's compromised immune system.

SYMPTOMS: Weight loss, persistent infections in the chest, diarrhoea, flu and headaches.

MODES OF TRANSMISSION: From infected mother to child, intravenously and sex with a positive partner.

WE ARE THE BEST



ONLY R1750

This unique polished-imbuia Rosemary Bedroom Suite is so different.
DEP. R300 AND 24 x R82 P.M.
(Wardrobe and bedding extra)

SPECIALS FOR CASH . . .

- Double Base and I/Spring Mattress (Was R450) NOW R309,50
- Single Foam Covered Mattress R69,95
- Vinyl Rolls 365 x 260 cm R89,95
- Bedside Lamps (pr) R55
- Self-stick Tiles per box of 10 ..... R35
- Plastic Runner R7,95
- Carpets 180 x 275 R79,50
- Carpets 225 x 275 R99,50
- Car Mats R2,95
- Super Rugs 137 x 180 ..... R49,50
- ALSO VERY LOW PRICES ON FRIDGES, STOVES, VACUUM CLEANERS AND DEEP FREEZERS! R11528

STILLFORDS
39 Kerk St. Johannesburg. Tel. 838-1187
between Rissik & Loveday

Killer cocktail of AIDS and TB menaces country

S/Times 5/12/93

By CAS St LEGER

VERONICA's dream is to see her 22-year-old son graduate from Stellenbosch University in two years' time.

But the 46-year-old Brakpan divorcee, a patient at the East Rand Santa Centre at Modderbee, is unlikely to have her wish granted.

She has the deadly mix of two organisms destroying her — TB and AIDS.

South Africa is sitting on a timebomb. The country is facing a huge outbreak of TB, thanks to the appearance of a drug-resistant strain of the disease, and the addition of AIDS to make a killer cocktail. (91)

The TB bacillus and the HIV virus which causes AIDS work together, making the progress of each disease more rapid and more virulent.

About 10 million South Africans are infected with the TB organism but do not fall ill unless something else — like poor nutrition or the HIV virus — triggers off the disease.

When the victim is HIV-positive, the type of TB is much more severe. And the patient develops fullblown AIDS much quicker than usual.

"AIDS and TB are terrible partners," said Professor Eric Glatthaar, chairman of the TB Advisory Group and professor of community health at the University of Pretoria.

TB often takes a different form in AIDS patients, attacking organs and bones rather than affecting the lungs. In AIDS patients, TB progresses 10 times faster than normal.

SPARK OF LIFE . . . Peter Young has lived a month more than expected Picture: COBUS BODENSTEIN

Last September, Veronica started spitting blood, and was eventually diagnosed as having TB. Her blood was tested and she was also found to be HIV-positive.

The TB attacked Veronica's throat, and AIDS has already made its appearance in the form of a fungal infection.

Veronica has little idea what AIDS is. She knows it is sexually transmitted and maintains she has not had a boyfriend since her husband left eight years ago.

"We are all church people," she said.

At the time her husband left, she was involved in a car accident and received "machine blood" during subsequent operations.

She blamed the transfusions for the AIDS, "but I didn't want to cause trouble by saying anything".

She believed she contracted TB from her father. "We all slept in the same bedroom. There are only two rooms in my house."

Mr Peter Young, a TB patient at Rietfontein Hospital, also on the East Rand, does not have AIDS but even so, TB is killing him.

His indispensable oxygen mask fails to hide the former electrician's glee. The 48-year-old man has won an extra month of life.

Seven months ago, Mr Young, whose lungs were destroyed by TB, was admitted to the Rietfontein Hospital. Doctors told him he had six months to live.

"I'm still here!" grinned Mr Young, who makes the most of the gift of extra time by pushing his wheelchair to the end of his link with his oxygen supply and enjoying the hospital garden and legions of cats.

He can only survive for 15 minutes without the oxygen mask.

About 100 TB patients out of 350 at Rietfontein are HIV-positive, and the same is true of 108 of Santa's 352 patients.

"We're facing a huge outbreak of TB. We're sitting on a timebomb," said Professor Glatthaar.

In addition to the AIDS factor, a new TB superbug, resistant to the usual drugs, is cutting swathes through entire families in South Africa.

Dr Theo Collins, consultant to Santa — the South African National Tuberculosis Association — has traced six families who have been virtually wiped out by the new strain.

With the new strain, the time in hospital stretches to 18 months and the cost of treatment, including hospitalisation, is R16 000 a patient.

If TB is detected early, the six-month-long course of tablets costs about R600. Hospitalisation costs R6 000.

Dr Brendon Girdler-Brown, specialist in the Directorate of Communicable Diseases with the Department of Health, said there were 80 000 new cases of TB every year.

HEALTH & DISEASE — T.B.

1994 - 1995

TB under spotlight

By Mokgadi Pela

A MAJOR tuberculosis conference is to take place in South Africa from March 13 to 17.

Organised by the Medical Research Council's National Tuberculosis Research Programme, the conference hopes to explore the impact of the link between HIV and TB.

Dubbed "TB — Towards 2000," the conference hopes to bring lively debate which will result in improved strategies for controlling this dreadful disease.

Experts from different parts of the world will deliver papers at the conference which will be held in Pretoria.

Papers will cover strategies for developing skills at all levels of health care in TB, reviews of modern concepts and clinical management of the disease.

TB accounts for more than 80 percent of communicable diseases notified in South Africa. With rates in excess of 600 per 100 000 reported in some regions, it can rightly be regarded as one of the most serious health problems affecting the country.

Organisers say the rapid increase in persons with HIV has resulted in a dramatic rise in deaths.

The conference will also deal with TB in animals, which experts say poses a threat to human health.

"This will ensure that veterinary TB control programmes remain effective in limiting transmission of TB from animals to man," conference manager Ms Jean Shute says.

Lending new life to SA's TB problem

Star 3/2/94

Remember the marionette on television which has its strings cut so that it collapses to represent another tuberculosis victim?

Get ready for the rise of the stricken marionette. Then watch it don a colourful T-shirt with the slogan "I'm a TB buster".

(91)

This is a brave image for a country ravaged by a disease which the World Health Organisation has labelled "a global emergency".

Since 1987 TB has been rapidly increasing in South Africa, most notably in the Western Cape. The national incidence now stands at 300 per 100 000 of population, with the Western Cape experiencing what many experts call an epidemic at 400 to 600 per 100 000.

This translates to over 80 000 TB notifications each year, and we can double that to take into account cases that are not notified. Around 2 000 people died of the disease last year.

The causes are manifold, including economic stress, droughts, unemployment, urbanisation, and also high levels of violence which impede the efforts of health workers.

Incubation

HIV is also an aggravating factor. TB accelerates HIV incubation times; and the presence of HIV increases an individual's chances of developing TB by between eight and 10 times.

"It is a serious situation, but we are convinced it's manageable. We've got the money, the knowhow, and the drugs. What we lack is control."

This is Professor Erik Glatthaar talking. He is head of the Department of Community Health in Pretoria University's Faculty of Medicine. He is also the president of Chasa (the Community Health Association of Southern Africa), an organisation established in 1990 with the aim of bringing together health workers and the broader community in the resolution of health problems.

Glatthaar offers a background to what is officially called the Western Cape TB Caseholding Project.

"It is widely acknowledged that about half of all South Africans carry the TB bacillus in a dormant state," he said.

"This dramatically enhances the spread of the disease from infected people to those around them. The secret of control of the disease is to treat infected people quickly, and to ensure they finish the treatment.

"This is of crucial importance. At the moment around 25 percent of all TB sufferers disappear before their treatments are complete (this is referred to as the non-compliance factor).

"They go back into their communities where they either die or continue to infect those closest to them. The key question, therefore, is how do we hold on to the cases that do present themselves for treatment?"

All major role-players involved in TB in the Eastern Cape have joined hands in the development of the programme, and they highlighted the 25 percent non-compliance problem as the major cause of high infection rates.

A plan of action was worked out. Patients diagnosed with TB are now attached to a supervisor whose job is to ensure that all patients under his or her care take their medicine until they are clear of the disease.

Groups of supervisors are being overseen by monitors with direct links to the local clinics and the health expertise centred there. The system is an extension of health services right into the homes and places of work of people who have contracted the disease.

Chasa has received a grant of R6 million from the Independent Development Trust (IDT) to facilitate the project.

Community-based non-governmental organisations have been given the job of identifying, recruiting and rewarding the supervisors and monitors.

In addition, extensive market research has been undertaken to determine patient needs. This information will be used to develop appropriate incentives and reward systems for patients and the community.

"This is a completely new approach," says Glatthaar. "We'll be launching a major publicity campaign soon. We need such a campaign. We need to turn around the negative feelings so prevalent in many communities.

"To cut down the incidence of non-compliance will make a major impact on the situation," he added.

The IDT grant will be sufficient to run the programme for about three years.

■ *Chasa can be contacted by telephoning (012) 323-5394, or by writing to Box 29375, Sunnyside 0132, Pretoria.*

Antibiotics soon useless?

(91)

CT 14/2/94

Call to shift research to vaccines

LONDON. — Antibiotics may soon become useless in the fight against bacterial infection, scientists warn.

This prompted a call yesterday by two professors for more research on vaccines to prevent bacterial disease.

"After 50 years of the antibiotic era, there is now a feeling that we may be heading towards a post-antibiotic era, a time when antibiotics can no longer be relied upon to cure major bacterial infections," said Professor Brian Spratt of the University of Sussex.

"The bacteria which cause meningitis and gonorrhoea, for example, already have strains that are resistant to penicillin," said colleague Prof John Maynard Smith. "They have achieved this by acquiring genes from related bacteria."

Recently there have been reports that certain types of tuberculosis have become resistent to certain types of drugs.

This led the World Health Organisation to warn in November 1993 that TB "could become effectively incurable if control efforts were not stepped up because multi-drug-resistant strains would continue to multiply if TB programmes in poor countries remained underfunded".

The risk of drug-resistant forms of TB is aggravated by the fact that TB is a common infection in people who are HIV-positive.

There should be a shift towards prevention, said Prof Spratt. "In some ways our ability to cure bacterial disease with antibiotics has reduced the emphasis on the development of effective vaccines," he said.

"There is no doubt that effective vaccines against several important bacterial diseases could be developed, if as much money was put into this area as has been put into the development of antibiotics." — The Telegraph plc, Staff Reporter

TB control 'a failure'

(91) CT 15/2/94

LONDON. — Control of tuberculosis in poor countries is a complete failure and deaths from the disease are set to rise dramatically, a French expert said yesterday.

Professor Jacques Grosset told a conference here that TB resurgence in South-East Asia and Africa was marked by an increase in HIV infection and a deterioration of treatment caused by a lack of resources and irregular drug supplies.

Prof Grosset said: "Despite the existence of drugs capable of curing 100% of patients, when available and used adequately, the control of tuberculosis in the Third World is a complete failure."

Prof Grosset, opening the two-day conference, added that the main problems faced by developing countries in combating the disease were not medical but "operational, organisational and financial". — Sapa

Healers help in fight against TB

CT (91)

TRADITIONAL healers and the Langa Clinic have joined forces in the fight against TB, with the healers identifying symptoms of the disease in patients and then referring them to the clinic.

Senior Langa Clinic nurse Mrs Ameerah Ngozi said quite a number of their patients had come to them after being referred by traditional healers, who have been trained to identify symptoms like coughing up blood and weight loss as signs of TB and not witchcraft. The clinic treats on average 150 TB patients a day. It was too early to tell if the new school feeding scheme would lessen the number of children infected with TB.

Staff Reporters, Sapa

TB strain drugs can't fight develops in Western Cape

(91) CT 18/2/94

□ Control of disease in Third World countries a complete failure

HENRI du PLESSIS
Staff Reporter

A STRAIN of tuberculosis resistant to medication has developed in the Western Cape.

Researchers put part of the blame on patients not completing courses of medication.

The Western Cape had the highest incidence of the disease in the world and accounted for a quarter of all the country's cases, said Bernard Fourie of the Medical Research Council.

"Between 2 percent and 4 percent of patients in the Western Cape are not reacting to medical treatment at all and the rate of infection is rampant," Dr Fourie said.

"It is still not understood why the rate of infection is that high here, although researchers suspect it could have something to do with socio-economic pressures."

Dr Fourie was reacting to a report from London that the battle against TB was being lost in Africa and Southeast Asia because organised facilities were inadequate.

"The epidemic is really worrying. Rates in the Western Cape are the highest in the world, and serious in the rest of the country."

Dr Fourie said the state had already allocated more than 50 percent of the funds available to fight infectious diseases to TB research — more than R200 million.

"It is therefore the disease that is the greatest cost to taxpayers."

The increasing prevalence of infection by HIV, the virus which caused Aids, would also have a negative impact on TB figures, Dr Fourie said, because the damage to the immune system caused by HIV made a patient more susceptible to TB.

It was already evident in Natal and parts of Transvaal, but reasearch had not yet been completed.

A growing number of patients treated by state TB clinics showed increased resistance to medication, with a growing percentage completely resistant.

This was a potential epidemic-within-an-epidemic and had researchers perplexed.

A possible cause was that patients who did not complete the six-month course of treatment built up a resistance, similar to the way bacteria were developing immunity to antibiotics.

Dr Fourie said health authorities in the Western Cape were working very hard, but there was a need for a standardised, combined strategy to fight the disease.

An international conference with delegates from Europe, the United States, the Far East and Africa was to be held next month in Pretoria.

"We are going from the point of view that there is a problem, and we will discuss facilities and knowledge available, what we need, as well as new discoveries that could help us plan a united strategy for Southern Africa."

A French TB expert said in London this week that control of TB in poor countries was a complete failure and deaths from the disease, once known in Europe as the "white plague", were set to rise dramatically.

Jacques Grosset, a professor at Groupe Hospitalier Pitie-Salpetriere in Paris, told a London conference, *Preparing for the resurgence of TB*, that TB resurgence in Southeast Asia, Africa, and the western Pacific was marked by an increase in HIV infection and a deterioration of treatment caused by lack of resources and irregular drug supplies.

"In spite of the existence of drugs, which, when available and used adequately, are capable of curing 100 percent of patients, the control of tuberculosis in the Third World is a complete failure," Professor Grosset said.

"If active measures are not taken rapidly, one can expect the number of tuberculosis cases worldwide to increase dramatically in the next 10 years."

In 1990 there were just over 7,5 million cases reported worldwide — about 7 million of them in developing countries. Of these 7 million, about 2,5 million were fatal.

TB threat rising — 36 die each day

(91) ARG 22/2/94

□ Poverty-stricken Eastern Cape hit badly

PORT ELIZABETH. — Thirty-six people die daily of tuberculosis in South Africa, and the situation is not getting better, the SA National Tuberculosis Association said.

While TB affects more people than Aids, there is an interrelationship between the conditions, said Santa national executive committee member Adele Ossher.

Aids weakens patients' immune systems, leaving them vulnerable to TB, she said.

"Most of us have (TB) germs which remain latent, but can become active when our bodies' resistance is lowered."

In the Eastern Cape, the number of TB and Aids infections climb steadily each year.

National Health Department researchers said 10 500 pulmonary TB cases were treated at local clinics last year, 1 093 more than the 9 407 reported in 1992.

Of 750 HIV-positive carriers identified in the region last year, 71 died, compared to 430 carriers and 57 Aids deaths the year before, said Port Elizabeth municipal officials who compiled the HIV-Aids data.

This is a dramatic increase from the 1991 statistics, when 190 carriers and 19 Aids deaths were noted. These figures were again sharply up on 1990, when 70 carriers and nine Aids deaths were recorded.

Pulmonary TB is the most common infectious disease.

In Port Elizabeth alone, 170 people out of 2 972 sufferers died from it last year.

In 1992, 141 out of the 2 939 recorded pulmonary TB sufferers died, according to Port Elizabeth medical officer Etienne du Plessis.

Twenty-seven cases of TB meningitis, which affects the brain and can leave patients deaf or blind, were reported last year.

In 1992, seven deaths were reported and 22 cases identified.

Dr Du Plessis said TB was a major problem in Port Elizabeth: "It's on the increase. We're very worried about it."

Asked why the disease was spreading, he replied: "It's a reflection of the socio-economic conditions."

The Eastern Cape is acknowledged as the country's poorest region — there is 48 percent unemployment in the Port Elizabeth/Uitenhage metropole, which makes up half of the region's population.

Adequate diets to fend off malnutrition and the provision of housing to ease overcrowding would give residents a better infection resistance, said Dr Du Plessis.

Mrs Ossher concurred: "Malnutrition and bad housing certainly have a lot to do with it, but emotional stress and alcohol abuse can also debilitate the body."

Patients stopping treatment halfway through a course because they felt better, or irregular treatment, were particularly dangerous as the germ became partially drug resistant and the infection therefore more difficult to cure.

TB symptoms are coughing, breathlessness, loss of weight and energy, pains in the chest, blood in the sputum and night sweats.

Though usually contracted in the lungs, TB also affects all the body's organs. Treatment is offered free of charge at clinics countrywide. — Sapa.

36 die of TB in SA every day

Sowetan 24/2/94

(91)

■ LATENT GERMS Malnutrition, bad housing and alcohol to blame:

THIRTY-SIX people die daily of tuberculosis in South Africa and the situation is not getting better, says the SA National Tuberculosis Association.

While TB affects more people than Aids, there is an inter-relationship between the two conditions, says Santa national executive committee member Adele Ossher. Aids weakens patients' immune systems, leaving them vulnerable to TB, she explains.

"Most of us have (TB) germs which remain latent but can become active when our bodies' resistance is lowered," she said. In the Eastern Cape, the number of TB and Aids infections climbs steadily each year.

National Health Department researchers say 10 500 pulmonary TB cases were treated at local clinics last year, 1 093 more than the 9 407 reported in 1992. In Port Elizabeth alone, 170 people out of 2 972 sufferers died from it last year.

The Eastern Cape is acknowledged as the country's poorest region: there is 48 percent unemployment in the Port Elizabeth-Uitenhage metropole — which makes up half of the region's population.

Ossher said: "Malnutrition and bad housing certainly have a lot to do with it but emotional stress and alcohol abuse can also debilitate the body."

TB symptoms are coughing, breathlessness, loss of weight and energy, pains in the chest, blood in the sputum and night sweats. — *Sapa*.

New moves to fight killer TB in Western Cape

(91) ARG 2/3/94

DAVID YUTAR
Staff Reporter

TUBERCULOSIS will claim 30 million lives around the world in the next decade — unless immediate action is taken.

This statistic was given at the opening of the TB Alliance, which aims to curb the disease in the Western Cape.

The alliance was initiated by the Community Health Association of Southern Africa, and aims to involve communities in the fight against TB.

It also wants greater efforts from health organisations such as Santa, and from local and metropolitan government structures in curbing the spread of the disease in the Western Cape.

Association president Professor Eric Glatthaar said the Western Cape had the highest incidence of TB in the world, and accounted for a quarter of the nation's cases.

The region's TB problem had reached alarming proportions, having steadily worsened since 1987, and a strain of TB resistant to medication had compounded the problem.

The disease accounted for 7 000 deaths in South Africa every year, while 8 million new cases were reported worldwide, 3 million of them fatal.

It was predicted that by 2000 there would be 10,3 million more cases of TB in South Africa.

Figures for the Western Cape showed the region had the world's highest incidence of the disease worldwide, with up to 600 people in every 100 000 being infected, compared with the national average of 300 in every 100 000.

Coloureds were most vulnerable owing to socio-economic factors such as overcrowding, unhygienic living conditions and poverty.

Professor Glatthaar said that where a person was TB and HIV-infected the chances of contracting active TB became 10 times greater.

And the simultaneous existence of TB and HIV infections greatly accelerated the onset of active Aids.

This "dangerous partnership" meant the country was "heading for a catastrophe" said Professor Glatthaar.

One of the biggest problems facing those treating TB was that patients did not complete prescribed treatment programmes.

Professor Glatthaar said the alliance hoped to show that the TB story was a "happy one" in that the disease could be beaten if properly treated.

● The alliance has been granted R6 million from the Independent Development Trust.

Doctors in row over TB claim

By CAS St LEGER S/Times 13/3/94

TWO of South Africa's top tuberculosis scientists are crossing swords with front-line TB fighter Santa by claiming that South Africa may be winning the battle against the disease.

The message of optimism is being taken to the continent's most important scientific conference on the disease in a decade, Tuberculosis — Towards 2000 — to be held in Pretoria from tomorrow.

Those delivering the positive message will be Dr Bernard Fourie, the Medical Research Council's TB programme leader, and Dr Karin Weyer, special scientist on the programme.

"I am cautiously optimistic that we are well on the way to winning the battle against TB," said Dr Weyer. (91)

Santa, however, takes the opposite view.

"TB is going to get a lot worse," said Dr Theo Collins, consultant and former head of the SA National Tuberculosis Association.

He said there were 15-million South Africans who carried the TB bug, but they would remain perfectly healthy unless they encountered some stress like AIDS.

Dr Weyer bases her findings largely on research she has carried out at 10 TB hospitals into patients' resistance to one of the major drugs used in treating the disease, a monitor of the success or failure of TB programmes.

Single drug resistance has plunged from 30 percent of patients in 1980 to 12 percent in 1990 — indicating that SA's TB treatment programme is working.

The graph has levelled off since, and Dr Weyer warned that the emergence of the feared TB superbug — multiple drug-resistant TB — and by the link-up of TB with AIDS could cause a severe blow.

Up to 20 percent — or 16 000 of the annual crop of 80 000 new TB patients — are HIV-positive.

Two out of every 100 TB patients here have multiple drug-resistant TB — still too high, said Dr Weyer, but in control. In New York, the rate is 30 out of every 100 TB patients.

Dr Collins said that Santa's clinics, which operate 4 000 TB beds countrywide, recorded a 20 percent increase in multiple drug-resistant TB.

"No survey of multiple drug-resistant patients has ever been done. My impression is that the incidence is steadily increasing. We will be seeing more patients."

Africa urged to spend more on curbing TB

(91) ARGT 15/3/94

☐ 3 times as much money needed

PRETORIA. — The World Health Organisation has warned that tuberculosis is Africa's biggest killer and, if the rate of infection is not curbed, it will kill millions.

"Africa must urgently give the highest political commitment to fighting tuberculosis, and show this by dramatically increasing budget allocations," said WHO adviser Peter Eriki.

"Africa is sitting on a disaster, a time bomb. Nobody will excuse Africa if it does not move quickly to stop the epidemic," he said.

Ugandan-born Dr Eriki, based at WHO's Africa headquarters in Congo, was speaking after delivering a keynote speech in Pretoria at the beginning of a four-day international conference on tuberculosis.

He said Africa spent only $20 million (R68 m) a year in combating the disease instead of the minimum $60 million (R200 m) WHO estimated was needed.

"This disease is curable and yet it is the biggest single killer in Africa.

"The main reason for this is lack of finance from governments. This is why WHO last year declared TB a global emergency, needing most urgent measures," said Dr Eriki.

In 1992, WHO estimated that out of Africa's population of 552 million, about 171 million had been infected by the disease. Of those, 1,25 million developed "active tuberculosis" — and were likely to die.

At least 500 000 people died that year and more were dying now, Dr Eriki said.

By comparison, Aids was killing 100 000 Africans a year and its infection rate was lower, he said.

"The main age group dying from tuberculosis is between 15 and 49, the productive segment. If these people are decimated, Africa will sink beyond despair." — Sapa-Reuter.

WORLD

TB scourge spreading after 'years of worldwide neglect'

ARGT 28/4/94 (91)

□ 'New strains emerging'

THE HAGUE. — Tuberculosis causes more deaths than Aids, malaria and cholera combined — but the United Nations health agency says the world has largely ignored it.

In spite of a cheap and effective cure, the World Health Organisation (WHO) says years of neglect have allowed the disease to spread and potent drug-resistant strains to emerge.

"For almost everybody it's been a low priority," said Richard Bumgarner, deputy-manager of the WHO tuberculosis programme, during a visit to The Hague.

Rich countries had overlooked tuberculosis in their foreign aid programmes and poor countries had also placed it near the bottom of their agendas. Tuberculosis control projects had consequently suffered from a shortage of money.

"We have been living hand-to-mouth, begging here and there," said Mr Bumgarner.

The WHO had called on rich countries to provide an extra $100 million (R350 million) a year to help poor countries fight the disease, saying this would save 12 million lives over the next 10 years.

If its plan was not adopted the annual number of tuberculosis deaths would rise to four million a year by 2004 from three million a year now.

In 1990 aid donors spent $185 million (R648 million) fighting Aids in developing countries, but only $16 million (R56 million) fighting tuberculosis, which killed five times as many people.

The World Bank had concluded that tuberculosis control was one of the most cost-effective forms of treatment.

"If you want value for money, tuberculosis is a fabulous disease to invest in," said Mr Bumgarner.

Unfortunately many doctors and public health officials viewed it as unworthy of their attention.

"Let's face it, its not very sexy to deal with an old infectious disease like TB ... its old, its dirty and it affects poor people who don't vote."

The WHO itself was partly to blame for not conveying clearly the costs and benefits of tuberculosis control, Mr Bumgarner said.

But that had changed. The agency was promoting a six-month course of treatment that could cure a patient and prevent him or her from infecting others for as little as $13 (R46).

Well-run programmes had already enabled countries such as China, Chile, Honduras, Malawi, Malaysia and Tanzania to achieve cure rates of 80 percent or more.

Patients must be carefully supervised because failure to complete the treatment could give rise to drug-resistant strains of the disease, which could be costly — or impossible — to cure.

Drug resistance developed when a patient did not finish the course of medicine, allowing some germs to survive and multiply after they had acquired resistance to the drugs.

"Health workers must directly observe the swallowing of those drugs, record it in a special ledger and supervise and analyse that ledger," said Mr Bumgarner.

Whenever a correctly administered programme was put in place it quickly brought tangible results.

"Most medical programmes were evaluated in terms of the resources they use, but in TB we count the number of people cured, not the number of pills given."

Small victory in war against TB

(91) CT 29/4/94

BOSTON. — A programme in which tuberculosis patients are required to take their medicine under the supervision of a health care worker has dramatically raised the success rate of the treatment.

It has also cut the risk of patients contracting a drug-resistant strain of TB, according to a report in yesterday's New England Journal of Medicine.

TB is difficult to cure once the bacteria have built up a resistance to conventional drugs.

Patients often stop taking drugs once they feel better — which leads to the appearance of TB strains that learn through natural selection, to neutralise the medicine.

Scientists remain baffled by the global re-emergence of TB, a top US researcher said in Prague.

"Scientific ignorance in the pathogenesis of TB is enormous. We don't know how the organism enters the body, attaches to tissue cells, invades, survives, grows, spreads," Dr Barry Bloom told the Sixth International Congress for Infectious Diseases.

The World Health Organisation has declared a TB emergency, calling on rich countries to provide an extra $100m a year to help poor countries fight the disease, saying this would save 12 million lives over the next 10 years. — Sapa-Reuter

NEWS

Half adults in Africa suffer this disease

TB's link to Aids 'cause for concern'

Star 9/5/94

BY DAVID ROBBINS
HEALTH WRITER

The links between tuberculosis and HIV positivity hold such serious consequences for South Africa that a special public workshop is being planned for the Soweto/Eldorado/Lenasia area later this month.

Already, around 20 percent of patients admitted to Rietfontein, the PWV's main tuberculosis hospital, are testing HIV positive; and one of the conveners of the workshop, Professor Alan Fleming of Baragwanath, has warned of the consequences.

"We can expect a major resurgence of TB to ride on the back of the Aids epidemic," he said.

Fleming explained the ways in which TB and HIV interacted.

"HIV suppresses immunity and allows for a reactivation of TB, which is latent in about 50 percent of all adults in Africa.

"For the same reason, HIV also increases the chances of new TB infections and the effects of TB may accelerate the onset of opportunistic diseases in HIV carriers." (91)

In African countries where the Aids epidemic is already mature, at least 30 percent of Aids sufferers have active TB. In Zambia, up to 70 percent of newly diagnosed TB is found in people already testing HIV positive.

"The situation is aggravated by the emergence of multi-drug resistant TB worldwide," said Fleming.

The all-day special workshop on HIV/TB has been organised by the Soweto Eldorado Lenasia Aids Forum, and will be held on Saturday May 21 on the Soweto campus of Vista University.

One of the aims of the workshop, to be addressed by medical scientists, will be to formulate strategies for the control of TB in the Selaf area.

Among the strategies to be discussed will be chemoprophylaxis, a system of treatment to prevent active TB from developing in HIV-positive patients, and "directly observed therapy", which employs counsellors who ensure that TB treatments are adhered to.

For further information on the worskshop, telephone Fleming on (011) 933-1740, Dr D J Martin (011) 882-9910, or Enea Motaung (011) 982-1016/27.

Computerised geographical info on TB

(91) CT 11/5/94

Staff Reporter

A NEW computerised geographical information system (GIS) being developed by the Cape Town City Council will be able to provide maps of where the incidence of tuberculosis is highest.

As part of a social and development atlas, maps will also be available detailing infant mortality rate problem areas, according to the latest City Planner's annual report.

"Data on education and crime are also held and will be analysed in terms of relevant variables of the 1991 census," the report says.

The provision of land information data has been made possible with the acquisition of the geographical information system and the setting up of data bases.

This system is to be the major tool to supply information to do analyses and to supply answers to questions that will assist managers and planners to make decisions.

The GIS captures information in map "layers".

Thursday June 30 1994 SOWETAN

HEALTH Help stop TB

TB is an infectious disease

Sowetan 30/6/94

By Mokgadi Pela

(91)

TUBERCULOSIS is an infectious disease caused by germs called *tubercle bacilli*.

An infectious disease can be passed from one person to another. Such diseases include TB, polio, diphtheria, whooping cough and smallpox.

Germs are so small that they cannot be seen with the naked eye and can only be seen with an instrument called a microscope.

TB is caused by germs and not by bewitchment. Many people have a few of these germs living quietly in their lungs, but they are not sick because their bodies are strong and do not allow the germs to multiply and cause trouble.

In such people the germs do not cause big sores or holes in the lungs and there is nothing to see on X-ray. They can however check their presence through a simple skin test.

TB germs are found in the sputum of a sufferer. When a TB patient coughs, sneezes or spits carelessly, these germs spread into the air and can be absorbed by other people. TB is thus spread from person to person, without their knowing it.

Some of the known symptoms of TB are:

- Persistent cough and breathlessness;
- Tiredness or weakness of the body;
- Loss of weight and appetite;
- Night sweats;
- Pains in the chest; and
- Bloodstained sputum.

TB can be prevented:

- By vaccination;
- Covering mouth when coughing;
- Not spitting carelessly; and
- Treating diagnosed cases.

It is the unknown case of TB, or the patient not taking regular treatment,that is dangerous.

The patient who receives regular treatment is not dangerous and does not spread the germs to others.

Warning of TB linked to HIV

HIV-ASSOCIATED tuberculosis is set to become an immense threat to health services, the Medical Research Council (MRC) has warned in its annual report.

The risk of disease from latent infection increased tenfold in people infected with HIV, the MRC said.

Meanwhile, National Health director-general Dr Coen Slabber said yesterday nearly half of the 3 357 reported Aids cases in South Africa were in the economically-active 18-25 age group.

Addressing the parliamentary joint committee on finance, he said the current estimate of pregnant women testing HIV-positive countrywide is 565 000. CT 30/6/94

In the Western Cape, the rate of HIV-positive pregnant women was about 1,33%.

The incidence of TB in the coloured community in the Western Cape was the highest in the world. More than 8 000 cases were reported last year.

"There is no way the department can solve TB without solving the underlying social problems," he said. — Staff Reporter, Sapa

Shack conditions cause TB

Sowetan (supp to Sowetan) 8/7 - 12/7/94

THE RECENT floods and the onset of winter have caused an outbreak of tuberculosis (TB) at the Delport Farm squatter camp.

"Die Plaas", as it is known by residents, has no toilets, no water, no garbage removal and most of the residents — including very young children — have had TB in the past year because of the damp.

Mr Adam Pienaar, spokesperson for Delport Farm residents, said they desperately need help.

"We know we won't get houses immediately. All we want is water, toilets and for the council to come and collect the rubbish once a week.

"We have to walk over the rails to get water. We can't dig any more holes for the rubbish because everywhere you dig there's already rubbish. The bushes are full of mess because the people have no toilets," Pienaar said.

(91)

Ms Merle Blaaitjies, who is six months pregnant, said: "When the rains came it was wet in my house. A person can't sleep in a wet bed. So many people at the "Plaas" have TB because of the wet.

"I want my life to change. I want my child to live in a house with brick walls and water in the tap. I want my child to be able to play on the ground and not worry about the germs. That's all I want."

Another resident who calls herself "Laiga van die Kerk" said residents were prepared to pay for services.

"We can't expect everything for free from the new government. We want to pay. Most of our husbands work so we can easily afford it.

"We want a better future for our children. We're willing to do our part. Now we want the government to do theirs," she said.

Drug-resistant TB 'can still be overcome'

CT 29/7/94 (91)

LONDON. — Resistance to antibiotics shown by some strains of the tuberculosis-causing bacteria could be overcome, scientists said yesterday.

The discovery, reported in the Lancet medical journal, means doctors should be able to treat tuberculosis through a careful prescription of drugs and monitoring of treatment.

The news should not be seen as cause for complacency, since the World Health Organisation estimated the disease would kill 30 million people in the 1990s alone, Lancet said.

"The resurgence of tuberculosis in the developed world is an indictment of national public health systems that have failed to translate their own rhetoric into successful campaigns to control the disease," it said.

The scientists, led by doctors from the Institut Pasteur in Paris, studied 37 strains of the tuberculosis bacterium showing resistance to one or more of the antibiotics used to treat the disease.

They found the resistance was not due to a new and previously unknown resistance mechanism but to difficulties in treatment. — Sapa-Reuter

TB alarming in Cape — Rasool

CT. 15/8/94 (91)

TUBERCULOSIS, the major health problem of the Western Cape, should be used as the barometer of success of the socio-economic upliftment programmes of the Reconstruction and Development Programme, Western Cape Health and Welfare Minister Mr Ebrahim Rasool said at the weekend.

Speaking at a graduation function for TB Alliance Community volunteers, Mr Rasool said the situation was "alarming" in the Western Cape, where one percent of the population was infected and became ill with TB.

He blamed apartheid for the epidemic levels and said failure to deal effectively with TB would hamper all efforts of the RDP.

The TB Alliance has put together an innovative programme of community-based volunteers to supervise the treatment of TB.

More than 140 volunteers from Khayelitsha, Langa and Nyanga "graduated" at the ceremony. — Sapa

TB 'costs SA R200m a year'

(91)

CT 27/8/94

Incidence in W Cape among top in world

By BARRY STREEK
Political Staff

TUBERCULOSIS was costing South Africa about R200 million a year and in the Western Cape the incidence of the disease was among the highest in the world, the Medical Research Council (MRC) said yesterday.

"There can be little doubt that tuberculosis constitutes one of the major health problems in South Africa," it said in its 1993 report, which was tabled in Parliament.

Although the national rate for TB was 366 per 100 000 people, the rate in the Western Cape was 718 per 100 000.

In 1992, 76 003 new cases of TB were reported in South Africa, but despite major advances in anti-TB drug therapy and control strategies, TB was more plentiful in the world than ever before.

"Each year 10 million more people become diseased and three million die of this fully preventable and curable condition."

The MRC also said the greatest cause of perinatal deaths at Tygerberg Hospital was premature labour, and 20% of patients give birth before 38 weeks of gestation, compared with six percent in Europe.

"Of all babies born at Tygerberg, nearly eight percent weighed less than 1 500g at birth, with 60% of these surviving.

"The cost of treating a premature baby needing ventilation and weighing less than 1 000gm is R45 050, and babies weighing less than 1 500gm at birth needing the same care cost R35 510 to treat."

The MRC said a study by the Centre for Epidemiological Research in Southern Africa (Cersa), which showed that 56,9% of children with diarrhoea living in Khayelitsha were forced to travel over 30km to Red Cross Children's Hospital because of the lack of facilities at weekends, had led to the establishment of a 24-hour oral rehydration unit in Khayeltisha.

TB threat on the increase

Political Staff

THE TB threat in South Africa would increase even more as HIV infection spread, said the Minister of Health, Dr Nosozana Zuma.

Dr Zuma said this week that a standardised tuberculosis patient register and multi-drug resistant register would be introduced nationally, based on a successful pilot study in the Western Cape.

She said in the Senate the World Health Organisation had declared TB a global emergency.

"A worrying feature is that we cure only 79% of patients. No less than 17% abscond," said Dr Zuma.

(91) CT 3/9/94

TB row: Day care kids to be tested

By GLYNNIS UNDERHILL

CHILDREN from a day care centre in Mowbray will be tested for turberculosis infection today after an employee was diagnosed with the disease.

Western Cape Minister of Economic Affairs Dr Allan Boesak and Western Cape Health and Social Services Minister Mr Ebrahim Rasool both have daughters at the Gingerbread House Day Care Centre.

At a heated meeting this week parents accused the centre's owner of not telling them a worker was infected.

The Medical Officer of Health, Dr Michael Popkiss, said yesterday that he would be investigating why a Groote Schuur Hospital doctor had sent the notification of the diagnosis of TB to his department by mail.

The letter had arrived at his office on Monday — a full week after the worker was diagnosed as having TB — and this had caused a delay in alerting parents, he said.

"These days with telephones and faxes, one wonders why he had to write a letter," said Dr Popkiss.

The strain of TB that the worker had was not the most infectious but the children would undergo skin tests at the expense of the City Council, he said, adding that he would be "surprised" if any had contracted the disease.

CT 7/9/94

Dr Popkiss said that TB occurred in the Western Cape on a scale "unprecedented in the world" and there were 20 000 notifiable cases in the region each year.

(91)

TB 'will increase while poor socio-economic conditions remain and HIV infection grows'

LIBBY PEACOCK
Health Reporter

TUBERCULOSIS in greater Cape Town is still increasing annually and last year about 12 000 new cases were notified, says the outgoing Cape Town chairman of Santa, Stewart Fisher.

Dr Fisher was speaking at the 58th annual meeting of the organisation.

He said the increase would continue as long as poor socio-economic conditions remained and HIV infection increased.

A personal highlight in the past year was that community involvement had been insured through the establishment of Santa care groups in various areas, he said.

These groups were made up of volunteers from the community who had a special interest in the TB problem around them.

The organisation had reconsidered its role and function and would in the future concentrate more on the formation of care groups in various communities, with group members being much more involved in decision-making and implementation.

(91) ARG 20/9/94

Acting mayor Llewelyn van Wyk, who chaired the meeting, said the epidemic showed no signs of abating. He encouraged the creation of support groups and said it was important to promote awareness of TB symptoms.

Aiden Keyes was elected the new chairman of Santa-Cape Town. The organisation, formerly the Cape Province Tuberculosis Council, is now officially known as Santa-Cape Town in terms of changes to the constitution adopted yesterday.

The Argus, Tu

ARG 22/9/94

High SA TB rate a 'disgrace'

(91)

THE Western Cape has the highest rate of tuberculosis infection in Africa, Health Minister Nkosazana Zuma said.

She told the parliamentary select committee on health that South Africa ranked among Africa's worst-affected countries, with about 250 people in 100 000 infected with the disease.

In Tanzania the rate was 140, in Nigeria 222 and in Zambia 345.

But the rate for the Western Cape alone was 709 — the highest on the continent, Dr Zuma said.

In 1993 the Department of Health was notified of 5 800 new cases nationally and there were 2 101 deaths from TB.

"These figures are a disgrace," said Ms Zuma.

She added that in other countries where development was on a par with South Africa the disease was no longer a problem. — Reuter.

ARG 22/9/94

High SA TB rate a 'disgrace'

(91)

THE Western Cape has the highest rate of tuberculosis infection in Africa, Health Minister Nkosazana Zuma said.

She told the parliamentary select committee on health that South Africa ranked among Africa's worst-affected countries, with about 250 people in 100 000 infected with the disease.

In Tanzania the rate was 140, in Nigeria 222 and in Zambia 345.

But the rate for the Western Cape alone was 709 — the highest on the continent, Dr Zuma said.

In 1993 the Department of Health was notified of 5 800 new cases nationally and there were 2 101 deaths from TB.

"These figures are a disgrace," said Ms Zuma.

She added that in other countries where development was on a par with South Africa the disease was no longer a problem. — Reuter.

SA scientists in TB study

CT 29/9/94 (91)

From LINDA ENSOR

LONDON. — Leading South African medical scientists are participating in a R55 million research project, funded by multinational pharmaceutical giant Glaxo, to find a cure for tuberculosis.

Of the R55m, R36m would be spent by SA laboratories involved in the five-year project, the single biggest medical research project undertaken in the country. The total annual research budget of the SA Medical Research Council is about R40m.

The aim of the research is to find new ways to prevent and treat TB, which kills about three million people worldwide each year. It is the highest cause of death from a single infectious disease.

Far from being vanquished, there has been an unexpected comeback in the disease in industrialised countries, mainly due to the Aids epidemic. People who are HIV positive are more prone to fall ill with infections such as TB.

In developing countries where TB has been a major health hazard throughout the century, the spread of Aids has compounded the problem.

An "intensive effort aimed at improving the success of initial TB treatment" is necessary to overcome a growing problem of resistance to drugs, according to a team of researchers whose work, to be submitted to the South African Medical Journal, is summed up here by Health Reporter LIBBY PEACOCK

22/11/94 ARG

TB control hit by drug resistance

(91)

TUBERCULOSIS accounts for more than 80 percent of all communicable diseases notified in South Africa, and TB control programmes are threatened by a serious "man-made problem" — drug resistant TB.

From the results of a recent comprehensive survey done in the Western Cape by the Medical Research Council's National Tuberculosis Research Programme, it appears that patients with a history of TB treatment generally have an almost three times higher risk than "first-time patients" of drug resistance.

To avoid the further development of this problem, an "intensive effort aimed at improving the success of initial TB treatment" is necessary, according to the team of MRC researchers who did the study.

They say that the "best way to prevent drug resistance is to ensure that initial treatment is successful in more than 85 percent of new cases".

Specialist scientist Kain Weyer and three colleagues said in the paper — which has been submitted to the South African Medical Journal, but has not yet been published — that an increase in the number of cases of drug resistant tuberculosis have been observed locally and internationally, owing mainly to ineffective treatment, and in some instances, by the spread of HIV infection.

Drug resistance posed "a serious threat" to TB control programmes.

The researchers studied drug resistance among more than 7 000 TB patients older than 15 in the Western Cape, where incidence rates are up to three times higher than in other regions in the country.

Of the 7 266 people tested, 32 percent had a prior history of treatment, 63 percent had no prior history and the history of five percent was unknown.

From the results it appeared patients with a history of previous TB treatment in general had an almost three times higher risk of drug resistance.

The standard treatment for new TB patients in the Western Cape is Rifater, a triple combination agent containing the drugs *isoniazid*, *rifampicin* and *pyrazinamide*.

HEALTH NEWS *Some 5,6 million people threatened by the twin factor*

(91) Sowetan 5/1/95

Concern over TB and Aids link

By Mokgadi Pela

CLEAR MESSAGE *SA needs to act quickly to prevent a catastrophe:*

LONG after 1994 has passed, medical scientists will still recall the terrible combination of tuberculosis and Aids that emerged during this period.

This twin factor has become a reality in countries such as the United States and South Africa. With Aids alone having created enough headaches, the spectre of its link with TB sends a chill down the spine.

The Medical Research Council's National Aids Research Programme says the number of additional cases of TB can be expected among HIV-positive patients with implications for the diagnosis, management and control of TB.

Spokesman Dr Malcolm Steinberg believes that due to the strong link between HIV and TB, a strategic plan for dealing with the estimated 10-fold increase in cases over a relatively short period in the immediate future will require political commitment and national will.

Among the objectives of such a strategy would be:

- A uniform strategy throughout South Africa based on the principles of the International Union Against Tuberculosis and Lung Disease and of the World Health Organisation;
- A plan to deal with HIV and TB co-infected individuals; and
- The creation of training opportunities and recruitment of international involvement.

Overall, the message appears to be that a strong TB control strategy is needed. This will, hopefully, help reduce the unacceptably high TB figures in South Africa and also assist in the control of the HIV epidemic.

Latest figures show that in South Africa between six percent and 20 percent of newly diagnosed TB patients acquire HIV.

There are, however, several problems in treating TB patients such as:

- Non-compliance with treatment;
- The emergence of multi-drug resistant TB;
- A shortage of drugs in developing countries; and
- Lack of coordinated national control programmes.

Another burden is the issue of preventive TB treatment for HIV-positive patients. According to *Panos*, a London-based magazine, the twin epidemics of TB and Aids are showing a dangerous tendency to coalesce and to co-infect individuals.

WHO estimates that at least 5,6 million people are infected with HIV and TB worldwide. For individuals, the implications are grave. "It has been proven without doubt that dual infection with HIV and TB triggers off active TB in people with latent TB because of weakened immune system." Recent research has shown that TB can activate HIV from a latent state in infected cells.

Dr Paul Nunn of the WHO's TB Programme says people with HIV are "more likely to develop active TB". He says the TB epidemic is growing at a worrying rate, particularly in the developing world.

In Africa, TB has already become the prime cause of death in adults with HIV. WHO has called for political commitment from all countries to control TB by means of public health interventions, including adult health programmes and basic services like water and sanitation. At the recent conference in Pretoria, Dr Peter Erikin of the WHO's Afro Region said he expected South Africa to take the lead in the region and to cooperate in terms of research, control strategies and provision of laboratory equipment and drugs. The WHO TB Programme has given the highest priority to strengthening TB control programmes in countries where they are poorly developed and where the HIV and TB prevalence is high. While TB is not such a major problem in the developed world, it has been rising in several European countries. Much of the increase has been attributed to immigration but a growing number of cases seem to be linked to HIV, especially in southern Europe. The message is clear that — like the rest of the world — South Africa, with its expertise, resources and infrastructure to move things in the right direction, needs to act quickly to prevent a catastrophe.

S • U • M • M • E • R

Sale!

TB 'out of control': 30-m people at risk

(91) Star 18/1/95

Chicago — Tuberculosis is out of control in some parts of the world and may kill 30 million people this decade, according to a study published yesterday.

"The magnitude of the global tuberculosis problem is enormous," the World Health Organisation and the US Centres for Disease Control and Prevention said.

Their report blamed the spread of TB in part on AIDS, which leaves victims susceptible to such infections, and the emergence of strains of the disease that have become drug-resistant.

But it said the epidemic is simply "out of control in many parts of the world" where poor health care practices exist.

About 95 percent of all new TB cases occur in developing countries, with the highest infection rates recorded in sub-Saharan Africa and south-east Asia.

The study said about 90 million new cases of TB will have been recorded from 1990 to 1999.

"Among adults, TB is the world's foremost cause of death from a single infectious agent. If worldwide control of tuberculosis does not improve ... 30 million deaths are expected in the decade 1990 to 1999."

In the United States the number of TB cases being reported each year has increased by about 14 percent from 1985 to 1993, the report said.

The American Lung Association said the figures foretell "an alarming health emergency for the United States".— Sapa-Reuter.

TB — a public health priority in dire need of cheaper drugs

(91) Sowetan 26/1/95

By Mokgadi Pela

THE forthcoming conference on Tuberculosis and Aids at the University of Stellenbosch should come up with strategies that will deal a deathblow to this emerging twin evil.

From Chicago to Cape Town the trend is the same — TB sufferers have become easy prey to HIV.

Experts note clear evidence that infection with HIV activates TB in people whose disease had been inactive and that TB may hasten the progression from HIV to Aids.

They say people with latent TB have a much greater chance of developing active TB if they also harbour HIV. Whereas in the early days, it was common to see TB reactivating due to malnutrition, stress and socio-economic factors, nowadays HIV compromises the immune system.

With TB killing more adults each year than any other infectious disease — more than Aids, diarrhoea, malaria and other tropical diseases combined, it's clear the world is losing the race against time.

In 1993, 89 463 new cases of TB were notified in South Africa with 2 341 deaths. The highest incidence rate was found among the coloured population, followed by Africans.

Dr Des Martin, who is deputy director of the National Institute of Virology and a member of the Medical Research Council's Aids Virus Research Unit, told *Sowetan* in an interview that: "South Africa needs effective and inexpensive drugs against TB. What we see now is that treatment extends between six to nine months. The compliance rate is not that pleasing as some people abandon treatment once symptoms disappear.

"We should also follow HIV-infected people closely to detect early TB disease. This will enable patients to lead more manageable and productive lives.

"The country should also increase its initiatives for HIV in terms of education, empowering women and encouraging people to use condoms."

Martin added that massive research needed to be undertaken in the area of childhood TB and HIV infection.

According to the Department of Health, the advent of HIV and its link with TB has made the disease an urgent public health priority. In line with its TB control programme, the department will send its core personnel to attend training courses in Tanzania in April and November.

The South African TB control programme will be reviewed by the World Health Organisation in 1996.

Experts say TB has risen sharply in the past decade mainly because the public health community relaxed when the disease seemed conquered.

WHO says TB is fast becoming the world's most urgent health crisis, and without more funding, could claim 30 million lives in the next decade.

Dr Charles Felton, a leading TB specialist who works in the heart of the disease's resurgence in the US, New York's Harlem, said: "When the incidents of TB went down, our guard was let down."

And Felton, chairman of the pulmonology section at the Harlem Hospital Centre, said TB returned for the same reasons it flourished up to the early 1900s. These were poverty, homelessness and immigration, but now there is also the link with HIV. Experts have also stressed the need to ensure that those identified with active TB get the full six-month antibiotic treatment, and not drop out after a week or so when the symptoms are gone.

It becomes clear that with the necessary political will on the part of the government, South Africa, along with the rest of the world, can go a long way to combating this dangerous dimension of Aids and TB. Results of the conference will be awaited with keen interest.

'The country should also increase its initiatives for HIV in terms of education, empowering women and encouraging people to use condoms'

Gloomy view of tuberculosis sketched

BD 27/1/95

CHICAGO — Tuberculosis will strike 90-million people this decade and will kill 30-million of them if worldwide efforts against it do not improve, researchers predict. (91)

"The magnitude of the global tuberculosis problem is enormous," the reseachers wrote in the January 18 issue of The Journal of the American Medical Association.

Ninety-five percent of cases are in developing countries. The disease was gaining fastest in the western Pacific and southeast Asia, where two-thirds of infected people lived, said the authors, a team led by Dr Mario Raviglione of the World Health Organisation in Geneva.

Tuberculosis cases worldwide can be expected to increase to 8,8-million this year and to 10,2-million by the year 2000. More than 7,5-million cases occurred in 1990.

Assuming that treatment programmes remain at their 1990 effectiveness level, 3-million tuberculosis deaths can be expected this year, and 3,5-million deaths can be expected every year by 2000.

"Without recognition of the tuberculosis crisis confronting the world and prompt, effective action, the tuberculosis epidemic can be expected to worsen," the authors say.

TB was on the decline until 1985, when a worldwide resurgence began.

Several factors are to blame, they say. Children born decades ago in areas of high population growth are reaching ages where rates of TB sickness and death are great. Also, famine, war and natural disasters are creating large groups of displaced, malnourished people in crowded conditions that foster the spread of TB. And the AIDS virus is spreading, adding to the vulnerable population.

In 1990, 4,2% of all tuberculosis cases were associated with the AIDS virus HIV. In the year 2000 an estimated 13,8% of all TB cases may be HIV-associated, say the researchers.

The WHO declared tuberculosis a global health emergency in April 1993. "It hasn't changed a great deal," says Dr Dixie Snider of the US Centres for Disease Control and Prevention, a co-author of the report.

Tuberculosis is spread when an infected person coughs or sneezes bacteria-laden water droplets into the air, which someone else inhales.

Antibiotics can cure the disease, but they must be taken daily for months, and an incomplete course of treatment can produce drug-resistant disease.

"It doesn't cost a lot to deal with the problem, at least to keep people from dying, but it's beyond the investment some of the poorest countries can make," Snider says. — Sapa-AP.

TB on fast track to global disaster

WeekendStar
January 28-29 1995

(91) Star 28/1/95

TUBERCULOSIS cases worldwide can be expected to increase to 8,8 million this year.

CHICAGO — Tuberculosis will strike 90 million people this decade and will kill 30 million if worldwide efforts against it don't improve, researchers predict.

"The magnitude of the global tuberculosis problem is enormous," the reseachers wrote in the Journal of the American Medical Association last week.

About 95 percent of cases are in developing countries. The disease is gaining fastest in the western Pacific and southeast Asia, where two-thirds of infected people live, said the authors, led by Dr Mario Raviglione of the World Health Organisation in Geneva.

Worldwide, tuberculosis cases can be expected to increase to 8,8 million this year and to 10,2 million by 2000. More than 7,5 million cases occurred in 1990.

Assuming that treatment programmes remain at their 1990 effectiveness level, 3 million tuberculosis deaths can be expected this year, and 3,5 million deaths annually by the year 2000, the authors said. More than 2,5 million died in 1990.

"Without recognition of the tuberculosis crisis confronting the world and prompt, effective action, the tuberculosis epidemic can be expected to worsen," they said.

TB was on the decline until 1985, when a worldwide resurgence began.

Several factors are to blame, they said. Children born decades ago in areas of high population growth are reaching ages where rates of TB sickness and death are great. Also, famine, war and natural disasters are creating large groups of displaced, malnourished people in crowded conditions that foster the spread of TB. And the AIDS virus is spreading, adding to the vulnerable population.

In 1990, 4,2 percent of tuberculosis cases were associated with the AIDS virus, HIV. In the year 2000, an estimated 13,8 percent of all TB cases may be HIV-associated, they said.

The WHO declared tuberculosis a global health emergency in April. "It hasn't changed much," said Dr Dixie Snider of the US Centres for Disease Control and Prevention, a co-author of the report.

Tuberculosis is spread when an infected person coughs or sneezes bacteria-laden water droplets into the air, which someone else inhales.

Antibiotics can cure TB, but must be taken daily for months, and an incomplete course of treatment can produce drug-resistant disease. — Sapa-AP.

Is the WHO losing the health battle?

■ Last year, Health Minister Nkosazana Zuma declared tuberculosis and Aids to be South Africa's biggest health problems. But who's doing anything about it?

(91) ARG 28/11/95

PAUL DIETRICH

TUBERCULOSIS is rampant again all over the world, with the incidence of TB in the Western Cape among the highest in the world.

And the World Health Organisation expects South Africa to take the lead in the region and to co-operate in terms of tuberculosis research, cortrol strategies and provision of laboratory equipment and drugs.

The view was expressed by the WHO's Dr Peter Eriki, a keynote speaker at the Medical Research Council's "Tuberculosis — Beyond 2000" conference held in Pretoria last year.

It is a reasonable expectation, given South Africa's problems and status in the region. But questions must be asked of the body expecting such a lead.

The WHO has, over the past few years, drastically changed its focus from being the leading international organisation fighting disease, especially in the third world, to being a co-ordinating body concerned primarily with organising conferences and generating reports and directives such as the above.

The current resurgence of TB is primarily due to its devastating link with HIV: the Aids virus destroys the human cells that keep the TB bacteria dormant. The problem with TB, like most infectious diseases, is that it does not stop at national borders. Hence the fight must be directed by a regional or multilaterial international health organisation.

The importance of such an organisation rests on the enormity of the challenges ahead.

The new plagues of the 1990s (TB, Aids and hepatitis) afflict hundreds of millions of people. Last year, cholera epidemics put 90 to 120 million people at risk in Africa, Latin America and the Caribbean. Measles and diphtheria are now epidemics in Russia. New virulent strains of malaria, resistant to the usual drug treatments, will have killed an estimated two million people in 1994, while more than six million people will have been crippled by leprosy. The WHO's own statistics show that over 1,8 billion people will have been affected last year by vaccine-preventable diseases.

But while the world is experiencing an explosion of such epidemics, the WHO's disease prevention and control programmes have been reduced over the past 10 years to 12,5 percent of its regular budget, down from 16 percent. Even more revealing is that the organisation has recently cut its TB budgets by 6 percent in Africa and 25 percent in Asia, where the largest number of people are infected.

In Asia for example, the WHO's budget to confront this leading killer is just over $400 000 a year. Estimates place the number of South-East Asians infected by TB at over one billion. This means that the WHO can contribute about one US cent for every 400 people infected.

The problem, however, is not a lack of money, but a failure to set the right priorities. The WHO is well funded, with a budget of almost $1 billion a year — more than any other UN organisation. It could easily find the $100 million to fight TB in its own budget. But 500 other programmes compete for resources — such as seat-belt safety advertising campaigns, Oral Hygiene Week celebrations and the distribution of millions of world No-tobacco Day bumper stickers.

The tragedy is that while the WHO carries out such low-priority public awareness campaigns, basic health needs in developing countries are not being tackled. With modern vaccines and medicines now available to prevent many killer diseases, the misallocation of resources is often the only obstacle to saving lives.

But it is the WHO, which is supposed to be the world's leading multilateral health organisation, that devotes less than 1 percent of its regular budget to malaria — a disease it has described as the "most serious health problem in the poorest areas of the world".

The WHO's resources trickling down to the countries most in need have at times become a ludicrously small portion of its expenditures. With its high overheads and salaries, it now costs the WHO $8 to plan for and spend $2 on actual programmes.

These shortcomings are starting to draw much-needed public scrutiny. Last month, the prestigious British medical journal The Lancet blamed the WHO for failing to provide "global direction" in the fight against TB. It tactfully suggested that the WHO's "political complexities" often hampered progress.

A number of WHO officials grumbled at last September's Aids conference in Tokyo that funding for its global programme on Aids had been cut from $90 million to only $70 million in 1994. What they didn't mention was that donor nations have severely criticised the WHO for wasting most of the money given to it to fight Aids.

Even the United Nations is fed up with the WHO's management. It recently stripped the WHO of all responsibility for Aids-related programmes. It is now creating a new Geneva-based UN agency to lead the world-wide fight in combating the Aids epidemic.

The sad fact is, the world desperately needs a serious international health organisation that will do more than convene conferences and issue press releases.

But as long as the WHO fails to oversee a major reform in how it allocates its resources, the money it has been given is unlikely to result in any real improvement in TB or the treatment of other diseases in the organisation's mandate.

If the WHO refuses to refocus its spending on disease control and health emergencies, the UN will be forced to create a new international health organisation to deal with these epidemics, similar to its new UN agency to combat Aids.

■ *Paul Dietrich is president of the Institute for International Health and Development in Washington DC.*

New TB register a powerful weapon

(91)

ARG 31/1/95

Staff Reporter

WITH 140 000 South Africans a year being treated for tuberculosis — and about 90 000 new patients expected a year — the Department of Health has an invaluable new weapon in the new national TB register.

The register, launched yesterday, will be a standardised record of information on diagnosis and treatment and will for the first time provide a clear idea of the incidence of TB in the country.

Globally, there are 10 million new TB cases every year while in Africa, eight million people are currently infected.

TB kills more adults every year than any other infectious disease.

Curing TB the "first time round" was Department of Health's aim, Neil Cameron, director of the department's Communicable Disease Control division, said at the launch of the register.

"The new national TB register is a tool which can enable us to do this," he said.

Bernard Fourie, leader of the Medical Research Council's National TB Research Programme, said: "TB was declared a global problem by the World Health Organisation (WHO) two years ago. "Africa is a particularly vulnerable continent because 80 percent of all HIV-positive persons inhabit it."

Almost four million Africans were co-infected with TB and HIV, with South Africa not being exempt from this phenomenon, he said.

"We investigated registers from other countries, both developed and developing," said Dr Karin Weyer, specialist scientist on the MRC National TB Research Programme, "and spent about a year devising one to suit the South African situation.

The register has been tested in a research project with feedback coming from the health care workers who used it.

Both busy city clinics and remote rural clinics were part of this project.

Dr Cameron saw the creative interaction between the Department of Health and the MRC as a vital part of the development of the national register.

Register started on killer disease

CT 31/1/95

(91)

Staff Reporter

A NATIONAL tuberculosis (TB) register has been launched to obtain accurate information on the disease which kills more adults every year than any other infectious disease.

The register will be implemented by the Department of Health at TB clinics nationwide next month.

At a press conference yesterday, Dr Bernard Fourie, programme leader of the Medical Research Council's national TB research programme, said TB was the most widespread infectious disease in the world. It caused about three million deaths a year.

A third of the world's population was infected with TB and at least 10 million new cases were reported annually.

In Africa eight million people were infected with TB — 3,8m of whom were also HIV-positive.

Accurate details on TB sought

Dr Fourie said about 80 000 people were infected with TB in South Africa. The Western Cape — with 18 409 — had the highest number of cases, followed by the Free State with 11 534.

"The register will make it possible to gather accurate information on who has contracted the disease and the outcome of treatment. This information has not been collected nationally in a standardised way before, which made accurate interpretation of TB statistics virtually impossible.

"Before we can improve the situation, we must know the nature and magnitude of the problem," Dr Fourie said.

He said the register was based on the World Health Organisation register and would contained accurate records on individual patients.

It also allowed for periodic reporting on the efficiency of the national TB control programme and the trends of the disease.

Dr Neil Cameron of the Department of Health said the register would shift the control of TB from the higher health authorities to the clinic.

"This would enable clinic staff to make much better use of their patient statistics, to streamline services and reduce the workload," he said.

NEWS FEATURE *The nuts and bolts of fighting SA's*

At last, a record of the TB battle

(91) Sowetan 2/2/95

By Mokgadi Pela

■ GRASSROOTS CLINICS *Will be responsible for monitoring patients:*

THE DEPARTMENT OF Health is to implement a nationwide registration and recording-of-information programme on the diagnosis and treatment of tuberculosis at the grassroots clinics treating the disease.

This follows extensive testing by scientists from the national TB research programme of the Medical Research Council and epidemiologists of the Department of Health.

Experts say the registration system will for the first time shed light on the incidence of TB in South Africa.

"As a management tool, the register will now make it possible to gather accurate data on the certainty of diagnosis and the outcome of treatment," the department and the MRC said in a joint statement.

Major hurdle

"Previously this information was not nationally collected in a standardised way which made accurate interpretation of TB statistics practically impossible. This has been a major hurdle in improving the TB situation in South Africa, where some regions currently record TB rates ranking among the highest in the world,"

"Before we can hope to improve the situation, we need to know the nature and magnitude of the problem and then plan appropriate intervention."

Dr Karin Weyer, specialist at the MRC said: "Up to now, we have not had a clear description of the problem because of conflicting definitions of what constituted a TB case and widely differing views on its management."

Trends

"As researchers, we couldn't reliably estimate TB trends because the size of the infectious pool — those patients responsible for spreading the epidemic — was unknown," she added.

In addition, no evaluation of treatment results could be made previously since there was no proper systematic monitoring of patient progress over the six-month treatment period.

An international TB conference organised by the MRC's national TB research programme in Pretoria last year brought the problem to a head and led to the department's commitment to standardising TB control procedures.

Based on the framework for TB control recommended by the World Health Organisation, the new register will ensure that accurate records on individual patients be maintained

It also allows for periodic reporting on the efficiency of the national TB control programme in terms of treatment outcome and the epidemiologic trend of TB in communities.

The register contains information on the type of TB, case classification and the results of sputum tests before and during treatment.

Director of communicable disease control of the Department of Health, Dr Neil Cameron, said: "We now have a system which has been tried and tested, both locally and internationally.

"It has been adapted for the South African situation and places responsibility for TB control right at the clinic level. This empowers staff to measure their own performance and to develop targeted intervention strategies.

"We hope that this register will enable clinic staff to make much better and timely use of their patient statistics to streamline services and reduce workload. The success of control programmes can therefore be monitored directly at clinic level so thst improvements in the service can be implemented without delay."

RDP 'sells out' environment

CATHERINE CROOKES

THE reconstruction and development programme (RDP) White Paper "sold out the environment," the Twenty Twenty environmental initiative's new project leader, Rupert Lorimer, said last week.

Development and the environment could not be separated, yet the White Paper's authors, in their attempt to raise the nation's productive capacity through industry, placed emphasis on finite, depletable resources, he said.

The RDP should rather consider utilising natural resources which, if managed correctly, were infinite. BD 6/2/95

Lorimer, DP environment spokesman for a number of years and a key figure in pre-election peace structures, has retired from party politics to concentrate on promoting environmental concerns. Last week he took over leadership of the Twenty-Twenty project, a campaign for the establishment of a "sustainable" SA by the year 2020.

He wants to get sustainable development incorporated into the RDP agenda and into the new constitution. "With so much emphasis being placed on human rights it is now time to emphasise human responsibility. The RDP is holy writ, but if it is not based on sound environmental principles it will fall flat."

Lorimer has called for the Environment Ministry to be placed under the the President's office, with similiar powers being vested in Jay Naidoo's RDP Ministry. This would allow environmental concerns to be integrated into all policy decisions.

Elevating the status of the Environment Department should include an environmental auditor-general to oversee a national accounting system based on the principles of resource economics.

Twenty Twenty aims to forge partnerships between environmental groups and organs of civil society, including government, business, labour, non-governmental organisations and local communities.

PROUDFOOT SOUTH AFRICA

A Proudfoot PLC Company

REALISE YOUR FULL POTENTIAL

Registration system for TB

(91) EDWARD WEST BD 6/2/95

CAPE TOWN — The incidence of tuberculosis (TB) in the Western Cape was among the highest in the world, with trends in the coloured population showing sustained, steeply rising rates in most age groups and both sexes, the Medical Research Council and the Health Department said last week.

The department announced the implementation this month of a national register to standardise the recording of information at TB clinics.

Medical Research Council specialist scientist Karin Weyer said the registration system would for the first time make it possible to get a clear idea of the incidence of the disease in SA.

DISTILLERS CORPORATION (SA) LIMITED

(Reg. No. 88/05808/06)

NOTICE TO SHAREHOLDERS

Declaration of Dividend No 13

Notice is hereby given that the Board of Directors has declared an interim dividend of 14 cents (1994: 12 cents) per ordinary share on 3 February 1995.

Dividend cheques will be mailed on 24 February 1995 to the holders of ordinary shares who are registered in the share register of the company on 17 February 1995.

TB group expands to Kuils River area

(91)

CT 28/2/95

THE South African Tuberculosis Association is expanding its support groups, with a new one opened recently in Kuils River.

Initial moves toward starting the group were made last year, but the first official meeting at which an interim chairman was elected was held last week.

According to Ms Dulcie Erasmus, the projects manager for the Western Cape, there was a tremendous increase in the number of cases reported in the Kuils River area in 1993 and 1994.

"With an increase of some 400 cases it was evident at our initial meeting that the community was keen to implement a plan of action to counteract its spread," she said.

Through a network of voluntary workers Santa's major focus is to ensure TB patients are supported and helped in the maintenance of their medication programmes.

Patients

Ms Erasmus explained that at least 30% of TB patients did not complete their medication, which led to their developing an immunity as well as spreading the highly infectious disease to others.

A busy suburb of the northern areas, Elsies River has four clinics which treat some 900 patients.

Santa has 80 volunteers in Elsies River who are involved in a "case-holding project", which means they supplement the work done by the clinics, by helping patients and where necessary visiting them at home to ensure they take their medication correctly.

All Santa volunteers receive training and are not put at risk. Volunteers are welcomed.

Clinics are also run in Belhar, Ravensmead and Uitsig.

A new support group is to be started shortly in Bishop Lavis.

The Western Cape, with its high incidence of alcohol abuse and cold winters, is particularly hard on TB patients.

Socio-economic conditions such as overcrowding and malnourishment are major contributing factors to the spread of TB.

TB is curable and treated patients will not infect others.

Picture: BRENTON GEACH, The Argus.

FIGHTING TB: Yogeshwari, co-founder of the Rondebosch-based Ananda Kutir Yoga Centre, takes tuberculosis patients through their breathing exercises at the Nyanga Clinic.

Yoga helps TB sufferers cope

ARG 8/3/95

LIBBY PEACOCK (91)
Health Reporter

THE setting is an open courtyard a stone's throw from the sprawling squatter settlement of Nyanga East.

A large group of people, young and old, some with toddlers or babies, are engaged in a series of flowing movements.

Suddenly they all break into a beautiful, rhythmic song, continuing their rhythmic exercises. This is interrupted by some sporadic coughing.

The explanation for this rather unusual sight is that the people are all tuberculosis patients — some very ill — and they are doing yoga, which includes specific breathing exercises.

The Nyanga area has the highest TB rate in the world, a problem exacerbated by widespread undernourishment and poor living conditions.

Eleven years ago the Rondebosch-based Ananda Kutir Yoga Centre, a non-profit, charitable organisation, started reaching out to these patients by providing simple, nutritious meals and voluntary yoga exercises.

The project started off with about a dozen TB patients — now hundreds of patients are reached weekly in Nyanga, nearby KTC, and, from next month, also in Crossroads.

Says Swami Parvathi, a founder of the centre and a former TB nursing sister: "Yoga is a great system. The breathing techniques have a revitalising effect on the lungs. The techniques are designed to promote healthy lung tissue."

She said not only did the exercises contribute towards the balancing of a healthy body and mind, it also contributed towards "self-empowerment", by helping people to take responsibility for their health.

Contrary to some people's perception, the exercises had "nothing to do with religion", but rather with an holistic health philosophy.

The patients arrive at the Nyanga Clinic every Thursday for their TB medication.

The donated food — including protein-filled sandwiches, a boiled egg and a piece of fruit — and the exercises are not only important for the healing process, they are also an added incentive for patients to continue with treatment and medication.

The exercises continue for only about 10 or 15 minutes, as too much would be harmful, but leaflets with simple instructions in Xhosa, as well as drawings of stick figures doing the exercises, are handed out so that patients can do the exercises at home.

One patient is 48-year-old Xolisi Voyi, who lives in New Crossroads with his sister and her children. He was first diagnosed with TB in 1993, but only recently started attending the clinic regularly.

He said he was feeling "very much better" and that the exercises, which he did at home every morning, "definitely" helped.

World faces TB threat

(91) ARG 22/3/95

The Argus Foreign Service

LONDON. — Tubercolosis now threatens a third of the world's people — largely because of the failure to use cheap drugs which can cure it.

This is the warning in a World Health Organisation report published here yesterday. It says two billion people will become infected over the next 10 years.

erturning top of death list

Sowetan 19/4/95

TB will kill up to 4 million

(91)

By Glenn McKenzie

TUBERCULOSIS will kill up to 4 million people a year by the year 2005 unless a little-used control strategy is implemented globally, the World Health Organisation has predicted.

In a recent report, WHO declared that a form of treatment known as Dots (directly observed treatment, shortcourse) developed in Tanzania was the "only hope for reversing the course of the global TB epidemic".

The treatment, which has also been adopted in China and New York in the United States, involves health workers who actually view each patient taking the correct combination of anti-TB medicines. Dr Arata Kochi, director of the WHO TB programme, has estimated that the Dots treatment could save 12 million lives in the next decade. The cost for governments would be an additional R1 billion a year.

According to WHO, cure rates in Tanzania rose to nearly 80 percent since the Dots programme was initiated. In New York, officials had "significantly stemmed" the disease.

TB is an infectious disease transmitted by bacteria spread into the air by coughing or sneezing.

WHO declared the disease a "global emergency" in 1993. Since then, the disease has killed an estimated 6 million people around the world. In South Africa TB has claimed 10 000 lives.

In recent years, as many as 100 million people have become infected with new drug-resistant strains of the TB that do not respond well to drugs.

"As faulty TB programmes help spread drug-resistant strains, we will come closer to returning to the day when we will once again have no treatment for TB, except isolation in sanitoria," said Kochi.

Two-year target for WHO strategy

CT 24/4/95 (91)

SPECIAL CORRESPONDENT

JOHANNESBURG: Health officials have set a two-year target for implementing World Health Organisation-recommended strategies for controlling tuberculosis, says Dr Neil Cameron, director of Communicable Disease Control at the Department of Health.

He was reacting to a report from the WHO's TB Programme, suggesting countries divert all TB funds into directly-observed treatment — a six-month treatment plan where health staff supervise the medication of patients with TB.

About 145 000 TB patients are treated each year, with a 70% compliance rate, he said.

The WHO recommendations are based on the success of programmes in China, New York and Tanzania, where recorded cure rates topped 80%.

Disease kills 3-m a year

TB menace poised to soar worldwide

(91)

STAR 24/4/95

■ BY JANINE SIMON

The global tuberculosis epidemic kills 3-million people a year and threatens humanity more than any other communicable disease, according to the World Health Organisation's TB programme.

And, warns WHO, the situation is worsening because:

■ Humans are breeding incurable strains of drug-resistant TB as they fail to complete or receive improper treatment — a feature common in poorly funded TB control programmes. Up to 100-million people might be infected with drug-resistant strains.

■ The HIV epidemic is creating additional TB cases.

Researchers believe that at least 30% of people infected with both TB and the HIV virus will develop active TB as opposed to only 5 or 10% of those infected with TB alone.

Within five years TB is expected to be the leading cause of death among patients with HIV, particularly in Asia where it is already the leading opportunistic disease in up to 70% of AIDS patients.

■ A new TB epidemic has broken out in eastern Europe and the former Soviet Union. This has profound implications for TB control in western Europe, to which many refugees migrate.

According to WHO, all public funds should be directed or diverted into directly observed treatment — a six-month programme where health workers observe diagnosed TB patients taking their medicine.

This had been proved in programmes in New York City, Tanzania and China to be the most cost-effective way to stop TB's further spread as it prioritised curing the sick and prevented spreading infection and the growth of drug-resistant strains.

Other methods of treatment were "well-meaning" but less effective given the current emergency.

Two-year strategy to fight epidemic

■ BY JANINE SIMON

Health officials have set a two-year target for implementing World Health Organisation-recommended strategies for controlling tuberculosis, Dr Neil Cameron, director of communicable disease control at the Department of Health, has announced.

He was reacting to a report from the WHO's TB programme suggesting that countries divert all public money for TB control into efficient, cost-effective, directly observed treatment — a six-month treatment plan where health staff supervise the medication of patients who have been properly diagnosed and classified.

Between 140 000 and 150 000 TB patients were treated each year, with a 70% compliance rate. Cameron said the aim was to push the rate of first-time cures to 85%.

According to Cameron, provincial MECs had agreed that action on TB treatment and control was needed within two years if the country was to deal with the TB increase expected to be created by the HIV epidemic.

Efforts had been hampered by the reorganisation of the health services, but the department was now setting up a new national TB programme.

Clinics had been encouraged to measure compliance for the past two years, and an official tuberculosis patient register had been set up in 4 000 clinics in January to assist nurses in this regard.

The first quarterly reports were being compiled, and its effectiveness could be assessed in six months.

Clinics were also focusing on identifying adult patients who were spreading the disease by coughing infected sputum, and the department was examining how to improve transport and feedback times between its clinics and laboratories.

WHO officials were expected in SA in July to assist with training, Cameron added.

■ The WHO recommendations were based on the success of programmes in China, New York and Tanzania, where recorded cure rates topped 80%.

WYNBERG

'TB worst in world'

ARG 18/5/95

(91)

Result of 'unemployment, poverty'

Staff Reporter

The Wynberg area has an average of 699 tuberculosis sufferers for every 100 000 inhabitants — a ratio at least 14 times higher than the worst scenario worldwide, according to shock figures released by the South African National Tuberculosis Association (Santa).

The region includes the depressed areas of KTC, New Crossroads and Guguletu, where reported cases increase every year.

The worst TB areas in the Peninsula are, however, Elsies River, Ravensmead and Uitsig where the ratio of 1 012 sufferers per 100 000 people is up to 50 times higher than international levels, according to Santa.

Manenberg and Mitchell's Plain, although considered problematic, have a much lower ratio of about 126 sufferers per 100 000 people — still alarmingly high when compared to round-the-world figure of between 20 to 50 people per 1 000.

The main cause of tuberculosis is unemployment and poverty in the depressed areas which results in overcrowding and malnutrition — conditions in which the disease flourishes, according to Dulcie Erasmus, a Santa community projects manager.

She says the incidence of tuberculosis is increasing every year, in spite of the fact that the disease is curable and preventable.

To broadcast this encouraging news, Santa embarked this week on a TB awareness campaign, the slogan of which is "Spread the message, not the disease."

The thrust of the campaign is to encourage people who have symptoms of TB to come to the Santa clinic and, if diagnosed, to undergo and complete a course of treatment.

Because sufferers often stop taking the medicine when they feel better, they have relapses that are often more serious than the initial illness, according to Sister Erasmus.

This also has the effect of sensitising the disease to the medicine, making it more difficult to cure.

Target areas in Santa's campaign include Macassar, which also has one of the highest TB levels in the Western Cape, and Cape Flats areas like KTC and Nyanga, where cases increase every year.

An average of between 15 and 20 sufferers are diagnosed in Macassar every month.

The Macassar project began on Monday with puppet shows at all the area's creches.

Competitions, sponsored by Sanlam, are being held in a bid to make children aware of the dangers of the disease. Talks, accompanied by videos, will be given at schools and at police stations.

The campaign is aimed at residents and also at people working in the area.

The anti-TB projects end with various activities at the Macassar civic centre on Saturday.

This will start with a procession at 9am, puppet show at noon, karate demonstration at 11.15am, crawl-a-thon at 1.30pm, followed by the judging of the poster and drawing competition.

A Miss Santa beauty competition will be held there at 2pm.

HIV test link to TB 'no problem in SA'

(91)

CT 30/5/95

LISA TEMPLETON

SOUTH AFRICAN researchers say "we don't have a problem here", after false positive HIV test results in leprosy patients raised fears that the related infection tuberculosis (TB) could also yield false positive HIV results.

A study done in Kinshasa, Zaire, showed that people infected with leprosy could yield false positive results for HIV infection.

This discovery raised fears that similar false HIV positive results could be drawn from tuberculosis patients, as TB shares some of the properties of the organism which causes leprosy.

The study in Zaire set out to determine the relation between leprosy and human retroviral infections, for example Aids. The study found that a cross reaction to the HIV Elisa test could yield positive results.

Dr B Fourie, of the Medical Research Council, said in the publication Aids Scan, that the implication that "HIV-1 tests could be false positive in tuberculosis patients could be considerable".

Dr Des Martin of the National Institute of Virology, said that while an implication for positive results for Tuberculosis patients might exist it "doesn't show in [South African] TB patients" and that "we don't think that this is a problem here".

Curing TB should be a community service

(91) Star 6/6/95

IT IS a truism that TB is one of South Africa's major health problems. But are the new health care structures currently being installed easing or exacerbating this problem? Health Writer David Robbins unearths some forthright answers — and some new ideas

In Gauteng alone last year, more than 10 000 new cases of TB were notified. The situation in the Western and Eastern Cape, and especially in the old homelands, is even worse.

One of the reasons for the burgeoning epidemic is that TB sufferers don't always take their full course of tablets. This means that many of the TB bacilli in their lungs live to fight another day.

Even worse, it means that the surviving bacilli mutate into drug-resistant nasties which are impervious to all treatment.

Other reasons, of course, are poor nutrition, overcrowding, and the increasing incidence of HIV positivity which renders carriers many times more susceptible to tuberculosis infection.

"I believe that we are facing a TB epidemic which we won't be able to control," says Dr Theo Collins, a medical consultant.

He insists that the situation is aggravated by the new administrative and budgetary arrangements being established at a national level and in the nine provinces.

"Of course, the situation was pretty chaotic under the old dispensation. Having 14 different health ministries didn't help. And the control and treatment of TB has been traditionally underfunded, perhaps because it was seen primarily as a black person's disease."

But the new arrangements seem not much better. Although the directorate of communicable disease control has been retained, the money previously specifically earmarked for TB (especially for the state-run hospitals) has now been absorbed into the general provincial health budgets.

And there's no guarantee that TB services won't be affected by the general scramble to divert funds from curative to preventive and promotive care.

"New budgetary constraints at these hospitals are causing patients to be turned away," says Collins. "I know of several cases where this has happened. One woman who was diagnosed in the highly infectious stage of the disease was referred around Gauteng for six weeks before finding a clinic which would actually treat her.

"Many TB centres are under financial siege, which affects the services they provide. Santa (the South African National Tuberculosis Association) provides nearly 5 500 TB hospital beds nationwide. This service used to be funded on a patient/day tariff negotiated directly with National Health in Pretoria.

"Now the association is having to separately re—negotiate with all nine provincial health ministries. And in the present financial climate cutbacks are becoming a real threat."

Collins explained that the danger would be that health authorities might base their planning on reported cases of TB, which would rapidly bring more chaos to attempts to control the disease. Although only 2 500 deaths were officially attributed to the disease in 1994, most experts agree that the real figure was closer to 13 000.

What can be done?

Collins' response is unequivocal. "We need a dedicated budget for TB control which is administered by one central authority. The regional TB authorities should be strengthened, and dedicated TB training should be introduced for doctors and nurses to help diagnose the disease in its early stages when it is relatively easy to cure. Our diagnostic skills are notoriously poor. I've often seen lung cancer diagnosed as TB, and vice versa.

"A very real danger is that TB control is going to get lost in overall health services, especially at the primary health care level.

"It is also imperative that sufferers complete their courses of treatment once they have begun. This is the only way to begin to cope with the wave of drug-resistant TB which is threatening to engulf us."

Julia van Heerden, the director of Santa Johannesburg, explains that a system known as directly observed therapy (DOT), which assigns people on TB treatment to a network of individuals who become personally responsible for the continuity of treatment, could make an impact on the size of the epidemic.

Van Heerden talks with some enthusiasm about what she calls "the human factor".

"Perhaps our approach to the disease has been wrong in the past. We have talked almost exclusively about the epidemiology rather than the people. We need a far greater understanding of the patient; and we also need to understand his or her value in the community."

In line with this shift in thinking, Santa Johannesburg has launched a new initiative.

"We have become actively involved in consulting with our patients with regard to economic self-sufficiency via income generation programmes such as sewing for women, and brickmaking and bricklaying for the men," Van Heerden explains.

"We have also linked with the Small Business Development Corporation. The response to this initiative from the patients has been incredible. We're giving them a new purpose for living — and for completing their treatments."

At the same time, of course, Van Heerden is building up a contactable network of old TB patients in various Johannesburg communities who could later prove invaluable in providing communities with a greater insight into the causes and symptoms of the disease, and more particularly as DOT volunteers.

"It's a long-term approach. Of course we acknowledge that improved employment oportunities, diet and housing will help to reduce the alarming TB threat.

"We acknowledge that Santa should become much more of a pressure group in this regard, as well as in urging authorities to consider a dedicated TB administration and centrally controlled budget.

"But at ground level, we believe that we can make a difference by focusing some of our attention on the human factor. And we'll need all the help we can get here."

Quick READ

TB figures rising

TUBERCULOSIS and sexually transmitted diseases, including HIV, continue to be major public health problems, says the Department of Health (91)

The department's report for 1994 says TB figures are rising — 89 278 new cases were reported last year compared to 86 000 for 1993. ARG 9/6/95

Now there's a new TB sleuth

BY JANINE SIMON

Yet another new testing product — this time, a space age method which uses a single test-tube to diagnose tuberculosis in four hours — is to be launched in South Africa today. (91)

The product is one of a wave of new diagnostic tests, including a device which can test for HIV from oral fluids.

Between 140 000 and 150 000 people a year are treated for TB in South Africa. Most are diagnosed by examining a stained sputum sample under a microscope; or by growing TB cultures in the laboratory, which can take up to eight weeks.

The new test has been developed by a US company, Gen-Probe, and works by concentrating down the TB bacillus in the sample, then exploding open the cell and copying it a billion times, which means a diagnosis can be made even if only one cell is present in the sample.

Bernie Vorster of distributors Ridge Diagnostics says the test, which wholesales at about R100, can play a role as a swift, second test to confirm questionable TB cases, or to diagnose TB from fluids other than blood. Star 21/6/95

It is expected to be well received in the private sector, but is unlikely to be widely used on the public.

Sputum sample microscopy is an easy, functional test that costs only R2,50 and can immediately identify infectious cases, says Dr Karin Weyer, senior specialist scientist with the Medical Research Council's national TB research programme and a member of a working group that evaluates new tests for the disease.

New policies to control TB focus on treating smear-positive cases with direct observed therapy, the method of treatment favoured by the World Health Organisation, she added.

(2) whether he will make a statement on the matter?

N795E

The MINISTER OF JUSTICE: Mr Speaker, I apologise for the Minister of Sport and Recreation's absence. He has asked me to read his reply. If there are any follow-up questions, they will be referred to him.

(1) Yes.

According to a report in the *Pretoria News* of 22 May 1995 of an interview that ITV's Mr Trevor McDonald had with the President the latter reportedly decried the lily white nature of the team, particularly with the withdrawal of Chester Williams, and expressed the hope that it was the last South African World Cup team with such a make-up.

(2) No.

Post Office/Telkom technology used to divert/intercept cheques/funds

*50. Mr L T LANDERS asked the Minister for Posts, Telecommunications and Broadcasting:

(1) Whether any of the telecommunication services and/or allied technology of the Post Office and Telkom were used by a former South African Police captain, whose name has been furnished to his Department for the purpose of his reply, to intercept and divert cheques and funds intended for the National Union of Metalworkers of South Africa through the use of a Nedbank account in the name of Nicholas Umsa; if so, (a) on whose instructions and (b) in terms of what statutory and/or other provisions did the Post Office and Telkom act;

(2) whether he will make a statement on the matter?

N808E

The MINISTER FOR POSTS, TELECOMMUNICATIONS AND BROADCASTING:

(1) and (2) The Chief Executive of the South African Post Office, Mr Donald Masson, has informed me as follows:

On 1 November 1994 attorneys Bell, Dewar and Hall wrote a letter of demand to the Minister on behalf of the National Union of Metal Workers claiming an amount of R1 500 000 from the Minister. It was claimed that officials of the Post Office intercepted or assisted in the interception and fraudulent appropriation of monies belonging to the Union.

The Post Office rejected the allegations as vague and unsubstantiated by facts and on 15 November 1994 requested the attorneys to provide further particulars to allow for the matter to be investigated. To date nothing further has been heard from either the attorneys or the Union, nor have legal proceedings been instituted against the Post Office.

As far as the allegation of the interception of cheques and funds belonging to the Union is concerned, our enquiries from personnel who were in the service of the former Department of Posts and Telecommunications at the time of the alleged incident during 1989 have thus far produced no results. Records of that time are unfortunately also no longer available. Until such time as further information is forthcoming from the attorneys representing the Union, the matter has been put on hold.

Mr L T LANDERS: Mr Speaker, arising from the hon the Minister's reply, I want to ask him if he is aware that in the trial of former Security Police Captain Bellinghan the judge found that there was *prima facie* evidence that Captain Bellinghan had indeed been involved in the interception and misappropriation of monies of the National Union of Metalworkers of SA.

Is the hon the Minister further aware, in view of the police investigation and evidence obtained in the murder trial of Bellinghan, that the matter has been referred to a special investigation team under the auspices of the Attorney-General of the Transvaal, Jan d'Oliveira? Will the hon the Minister give this House the assurance that he will personally ensure that such an investigation will enjoy the required co-operation of everyone in the Department of Posts, Telecommunications and Broadcasting, particularly of his Director-General, who, it is alleged, was intimately involved in the NP's campaign to win the hearts and minds of the Black community?

The MINISTER FOR POSTS, TELECOMMUNICATIONS AND BROADCASTING: Mr Speaker, I am aware of the outcome of the trial of Mr Bellinghan in the Gauteng region. We are also aware of the judge's remarks and of the investigation.

It is not my place to comment on matters that are under investigation by the SAPS, but that of the relevant Minister, the Minister for Safety and Security.

I can give this House the assurance that the Department of Posts, Telecommunications and Broadcasting will give the police all the co-operation they require to get to the bottom of this matter. I also give the firm undertaking that all members of the Department will co-operate in this fashion.

Daily death-toll from tuberculosis/multiple drug resistant tuberculosis (91)

*56. Mr M J ELLIS asked the Minister for Health:

(1) (a) What is the average daily death-toll from tuberculosis, (b) what percentage of these deaths is attributable to multiple drug resistant tuberculosis, (c) what has caused the emergence of multiple drug resistant tuberculosis and (d) when did this strain first emerge in South Africa;

(2) whether any treatment is available for multiple drug resistant tuberculosis; if so, what are the relevant details?

N814E

The MINISTER FOR HEALTH:

(1) (a) About eleven (11) people per day die in South Africa from tuberculosis, (b) about 10% of these deaths are due to multiple drug resistant tuberculosis, (c) the main cause of multiple drug resistance is where treatment has been either partially or completely discontinued before cure has been achieved, (d) multiple drug resistance probably emerged soon after treatment was first started in South Africa.

(2) The accepted drugs for treating multiple drug resistant tuberculosis are available in South Africa. Good treatment is costly as it usually means specialist attention over a long period with expensive drugs and many laboratory tests. This is only available in the larger centres and depends on the availability of skilled staff at the hospital concerned.

While not denying such patients treatment, the Department of Health's primary responsibility must be to ensure that tuberculosis patients are cured the first time they are put onto treatment.

There is a major drive to do just that

— by introducing a uniform clinic register

— by improving tuberculosis laboratory facilities

— by intensive training

— by the introduction of the latest treatment regimens

— by the improvement of the management of the Tuberculosis Programme

— by improving access to health care services

— by measuring more accurately the scope of the epidemic and the outcome of treatment.

Hansard 28/6/95

Of course, to bring about a dramatic improvement in the tuberculosis situation in the country, we need more than just the work of the Department of Health. Tuberculosis is known to flourish in conditions of overcrowding, poor housing and poor nutrition. Unless we also improve these aspects of the living conditions of our people, the Department of Health will not be able to deal satisfactorily with tuberculosis in this country.

Questions transferred for oral reply in terms of Rule 202:

RDP process at provincial level: communication/interaction

*1. Mr G Q M DOIDGE asked the Minister without Portfolio: [Written Question No 279]

(1) Whether, with reference to his reply to Question No 99 on 10 April 1995 (*see* Hansard, 2 May 1995) and to certain documentation which has been furnished to his Office for the purpose of his reply, he will furnish further particulars on the issues of the (a) communication and interaction in the RDP process at provincial level, (b) involvement of active Members of Parliament at local level in the processing of business plans at local level and (c) failure of MPs to assist the RDP units and the provincial government in identifying which communities need assistance and what level and type of assistance is so needed; if not, why not; if so, what are the relevant details;

Hansard 28/6/95

MPs told of steps to cut TB increase

Political Correspondent (91)

ABOUT 11 people a day die in South Africa from tuberculosis, and deaths from multiple drug-resistant tuberculosis will increase unless urgent steps are taken, Health Minister Nkosazana Zuma has warned.

About 10 percent of TB deaths are because of multiple drug-resistant tuberculosis, caused by interrupting or stopping treatment before the disease is cured.

Replying yesterday in the national assembly to questions by Mike Ellis (DP), Dr Zuma said drugs for treating multiple drug-resistant TB were available in South Africa, but treatment was costly because it meant specialist attention for a long time with expensive drugs and several laboratory tests.

This was available only in larger centres, and success depended on the availibility of skilled staff at the hospital.

Steps to boost treatment included: ARG 30/6/95

- Introducing a uniform clinic register.
- Improving TB laboratory facilities.
- Intensive training.
- Introducing the latest treatments.
- Improving the management of the TB programme.
- Improving access to health care centres.
- More accurate measuring of the scope of the epidemic and the outcome of treatment.

Hansard

(91)

issue within the ambit of the Minister of Education.

Tuberculosis: treatment/prevention

420. Dr I M CACHALIA asked the Minister for Health:

(1) Whether any data has been collected and/or estimates have been made by her Department in respect of the total expenditure on (a) preventive measures against and (b) the treatment of tuberculosis by (i) (aa) public and (bb) private sector health services and (ii) voluntary organisations; if not, why not; if so, what are the relevant details in each case;

(2) whether any structures exist to ensure the involvement of other relevant government departments in developing and implementing strategies to combat tuberculosis; if not, what is the position in this regard; if so, what structures;

(3) whether her Department has (a) developed or is developing reduction targets in respect of (i) the number of tuberculosis cases notified and/or (ii) mortality rates and (b) adopted any specific policies aimed at reducing the levels of tuberculosis amongst the so-called Coloured population in the Province of the Western Cape; if not, why not; if so, what are the relevant details in each case;

(4) whether her Department has held discussions with members of the Western Cape provincial administration in regard to measures to reduce the incidence of tuberculosis in the province; if so, what are the relevant details;

(5) whether her Department has considered the need to earmark any of the budget allocations to provincial administrations for the specific treatment and prevention of tuberculosis; if so, what are the relevant details?

N895E

The MINISTER FOR HEALTH:

(1) The total expenditure on tuberculosis is estimated as follows:

(a) Preventative measures

(i) (aa) *Public sector*
BCG vaccine and health education material, not including staff time R4 million

(bb) *Private Sector Health Services*
Mines, chest X-rays, chemoprophylaxis R6 million

(ii) *Voluntary organisations*
* South African National Tuberculosis Association (SANTA) and
* The Community Health Association of Southern Africa (CHASA) Health Education programmes R5,5 million

(b) Treatment of tuberculosis

(i) (aa) *Public Sector*
Tuberculosis drugs R37 million
Provincial tuberculosis beds R60 million
Outpatient care R30 million

(bb) *Private Health Sector*
Mine and Life Care Hospitals R116 million

(ii) *Voluntary organisations*
SANTA R73 million
TOTAL R331,5 million

Other costs include the treatment of tuberculosis cases in non-tuberculosis hospitals, for example academic and rural (formally homeland) hospitals, the treatment of multidrug resistant tuberculosis and tuberculosis research. The total expenditure is over R400 million per year, most of which is funded directly or indirectly out of the Health Budget.

(2) There is a national Tuberculosis Advisory Group. Members include representatives of the Medical Research Council, universities, voluntary organisations and provincial tuberculosis coordinating committees.

The provincial tuberculosis coordinating committees consist of local health authorities, academics, non-governmental organisations and members of the community.

Coordinating with other government departments occurs when the needs arise, for example consultation on welfare grants. Intersectorial consultation occurs mostly at local government level. It is envisioned that the new local and regional government structures will facilitate easier cooperation between health and housing, for example.

(3) (a) The target of the Tuberculosis Control Programme in South Africa is:

* to cure 85% of the detected smear positive tuberculosis cases and to detect 70% of existing cases by the year 2000.

The programme in South Africa is in line with the World Health Organization's global programme against tuberculosis. The aim is to have a uniform tuberculosis policy framework for the whole country. Management and training systems are at present being put into place in order to ensure a working and measurable tuberculosis programme which is also integrated into the Primary Health Care approach of the Department.

(b) In the Western Cape the following measures have been introduced:

* A greatly improved information system which will more accurately measure tends in the epidemic and cure rates.
* Training of staff with special emphasis on a more client orientated approach in order to encourage patients to complete their treatment and facilitate community involvement.
* The Provincial Health Department is cooperating with the community-based projects of SANTA, CHASA and the Medical Research Council (MRC).
* Laboratory services are being improved especially to provide more rapid communication of results.

(4) The Western Cape Provincial Administration is represented on the Tuberculosis Advisory Group where strategies to reduce tuberculosis are discussed at regular meetings.

Good informal communication occurs between those involved at provincial and central levels. The provincial Tuberculosis Coordinating Committee in the Western Cape is attended by senior officials of the central Department of Health.

(5) The provincial health departments have agreed to earmark funding for tuberculosis drugs in accordance to the new tuberculosis treatment regimens. The total budget for all nine provinces is about R37 million.

Doctors: inquiries/criminal charges

430. Mr M J ELLIS asked the Minister for Health:

(1) whether any inquiries were instituted by the South African Medical and Dental Council in terms of section 41 of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No 56 of 1974), into allegations of improper or disgraceful conduct by doctors in (a) 1993 and (b) 1994; if so, (i) how many (aa) inquiries were held in each of these years and (bb) doctors had their (aaa) names removed from the register and (bbb) registration suspended as a result of these inquiries in each of these years and (ii) what were the principal grounds on which doctors had their (aa) names removed from the register and (bb) registration suspended;

(2) whether any criminal charges were laid against any doctors in (a) 1993 and (b) 1994; if so, (i) how many, (ii) how many of these resulted in convictions and (iii) what were the principal grounds on which doctors were convicted?

N914E

The MINISTER FOR HEALTH:

(1) (a) 1993: Yes.

(b) 1994: Yes.

(i) (aa) 1993 Medical 78; Dental 13

R400 million in fight against TB

CT 18/8/95 (91)

SOUTH AFRICA would spend more than R400 million fighting TB during the current financial year and special steps had been taken in the Western Cape, the Minister of Health, Dr Nkosazana Zuma, said on Wednesday.

Jabs can't prevent deadly TB strain

ST(m) 20/8/95 (91)

By CAS St LEGER

THE anti-tuberculosis vaccine given to babies in South Africa is failing to protect children against a deadly strain which can cause blindness, deafness and paralysis, says Dr Theo Collins, a leading consultant for the SA National Tuberculosis Association.

Dr Collins said this week a study by Tygerberg Hospital had found eight of every 10 children who had developed TB meningitis, a serious type of TB, had been vaccinated against TB.

"No anti-TB vaccine anywhere in the world is 100 percent effective," said Dr Collins. There had been 400 recorded cases of TB meningitis in 1993.

Symptoms start with a high fever, headaches, fits and vomiting — which could be confused with symptoms of many other illnesses.

"Parents living in a high TB area like the Western Cape should be aware that, even if their children have been vaccinated against TB, they might still get TB meningitis," said Dr Collins.

The Tygerberg Hospital study showed that between 1985 and 1992 at least 161 children (83 percent) had developed TB meningitis despite receiving the vaccine.

Dr Collins said that despite the vaccine's failure to protect against this serious strain of TB, it was still worthwhile continuing the vaccination programme to protect against ordinary TB.

The vaccine is imported from Japan, as is the nine-needle injection gun used to deliver the dose. Japan had a good record in preventing TB in that country, Dr Collins said.

He believed one reason for the apparent failure of the vaccine was the injection gun. The original type had broader needles which delivered a larger dose. This type was dropped because of sterilisation difficulties when AIDS appeared.

The department was considering changing the needles to make the vaccination more effective.

Gencor AIDS toll one a day

(91)

Kathryn Strachan

THIRTY workers at Gencor were dying of AIDS each month, chairman Brian Gilbertson said on Friday.

Gencor's medical personnel had estimated that about 20% of the workforce of about 100 000 on its gold, platinum and coal mines were infected with the HIV virus. The figure was probably higher in Richard's Bay where the company had significant investments.

"We are very concerned," he said. "It actually hits home when people working for us are dying at this rate."

There was also a marked increase in tuberculosis sufferers, a rising number of whom were HIV positive. This increased the cost of treatment and would have a significant effect on health services.

"The loss of these skilled people will eventually impact on companies and on the national economy ... the losses are growing," he said.

Gilbertson said Gencor ran awareness programmes, but these seemed to have been no more successful than they had been elsewhere.

"The question now is how to deal compassionately with the numbers that will

BD 4/9/95

Continued on Page 2

AIDS (91)

Continued from Page 1

BD 4/9/95

become sick and with their dependants," he said. "We don't have any perfect solutions, but we are trying to develop an integrated and comprehensive approach."

AIDS was emerging as a far more life-threatening factor than mine accidents. Pre-employment screening had not been proposed, he said. In any case it did not address the basic problem and the existing infection in the workforce.

The government health department's HIV/AIDS programme director Quarraisha Abdool Karim said that with the introduction of HIV infection into SA in about 1987, and with about 2-million people infected, it was not suprising that the country was now starting to see people dying of AIDS-related diseases.

Migrant workers and their spouses were three to five times more at risk of HIV infection, she said. Social conditions on the mines such as single sex hospitals, the presence of prostitutes, and the distance from a stable family life, all placed migrants at greater risk.

She said despite the high levels of infection, there was still potential for intervention such as awareness programmes and condom distribution. The problem with awareness programmes in the mining industry was that they had been imposed by management and had not been implemented in consultation with workers — and were therefore viewed with suspicion.

An integrated approach and a programme which was sensitive to workers was needed, she said.

Kevin O'Grady reports that Cosatu assistant general secretary Zwelinzima Vavi said on Friday that companies responsible for housing labourers in hostels should pay for their medical treatment when they became infected with AIDS and should compensate their families for lost income.

He was addressing a Chemical Workers' Industrial Union conference on health, safety and the environment.

The time had come for Cosatu to make a "decisive intervention" on the AIDS issue because "thousands of our members and members of society are on a daily basis being infected with this disease", he said.

"The cruel and inhuman bosses who enjoyed the benefits of apartheid's migrant labour system, single sex hostels and influx control are now turning their backs on the consequences of the life they imposed on workers," said Vavi.

New TB menace emerges

LAWRENCE ALTMAN of the New York Times News Service reports from Washington

(91) ARG 21/9/95

FIFTY years after tuberculosis became curable, a worldwide surge in drug-resistant strains of the disease is occurring not just because of the limits of medical science but also because of the profit motives of pharmaceutical companies, experts at an international meeting here last week said.

There are more cases of tuberculosis today than ever worldwide. At least two million people die from it each year, many from strains of the bacteria that have become resistant to the available drugs.

Yet, even though new drugs have been developed and are ready for testing, pharmaceutical companies are unwilling to invest the money it would take to bring them to market, said participants at the meeting, which was sponsored by the Lancet, an international medical journal published in London.

Pharmaceutical companies have asserted that it can cost more than $200-million to bring a new drug to market. Critics have questioned the accounting the companies used to arrive at this figure.

Many participants, in all 250 experts from 40 countries, also strongly criticized the World Health Organization, a UN agency in Geneva, for spending minuscule amounts on tuberculosis after declaring it a "global health emergency."

While it was the first time the agency had so designated any disease, it spent only $800,000 of its $1-billion annual budget on tuberculosis. It also spent $4.6 million from other sources on tuberculosis last year.

The tuberculosis bacterium that has infected 1,75-billion people worldwide. It makes 8-million people sick each year and its death toll of 2-million, out of the 50-million people who die worldwide each year, makes it the leading killer among infectious diseases, the World Health Organization has said.

An overwhelming majority of cases occur in developing countries; fewer than 10 percent occur in developed countries.

Some strains in the United States have become resistant to the seven standard drugs. The resistance problem also has gained a foothold in third world countries, where its threat is even greater because it is less likely to be monitored and drugs are available without prescription, leading to overuse and misuse.

The worsening problem reflects a lack of political leadership in battling the disease, a soaring world population that lives under crowded conditions, and, to a lesser extent, its occurrence as a complication of AIDS, participants said.

Council helps families of terminally ill

(91) Star 25/9/95

■ BY HOPEWELL RADEBE
CITY REPORTER

The Brakpan Town Council has started a R100 000 feeding scheme for families whose breadwinner suffers from a terminal disease like AIDS.

Acting Town Clerk Andre Ludick said the feeding scheme started operating at the beginning of August after the council made provision for R100 000 in its 1995/96 budget.

Ludick said the council was presently the only financial contributor to the scheme, although volunteers were assisting with food distribution.

"However, the scheme's duration would depend on the decisions made by the new council after the local government elections," he said.

"Since the need is so big, beneficiaries are very grateful and don't really complain," he added.

Ludick said it was easy for the council to compile a register with the names of family members suffering from these diseases because its health department was running various programmes aimed at educating sufferers of diseases such as AIDS and tuberculosis.

Before any person qualifies to benefit from the scheme, social workers conduct a thorough investigation of their specific situation.

Single tablet concept could aid TB sufferers

BD 26/9/95 (91)

Kathryn Strachan

A BREAKTHROUGH in TB control could follow from a new pharmaceutical industry initiative to combine all the necessary medicines in a single tablet, an international expert on the disease said on Friday.

Colorado University medical Prof John Sbarbaro is advisor to the UN World Health Organisation.

On his visit to SA to promote the new concept in drug manufacturing, Sbarbaro said the biggest problem in controlling TB was the lack of compliance by patients. The TB cure is complicated as it required about 10 tablets a day over a period of six months. Patients begin to feel much better in the early stages of treatment and frequently stop taking the medicine as they do not see the point. Thus the patient remains infected, possibly with an organism which has now become drug-resistant, and spreads the bacteria.

Patients treated for drug-resistant TB faced a 50% mortality rate, while TB treatment applied with supervision had a success rate of more than 95%.

The range of pills also confuse patients, who often skip out the pills they do not like. For this reason, Sbarbaro said the only effective approach to overcoming the problem was combination tablets which were administered directly by nurses.

This message came out of the global TB conference, held in Paris last week. Non-adherence by patients and health providers were listed as the biggest TB control problems facing this century.

A single tablet makes the process easier for the patient, thereby increasing the chances of the medicine being taken properly, and fewer drugs mean less problems with supplying clinics with stock.

On Friday SA-based Lederle Laboratories introduced the first triple drug compound, containing the new ingredient ethambutol.

TB accounts for 26% of avoidable deaths in adults in the developing world. During this decade about 30-million people are expected to die from the disease.

The WHO forecasts a 58% increase in the incidence of TB between 1990 and 2005. Almost all TB deaths will occur in developing countries.

In SA 234 per 100 000 people develop active TB each year, as opposed to 10 per 100 000 in the US. Up to 7 000 South Africans die from TB each year.

New treatment for osteoporosis

Kathryn Strachan

THE first non-hormonal drug for the treatment of osteoporosis in postmenopausal women is to be launched in SA today.

Alendronate sodium (the generic classification) is the first in a class of medicines called aminobisphosphonates, being developed as a non-hormonal treatment. Aminobisphosphonates decrease the rate of bone resorption — the process by which bone is broken down. After menopause, the rate of bone resorption accelerates, thinning bones by reducing bone mineral density and leaving them more susceptible to fracture.

In clinical trials conducted for three years, involving 994 postmenopausal women with osteoporosis in 16 countries, alendronate was shown to increase bone mass and reduced by nearly half the risk of spinal fractures.

In these trials the drug has generally been well tolerated.

Bone-thinning osteoporosis affects about 300 000 South Africans and 140-million women world-wide. One out of every two women over the age of 55 and one in eight men are likely to have an osteoporosis related fracture — most commonly of the vertebrae, wrist and hip — in their lifetime.

The health cost is huge: about $10bn a year in the US alone.

Tuberculosis kills 7 000 a year in SA

(91) BD 27/9/95

Kathryn Strachan

SA HAD one of the highest incidence rates of tuberculosis worldwide, with up to 7 000 people dying from it each year, a symposium held last week heard.

In SA 100 000 new cases were reported each year. The high incidence rate was highlighted in a comparison with the US, where the SA rate was 23 times higher.

UN World Health Organisation consultant on tuberculosis, John Sbarbaro, who is in SA to promote new ways of controlling the disease, told the symposium the disease accounted for 26% of avoidable deaths in adults in the developing world. During the 1990s about 30-million people would die from it.

The organisation had forecast a 58% increase in the incidence of tuberculosis during the period between 1990 and 2005, and almost all these deaths would occur in developing countries.

On a geographical basis, the incidence increased from Gauteng towards the Western Cape. And with AIDS bringing out latent tuberculosis infection, the statistics would only worsen. The Medical Research Council predicted that it would be the largest killer of HIV-positive patients by 2000.

Other factors leading to an increase in tuberculosis infection were the emerging strain of multi-drug-resistant tuberculosis and the fact that control programmes were poorly managed.

Rapid urbanisation and poverty had exacerbated the problem, with overcrowding, poorly ventilated dwellings and work environments, such as mines and factories, enhancing its spread.

Workers were often afraid of being dismissed from their jobs when they contracted the disease. However, health authorities had urged companies to treat infected workers, who remained fit enough to perform their duties. Negative spin-offs from treating patients at the workplace would be slight, while the benefits to the individual would be immense. The costs to the company of training new workers would also make dismissal counter-productive.

Government had made tuberculosis control a priority of its reconstruction and development programme, and was spending R600m a year on the disease.

Investment streaming into KwaZulu

BD 27/9/95

Nicola Jenvey

DURBAN — The KwaZulu-Natal marketing initiative had already attracted new foreign investments worth R214m, compared with a targeted R640m before February 1998, chairman Peet Marais said yesterday.

The organisation promotes the comparative advantages of investing in this region to local and foreign businesses, working on a 50-50 partnership basis with the provincial government.

Addressing a dinner after the marketing initiative's annual meeting last night, Marais said a strategic inward investment marketing programme had been devised in February which demanded that R640m be invested within three years. It was estimated that 155 new projects would be created over that period.

"KwaZulu-Natal is getting its fair share of the (foreign investment) market and indications are that these targets will be met. However, government plays a pivotal role in designing and implementing investor-friendly policies," Marais said.

Government had to become "true partners" with the private sector to promote strategies which sustained economic growth, ensured SA achieved an improved international investor rating, provided a tax regime conducive to high returns on investment and increased competitiveness. Exchange controls had to be abolished, the rand exchange rate kept stable and law and order restored.

Marais said KwaZulu-Natal had attracted 36,4% of the new investment projects — local and foreign — approved by the Board for Regional Industrial Development since August 1991.

When only foreign investments were considered, the province had attracted 53,8% of the board's projects approved for SA.

From January last year to August this year, 119 new projects were approved for KwaZulu-Natal with the marketing initiative facilitating 47%. These investments were expected to generate R774m for the province and to create 8 920 new job opportunities.

Marais said 60% of foreign projects attracted to the region had originated in Taiwan or the People's Republic of China. The remainder had been spread throughout the rest of the world.

Drug firms accused of abetting TB's resurgence

(91) Star 14/10/

15

By LAWRENCE ALTMAN

Washington – Fifty years after tuberculosis became curable, a worldwide surge in drug-resistant strains of the disease is occurring not just because of the limits of medical science, but also because of the profit motives of pharmaceutical companies, experts claimed at an international meeting in Washington recently.

There are more cases of tuberculosis today than ever, worldwide. At least 2 million people die from it each year, many from strains of the bacteria that have become resistant to the available drugs.

Yet, even though new drugs have been developed and are ready for testing, pharmaceutical companies are unwilling to invest the money it would take to bring them to market, said participants at the meeting, which was sponsored by *The Lancet*, the international medical journal published in London.

Pharmaceutical companies have asserted that it can cost more than $200 million to bring a new drug to the market. Critics have questioned the accounting used to arrive at is figure.

Many participants – in all 250 experts from 40 countries – also strongly criticised the World Health Organisation for spending minuscule amounts on tuberculosis after declaring it a "global health emergency." Tuberculosis bacteria make 8 million people sick each year and its death toll of 2 million, out of the 50 million people who die worldwide each year, makes it the leading killer among infectious diseases, the World Health Organisation says.

Most cases occur in developing countries; fewer than 10% occur in developed countries. In the United States, for example, there were about 26 000 new cases of active tuberculosis reported last year. Participants at the conference said drug company officials had told them that the low number of cases in the US represented too small a market to warrant large investments.

Some strains in the US have become resistant to the seven standard drugs. The resistance problem also has gained a foothold in third world countries, where its threat is even greater because it is less likely to be monitored and drugs are available without prescription, leading to abuse.

The worsening problem reflects a lack of political leadership in battling the disease, a soaring world population that lives under crowded conditions, and, to a lesser extent, its occurrence as a complication of AIDS, participants said.

Although most tuberculosis is still curable, "millions of infected people do not have access to existing drugs that do work", Dr Barry R Bloom, an international leader in TB research from the Albert Einstein Medical School in the Bronx said at the meeting

Because tuberculosis is communicable, "the benefits of treatment are not just to the patient, but to society", Dr Philip C Hopewell of the San Francisco General Hospital said.

Dr Earl S Hershfeld of the University of Manitoba, said: "Politicians in developed countries need to understand that tuberculosis in developing countries will affect citizens in developed countries through spread from travel and immigration, and so the political will must begin at home."

Yet, Dr Lee Reichman, executive director of the National Tuberculosis Centre at the New Jersey Medical School in Newark, said at the meeting that when he briefed a New Jersey political leader about a growing tuberculosis problem in that state, the elected official, whom he did not name, said: "My constituents don't get TB!"

The political indifference translates into considerable neglect by scientific and public health organisations of a serious health problem – tuberculosis is second to cigarettes as "the most lethal agent" known, said Dr William Foege of the Carter Centre in Atlanta and a former director of the Centres for Disease Control and Prevention.

"As costly as drugs are, the World Bank has said tuberculosis is one of the most cost-effective diseases to treat, and yet it is surprising there is so much trouble selling control," Foege said in an interview. – New York Times News Service

5% of TB patients 'are drug-resistant'

(91) CT 24/10/95

ABOUT five percent of Tuberculosis patients are infected with a strain that is resistant to the drugs most often used to treat the disease, says National Virology Institute head Dr Barry Schoub.

Presenting the South African picture on Aids to the British Medical Association's conference in Cape Town, he said multi-drug resistant TB was a looming problem in the country.

Between six percent and 20% of newly diagnosed TB patients were HIV-positive and of these, five to eight percent developed active TB.

The incidence rate of TB in 1995 was 226 per 100 000 people, predominantly in the black population.

"In the coloured population of the Western Cape, the incidence figure is even higher — 680 per 100 000 in males and 500 per 100 000 in females — one of the highest rates in the world," Dr Schoub said. — Sapa

Wisdom – and science – needed to fight TB

CT 25/10/95 (91)

STAFF REPORTER

SCIENCE is necessary but not enough in the treatment of tuberculosis — economic, political and other social issues must also be addressed.

Professor Solomon Benatar, head of the Department of Medicine at UCT, said this at the British Medical Association's overseas clinical congress being held at the Cape Sun this week.

He said tuberculosis remained a major health problem world-wide and it could become untreatable with the emergence of multi-drug resistance or because effective drugs could become so expensive.

He said the inability to control tuberculosis despite scientific progress, which has made it possible to treat and cure almost any tuberculosis patient, illustrates the need also to address economic, political and social issues.

"Failure to address these issues has adverse implications for industrialised and developing countries and their citizens."

He said the disparity between industrial countries and developing countries was widening — in 1990, 77% of the population lived in the developing world and this figure was expected to increase to 88% by the year 2100.

He said wisdom was needed to restructure society — as well as scientific knowledge.

Provincial Minister of Health and Welfare Services Mr Ebrahim Rasool made a surprise visit to the congress yesterday to hear Professor Benatar's address.

Call to tackle TB causes, not cures

ARG 26/10/95 (91)

JENNY VIALL
Health Reporter

TACKLING the problem of tuberculosis will require more than medical science, which is necessary but not enough in an interdependent world.

Solomon Benatar, head of medicine at the University of Cape Town, said this at the British Medical Association's Clinical Congress in Cape Town.

He said that with the emergence of multi-drug resistance, tuberculosis could become an untreatable disease in the future, in spite of scientific advances that had made it possible to treat and cure individual cases.

Economic, political and social forces had to be addressed to enable scientific advances to be effectively implemented in an increasingly interdependent world, said Professor Benatar.

The changing world order would hopefully see wisdom replacing knowledge, and interdependence replacing independence.

Professor Benatar said science had to be linked with other components of human development for it to be successful.

A new economic world order that linked financial aid to sustainable development was also necessary.

Tuberculosis was still a major health problem worldwide, with an estimated one-third of the world's population infected with it.

Every year saw eight-million new sufferers, more than 95 percent of these in developing countries.

HIV infection also was increasing the proportion of those in whom infection would progress to tuberculosis disease.

Professor Benatar said tuberculosis could become untreatable because of the unavailability of effective drugs, or because these were so expensive and had to be given for such prolonged periods that only the richest would be able to afford treatment.

"The opportunity to treat tuberculosis effectively is within our capabilities, yet less than 50 percent of people have adequate access to TB therapy," he said.

Mobile lab new weapon against TB

ARG 21/11/95 (91)

The South African Institute for Medical Research (SAIMR) is evaluating its latest weapon in the desperate war against tuberculosis — a made-to-order demountable mobile laboratory carried on a rugged one-ton bakkie.

Demountable units have been used as mobile clinics for years, but this is the first to be converted into a fully equipped laboratory, complete with microscope, safety cabinet, fridge, gas points and other equipment, according to Clive Mallen, MD of the manufacturing company.

The independently-powered unit's main advantage is that it allows laboratory analysis of specimens, and so, too, immediate treatment.

SA receives priority from TB initiative

Kathryn Strachan (91)

BD 6/12/95

SA WILL be the first country prioritised in the World Health Organisation's TB initiative to be launched next year.

The Global Tuberculosis Education Fund will form partnerships with key governments in the developing world. In its strategy of reaching out to leaders with unusual moral, political or financial clout in their regions, SA has been chosen as the first area of activity because of President Nelson Mandela's standing — and the fact that he is "the most famous TB victim alive".

The fund aims to raise awareness of the disease, educating politicians, communities and health workers about the extent of the epidemic and the cost-effective solutions which exist to control it, as well as raise funds worldwide.

Two years ago about 40% of the population in southern Africa was infected with TB. Weak primary health care systems, high levels of migration and the heavy effect of the AIDS epidemic have combined to worsen the TB situation in southern Africa.

According to the WHO, donor governments need to provide a minimum of 0,2% of their foreign aid budgets to help the worst affected countries establish TB control programmes. Badly administered control programmes, however, could encourage the spread of multidrug-resistant strains of TB.

WEDNESDAY
DECEMBER 6, 1995 ★

DOCTORS WARN OF COMPLACENCY

Childhood diseases on the way back

CT 6/12/95 (91)

LONDON: The struggle to control childhood diseases is facing a setback as changing lifestyles expose children to old and new diseases, UK doctors have warned.

CHILDHOOD infections, thought to have been beaten by immunisation and better health standards, are on the way back and doctors are not adequately prepared to deal with them, the British Paediatric Association warned yesterday.

Foreign travel was causing more cases of malaria in Britain, tuberculosis was increasing and the outbreak of diphtheria in eastern Europe posed a risk to visitors.

In Britain, the number of children with Aids — inherited from HIV-positive mothers — was set to double by the end of the decade and recent fatal cases of meningococcal disease resulted in the temporary closure of a school.

Professor Roy Meadow of St James' Hospital in Leeds said immunisation and antibiotics had lulled doctors into a false sense of security.

Infections

He said: "We have got a little bit complacent because doctors have got used to the idea nowadays that accidents cause more childhood deaths than infections."

The association has produced a Manual of Childhood Infections listing nearly 80 infections, their symptoms, methods of diagnosis and treatment.

Emerging, or re-emerging, infections are said to include ebola fever, plague, tuberculosis, haemolytic uraemic syndrome and ringworm.

"All require that doctors know how to recognise and respond to both exotic and common infections," said the association.

Professor Alexander Campbell, chairman of the National Joint Committee of Vaccination and Immunisation, said: "Despite the outstanding successes in control of childhood infectious disease, any complacency about infection and its control has been severely shaken by recent events.

"The rapid growth of air travel means that we must be as aware of the epidemiology of infection in other countries as we are of events in our own back yard." — The Telegraph plc

CHILD MALNUTRITION A MAJOR PROBLEM

SA's generation of stunted children

(90) CT 7/12/95

THE SHOCK FINDINGS of a national health survey reveal that South African children exhibit high rates of malnutrition.
BARRY STREEK reports.

MORE than 1,5 million children in South Africa are stunted because of long-term malnutrition, a national health survey has found.

It was also estimated that 660 000 preschool children were identifiably malnourished.

These shock findings underline the nutritional importance of the national primary school-feeding scheme, which was initiated by President Nelson Mandela in one of his first acts when he took office on May last year.

The primary school nutritional feeding scheme is now known as one of the RDP's presidential lead projects.

The survey of 11 430 children nationwide found that almost one in four children was stunted and one in ten underweight.

The results of the survey, which was sponsored by the Department of Health and the United Nations Children's Fund (Unicef), have been published in the latest edition of Epidemiological Comments, which is published by the Department of Health.

"According to international criteria, stunting is a major problem in the country, especially in some provinces and, in general, it was more prevalent in rural than in urban communities, in children living in traditional or informal type of housing and in those whose mothers were less well educated," the survey said.

It also found that one in three children had a marginal vitamin A status and this "indentifies the country as having a serious public health problem of vitamin A deficiency".

Anaemic

Another finding was that one in five children was anaemic, one in 15 moderately anaemic and one in 500 severely anaemic, while one in ten children were iron depleted or deficient, one in 20 severely iron depleted or deficient and one in 20 had iron deficiency anaemia.

The medical researchers involved called for a national high dose vitamin capsule distribution programme to be instituted, starting with the provinces at highest risk.

The Department of Health should also investigate the feasibility of establishing and maintaining a nationally valid sampling frame for children, they said.

HEALTH & DISEASE

TB

1997

Student unrest at universities/technikons

*34. Mr T D LEE asked the Minister of Education: [Written Question No 580]

How many cases of student unrest occurring on (a) university and (b) technikon campuses in South Africa were brought to his attention during the period 1 January 1996 up to the latest specified date for which information is available? N966E

The MINISTER OF EDUCATION:

Information in this regard is available for the period 1 August 1996 to 9 July 1997 only. The cases of student unrest being mentioned, must be regarded as major incidents that the Department is aware of:

(a) 9 cases on university campuses.

(b) 10 cases on technikon campuses.

Employees leaving service as result of voluntary retirement/packages/transfers

*35. Mr N J GOGOTYA asked the Minister of Defence: [Written Question No 589]

(a) How many employees left his Ministry during the period 1 January 1996 up to the latest specified date for which information is available, as a result of (i) voluntary retirement, (ii) retirement packages, (iii) transfers from his Ministry and (iv) retrenchment packages and (b) what position did each of these persons hold? N975E

The MINISTER OF DEFENCE:

(a) Since 1 January 1996 thirteen members of the staff at the Ministry of Defence left the service of the Ministry.

(i) One assistant private secretary and two drivers left the Ministry for other employment.

(ii) One assistant private secretary took a voluntary severance package.

(iii) Eight members were transferred back to their Arms of Service having completed their tour of duty at the Ministry.

(b) One member demilitarised to take up a post as Director Conventional Arms Control on the staff of the Secretary for Defence.

*36. Mr A WATSON – Finance. [Written Question No 595] [Removed.]

Provinces: houses built

*37. Mr J A RABIE asked the Minister of Housing: [Written Question No 600]

(a) In 1996 and (b) during the period 1 January 1997 up to the latest specified date for which information is available, (i) how many houses were built in each of the provinces, (ii) what was the breakdown in respect of the various housing fund schemes which were used and (iii) how many individual ownership subsidies were granted? N986E

The MINISTER OF HOUSING:

(a) (i) and (b) (i) The Department, through its Nomvula system, collects statistics of houses completed or under construction in the provinces. The system does not differentiate between 1996 and 1997 figures and hence it is only possible to provide a holistic figure in respect of houses completed or under construction since the inception of the Government's subsidy system in 1994.

Since March 1994 until 30 June 1997 a total of 300 983 houses were already built or under construction in the provinces.

A breakdown for each province is as follows:

Eastern Cape:	25 727
Free State:	24 154
Gauteng:	81 425
KwaZulu-Natal:	40 921
Mpumalanga:	22 181
Northern Cape:	10 771
Northern Province:	22 079
Western Cape:	38 224

(a) (ii) and (b) (ii) The total rand value in respect of the various housing subsidy schemes since March 1994 until December 1996 and the period from January 1997 until the end of June 1997 is as follows:

Period	Project linked (reserved)	Project linked (beneficiaries)	Individual	Credit linked (savings route)	Consolidation (reserved)	Consolidation (Beneficiaries)	Institutional (reserved)	Institutional (Institutions)
15/3/94 - 31/12/96	352 130	90 498	39 386	35	29 513	5 155	1 042	13
1/1/97 - 30/6 /97	242 675	36 023	18 311	1	4 128	6 956	1 076	320

(a) (iii) and (b) (iii) During 1996 a total of 106 692 individual subsidies (project linked and individual subsidies) were approved by the nine provincial housing boards in respect of beneficiaries that bought residential properties.

I would also like to indicate that since 15 March 1994 until 31 December 1996, 352 130 project linked subsidies have been reserved by the provincial housing boards in more than 660 projects that were approved by the PHBs.

*38. Mr K M ANDREW – Finance. [Written Question No 609] [Removed].

*39. Mr J A JORDAAN – Public Works. [Written Question No 631] [Question standing over.]

SA Schools Act published in newspapers

*40. Mr R S SCHOEMAN asked the Minister of Education:† [Written Question No 632]

(a) In (i) which and (ii) how many newspapers did the supplement on the South African Schools Act, 1996 (Act No 84 of 1996), appear in April and May 1997, (b) what is the circulation of each such newspaper, (c) in which languages was the supplement published and (d) what did the costs of publishing the supplement amount to? N1072E

The MINISTER OF EDUCATION:

(a) (i) and (ii) The supplement on the South African Schools Act, 1996 (Act No 84 of 1996), appeared in 14 newspapers, namely: The Star, Beeld, Cape Argus, Die Burger, the Daily News, the Volksblad, the Sowetan, Eastern Province Herald, Diamond Fields Advertiser, Daily Dispatch, Indaba, Chalk Line, City Press and The Teacher. Because of the costs involved, it was not possible to insert into all the major daily newspapers. A selection to ensure country-wide coverage within this constraint was necessary and it was hoped that this selection would meet that requirement.

(b) The circulation of each newspaper is as follows:*

– The Star	156 358
– Beeld	110 311
– Cape Argus	82 142
– Die Burger	94 193
– Daily News	72 130
– Volksblad	28 261
– Sowetan	211 178
– EP Herald	32 193
– DF Advertiser	7 368
– Daily Dispatch	38 546
– The Indaba	36 814
– Chalk Line	50 000
– City Press	262 214
– The Teacher	125 000

* Information obtained from the April 1997 edition of South African Rates and Data (SARAD), the Guide to Media Selection.

(c) The supplement was published in English and Afrikaans.

(d) The total cost amounted to R697 592,72. This includes the research, writing design, illustrating, proofing, translation, printing, freighting and insertion into the above newspapers, and the printing and freighting of an additional 200 000 copies for distribution on demand.

Provinces: tuberculosis

*41. Mrs P W CUPIDO asked the Minister of Health: [Written Question No 637]

(a) How many cases of tuberculosis were reported in each of the provinces (i) in 1996 and (ii) during the period 1 January 1997 up to

the latest specified date for which information is available and (b) what was the percentage increase or decrease in the incidence of tuberculosis in 1996 as against (i) 1994 and (ii) 1995? N1077E

The MINISTER OF HEALTH:

(a) (i) Provincial distribution of reported TB cases for 1996, as on 3 August 1997

Province	*Number of cases*
Eastern Cape	22 322
Mpumalanga	2 167
KwaZulu/Natal	11 995
Northern Cape	2 834
Northern Province	3 305
North West	4 099
Free State	8 621
Gauteng	10 326
Western Cape	17 260
Total	82 929

(ii) Provincial distribution of reported cases for 1997 as on 30 April 1997

Province	*Number of cases reported*
Eastern Cape	3 451
Mpumalanga	817
KwaZulu/Natal	2 275
Northern Cape	126
Northern Province	443
North West	1 829
Free State	2 528
Gauteng	3 180
Western Cape	3 419
Total	18 068

(b) Percentage of decrease of TB incidences in South Africa for 1996 as compared to 1994 and 1995

Year	Number of reported cases	% of variation as compared to 1996
1994		
1995	73 532	
1996	97 997	33%

Source: Provincial Health Departments, April 1997

Social pensions not received monthly

*42. Mr P C MCKENZIE asked the Minister for Welfare and Population Development:† [Written Question No 639]

(1) Whether any persons who are lawfully entitled to social pensions and to whom pensions have indeed already been paid out, are currently not receiving their pensions monthly; if not, what is the position in this regard; if so, (a) how many, (b) what are the reasons therefor and (c) in respect of what date is this information furnished;

(2) whether any steps are envisaged to rectify this situation; if not, why not; if so, (a) what steps and (b) when;

(3) whether any steps are envisaged to help pensioners who for months now have not been receiving any income; if not, why not; if so, what steps? N1079E

The MINISTER FOR WELFARE AND POPULATION DEVELOPMENT:

(1) Yes,

(a) exact figures are not available, as the reasons for non-payment may vary as explained in paragraph (b),

(b) there are various reasons for a beneficiary not receiving payment. This can range from:

* the beneficiary not collecting his or her grant
* incorrect bank account numbers supplied by beneficiaries
* system functionality
* provincial network problems
* data integrity problems
* the grant lapsed after the beneficiary failed to collect benefits for three consecutive months

The following reports on specific cases were received from the provinces:

In the Eastern Cape the benefits of approximately 32 000 lapsed before the systems of the ex-Transkei and ex-Ciskei could be amalgamated onto the transverse computer system.

In the Northern Cape 78 records were rejected by the system as they did not comply with system requirements and vouchers were not generated in respect of 1 996 cases, because the beneficiaries have either passed away, the grant was cancelled or children in respect of whom a maintenance grant was paid, left school.

In Mpumalanga 583 beneficiaries did not receive payment, because they have not claimed their grants for three months and

(c) for the month of May 1997;

(2) yes,

(a) the Eastern Cape Department Welfare has re-instated 1 300 of these cases and are investigating the rest to determine whether they still qualify for a grant.

The Northern Cape Department of Health and Developmental Social Welfare has been engaged in a process to encourage those beneficiaries who are encountering problems with their payments to contact their respective regional offices.

Mpumalanga is in the process of investigation and reinstating the cases concerned.

The national and provincial welfare departments are continuously testing the computer system in order to improve its functionality. The national Department of Welfare is conducting an investigation to improve network and communication facilities.

A national project has been launched to address data integrity problems. This entails the re-registration of all beneficiaries to eliminate duplicate and invalid records taken on during amalgamation, the enrichment of data and a review of the transverse social grants system and

(b) continuously.

(3) social relief is issued. Some of the provinces employed contract workers to deal with backlogs and other provinces set up central sites where applications are captured and enquiries dealt with.

Department: foreign advisers

*43. Mr P I BIKITSHA asked the Minister of Trade and Industry: [Written Question No 643]

(1) Whether any foreign advisers are currently involved in projects for his Department; if so, (a) how many, (b) what are the particulars of these projects and (c) which countries are involved in these projects;

(2) whether any foreign countries have made grants towards these projects; if so, (a) which countries and (b) what is the (i) nature and (ii) extent of such grants;

(3) what is the total cost of these projects to the Government? N1083E

The MINISTER OF TRADE AND INDUSTRY:

(1) (a) 3 foreign advisers

(b) (i) Capacity building for Centre for Small Business Promotion (CSBP) – National Small Business Strategy (USA)

(ii) Khula Enterprise Finance Limited (European Union)

(iii) Computerisation Patents Offices Word (France)

(c) USA
European Union
France

(2) (a) USA
United Nations Development Programme

(b) (i) USA: Assistance to DTI for access and ownership of assets by disadvantaged South Africans.

UNDP: Capacity building in small business

(ii) USA: US$2 500 000 over three years

UNDP: US$760 000 over three years

(3) South Africa has to make an in-kind contribution of US$833 333 and R2 000 000 respectively covering office space, staff time and equipment.

HEALTH & DISEASE

- TUBERCULOSIS -

1998 - 1999

Controlling AIDS, TB is Shisana's priority

(91) BD 28/1/98

Josey Ballenger

HEALTH director-general Olive Shisana yesterday announced her department's objectives for the year at a conference in Midrand.

Controlling communicable diseases, continuing to improve access to health services, augmenting the health information system and stepping up antiviolence initiatives would be priorities this year, she said.

At a health care symposium organised by the Institute for International Research, Shisana said the department was drafting the Tobacco Control Bill to "further discourage" tobacco use by children in line with World Health Organisation recommendations.

Shisana said research by the Medical Research Council and the Human Sciences Research Council showed the prevalence of smoking in SA had decreased by 2% in 1996 from the previous year, which meant about 500 000 fewer smokers.

The control of the spread of AIDS, as well as the treatment of sexually transmitted diseases, would be priorities. Government aimed to control the prevalence of tuberculosis and reach an 85% cure rate and would expand its programme in each province. The control and treatment of mosquito-borne diseases, especially in malaria-prone KwaZulu-Natal, Mpumalanga and Northern Province, was also vital.

One of three "key" pieces of legislation to be presented to Parliament this year would be the National Health Bill, which would provide a framework for the policies outlined in the white paper on the transformation of the health system.

She said the controversial Medical Schemes Amendment Bill aimed to contain costs and ensure beneficiaries were "able to obtain a basic package of care that is affordable".

On access to health care, Shisana said measures would be implemented to contain the cost of drugs. These included establishing a new Medicines Control Council and a pricing committee, controlling the theft of drugs from public institutions and the licensing of pharmacies and dispensing doctors.

Strategies to improve the health information system would continue, including the disease surveillance system, and birth and death notification.

Shisana said antiviolence initiatives would be provided including surveillance, referral centres and empowerment and trauma counselling courses for health care personnel.

DP agrees on regulating health care

BD 28/1/98

Josey Ballenger

DEMOCRATIC Party health spokesman Mike Ellis said yesterday he agreed with the health department that the private sector needed regulation to provide affordable and accessible health care for all, but questioned how government proposed doing so.

At a health care symposium in Midrand organised by the Institute for International Research, Ellis said steps needed to be taken to reduce or prevent abuse in regulating the sector.

"If it is to be regulated and legislated against to such an extent that it becomes little more than an effete extension of the public health care sector and cannot operate freely, then I believe we will face the collapse of the entire health service in this country".

He accused Health Minister Nkosazana Zuma of not adequately collaborating with the private sector on health bills last year and said the "pattern" looked set to continue.

IN BRIEF

Tuberculosis control programme 'unfocused'

(91)

SA'S tuberculosis control programme was unfocused and only four out of every 10 patients were being treated effectively, the health department said yesterday. BD 5/3/98

Head of communicable disease control Dr Neil Cameron said the department intended improving the rate of patients cured by adopting an internationally renowned control strategy.

This approach required health workers to ensure that patients were directly observed for at least the first two months of their treatment.

The epidemic of tuberculosis, which is almost fully curable, kills about 1 000 people each month in SA.

CAPE ARGUS, THURSDAY, MARCH 5, 1998

Joining the dots in fight against TB

(91)

ARG 5/3/98

Pretoria – South Africa's tuberculosis control programme was unfocussed and only four out of every 10 patients were being treated effectively, the Department of Health said yesterday.

"This shows poor performance," said Dr Neil Cameron, head of communicable disease control.

"A visit by international experts at the end of last year showed that the TB control programme was moving slowly and not well focussed."

He said the department intended adopting a control strategy known as the Directly Observed Treatment Short-course (DOTS).

This approach required health workers to ensure that patients were directly observed for at least the first two months of their treatment.

The department aimed to achieve this in at least a third of the country's clinics by December.

Tuberculosis, which is totally curable, kills about 1000 people a month in South Africa. – Sapa

Top medical academics back council on Virodene

ADELE BALEIA (92)

ARG 14/3

South Africa's leading medical academics have thrown their weight behind the Medicines Control Council in the Virodene row after an attack on the council by Deputy President Mbeki.

The academics said yesterday they were greatly concerned by the "political interferences" in the function of the statutory body.

The heads of departments of medicine at the five medical schools in South Africa have called for an urgent commission of inquiry into the controversy over the AIDS drug Virodene PO58.

Their statement follows Mr Mbeki's attack on the council for "censoring" research on Virodene and refusing to allow clinical trials to go ahead.

The council has refused to bow to pressure from the Government to use the "unsafe" drug in trials on people with the human immuno-deficiency virus or AIDS until the researchers follow the correct protocol and submit their research to peer review.

In a signed letter, the academics in the departments of medicine at the universities of Cape Town, Stellenbosch, Natal, Witwatersrand and Medunsa said: "This council has an admirable record in its dealing with many complex issues over many decades.

"Its concern for the health of individuals and the health of the public is beyond question and it has served the South African public with the highest degree of integrity under the leadership of its chairman, Professor Peter Folb."

The academics said public confidence in the council should not be undermined by anything other than "documented factual information".

Professor Folb has said the council "must be left to do its work according to proper standards that will offer reasonable prospects to patients and prevent their being exploited".

The Medical Association of South Africa (Masa) has called for an end to the debate surrounding the drug.

The organisation said it supported Health Minister Nkosazana Zuma in her commitment to stem the AIDS epidemic and had advised her to seek conclusive answers on the drug's efficacy as quickly as possible.

"From a scientific point of view, we need to know: does Virodene work or not? This can be achieved by way of acceptable scientific protocols and entrenching ethical principles," Masa said in a statement.

Song and dance over Virodene: page 20

Britain's Princess Anne chats to forest rangers of the National Banco Park, north of Abidjan in Ivory Coast, on Monday. The princess arrived on Sunday for a three-day visit at the invitation of the Ivory Coast head of state.
PIC: AFP

Drive to highlight Aids, TB

By Mokgadi Pela

THE Black National Conference of Review (BNCR) is to hold country-wide workshops from April to highlight the seriousness of tuberculosis and HIV in South Africa.

BNCR spokesman Mr Tsepo Sibusi said the workshops would be held in informal settlements, mining areas, rural areas and other places still to be identified.

He said: "We will enlist the help of our health desk, experts, labour unions, non-governmental organisations and all relevant role players in the struggle against the twin evils of TB and Aids.

"We have already established links with trade unions operating in mining areas in places as far afield as the Northern Cape and the Penge asbestos mine in Northern Province."

Sibusi said political parties should join the Government in its efforts to rid the country of the scourge of HIV and TB through programmes.

"Considering that sub-Saharan Africa accounts for more than 66 percent of HIV cases in the world, we have to act fast before it's too late. The BNCR will, therefore, become an active participant in the struggle against Aids and TB," Sibusi said.

Figures provided by Health Minister Nkosazana Zuma from antenatal surveys show a national average of 16 percent compared to last year's 14 percent.

Sibusi called on organisations and individuals wishing to take part in the campaign to contact the BNCR at (011) 333-2032.

Sowetan 18/3/98

SA under fire over lack of progress in treating TB

(91)

ARG 20/3/98

Data not provided

TYRONE SEALE
FOREIGN SERVICE

London – South Africa has been labelled by the World Health Organisation (WHO) as one of 16 countries threatening global efforts to control tuberculosis.

South Africa is among eight middle to upper-income countries where TB control is questioned, even although these countries have the finances to combat the infection described by WHO as a global emergency.

Members of a WHO ad hoc committee that has surveyed measures against TB in 212 countries reported here yesterday that progress being made against the global TB epidemic in most countries was satisfactory, but was not in many of the 22 countries with most of the world's TB cases.

South Africa was listed 12th among the 22 most problematic countries, and part of the country's poor showing could be put down to the government not providing the WHO with full data on progress in the implementation nationally over the past two years of the directly observed treatment, short-course (Dots) strategy.

More than 1,7-million patients had received effective Dots treatment since this strategy was introduced globally.

In parts of China, 96% of new patients had been cured, while in Peru widespread use of Dots for more than five years had seen 91% of patients cured and a reduction in the spread of the disease.

But, WHO was concerned that in spite of political commitment demonstrated by the national and provincial health ministries in South Africa, co-ordinators had not yet been nominated in all the provinces.

While the Government spent half a billion rand on treating TB every year, funds were misdirected to hospitalising patients for long periods, and to the treatment of multi-drug-resistant (MDR) TB cases.

Kraig Klaudt, head of the policy unit of the WHO global TB programme, said that while the resistant TB in South Africa accounted for less than 2% of the total infections, it absorbed a third of the national TB budget.

Drugs used to treat resistant TB were 100 times more expensive than those for conventional strains.

Mr Klaudt believed that more money spent on prevention automatically would reduce the demand for resistant TB intervention.

He also criticised the national TB programme for over-emphasis on hospitalisation, which, he said, took breadwinners out of the economy and added to the poor socio-economic conditions in which TB thrived.

"We have been perplexed about why the South African government has moved so slowly.

"The resources and sound minds are available, but yet little progress is being made."

Mr Klaudt said that while the decentralisation of health services was helpful in approaching other public health risks, TB required stricter central control and monitoring.

His view was echoed by Emmanuel Kasonde, a member of an ad hoc committee and former Zambian finance minister, who said South Africa and its neighbours needed to co-operate closer in equipping health strategists with the managerial skills to beat the TB epidemic.

TB epidemic out of control — WHO

LONDON: A tuberculosis epidemic is out of control in many countries and unless urgent action is taken, nearly one billion more people will become infected and 70 million will die by the year 2020, the World Health Organisation says.

"The TB epidemic is now increasing in many countries, with devastating consequences," the WHO said.

"This year, more people will die of TB than in any other year in history."

At a three-day meeting which ended yesterday, public health and tuberculosis experts assessed whether 22 countries which account for 80% of the world's TB cases were making progress in controlling the infectious disease.

The WHO identified 16 countries lagging in TB control, including South Africa, Russia, Thailand, Brazil, Iran, Mexico, the Philippines and Indonesia.

It said that because of the backsliders, the WHO target of detecting 70% of cases and curing 85% by 2000 would not be met.

"Some governments did not take the WHO's declaration of a global TB emergency seriously," Dr Arata Kochi, head of the WHO's Global TB Programme, told a news conference.

"Countries that did — such as Bangladesh, Vietnam and Peru — are making excellent progress toward controlling TB."

The other eight countries cited for inadequate control measures are Afghanistan, Ethiopia, India, Myanmar (Burma), Nigeria, Pakistan, Sudan and Uganda.

Only three of the 22 countries would reach the WHO target by 2000 — Vietnam, Tanzania and Peru. Three others — China, Congo and Bangladesh — had made significant progress, the WHO said.

The WHO experts concluded that "insufficient political will to control TB is the greatest single constraint to progress".

Tuberculosis, which attacks mainly the lungs, intestines, skin and brain, is a bigger killer than malaria and Aids combined, and kills more women than all the combined causes of maternal mortality.

Every year, between two and three million people die from TB, including 100 000 children.

In 1993, the WHO, in an unprecedented step, declared tuberculosis a global emergency. Between 1993 and 1996, TB cases increased 13% worldwide.

The WHO said there were nearly three million new TB cases in South-East Asia every year and nearly two million in sub-Saharan Africa.

Over a quarter of a million new cases occur annually in Eastern Europe, where TB deaths are rising after almost 40 years of steady decline. — Sapa-AP

(91) CT 20/3/98

SA a prime culprit

PRETORIA: South Africa is re-orienting its TB programme to improve monitoring, says the Department of Health's director of communicable disease control.

Dr Neil Cameron said yesterday that the department had reviewed its TB programme in 1996 with the assistance of two World Health Organisation consultants and the International Union Against Tuberculosis.

South Africa had started implementing the new WHO global programme, which aimed to detect 70% of cases and cure 85% by the year 2000. But the department had found that changes at clinic level were slow.

Cameron said about 102 000 TB cases were reported in 1996. The figure was expected to be higher for 1997.

Cameron agreed with a WHO assessment that South Africa was one of 16 countries lagging in TB control and that the country was one of the 22 worst affected by the disease. — Sapa

'Struggling' SA to observe TB day

(91)

Sowetan 23/3/98

By Mokgadi Pela

SOUTH Africa's tuberculosis epidemic will once again come to the fore when the country joins the rest of the world in observing World TB Day tomorrow.

This is at a time when South Africa has been identified with those countries that have failed to curb the disease.

Only last week, the World Health Organisation (WHO) declared in London that South Africa was among 16 countries in the world struggling to control TB.

The WHO said "lack of progress in these countries is threatening global TB control efforts".

The WHO said global TB control targets for 2000 would not be met because the 16 countries had moved too slowly in using Directly Observed Treatment Shortcourse (Dots), a strategy proven to be effective in controlling TB.

These countries are the source of over half of the world's seven million annual TB cases.

Insiders say the Ministry of Health hopes to encourage health workers to commit themselves to Dots, to ensure patients take and complete their six to eight months' treatment.

A study conducted by international experts in 1997 showed that the TB control programme was moving slowly because the ministry was effectively only managing four out of 10 infected TB patients in all health facilities.

The ministry has committed itself to address this situation as a matter of urgency.

Experts say TB is completely curable if the patient completes the Dots programme. If completed without interruption, the patient is unlikely to be infected again.

Experts further say interrupted medication taking can lead to multi drug resistance, which is the stage where a patient becomes sick again because the body may have developed resistance to the TB drugs they had taken before.

Already, over 1 000 South Africans die of TB each month.

Language board supports Omar

Sowetan 23/3/98

By Saint Molakeng

THE Pan South African Language Board (PSALB) is excited that Justice Minister Dullah Omar made history by introducing a bill in Xhosa before Parliament last week.

It was the first legislation to be set down in a language other than English or Afrikaans.

The bill is titled Umthetho Oyilwayo Wofakelo Silungiso Kwimibandela Yasenkundleni, Xhosa for the Judicial Matters Amendment Bill. The three-page legislation constitutes technical amendments to certain existing laws.

PSALB chairperson Professor Nxalati Golele said the change should be regarded as a significant step towards multilingualism.

"We are happy Parliament has set a good example which proves that it supports multilingualism," Golele said.

Previously Golele complained to *Sowetan* that Parliament failed to implement multilingualism as spelt out in the Constitution.

"If Parliament uses African languages, citizens will appreciate that all languages are equal. People have been wondering when language equity would be practised."

"Everyone should be allowed to use languages of their choice. People should learn African languages to reverse the prevailing expectations that only Africans have to learn European languages."

Golele suggested that Parliament and Government bodies should establish translation facilities for indigenous languages to enjoy the same freedom as Afrikaans and English.

Although the National Party supported Omar's move, it questioned his timing as a meeting on language policy was scheduled for this week.

Judgment day today

JUDGMENT in the case of three policemen accused of stealing R2 million in a raid on a Lenasia businessman's house in 1995 will be passed in the Soweto Regional Court today.

Johan Beukes (30), of Norwood in Johannesburg, Kenneth Tshikalanga (28), of Tshiawelo in Soweto, and Morne Coetzee (26), of Krugersdorp on the West Rand, are out on bail of R10 000 each.

A fourth accused, Thamabran Naidoo (44) of Lenasia, who is a relative of Mr Viyandrakamar Naidoo, whose house was allegedly raided by the three policemen, had charges against him withdrawn.

According to the state, the three policemen visited the businessman's house on November 25 1995 and told his wife they were from the Durban diamond and gold unit and that they believed her husband was dealing illegally in gold and diamonds.

They then searched the house and allegedly stole R2 million. – *Sowetan Reporter.*

TB research gets R80m funding

(91)

UK-BASED pharmaceutical group Glaxo Wellcome would support five more years of tuberculosis (TB) research in SA through its programme Action TB with funding of more than R80m, group chairman Richard Sykes said yesterday.

The programme, which aims to find a more effective drug for TB, is the largest investment in basic TB research by a pharmaceutical company in the world.

New centre tackles TB treatment problems

(91)

Josey Ballenger

BD 24/3/98

THE fight against tuberculosis (TB) will get a boost from the Medical Research Council's establishment of a reference centre to make treatment more tolerant to patients — and develop drugs' compliance with new international standards, the council said yesterday.

"Our goal is to improve the quality of TB medication, while at the same time simplifying it for patients who have to take up to 24 tablets every day for six months," said Bernard Fourie, director of the council's national TB research programme. Fourie will co-ordinate the centre.

The announcement came as a precursor to today's World TB Awareness Day.

Fourie said the centre would work toward developing fixed-dose "combination therapy" which could reduce the number of tablets to a maximum of five a day. Because the treatment is lengthy and patients are often deceived by almost immediate improved health, failure to complete treatment is high. This leads to patients' continuing to infect other people and possibly developing multidrug-resistant TB, which is fatal in about 70% of cases.

The centre would also test whether current and prospective drugs satisfy requirements of the Medicines Control Council and international regulatory authorities. Most available medicines are not licensed for international guidelines released last year by the World Health Organisation.

Fourie said "good, accurate, timely diagnosis" and effective treatment were essential in the fight against TB, a curable disease which nonetheless afflicts SA more than any other country. An estimated 160 000 South Africans became infected last year, 10% of whom were children.

Tuesday March 24 1998 **SOWETAN**

'Battle against TB can now be won'

(91)

By Mokgadi Pela

A LEADING medical scientist has expressed confidence that, by employing the right strategies, South Africa would reduce the impact of tuberculosis on the health service and the economy.

The director of the Medical Research Council's (MRC) National TB Research Programme, Dr Bernard Fourie, said on the eve of World TB Day (March 24) that already four provinces had shown improvement in reducing the impact of TB.

"This they have done by implementing the Directly Observed Treatment Shortcourse (Dots), an internationally renowned TB control strategy," Fourie said. The provinces are Mpumalanga, Northern Province, Western Cape and North West.

Fourie was addressing the media in Midrand, Johannesburg, at a function to announce the establishment of the MRC's Reference Centre for the Chemotherapy of Mycobacterial Diseases. The centre will be used to evaluate new and current drugs for TB.

He conceded that TB had reached epidemic proportions in South Africa, with rates of up to 60 times higher than those currently seen in the United States or Western Europe.

Last year, the country had an estimated burden of 160 000 newly reported cases, and MRC researchers predict that if current trends continue, about 3,5 million people will contract TB in the next 10 years.

Fourie said: "Not all is doom and gloom in South Africa as results of the four provinces indicate." It was up to six other provinces to move fast in the battle against TB.

Sowetan 24/3/98

Govt firmly behind the fight against TB

(91) CT 24/3/98

ROBB NORTHEY

PRETORIA: While South Africa lies near the bottom of the class on the World Health Organisation's (WHO) latest tuberculosis report card, the country's researchers have something the rest of Africa's doctors want — real government backing.

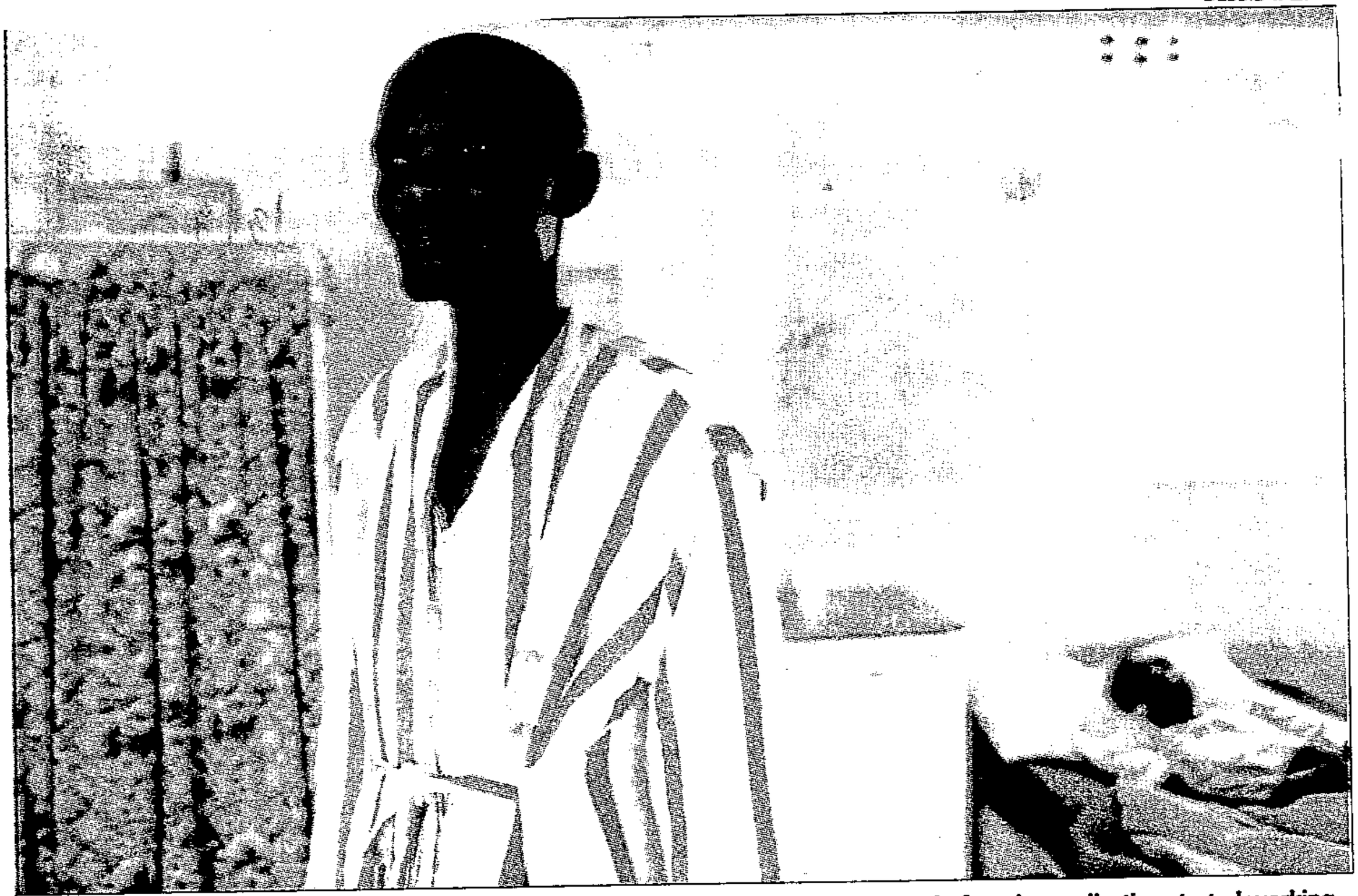
And South African researchers are playing a key role in fighting TB in Southern Africa.

Their involvement in the Southern African TB Control Initiative is helping both the poorer countries in the region and South Africans.

The sub-region is among the worst-affected areas in the world, with an average of 198 out of every 100 000 people in the region reported to be suffering from the disease.

Globally, the average is only 60 cases per 100 000 people.

The ball now lies in the provincial health authorities' court, according to Dr Refiloe Matji of the Department of Health. Funding, she says, has already been provided for by Health Minister Nkosazana Zuma.



Feeling strong ... tuberculosis patient Jetro Ncube believes he was practically a dead man before the medication started working.

Treatment has given sufferer new lease of life

Star 24/3/98 (91)

By Areso Thom

Jetro Ncube (42) believes he has been given a second lease of life after being diagnosed with tuberculosis eight months ago.

"I was dying, but now I am strong," Ncube said.

He contracted TB while working on a Boksburg mine in 1979.

"I had constant pain in my chest, but the mine hospital never diagnosed TB," he said.

Ncube was later admitted to Johannesburg Hospital after being correctly diagnosed.

Two months later he was transferred to the SA National Tuberculosis Association's hospital in Soweto.

Santa's hospital is not a hive of activity. TB patients seem to wander around slowly, their frail bodies in hospital-issue gowns. They sit in little groups, not saying much, mostly staring into space.

In the wards, small, huddled bundles under blankets are the only indication of life.

Clutching his fists to his side, Ncube tries to explain what having TB is like.

"You have no power, you feel weak, you cough and you sweat. You feel as if you are dying, as if you are already dead."

Ncube said the symptoms started in 1979 when he worked at the mine. Eventually, 18 years later, a doctor told him he was suffering from TB.

Sitting next to Ncube on a bench is Andries Motlhabane (51), a panelbeater from Potchefstroom. He is being treated for the second time.

"I was treated for the first time in 1967. I made the mistake of returning to my job, spray-painting cars, and the TB returned," he said.

"When I started feeling weak and the coughing returned, I knew what was wrong. It is really painful when you cough. Your lungs feel as though they are being ripped from your chest."

Motlhabane said his younger brother had also contracted the disease while working at the same panelbeater.

Motlhabane has been receiving treatment at Santa since January. Before that he was treated at Potchefstroom Hospital.

"The TB medication is good. It really works," he added.

"I am shy to tell other people that I have TB because they might reject me, but that just drives me to take my medication and get better," Motlhabane said.

Ncube indicated that he would be returning to his job as a petrol station supervisor, but as for Motlhabane, he said he sees no other option but to go on pension.

State support helps doctors to fight TB

(91) Star 24/3/98

Most sufferers in South Africa are male and in their 30s, with up to half of them also being infected with HIV

By Robb Northey

South African researchers are playing a key role in fighting TB in southern Africa. Their involvement in the Southern African TB Control Initiative is helping poorer countries in the region and South Africans afflicted by the disease.

TB is a bacterial scourge that primarily attacks the lungs, killing off the tissue and leaving big holes. This means that there is less surface area through which oxygen can pass from the inhaled air into the bloodstream.

The World Health Organisation's Dr Eddie Maganu says this form, known as pulmonary TB, afflicts about 85% of TB sufferers. In the other 15% of cases, the bacteria attacks the lining, or meninges, of the brain; the bones – especially the hip and vertebrae; or, less often, several parts of the body at the same time.

The subregion has an average of 198 out of every 100 000 people suffering from the disease. Globally, the average is only 60 cases per 100 000 people, says the Southern African TB Control Initiative.

In South Africa, the WHO estimates that in 1996 only 78% of infectious TB cases were detected by health authorities.

Dr Refiloe Matji, of the Department of Health, told the 12th conference of the Africa Region of the International Union Against TB and Lung Disease in Nairobi last week that 102 952 patients had been treated for TB in 1996 with a cure rate of only 52%. She said a cure rate of 85% was the target of most TB workers.

Most of these sufferers were male, in their 30s, with up to 50% of them also infected with HIV, said Dr Karin Weyer of the Medical Research Council in Pretoria.

For many of Africa's doctors, the battle ground has shifted from finding a cost-effective cure to getting government backing and funds to set up the administrative systems needed to cover all of a country's population. But in South Africa the problem is to establish the administrative back-up system needed to combat the disease effectively.

Back-up system is needed

Most countries in sub-Saharan Africa use the WHO's Dots programme – Directly Observed Treatment Short-course – to treat patients.

This involves patients undergoing at least six months' treatment with medication being taken daily for the first two months, watched by a health worker. After that, the patient takes home a month's supply of medicine at a time. The Dots treatment is cheaper, more effective and easier than isolating patients in sanatoria for up to 18 months.

Having adopted the Dots programme only in 1996, the country can expect to see an improvement in results within the next few years as more health districts implement the Dots strategy. The ball now lies in the provincial health authorities' court, said Matji. Funding for the programme, she says, has already been provided for by Health Minister Nkosazana Zuma.

Yet only four provinces have full-time TB co-ordinators, with another three provinces having temporary staff assigned to TB programmes, Matji said.

By last year, 15 demonstration districts had been set up, but only three of these were running well. Those in the Western Cape and Mpumalanga achieved cure rates of 85% in patients who had never had TB before, Matji added.

The national Health Department said in a statement it hoped to increase the number of functional district programmes to 90 by the end of this year.

Dr Matji said part of the problem was that TB control programmes fell under the control of provincial governments and that there was no direct control at national level.

She added that the provinces were delaying the implementation of programmes at district and regional levels.

Tuesday March 24 1998

Department of Health renews attack

(91) Star 24/3/98

By Aeso Thom
Health Reporter

The Department of Health will mark World TB Day today by renewing its attack on this curable disease that is estimated to have killed about 13 000 people every year in South Africa – one person every 40 minutes.

The rising Aids problem is compounding the endemic nature of TB. HIV attacks the immune system, making the body vulnerable to TB.

Head of communicable disease control Dr Neil Cameron said the Health Department intended improving the cure rate for TB patients by adopting an internationally renowned control strategy known as the Directly Observed Treatment Short-course (Dots).

This approach requires health workers to ensure that patients are directly observed for at least the first two months of their treatment.

"We want to use Dots to ensure that at least nine out of 10 patients test negative for all traces of TB infection in their sputum after treatment for a period of two to three months," Cameron said.

Patients tend to stop taking their treatment as soon as they start feeling better, exposing themselves to the risk of sustaining a more serious drug-resistant TB.

Interrupted medication taking could lead to multi-drug-resistant TB (MDR-TB), which is the stage when a patient becomes sick again because the body might have developed resistance to the TB drugs taken before.

There are 2 000 new cases of MDR-TB each month, with more than half of these patients dying within two years.

Killer-in-a-cough tops list

Star 24/3/98 (93)

A few facts about TB:

- TB is a bigger killer than malaria and Aids combined, and kills more women than all the combined causes of maternal mortality.
- Someone in the world is infected with TB every second.
- TB kills about 10 000 South Africans each year, mainly young men and women.
- Women are more vulnerable to TB during pregnancy because pregnancy lowers their immune system.
- HIV patients are more prone to developing TB.
- TB is the most common opportunistic infection and the biggest killer of people with Aids.
- Last year there were 2,2 billion people infected with TB and 30,6 million with HIV in the world.
- More than 2 500 HIV-positive people died of TB in 1996 in South Africa.
- TB is spread through coughing. A person who is sick with TB and is not on treatment coughs TB germs into the air and another person breathes them in.
- Signs and symptoms of TB include coughing for more than three weeks, loss of appetite and weight loss, night sweats, tiredness, chest pain and coughing blood.
- TB patients on appropriate treatment are not infectious.

I have TB infection, says Health Minister Zuma

CLIVE SAWYER (91) ARG 25/3/98
POLITICAL CORRESPONDENT

Health Minister Nkosazana Zuma has a special understanding of people with tuberculosis – she has the infection herself.

Dr Zuma made the disclosure in the National Council of Provinces yesterday, International Tuberculosis Day.

She was replying to questions during debate on the Adjustment Appropriation Bill, the annual opportunity for members to question ministers on their budgets.

William Mnisi, a Democratic Party delegate from Gauteng, said South Africa was one of 16 countries which did not comply with standards of TB control.

He asked whether Dr Zuma would use additional funds in her budget for improving the "shocking" standards of control of the disease.

Acknowledging that the country was not dealing with TB as it should, Dr Zuma said the reasons for this were historical.

If people did not have proper shelter or nourishment, they were prey to TB.

"The average black South African has the TB infection. I have," the minister said.

A person's immune system could fight off the disease, but poor nutrition or AIDS would allow TB to flourish.

Historically, the previous government had not taken steps to ensure TB was diagnosed quickly enough, and there had been no programme to supervise people to ensure that they took their medicine.

Health authorities had now begun implementing DOT – directly observed therapy – by putting a family member or friend in charge of ensuring that a patient completed a course of TB medicine.

POOR BELIEVE IT IS BETTER TO HAVE TB THAN LOSE STATE ASSISTANCE

Patients avoid medication to keep grants

(91) CT 25/3/98

CARE WORKERS are having difficulty persuading some TB sufferers to keep up their treatment, costing the government a fortune in disability grants. **JUDY DAMON** reports.

IN a tragic twist, impoverished families are avoiding lifesaving tuberculosis treatment to keep their disability grants.

Western Cape director of TB Care are Mrs Ria Grant says most sufferers live in extreme poverty and "probably have never seen that amount of money before", tempting them to default on TB treatments.

Before grants are issued, patients must be too ill to work and have to produce a medical certificate from a doctor or clinic. If they qualify, the government gives patients R470 plus a R100-a-child allowance each month.

Grant said: "The money is about 10 times more than what they are used to getting for the odd jobs they do.

"They believe it is better to be diseased than it is to be well once they see how much money they can get."

A "dependency syndrome" develops as the patient can now demand state support, she said.

Senior administrator for social services in Athlone Mr Clive Goldman, who issues grants, said he knew of at least 30 patients who had defaulted on treatment to keep their grants.

"They stop taking medication, show no co-operation with the clinics and do not complete their medical certificates after visits," Goldman said.

TB Care worker Mrs Mariette Williams said that once a sufferer skipped treatment, the immune system became resistant to regular TB medication — making the TB germ stronger and harder to kill.

"The sufferer was labelled as a multi-drug resistant patient and an alternative medication had to be found."

Resistant patients spread this stronger germ to other people and an early death could be inevitable without proper treatment.

Drug resistant TB can take up to two years to cure making the treatment much more expensive and costing the government more in extended disability grants.

Patients were closely monitored by their doctors and risked losing their grants — and hopes of being eligible again — if they were caught forfeiting treatment, other TB care workers said.

Grants were also cancelled if it was found that patients abused drugs and alcohol.

'The money is about 10 times more than what they are used to getting.'

Each week at least three patients lost their monthly government support, they said.

Goldman said that his department was going through a major "clean and update" process of patients' files to smoke out defaulters and unforeseen errors that had crept into the system.

Some patients started to default on taking medication when, after about three months of treatment, they no longer experienced the troublesome TB symptoms. This resulted in their becoming ill again.

TB Care workers said the cancellation of grants demoralised their patients and the counselling process had to begin all over again.

"They feel the state has forsaken them and that they will die anyway, so why bother. Only after we stress the utmost importance of treatment and when they become sick again, will they continue with treatment," Williams said.

WORLD TB DAY: Community treatment supporters from Ravensmead joined hands and sang at a World TB Day rally in Athlone Stadium yesterday.

PICTURE: THEMBINKOSI DWAYISA

TB remains the world's No 1 killer

CT 25/3/98 (91)

JUDY DAMON

WORLD TB Day is not a celebration. In spite of scientific breakthroughs, it is still the No 1 killer in the world — sending at least 13 000 South Africans to their graves each year.

A 1996 health report stated that 4 954 people had died of TB in the Western Cape alone.

Director of TB Care in the Western Cape Mrs Ria Grant said the epidemic would quadruple in the next 10 years if TB was not managed effectively.

The Aids epidemic is magnifying the TB scourge. In 1995 one in every four people who developed TB did so because they were HIV positive. At least half of all new cases are contagious and will spread the disease to an average of 10 other people each year.

However, with the implementation of the simple but effective Dots (directly observed treatments) programme, TB can be stopped in its tracks and save the government a fortune in treatment and disability funds.

Dots requires a specially trained person, at work, school or home, to supervise care of sufferers and watch patients swallow their tablets over a six-month treatment period.

So far Dots is working like magic, but a lack of funds threatens to cancel this lifesaving programme.

TB Care worker Mrs Mariette Williams said that they were spending at least R13 000 a month to maintain the four Dots clinics in Manenberg, Langa, Guguletu and Retreat.

"We approached the RDP for money — but that turned out to be a big joke. The request went from desk to desk and we were eventually promised R52 000, but when it was time for payment, they had no money."

She said TB Care had applied everywhere for funds to keep the project afloat, but with little success.

The Dots programme has the potential to wipe out tuberculosis, Williams said.

Treatment plan spans Africa

(91) CT 25/3/98

ROBB NORTHEY

PRETORIA: The Southern Africa TB Control Initiative (SATCI) is breaking the bonds of political boundaries to co-ordinate the fight against TB on a regional basis.

Stretching from Tanzania to the tip of Africa, SATCI representatives in 11 countries are in constant contact, sharing experiences, advice and resources to ensure that TB sufferers stand a better chance of surviving and recovering.

First mooted in 1993 in Mozambique by Dr Bernard Fourie of the South African Medical Research Council, TB programme managers met in Botswana in 1994 to discuss their co-operation and a year later, in Namibia, they formalised the organisation with the involvement of senior government officials from all 11 countries.

The member states are Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania, Zambia, Zimbabwe and South Africa.

Their example was followed by the establishment last week of a West Africa TB Control Initiative.

For a country like South Africa, which only relatively recently adopted the World Health Organisation's DOTS (directly observed treatments) regimen, the advantage of co-operating with Botswana and Mozambique, which have well-established TB programmes, is clear.

Lessons learned painfully in those countries can be swiftly adapted and implemented here.

For other countries, South Africa's infrastructure and access to advanced medical resources are also a boon.

There are plans to standardise on the drugs and dosages used in the treatment of TB and to co-ordinate the buying of drugs which would result in a cheaper price due to the size of the orders.

Standardising on treatment means that TB sufferers can go anywhere on the sub-continent and continue being treated in the same way.

This is an important consideration when one considers that much of the region's labour force travels to South Africa to work in the mines. Researchers in Botswana have found that the incidence of drug resistant TB is higher among people who have worked in South African mines.

Dr Eddie Maganu of the WHO warned that the governments of member states had still not taken full ownership, and that the organisation, while powerful, could only do so much on its own.

In this respect, SATCI aims to work as a unit in encouraging individual governments in the region to focus their attention on TB.

At a recent SATCI council meeting, national TB programme managers said they were committed to turning South Africa into a demonstration region for DOTS implementation. Dr Fourie and colleague Dr Karin Weyer predicted in a recent analysis of TB trends that by 2001 the incidence of TB could rise from 198 cases per 100 000 to 681 cases per 100 000 members of the population.

Sixty-nine percent of these new cases would be directly attributable to HIV-infection.

Zuma has personal bond with TB sufferers

Star 25/3/98

(91)

Political Staff

Health Minister Dr Nkosazana Zuma has a special understanding of people living with tuberculosis – she bears the infection herself.

Zuma made the revelation in the National Council of Provinces yesterday, on International Tuberculosis Day.

She was replying to questions during debate on the Adjustment Appropriation Bill, the annual opportunity for council members to put questions to ministers on their budgets.

Gauteng DP delegate William Mnisi said South Africa was one of 16 countries which did not comply with standards for TB control.

He asked whether Zuma would use additional funds in her budget to improve the "shocking" control standards for the disease.

Acknowledging that the country was not dealing with TB as it should, Zuma said the reasons for this were historic. If people did not have proper shelter or nourishment, they were prone to getting TB.

A person's immune system could fight off the disease, but poor nutrition or Aids would allow TB to flourish, she added.

Historic problems were that the previous government did not take steps to ensure TB was diagnosed quickly enough, and there had been no programme to supervise people to ensure they took their medicine.

Health authorities had now started implementing directly observed therapy by making a family member or friend ensure that a patient completed a course of TB medicine, Zuma said.

A pilot project in Mpumalanga using this therapy had pushed the cure rate from 50 to 80%.

Meanwhile, in the National Assembly, DP health spokesman Bukelwa Mbulawa moved a motion noting that TB killed more South Africans than Aids, malaria and murder combined, and that the country had one of the highest rates of TB infection in the world.

SA has urgent need for specialist TB centres

ARG 26/3/98 (91)

Patient transfer on cards as threat of closure faces key clinic

JENNY VIALL
HEALTH REPORTER

Although tuberculous care has moved away from hospitalisation towards home or clinic treatment, there is still a critical need for such centres as the D P Marais Clinic in Westlake.

In response to the proposed transfer of patients to the Princess Alice Hospital in Plumstead, Julie Roelofse, administrative manager for D P Marais, said some TB patients were too sick to be treated at clinics or home and needed to be in hospital.

D P Marais, a rehabilitation centre for people with TB run by the SA National Tuberculosis Association and funded by the provincial health department, is one of the hospitals the department proposes to close to save money. Ms Roelofse welcomed the move to the Princess Alice site because it was closer to public transport for patients' families.

Patients are usually those who have defaulted on their treatment or have multidrug-resistant TB.

The centre is admitting more people with TB and HIV, the virus which leads to AIDS. This has meant the centre's patient profile has changed from men between 35 and 45 to women in their mid-20s.

People with HIV are more susceptible to TB because they have weaker immune systems. Because HIV prevalence has doubled in the Western Cape in the past year, the number of people with TB is likely to increase.

The average stay at the centre is four to six months and for those with drug-resistant TB, up to 18 months.

The Western Cape has one of the highest incidences of TB in the world. The latest available figure for new cases is 21 794 in 1996. Meanwhile British pharmaceutical company Glaxo Wellcome has announced it will support a second five-year phase of basic TB research with a £10-million (about R83-million) grant to the Action TB programme. Announcing this on World TB day at a conference

ARG 26/3/98

at the Medical Research Council, company chairman Richard Sykes said the focus of Action TB would be on developing new drugs for the disease and identifying a vaccine. South African TB researchers will benefit from the grant, but it is unclear to what extent. During the first phase of Action TB, almost half the funding was used in five South African universities and 12 research centres.

(16)

Fight against TB to be stepped up

Sowetan 31/3/98 (97)

By Mokgadi Pela

THE ongoing fight against tuberculosis is to assume new levels with health workers taking the frontline in the campaign.

Head of the directorate for communicable diseases Dr Neil Cameron said yesterday health workers in all nine provinces would be encouraged to commit themselves to the Directly Observed Treatment Shortcourse (Dots), an internationally renowned TB control strategy.

A visit by international experts at the end of 1997 showed the TB control programme in South Africa was slow and unfocused. Experts concluded that only four out of 10 infectious TB patients in all health facilities were effectively managed.

"This shows poor performance. We want to ensure that Dots is achieved in at least a third of health facilities in the country by December 1998," Cameron said.

Dots requires health workers to ensure that TB patients are directly observed while taking their treatment for at least the first two months of therapy.

Patients are usually still sick during this period and are likely to accept advice from health workers.

However, as soon as they start feeling better, many patients stop taking treatment, putting themselves at risk of developing multi drug resistance – a stage where the body may develop resistance to the TB drugs they had taken before.

Cameron says health workers are encouraged to use the two month period to bond with the patient, build a relationship of trust during which patients are helped to understand the importance of completing treatment.

Meanwhile, latest figures show South Africa is in the middle of a TB epidemic, with about 1 000 deaths a month.

Mutant TB strain's deadly threat

(91)

MICHAEL SCHMIDT and BOBBY JORDAN

ST 3/5/98

HEALTH officials in South Africa are alarmed at the appearance of a mutant "multi-drug-resistant" strain of tuberculosis.

In the densely populated and largely rural Kwazulu Natal, recent studies indicate that the mutant strain could account for more than six percent of all TB cases.

Dr Andrew Robinson, Durban's acting medical officer of health, says: "TB treatment usually costs R3 000 over six months, but treating multi-drug-resistant TB costs more than R100 000 over two years. Even then, the patient has only a 30 to 50 percent chance of being cured.

"At least half of all South Africans are infected with TB. They're usually infected at a young age, but the body isolates the bacteria and neutralises it with calcium and other fibrous tissues. If infected people stay in good health, they feel nothing — but if they suffer malnutrition or severe stress, their resistance is lowered and they could become diseased with TB.

"Between 300 and 400 out of every 100 000 people are diseased with TB — far more than people with HIV, malaria and diahorreal diseases together. It's our biggest infectious disease."

Robinson lays the blame for the mutations on lazy doctors indiscriminately dishing out antibiotics and patients who fail to take all the medicine they're prescribed.

In the Western Cape, many impoverished TB patients — completely dependent on state health grants — are opting to live with TB rather than complete their prescribed treatment.

According to University of Stellenbosch paediatrician Dr Nolda Beyers, patients — who need to receive TB treatment to qualify for the grant — sometimes choose not to complete their treatment in order to draw it out for longer.

She says: "Many doctors aren't helping by prescribing the wrong drugs. Wrong prescription can lead to the growth of mutant organisms. We're seeing strains that are resistant to just about all the drugs we have — it's almost like being back in the pre-antibiotic era."

TB now the biggest killer of young women, as 900 million suffer

(91) ET 27/5/98

STOCKHOLM: Tuberculosis (TB) has become the single biggest killer of young women in the world according to a World Health Organisation (WHO) study released yesterday.

WHO figures presented to the first international meeting on TB and gender showed unprecedented levels of infection and death among women aged 15 to 44 with over 900 million suffering from the infectious lung disease worldwide.

It is estimated that in 1998 alone more than one million women will die of TB and 2,5 million others get sick from the airborne disease usually considered more common among elderly men. "This makes TB the single leading cause of deaths among women of reproductive age," WHO said in a statement at the end of the two-day meeting in Gothenburg, Sweden.

TB now accounts for nine percent of deaths worldwide among women aged 15 to 44 compared with war which accounts for four percent, HIV three percent and heart disease three percent.

Last year 1,2 million women died of TB, 316 000 in sub-Saharan Africa. An earlier WHO study said 2,9 million people died of TB in 1997. — Reuter

Local research breakthrough could yield cheaper treatment for cancer, TB

Star 10/6/98 (91)

ROBB NORTHEY

University of Pretoria researchers have developed a new series of compounds which it is hoped could have an impact in the fight against cancer.

The eight new molecules developed by the researchers could reduce the cost of treating cancer, tuberculosis and malaria by allowing doctors to treat patients with older drugs which have become ineffective as these diseases are resistant to them.

This also means that doctors will have a wider array of drugs with which to treat patients.

The new molecules, called Riminophenazines, have slowed the growth of cancer in laboratory tests. Although the research into TB is not as far advanced as the cancer research, it is hoped the Riminophenazines could help save the country millions of rands.

A Medical Research Council spokesman said it costs about R3 000 to treat a first-time TB patient. Treating a patient with multi-drug resistant (MDR) TB costs about R50 000 and there is only a 50% chance of success, the spokesman said.

Molecules have slowed cancer growth

She added that in South Africa about 2 000 MDR-TB cases are reported each year.

Professors Connie Medlen and Ronnie Anderson, along with team spokesman John Spence, have been working on this specific project for the past six years and yesterday achieved the milestone of having the molecules patented in the United States.

The US is one of the hardest markets to obtain patents in and their US patent is the last in a series of patents obtained around the world.

But it will take at least five years before the drug becomes available to the public. Researchers still have to conduct clinical trials – testing the drug first on animals, then on healthy human volunteers before it is tested on cancer patients, Anderson said.

"We are looking for a partner now, South African or international, to develop it further. Clearly, the ground-breaking work was done here and there needs to be some benefit to South Africa," Spence said.

Although none of the team could say what they thought the drug would cost when it becomes available, the drug on which it is based, Clofazimine, costs R221 for every 100 capsules.

The Riminophenazines were developed from Clofazimine, which has been used to treat leprosy for the past 30 years. It has very few side effects.

■ Riminophenazines work like no other cancer drugs currently on the market.

Instead of attacking the brain of the cell, the nucleus, or other vital parts of the cell, the new molecules act on the outer wall of the cell.

This is said to slow down the rate at which the cells can absorb Potassium, a vital element needed for the cell to grow and multiply, Anderson said.

Will take five years to develop drug

Cancer cells grow faster and absorb about three times as much Potassium as normal cells but Riminophenazines reportedly reduce the Potassium uptake significantly.

The other significant effect of these molecules has wider significance than just cancer treatment.

One of the major problems faced by doctors and drug companies is that viruses and bacteria develop a resistance to specific drugs and they become almost useless, necessitating the development of new drugs.

The disease cells recognise the drug and pump it out of the cell as soon as it enters and the drug has no effect.

Riminophenazines stop the pump from working and the drug stays inside the cell and can therefore act to kill the disease cell.

Science takes huge anti-TB leap

(91)

LONDON: A Franco-British team of scientists has cracked the genetic code of tuberculosis, an infectious lung disease that kills more people each year than malaria and Aids combined.

The Western Cape has the world's highest incidence of TB.

The team has deciphered the entire 4 000-gene sequence, or genome, of the TB bacillus, which should speed the development of new drugs and vaccines against the chronic airborne ailment that has defied scientists' best efforts.

"I think it will be a landmark in the history of tuberculosis research," Stewart Cole, a doctor involved in the research, said.

"We've identified all the genes and predicted what quite a few of them are doing, so it opens up thousands and thousands of new areas for people to do research in."

It took the scientists from the Pasteur Institute in France and Britain's Sanger Centre more than two years to complete the joint project, financed by the Wellcome Trust and reported in the science journal Nature yesterday.

Tuberculosis is not the first disease to be decoded.

Scientists have already mapped out the genome for Lyme disease and other bacteria, but the TB bacillus, mycobacterium tuberculosis, is the most sophisticated sequencing achievement and one that could have far-reaching implications for public health.

"I personally think it is the most important one to date," Cole said, adding that sequencing the genome for malaria, another infectious killer, would have similar significance.

One third of the world's population is infected with the TB bacillus. Three million people die of the disease each year. It is particularly dangerous for HIV sufferers because each disease speeds the progress of the other. — Reuter

Figures show TB on increase in E Cape

Star 13/6/98 (91)

Bisho – The number of reported cases of tuberculosis in the Eastern Cape increased by 1 853 last year, the province's health department reported this week.

Health MEC Dr Trudy Thomas said 27 800 cases were recorded in 1997, which represented an increase of 7,14% compared to the 1996 figure.

She said this could be attributed to the introduction of the World Health Organisation's system for recording and reporting the disease.

A policy for managing multi-drug-resistant TB would also be developed, she said. – Sapa

CAPE ARGUS 2/7/98 (91)

TB toddler's brave walk to health ...

Four-year-old Yamkela one of many who are helped

Aid: nurse Derek Manaxiwa is a familiar face as he records Yamkela's dosage each day

JENNY VIALL
HEALTH REPORTER

Each day four-year-old Yamkela Ngcawe walks alone from her home in Marconi Beam to the nearby clinic to get her tuberculosis medication.

Clutching her green clinic card in a plastic bag, she jauntily skirts pools of water on the dirt road to the clinic, the only concrete building in the informal settlement.

Nurse Derek Manaxiwa crushes Yamkela's tablets, mixes them with a pink syrup and hands her the plastic cup. Yamkela dutifully swallows the bitter mixture.

She's full of smiles, especially when she gets a piece of bread and jam, a bonus from the staff. Yamkela's story is a success story. It has been almost three months now that she has walked the 200m to the clinic every day.

In a few days she will no longer have to make the solo trip.

She will be officially cured of TB, thanks to the proximity of the clinic and an aunt who reminds her to go there every day. The Marconi Beam clinic was an essential service for the community, said sister-in-charge Mavis Buhlungu.

Built in 1995 by the Milnerton Medi-Clinic, its four staff members are paid by the clinic group and the province supplies the medication. A paediatrician works there voluntarily once a week.

"The clinic came about because people were so desperate for services they used to go to the Medi-Clinic for help, which of course they couldn't pay for," said Ms Buhlungu.

"Otherwise they had to spend R8 to get to Table View or Brooklyn, which many people can't afford."

Ms Buhlungu said she worried a bit about Yamkela, who lived with an aunt in a shack.

"It's never safe for children to walk alone but in this area children do. But Yamkela is always smiling, she never gets frustrated. And she's well nourished so she is obviously being well cared for. She's just sometimes a bit dirty."

Her mother is seldom home and there is no one else to accompany Yamkela to the clinic, but neighbours say they believe she is safe enough on her own. People are being moved out of Marconi Beam settlement to places like Du Noon and Joe Slovo because the area is to be developed.

There were no clinics in either so people still came to Marconi Beam for health care, said Ms Buhlungu.

The future of the clinic is uncertain but there is talk of it moving to Phoenix, near Joe Slovo.

"This is a curative, preventive and health-promoting community clinic," said Ms Buhlungu. "We see lots of people and it will be bad news if we don't move with the people of Marconi Beam."

It will be especially bad news for children like Yamkela and 18 others who get their daily TB medication.

"It's terribly important that we see children near where they live.

"This way we can catch infections early and that cuts down on the number of children who have to go to Red Cross (children's hospital)," said Cathy Buley, the doctor who works at the clinic one day a week.

LEON MULLER

Road to recovery: each day for three months Yamkela Ngcawe walks alone from her home in Marconi Beam to the nearby clinic to receive medication for tuberculosis

Scientific trials show TB sufferers are better off

(91)

JUDITH SOAL
HEALTH WRITER

CT 28/10/98

THE World Health Organisation has invested heavily in it. President Nelson Mandela has championed it. The Health Department says it is the only effective way to fight tuberculosis (TB). But its first scientific trial shows that it doesn't work.

Dots — the Directly Observed Treatment Shortcourse — has been hailed as the solution to the TB epidemic. It prescribes that every TB sufferer be watched every day while they take their medication to make sure that they finish the course of drugs. Health authorities hope this will reduce the number of cases and stop the development of drug-resistant TB.

In Cape Town, with the highest rate of new TB cases in the world, this is critically important. Yet a study conducted in clinics in Khayelitsha and Elsies River and published in the latest issue of the British journal *The Lancet* suggests it isn't happening.

"We found that patients who take their TB medication unsupervised are more likely to recover than those who go to clinics every day to be watched," said the Medical Research Council's Merrick Zwarenstein.

An editorial in *The Lancet* said this was the first published randomised trial of Dots.

"Is it ethical to implement a strategy that has not been properly tested?" asked Zwarenstein. "We wouldn't dream of registering a drug that hadn't been scientifically proven through random control treatment trials, why do we do this with the way we relate to patients?"

The research team divided 216 adults with TB into two groups. One group was told to come to the clinic every day to be given their medication. The other group came to the clinic weekly to collect the drugs.

Among first-time TB sufferers 60% of those who took the tablets at home completed the medication and recovered, compared to 54% who were supervised. Of those who had had TB before, 74% of the unsupervised group recovered compared to 42% of the supervised group.

"We think the findings can be explained through looking at the difference between support and surveillance," said Zwarenstein.

"Patients who are trusted with their own treatment tend to take responsibility for their health. Those who have to come to the clinics every day are placed in a more authoritative, alienating system.

"The nurses have little time to support these patients. They just line them up, give them the drugs and send them away. Is it surprising that so many of them drop out?

"The ones that come once a week are able to spend some time with the nurses and get the support they need."

Zwarenstein believes health authorities should re-evaluate their commitment to Dots.

"Stopping direct observation would be an enormous relief for the health services. Primary-care nurses spend 40% of their time watching patients take tablets.

"The health services asked us to do a study because they were unable to keep supervising every patient and started to give some patients medication to take unsupervised," said Zwarenstein.

The team are doing another study on the success rate of supervision by community health workers in comparison to self-supervision.

The national health department was not available to comment on the study, but Lilian Dudley of the Cape Metropolitan Council said the findings were useful.

"I don't think it shows that Dots doesn't work, just that giving out pills at clinics is not the best way of implementing Dots," she said.

supervising own medication

Campaign against TB is launched

CP 1/11/98 (91)

A COMMUNITY-based effort to create awareness of tuberculosis (TB) in Gauteng was launched this week with an initiative aimed at encouraging the community to get involved in fighting the high levels of the disease.

The new campaign, "adopt a patient", was launched under the auspices of the Global TB Education Fund, of which President Nelson Mandela (pictured on left) is International Patron-in-Chief.

The Fund is an international organisation involved in finding options for TB treatment.

The campaign is aimed at avoiding the high cost involved in hospitalising and treating TB patients. Community volunteers working with health workers will treat patients at home and at their workplace.

It is believed that through the Directly Observed Treatment Short-course (DOTS) programme, costs incurred by the Health Department will be lowered and the chances of controlling TB improved.

"The essence of the campaign is local involvement of community volunteers, who will encourage the patients to take their daily medication, while at the same time raising their morale during a difficult period in their lives.

"In this way the patient is motivated to take the medication and is more likely to effect eventual cure," the Department of Health said.

Call us!
Tel:402 1632 Fax: 402 6501
Street Address:
Media Centre, 2 Herb Street, New Doornfontein 2094
Postal Address:
P.O. Box 3413, Johannesburg 2000

SOWETAN Thursday November 5 1998

Doctors warn of TB, HIV disaster

(91)

By Mokgadi Pela

LEADING researchers have called on South Africa to redouble its efforts to control the spread of tuberculosis and HIV to avoid a disaster befalling the country.

Dr K Weyer and Dr B Fourie of the Medical Research Council (MRC) tuberculosis research programme said if no improvement took place in controlling HIV and TB, there would be an estimated 638 000 new cases of TB by 2005.

"Some 71 percent of all cases will be HIV-positive and the TB incidence rate per 100 000 of the population will reach 1 285," they said.

According to the Ministry of Health, about 160 000 people contract TB every year, while 10 000 die of it.

Weyer said the number of TB cases averaged 362 per 100 000 of the population, which was more than double the rates observed in other developing countries, and as much as 60 times higher than those currently in the United States and Europe.

In 1996, the average TB notification rate per 100 000 people was 154.

The highest rates were found in the Northern Cape (589), followed by the Western Cape (569), Free State (268) and Gauteng (170).

The notification rate in all the other provinces was below 100 per 100 000 of the population.

According to the latest survey by the South African Institute of Race Relations, there are also significant disparities between the races.

Coloured people had a notification rate of 530 and Africans 137.

The rate for Indians is 50 and for whites 14.

The ministry says the notification rate for coloured people doubled from 330 per 100 000 in 1970 to 671 in 1995.

In Africans, it halved from 361 to 179 over the same period, and in the case of Indians, it dropped from 152 to 69.

However, Fourie and Weyer said if the ministry succeeded in reducing the smear positive incidence rate by 50 percent and prevented 20 percent of new HIV infections by 2005, there would be 133 000 new cases by that year.

Campaign launched to stem rise of TB in Alexandra

By Anna Cox

The Global TB Education Fund has launched a new campaign in Alexandra following reports that the incidence of the disease has escalated by 23% in the area.

The campaign, called "Adopt a Patient", involves training community volunteers in co-operation with health workers on the Directly Observed Treatment Shortcourse (DOTS) programmes.

The community volunteers encourage and ensure that patients take their medication every day, providing support and raising morale.

"In this way the patient becomes motivated to continue the medication and is more likely to complete treatment thereby preventing relapses of the infection," said Griet Cloete, communicable diseases coordinator of Greater Johannesburg's Eastern council.

The campaign needed to be community driven because only with the involvement of the local community would the DOTS campaign increase the success rate of controlling TB in our society, she said.

The campaign in Alex is a joint effort between the Alexandra Community Health Forum, the Anti-TB Association of Alexandra, SANTA and the Global TB Education Fund.

"In the past, people with TB were admitted to hospital for extended periods of time to ensure that the lengthy treatment course was completed. The DOTS approach is more convenient and is cost-effective. As soon as the person is no longer infectious, he is able to return to the community and have his treatment managed by a trained volunteer. Programmes such as these are essential in maintaining the health of our people," she said.

A similar programme was successfully launched in Mpumalanga recently and has been one of the most successful undertaken by the health department in years.

"The cost-effective management of TB with the help of the community may be a goal within the reach of those living and working in Gauteng," she said.

The Global TB Education Fund is an international organisation which focuses world attention on TB and the available options for treatment.

It is currently highlighting the effectiveness of DOTS as an affordable and convenient treatment process.

(91)

Star 17/12/98

SA and Oxford teams seek genetic link in TB

(9) 23/3/99 ARG

DI CAELERS

A study at Tygerberg hospital, in co-operation with a group from Oxford University working in Gambia, is hoping to turn up a missing link between genetics and tuberculosis.

The study, which is expected to be complete in about three years, is focusing on a community near the hospital with especially high TB rates.

If successful, the study will influence future strategies to combat the disease, including vaccines and different drug therapy.

Paul van Helden, director of the Medical Research Council's Centre for Molecular and Cellular Biology, and head of Stellenbosch University's Department of Medical Biochemistry, said TB was a multi-factorial disease linked firmly to the socio-economic environment, and other diseases like HIV. But there was also almost certainly a genetic component.

"One might hypothesise that the Western Cape is not the most socio-economically deprived area in the country, or worldwide, yet the incidence of TB here is incredibly high.

"It may have historically been introduced in the Western Cape, but it also may be worst here because of genetics."

There was circumstantial evidence, although not in this country, for why TB could be genetic in rare families who were super-susceptible.

The Tygerberg study, which began about two years ago, is identifying individuals and families with TB. It looks at people exposed equally to the disease and living under the same conditions, some of whom get TB and some who do not.

"We are finding the most resistant and most susceptible people, comparing their genetic make-up, within and across families," Professor Van Helden said.

He and his colleagues aimed to collect data from 200 families and had reached about 55 families at this point.

"We are linked with a group from Oxford doing a similar study in Gambia. It is important to try to study genetics in different population groups because we are almost certainly not going to find one major gene defect in an average TB patient.

"In any one population group we will probably find 20 genes susceptible to TB. In another population group we will also find 20, and only some may be common. But once we find which are common, then we know those to be the really important genes," Professor Van Helden said.

They could then start thinking of new ways to combat TB, like completely new types of therapy involving immunology.

Between themselves and the Oxford group, they had already identified a number of genes "significantly involved in TB".

There were other aspects to the Tygerberg group's work, including studies of how many people were infected each year, whether certain behaviour had an effect, immunology and molecular biology, Professor Van Helden said.

'TB time bomb' threatens to explode

BRENTON GEACH

Fighting TB: treatment supporter in the Dots programme, Irene Louw, with patients Justine Swarts and Ashley Claasen

W Cape has one of highest rates in the world

(91) ARG 23/3/99

The "cursed duet" of tuberculosis and HIV, threatening to send South Africa's already spiralling TB statistics completely out of control, has the potential to wreck the health budget and bring the health service to its knees.

DI CAELERS

HEALTH WRITER

That is the warning sounded by TB experts, on the eve of World TB Day tomorrow, who say the country, and more particularly the Western Cape, is sitting on a time-bomb.

The Western Cape has one of the highest TB rates in the world – about 700 new cases per 100 000 people each year – and experts point out that experience in other African countries has shown the "multiplying factor" of HIV can double that number.

TB expert Peter Donald, associate professor in the Department of Paediatrics and Child Health at Stellenbosch University, said the rising rate of HIV here, combined with rapid urbanisation (a major contributing factor to the spread of TB), made for a "frightening scenario".

He said infectious diseases were always associated with urbanisation and South Africa had the highest rate of urbanisation in Africa. Changes in sexual practices accentuated the transfer of HIV/AIDS, and poor housing conditions accentuated the transfer of TB.

Worldwide, about one third of people are infected with the TB bug

Worldwide, about one third of people are infected with the TB bug. However, as many as 90% of people appear to have an innate resistance and never develop the disease.

The situation changes dramatically with infected people who then get infected with HIV – all will almost immediately get tuberculosis because their immune systems can no longer fight off TB.

Professor Donald said another factor was that having had TB did not confer life-long immunity. The extensive incidence of the disease here meant people could become re-infected once they had been cured, especially if they were HIV-positive.

Already as many as 60% of patients at the Brooklyn chest hospital were HIV-positive.

Aidan Keyes, the Western Cape's TB co-ordinator, said the current estimate was that 40% of TB patients in the province were also HIV-positive.

"We are now beginning to realise the significance of HIV and the contribution to the number of TB cases it's going to have."

He said the province's antenatal surveys, showed the Western Cape was lagging behind the rest of the country and the rest of Africa in respect of HIV. So the full impact of HIV on the incidence of TB here had yet to be fully felt.

HIV-positive people who get TB are treated the same way as other patients. The strategy here is known as Dots, or "directly observed treatment, short course".

Four major drugs are used and within two weeks of the start of the course, which involves taking medication five days a week for six months, patients are no longer infectious.

Technically, Dots should lead to 95% cure but because people often stop taking the medicine once they feel better, as many as 30% of them may relapse at some time.

'The TB/HIV duet has the potential to wreck the health control systems in the country'

Multi-drug resistant TB, where the patient becomes resistant to one or more of the drugs, is another major financial headache for health authorities. These patients are treated for between nine and 18 months, many have to be hospitalised, and they end up costing about R60 000 each to cure.

Professor Donald said patients could also catch multi-drug resistant TB from the start, and transmission of this type of TB in the case of HIV-positive people was easier, pointing to potentially crippling treatment costs for the future.

Tomorrow at the provincial legislature, local government ministers, parliamentarians, business leaders and other key decision makers will officially renew their commitment to the fight against TB.

"There can be no relaxation of effort. What is in fact needed is increased action and, as with the HIV/AIDS epidemic, a broadening of commitment and responsibility across all sectors," the Western Cape health department said.

Mr Keyes pointed to the example of one African country which brought down its TB statistics, through a control programme started in 1977, to the point that it forecast it would no longer need such a full-blown programme by 1995.

Then HIV started creeping in and the country now has 37 000 cases of TB a year.

"HIV blew the figures right out. It has the effect of bringing the health service to its knees," he said.

Professor Donald said managing South Africa's TB/HIV "duet" was going to prove an enormous challenge and would be an enormously expensive exercise.

"It has the potential to wreck the whole health budget and the health control systems in the country," he said.

What you need to know

- Tuberculosis is a disease caused by a germ called Mycobacterium Tuberculosis Bacterium.
- TB is contagious.
- TB is spread by an infected person through coughing, sneezing or spitting. This action releases the TB bacilli into the air and others breathe it in.
- Everyone can get TB but some lifestyles can make one more susceptible; things like smoking cigarettes or dagga, drugs, alcohol, poor diet and HIV/AIDS.
- The TB bacilli can be present in your body for years and only develop when your resistance is low.

Telltale signs

Seek help if two or more of the following signs are present:

- Persistent cough for more than three weeks; may be bloodstained at a later stage.
- Weight loss.
- Night sweats (especially early morning).
- Loss of appetite.
- Extreme tiredness.
- Chest pain.

DEBBIE YAZBEK

A will to survive ... Nthabiseng Mokgoko.

'I am a living example that TB is curable'

With more than 1 000 people dying of tuberculosis every month, Nthabiseng Mokgoko, is an example of how the disease can force you to stop being a victim and become a survivor.

"During the festive season in 1998 I was supposed to go on a picnic, but I felt too sick. By February I had lost a lot of weight and I was coughing," said Mokgoko.

Mokgoko (31) who saw many doctors was only diagnosed in August. "This is sad because I probably infected many other people during this time".

She still doesn't know where she became infected and initially refused to accept the diagnosis.

"I had an image in my mind of TB patients. I thought they all smoked and all drank too much liquor. I knew this wasn't me and thought (the doctors) must have got it wrong," she said.

Mokgoko was persuaded by a nurse to admit herself to a SA National Tuberculosis Association hospital for six months where she would receive her drugs under supervision.

"I didn't want to go, but she told me I would die if I refused.

"I was also lucky because I had a lot of support from my family and friends," she said.

While in hospital Mokgoko met a social worker from Santa in Johannesburg who invited her to visit a workshop in town.

"I went to their offices and told them I could sew although I know nothing. I soon learnt and later I started baking and making leather goods. I had to because this was my only means of income."

Mokgoko was soon appointed by Santa as a supervisor, teaching others to sew, bake, make candles and use the leathercraft machinery.

After a few years as supervisor, Mokgoko started going with social workers to communities to talk to people with the disease.

"I started going out with the social workers as an interpreter and now I am studying to become an auxiliary social worker," Mokgoko said proudly.

But this is not the end. According to Santa Johannesburg director Julia van Heerden, Mokgoko would probably go on to become a fully fledged social worker.

"She has been wonderful. Few people are so committed and determined to be a success," she said.

Despite the recent news that her mother has TB, Mokgoko is positive.

"I am a living example that it is curable and know my mother will be fine. I told her 'Mama, take your pills or you will die.'

"People have to remember that only so much can be done for them. In the end you must take care of yourself."

Scourge greater than Aids

(91) Star 24/3/99

*Tuberculosis killed more than 10 000 people in South Africa last year, but the disease can be controlled with good medical care, writes health reporter **Anso Thom***

While health workers, politicians and the world population are coming to grips with the HIV/Aids epidemic, tuberculosis is killing more people than malaria and Aids combined.

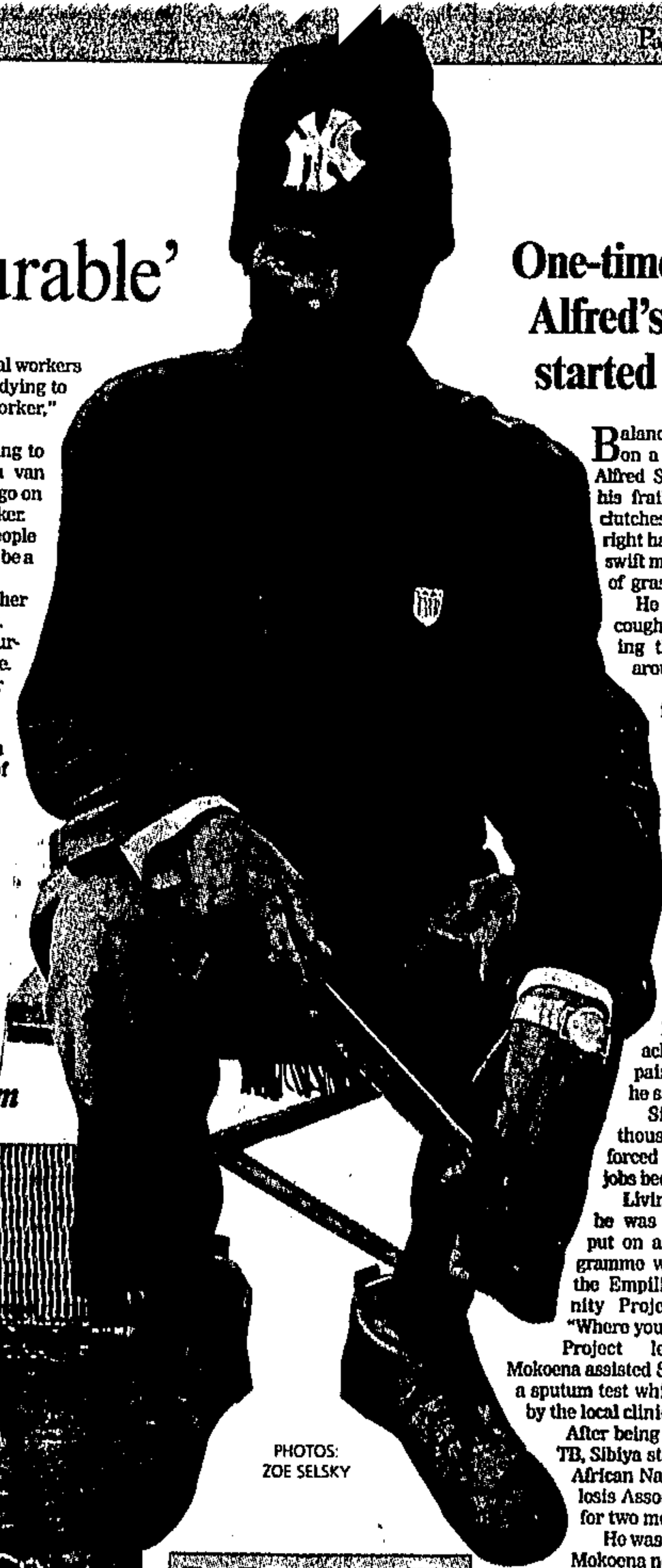
Declared a global epidemic by the World Health Organisation in 1996, TB killed more than 10 000 South Africans last year, while another two are infected in the time it takes to read this article (one every three minutes).

With World TB Day acknowledged across the world today, the spotlight once again turns to South Africa which is experiencing one of the worst epidemics in the world.

"TB has never enjoyed the high profile of other diseases and epidemics, probably because it has been with us for so long," said Hylton Smith, outgoing chief executive of the SA National Tuberculosis Association (Santa).

According to Dr Bernard Fourie, director at the Medical Research Council's TB Research Programme, South Africa is burdened by one of the worst TB epidemics in the world.

He estimated the number of new cases per year to be in the region of 180 000, more than double those observed in most other developing



PHOTOS: ZOE SELSKY

One-time miner, Alfred's decline started in 1974

Balanced precariously on a makeshift stool, Alfred Sibiya (68) bends his frail body over. He clutches the knife in his right hand and with one swift move cuts a clump of grass at his feet.

He looks tired and coughs before tightening the flimsy scarf around his neck.

"I started feeling sick in 1974. I was a miner at the time, at Simmer Jack," he says, thinking before answering questions put to him.

"I couldn't work. I struggled to sleep and had no energy. Sometimes I would sweat at night, I'd have headaches, sometimes a pain in my chest," he said.

Sibiya is one of thousands of people forced to give up their jobs because of TB.

Living in Kliptown, he was diagnosed and put on a treatment programme with the help of the Empilisweni Community Project (Nguni for "Where you get life").

Project leader Jeffrey Mokoena assisted Sibiya by taking a sputum test which was sent off by the local clinic for testing.

After being diagnosed with TB, Sibiya stayed at a South African National Tuberculosis Association hospital for two months.

He was discharged and Mokoena now ensures that Sibiya takes his medication every day. "I feel better now and I have more energy," said Sibiya.

Mokoena and a group of community leaders started Empilisweni three years ago.

It started as a project to clean the garbage dumped on every corner.

"It was creating a health hazard

The Facts About TB

- TB is curable;
- It kills more women than all the combined cases of maternal mortality;
- Someone in the world is infected with TB every second;
- TB kills about 10 000 South Africans each year, mainly young men and women;

(91) Star 24/3/99

Tuberculosis killed more than 10 000 people in South Africa last year, but the disease can be controlled with good medical care, writes health reporter ***Anso Thom***

While health workers, politicians and the world population are coming to grips with the HIV/Aids epidemic, tuberculosis is killing more people than malaria and Aids combined.

Declared a global epidemic by the World Health Organisation in 1996, TB killed more than 10 000 South Africans last year, while another two are infected in the time it takes to read this article (one every three minutes).

With World TB Day acknowledged across the world today, the spotlight once again turns to South Africa which is experiencing one of the worst epidemics in the world.

"TB has never enjoyed the high profile of other diseases and epidemics, probably because it has been with us for so long," said Hylton Smith, outgoing chief executive of the SA National Tuberculosis Association (Santa).

According to Dr Bernard Fourie, director at the Medical Research Council's TB Research Programme, South Africa is burdened by one of the worst TB epidemics in the world.

He estimated the number of new cases per year to be in the region of 180 000, more than double those observed in most other developing countries and up to 60 times higher than those currently in the United States or Europe.

Fourie said the relentless expansion of the HIV/Aids epidemic was turning the tide against the modest improvements recorded in some regions in Mpumalanga, North West and the Western Cape.

"At least 40% of TB sufferers in South Africa are now also infected with HIV. TB/HIV co-infection in provinces such as KwaZulu Natal, Mpumalanga and Gauteng has reached even higher levels and has already led to sharp increases in TB rates," Fourie said.

He said optimal TB control effort, with high cure rates and a significant decline in the transmission of HIV infection, would be required before stabilisation. An eventual downward turn in TB rates in the country might only become visible towards the end of this period.

South Africa's attempt at addressing the epidemic has come in the form of the Directly Observed Treatment Short-course (Dots) strategy.

Dots is an internationally recognised strategy and the best available to fight TB, according to Dr Ayanda Ntsaluba, director-general in the national health department.

Government's strategy has five core elements:

- Commitment to sustained TB control;
- Sputum microscopy to diagnose infectious patients;
- A standardised, TB drug combination;
- Direct observation of treatment for at least the initial two months of treatment;
- A standardised recording and reporting system which allows assessment of treatment results and overall programme performance.

TB patients are faced with the challenge of taking the combination medication every day for at least six months if they want to be sure of a cure.

Sadly, many patients stop taking their medication once they feel better, failing to complete their course.

Once the symptoms return, the patient is usually diagnosed with multi-drug resistant (MDR) TB, which costs thousands of rands to treat with many patients dying.

As a result the Dots strategy focuses on ensuring that TB patients are observed and supported when taking their medication.

Another serious complication of the TB problem in South Africa has been the emergence of MDR strains of the organism causing the disease.

Treatment observers can be health workers, employers, colleagues, family members or any responsible member of the sufferer's community.

The treatment of these patients costs at least 100 times as much as the cost of curing an ordinary TB patient infected with drug sensitive bacteria.

Annually 2 000 new cases of the drug resistant strain are added to an already existing pool, at least half of whom die uncured within a few years.

Currently the cost for treating a new case of TB is about R250.

Retreating a TB case comes to R500 and for MDR between R26 000 and R31 000.

Fourie said that 90% of the problem was due to poor performance in managing the disease at district level.

He accused clinics of gross wastage of drug stock, non-existent or incomplete case registers and poor service. He further called for an insistence on standardised procedures for the diagnosis and treatment of TB.

"The real challenge is to convince health providers that even if they do their best, infection rates will increase in the medium term, but ultimately will start to decline.

"Losing faith in the value of own effort is the biggest threat to achieving success," Fourie said.

In South Africa it was thought that the spread of TB was linked to colonialism.

In particular the mining industry was directly responsible for the rapid spread of the disease.

Poor ventilation, humidity, long working hours and close working proximity to the mines, as well as overcrowding and malnutrition in the compounds, created ideal conditions for TB.

Additionally the migrant labour system, forced removals and the creation of peri-urban slums further disseminated the disease.

World Health Organisation chief Gro Harlem Brundtland said last year that TB was a disease that many thought would disappear in our lifetime.

"But TB is killing more people than at any other time with almost all the deaths preventable," she said.

The number of TB patients that will die in this hour is equivalent to a Boeing 747 crashing.

PHOTOS: ZOE SELSKY

Breeding ground ... TB infection rates are high in Kliptown where children play among squalor and disregarded refuse. Alfred Sibiya (inset), an ex-miner living in this Sowetan suburb where many squatters add to the escalating filth, has been suffering from TB since 1974.

and had no energy. Sometimes I would sweat at night, I'd have headaches, sometimes a pain in my chest," he said.

Sibiya is one of thousands of people forced to give up their jobs because of TB.

Living in Kliptown, he was diagnosed and put on a treatment programme with the help of the Empilisweni Community Project (Nguni for "Where you get life").

Project leader Jeffrey Mokoena assisted Sibiya by taking a sputum test which was sent off by the local clinic for testing.

After being diagnosed with TB, Sibiya stayed at a South African National Tuberculosis Association hospital for two months.

He was discharged and Mokoena now ensures that Sibiya takes his medication every day. "I feel better now and I have more energy," said Sibiya.

Mokoena and a group of community leaders started Empilisweni three years ago.

It started as a project to clean the garbage dumped on every corner.

"It was creating a health hazard and we realised we needed to clean it if we wanted a healthier community," Mokoena said.

Empilisweni soon became involved in Aids education in the informal settlements such as Angola, Mandela Square and Joe Slovo.

"I think everyone started taking us seriously when they saw that many people were dying from Aids and TB," said Mokoena who also identified sexually transmitted diseases as a major health problem.

With unemployment one of the biggest problems in the densely populated settlements, Empilisweni now has 61 members who are trained in Aids education, first aid and the Directly Observed Treatment Short-course (Dots) strategy, adopted by government to fight TB.

Empilisweni work hand in hand with the local clinic.

"My grandfather had TB and I remember how my grandmother used to shout at him because he didn't want to take his medication.

"This has helped me to understand TB patients better," said Mokoena.

"When I ask them why they haven't come for medication, they say 'Why should I? I don't have food, I'm not working.'"

Although funding is almost non-existent, local businesspeople have assisted the project with funds and food parcels.

"It's hard, but you have to go on. One of the people who was on the Dots programme died in January," Mokoena said.

The Facts About TB

- TB is curable;
- It kills more women than all the combined cases of maternal mortality;
- Someone in the world is infected with TB every second;
- TB kills about 10 000 South Africans each year, mainly young men and women;
- Women are more vulnerable to TB during pregnancy because pregnancy lowers their immune system;
- People who are HIV positive are more prone to developing TB;
- TB is the most common opportunistic infection and the biggest killer of people with Aids;
- In 1997 there were 2,2 billion people infected with TB and 30,6 million with HIV in the world;
- More than 2 500 HIV positive people died of TB in 1996 in South Africa;
- A TB patient is not infectious while under treatment;
- By weakening the immune system, HIV/Aids was likely to cause 750 000 new TB cases globally.

Signs And Symptoms

- persistent cough;
- tiredness or weakness of whole body;
- loss of weight;
- loss of appetite;
- night sweats (even if it is cold);
- chest pains;
- coughing up blood;
- breathlessness.

How it Is Diagnosed

Microscopy is the best way to identify a TB bacilli on the patient's sputum. The SA National Tuberculosis Association uses lung x-rays to diagnose TB with sputum tests used in some cases to confirm the findings. Rapid confirmation of the results is vital.

Famous Ex-Patients

President Nelson Mandela; Archbishop Desmond Tutu; Cecil John Rhodes; Edgar Alan Poe; Eleanor Roosevelt; Louis XIII, king of France; Wolfgang Amadeus Mozart; Tutankhamun; and HG Wells.

Anti-TB effort 'dogged by wastage, bungling'

CT 25/3/99

JUDITH SOAL
HEALTH WRITER

(91)

SOUTH AFRICA spends R600m on tuberculosis every year — more than enough to control the epidemic — "but our efforts are dogged by wastage and mismanagement", the Medical Research Council says.

Tuberculosis is a curable disease, yet 107 000 new South African cases were reported in 1997. The 1998 figure is expected to be even higher.

"(The government's) level of funding should be sufficient," said Karin Weyer of the Medical Research Council's TB programme. "With this budget we are curing only 60% of patients with TB, yet in places like China and Bangladesh, where they can only afford about 10 cents per patient, they are achieving far better results."

'In places like China and Bangladesh ... they are achieving far better results.'

A recent analysis by the national Health Department showed a large discrepancy between the quantity of TB drugs purchased for clinics and the number of patients registered as receiving these drugs. Yet clinics are reporting drug shortages.

"This means that gross wastage occurs, or that drug demand is greater than anticipated and staff are not complying with the national requirement that patients be directly observed taking their medication," said the MRC's Bernard Fourie.

Treating ordinary TB costs about R250 per person. The problem arises when TB sufferers do not complete the course of treatment and develop drug-resistant TB. Renewed treatment costs R500 and treating multi-drug resistant TB costs 100 times that — about R25 000 per patient.

The Directly Observed Therapy Short-course (Dots) has been internationally hailed as a solution to drug-resistant TB. care workers while taking their tablets every day for six months.

But recent studies in the Western Cape point to problems with the way Dots is being implemented in South Africa.

An MRC study in Khayelitsha and Elsie's River found that patients who were given their tablets to take at home were more likely to recover from TB than those who came in every day to swallow the pills under the watchful eye of clinic staff.

Sixty percent of unsupervised patients recovered, compared to 54% of supervised patients.

Those who were being treated for a repeat bout of TB were even more likely to recover on their own — 74% of those who were unsupervised compared to 42% of those supervised.

The study was published in the journal the *Lancet* in October, causing a stir in health circles that have long regarded Dots as the answer to the TB epidemic.

Researcher Merrick Zwarenstein said at the time that the results could be attributed to the overburdening of clinic staff.

"The nurses have little time to support these patients. They just line them up, give them the drugs then send them home. Is it surprising that so many of them drop out?"

Research has shown that treatment supervised by community health workers has the highest rate of cure.

South Africa has about 2 000 new cases of multi-drug-resistant TB a year and the MRC says the cost of treating these cases will soon cost as much as the drugs needed for all the other TB cases in the country.

"We need to make a serious commitment to control the TB epidemic in this country," Fourie said.

"Poor performances in managing the disease at a district level probably repre-

SA's TB figures 'alarm' official

(91)

26/3/99 Sowetan

By Bhungani Mzolo
Health Reporter

MORE than 10 000 people die of tuberculosis in South Africa each year, director-general of the Department of Health Dr Ayanda Ntsaluba said this week.

Ntsaluba was speaking during the launch of a new TB publication called the "Faces of TB" as part of the international commemoration of World TB Day.

"With 107 000 tuberculosis cases in South Africa in 1997 and 10 000 deaths annually, the TB epidemic is still alarming," he said.

Ntsaluba said his department had made TB control a priority and had committed its resources to the implementation of the Directly Observed Treatment Short-course (Dots) strategy.

Dots advocates that TB patients be directly observed and supported when taking their medication every day until they are cured.

Ntsaluba said the department had implemented the Dots strategy in 63 pilot districts and was planning to expand these to 114 by the end of this year. He said this would ensure that two-thirds of the country was covered by Dots.

The department had also improved its TB laboratory services to ensure that infectious TB patients were diagnosed efficiently and started on treatment in time. It had also trained about 5 000 health workers on the Dots strategy to ensure that all districts had well-trained staff, Ntsaluba said.

IN LINE: Children stand in line at a nutrition kitchen in Uitsig for a daily meal. Children in poverty-stricken areas with high unemployment and overcrowding are vulnerable to TB infection. The kitchen is part of an action plan to try to conquer the disease. (Above) A little girl bravely shows off her battle scars after undergoing a Mantoux test at Uitsig Primary. The testing at schools in the area is part of ongoing research by Stellenbosch University into the level of exposure to TB by children in the community.

PICTURES: LOUISE GUBB

Fighting at the frontline of the battle against TB

(91) CT 26/5/99

In brief

CAPE TOWN has long been called the TB capital of the world. Why the disease occurs so prevalently here is not known but organisations such as the TB Care Association have been battling the disease for 70 years. TB thrives among the poverty stricken where living conditions are overcrowded and people's diet is haphazard and the stress of unemployment, lack of money, alcoholism grinds into the daily

MARIETTE Williams suggests that we meet outside the Phillipi police station. She says it firmly in the tone of voice I suspect she might use with a difficult patient. I have been trying to make a more complicated set of arrangements because I'm worried about my car. Not once have I mentioned this concern but Mariette knows the unease of strangers to Manenberg. She knows it exists for many — myself included — like an intimation of the apocalypse, an outtake from the movie *Blade Runner*.

"It's quiet at the moment," she reassures me, "your car will be alright."

We meet as stipulated and I follow her the

of 560 people per 100 000 has the dubious distinction of being the world's TB capital, as it has long been for unknown reasons.

Of course TB thrives among the poverty stricken where living conditions are overcrowded and people's diet is haphazard and the stress of unemployment, lack of money, alcoholism grinds into the daily life. On a map of Cape Town great parts of the city would be coloured by these conditions. Also TB is what Mariette and her colleagues call an "opportunistic disease" — an airborne bacteria ready to hook into the lungs of anyone whose immune system might be ailing. Anyone, say, who

ticularly vigilant with infectious TB sufferers that they do not infect HIV positive people. Should they contract TB they must be treated immediately. We have to keep down the pool of TB infection."

As an indication of how seriously the disease is taken internationally, the World Health Organisation declared the incidence of TB a "global emergency" in 1996. In the same year the Western Cape Department of Health declared TB a health emergency. The WHO's response was to institute a strategy called DOTS — Directly Observed Treatment Short course — which Cape Town has adopted.

expensive and difficult to cure. Most TB deaths occur in this group.

"There are just two simple statistics we have to remember," says Ria Grant. "The first is that 80% of TB patients only go to a clinic long after they've contracted the disease. The second is that one person can infect 20 others, through contact in the street, train, lift, and cafe. However, TB is curable and the treatment is free."

A top priority for Ria Grant and her colleagues is to make sure people take their medicine. This is where the DOTS programme comes into its own. Under this strategy volunteers from a particular community become "care sup-

ease occurs so prevalently here is not known but organisations such as the TB Care Association have been battling the disease for 70 years. TB thrives among the poverty stricken where living conditions are overcrowded and people's diet is haphazard and the stress of unemployment, lack of money, alcoholism grinds into the daily life. These conditions are typical of many parts of Cape Town and it is in these areas that the social workers of TB Care are implementing a programme that aims to cure 85% of new TB cases.

Ushwankathelo

IKAPA lisoloko libizwa njengentloko dolophu yesifo sephepha ehlabathini.Into yokwanda kangaka kwesisifo kulengingqi ayaziwa kodwa imibutho enjenge TB Care Association iyeyasilwa esisifo isithuba esingama -70 eminyaka. Esisifo sininzi kwindawo ezithwaxwa yintsokolo apho imeko zokuhlala zixineneyo yaye nokutya okusetyenziswayo ngabantu kungekho mgangathweni kunye nenzima yokungaphangeli, ukunqaba kwemali, nalapho ubunxila buyebuthabathe ubomi bemihla ngemihla. Ezimeko ziqhelekile kwinginqi ezininzi zeli lekapa yaye kulapho oonontlalontle balombutho bephumeza inkqubo ethi ijolise ukunyanga ama 85% engxaki zesisifo.

Kortliks

KAAPSTAD is reeds geruime tyd bekend as die TB hoofstad van die wereld. Dis onbekend waarom die siekte juis hier so volop is, maar organisasie soos die TB Sorg Assosiasie beveg die siekte reeds vir 70 jaar. TB teer op armoedige gemeeskappe, waar lewensomstandighede, oorbevolking en mense se eetgewoontes wisselvallig is. Die spanning van werkloosheid, tekort aan geld en alkoholisme knaag aan die daaglikse bestaan. Hierdie toestande is tipies van baie gedeeltes in Kaapstad en dis in hierdie gebied waar maatskaplike werkers bemoel met TB nou beplan om 'n program in werking te stel, met die doel om 85% van TB-gevalle te genees.

have been trying to make a more complicated set of arrangements because I'm worried about my car. Not once have I mentioned this concern but Mariette knows the unease of strangers to Manenberg. She knows it exists for many — myself included — like an intimation of the apocalypse, an outtake from the movie *Blade Runner*.

"It's quiet at the moment," she reassures me, "your car will be alright."

We meet as stipulated and I follow her the short distance to the Manenberg Clinic. A short distance that takes us off Lansdowne Road and skirts some vacant ground but it's far enough to separate one reality from another, to impress a sense of difference.

It's nine o'clock in the morning but already there are groups of men everywhere: lounging outside back yard gates, standing on the corners, leaning against posts. An old man sitting on an upturned plastic milk carton talks animatedly to a passerby. There is something so timeless in the cameo: a young man listening to an old man's story. The streets are active, noisy with running children and dogs, and women their hair in curlers beneath doeks watching and smoking. Yet the streets also look as they appear after a riot: littered with stones and half-bricks and smashed bottles and oddments of clothing.

The clinic is surrounded by a high fence of concrete poles and an automatic gate. The street is visible between the poles, but gangsters can't run in during their wars and use the clinic as part of the battleground, which happened before the fence was erected.

Mariette indicates the fence and shrugs: "A great pity. But that's just the reality of life here. Of course it's also to stop people breaking in to steal, and there's a security guard now because we can't afford to have the clinic vandalised. We've got to keep it open."

During the worst of the gang wars last year the clinic was forced to shut for three months but reopened in small offices on the other side of Manenberg. It was inconvenient and cramped, but this was an emergency and at least the clinic was up and running. "We were proud of that," says Mariette. "Let's just hope it doesn't happen again."

We go inside and she finds a small backroom where we can talk. Somewhere in the clinic a baby whines unceasingly.

Mariette is a University of Cape Town graduate. She was born and raised in Lansdowne and now lives with her husband in Kenwyn. She is committed to her work, and she talks honestly and bluntly about it and the conditions under which she has to work. She says if she told me her salary, I'd laugh. She's occasionally resentful that it's so low but then she'll chuckle and say: "That's NGO work, that's the reality." The thing is she cannot imagine being or doing anything else. For Mariette this is an exciting, relevant job. To use a war metaphor: a matter of being in the frontline of what she calls the "TB-HIV onslaught".

Mariette works for the TB Care Association, an NGO that is 70 years old and exists on grants from the Cape Town City Council, the Community Chest, donations from the public, and a government subsidy towards the cost of the social workers. Cape Town with a TB incidence stricken where living conditions are overcrowded and people's diet is haphazard and the stress of unemployment, lack of money, alcoholism grinds into the daily life. On a map of Cape Town great parts of the city would be coloured by these conditions. Also TB is what Mariette and her colleagues call an "opportunistic disease" — an airborne bacteria ready to hook into the lungs of anyone whose immune system might be ailing. Anyone, say, who is HIV positive. A statistic has it that 40% of those with HIV could develop TB.

This is of great concern to the people monitoring the city's health. They speak of TB now manifesting itself in the white population where it has been virtually unknown for decades. They talk, as Mariette does, of an onslaught.

"Consider," says Ria Grant who is the director of the TB Care Association, "as you walk down St George's Mall, 40% of the people you pass probably will have been infected with TB. If infectious people cough, sneeze, or spit in the street the bacteria is released into the air. If you have direct contact with such a person and if your immune system is weak you will probably develop TB.

"Our biggest problem in this city is HIV. That and TB are the terrible twins. We have to be par-

"As you walk down St George's Mall, 40% of the people you pass will have been infected with TB."

As an indication of how seriously the disease is taken internationally, the World Health Organisation declared the incidence of TB a "global emergency" in 1996. In the same year the Western Cape Department of Health declared TB a health emergency. The WHO's response was to institute a strategy called DOTS — Directly Observed Treatment Short course — which Cape Town has adopted.

The nature of TB is such that it requires six months of dedicated treatment. Six months of daily medication. If the medication is stopped after a few weeks or months the complications that set in are alarming: both for the patient and for society.

The facts are these: TB takes six months to cure. However, after a few months of medication patients start feeling better, and might stop the course of medicine. Within a few months they will become ill again but by now the TB bacillus will have mutated and the original medicine will no longer be effective. The cost of treating a patient with drug resistant TB is R35 000, against a cost of R3 500 for the "ordinary" version of the disease. And patients who are drug resistant transmit a TB strain that is drug resistant. In other words, a strain that is they've contracted the disease. The second is that one person can infect 20 others, through contact in the street, train, lift, and cafe. However, TB is curable and the treatment is free."

A top priority for Ria Grant and her colleagues is to make sure people take their medicine. This is where the DOTS programme comes into its own. Under this strategy volunteers from a particular community become "care supporters". They attend a five-day training workshop to learn about TB and the importance of directly observing "clients" take their medicine. "Clients," Mariette Williams explains is a better term than "patients," because it puts some of the responsibility for curing the disease on to the TB sufferer.

Until DOTS was inaugurated TB patients had to report daily to a clinic for their medicine. The clinic might have been some distance away and if someone skipped a few days it might be a week to 10 days before a nurse could get round to tracking them down. The system was far from perfect. Whereas DOTS puts a care supporter into the client's immediate neighbourhood. It's still up to the clients whether they choose a care supporter or the clinic, but those choosing a care supporter have a greater chance of staying the course.

Continued on Page 14

AT PLAY IN THE STREETS OF UITSIG: In poor areas, like Uitsig, children make do with what they can find to play with. A trolley becomes a vehicle of expression. In the background are three young men waiting for the start of the funeral of Sidney Christians who died of drug resistant TB on 8 December 1997.

an absolute challenge. I really enjoy it'

CT 26/5/99 (91)

A HELPING HAND: Susan Moore, who had drug resistant TB and is now cured, takes her medication under the supervision of Ouma Hector, a volunteer in the community.

TB in the Western Cape: Facts and figures

- The Western Cape has the highest rate of TB in the world.
- Other parts of the world are considered problem areas when there are 100 TB cases for every 100 000 people. The Western Cape is a red alert area with an average 559 TB patients per 100 000.
- A person with pulmonary TB can infect about 20 people.
- Some 80% of TB-sick people only go to a clinic after they have had the disease for some time. They will already have infected other people.
- TB tests and treatment are free. The disease is curable with a six-month course of medication.
- The cost to the state of treating each TB case is R3 500.
- About a fifth of pulmonary TB patients stop their treatment before the course has ended.
- These patients soon get sick again. By then the TB bacillus will have mutated and the original medication is no longer effective.
- The cost of treating "drug resistant" patients is R35 000.
- Patients who are "drug resistant" can transmit a TB strain that is drug resistant and therefore expensive and difficult to cure.
- Most TB deaths occur from this strain.

Continued from Page 13

In Manenberg there are 140 clients and 20 care supporters with a maximum of 10 clients each, although one, 65-year-old Auntie Martha, supports 15 clients. It's part of Mariette Williams' job to supply the bac- up to these care supporters. Which is no easy task at the best of times, and nothing short of impossible during the gang wars.

"I'm not a fearful person," she explains, "but about a year ago while I was sitting in this very office I heard shooting. These were serious guns and that was the first time I felt scared. Nowadays if I've heard something on the radio I phone ahead to find out what's happening here. And when I'm here, I'm careful. I watch what's going on in the street, I drive with the windows up, I keep the doors locked, that sort of thing. When it's quiet or there are flashy cars driving around you know there's going to be trouble.

"I'll tell you one thing, DOTS helped us enormously through the gang wars. Even under those desperate conditions we had a really good compliance rate. People would wait until the shooting died down then duck out and run to the care supporters. I think it's because a strong relationship develops between the client and the care supporter who lives here, who knows what's going on, that even during the worst times people will do their utmost to get their medicine.

"The only thing that sometimes concerns me is that if I get shot there has to be some contingency plan. And I don't mean get shot in that I'm being targeted, but that I get caught in the crossfire."

Mariette says this as if she's said nothing particularly out of the ordinary. And yet, I wonder, how many people have that consideration at the back of their minds as they go about their daily jobs. Not many. Also it is a measure of her personality that she's quick to add: "Can you imagine what it's like to live here under these conditions?"

We leave the clinic and drive to Anne's house in a quiet side street where the fences on either side are of corrugated iron. Anne is the care supporter for seven clients. She is short and open-faced with a ready smile, but also, I suspect, a will of iron. Each week she goes to the clinic to fetch the medicine for her clients and every day they come to her home to receive their tablets. She pops the tablets from a blister pack on to a perspex dish, they scoop them up and she watches them swallow the lot with a long glass of water. That way, as she says, there can be no cheating.

For this Anne receives a token gratuity of R40 a client. "The money helps," she laughs, "of course, yes, but I'm not doing this for the money. I'm doing this because I want to help people."

One of those she's helping is Isah who is 38 years old and was retrenched last November. Shortly afterwards he was diagnosed with TB.

"My dream is to be healthy again," he says. "I want to get a job when the treatment's finished so that I can support my family. In the end it's up to you to look after your own life, not so?"

Not so, although sometimes that is perhaps easier said than done. Mariette takes the long way back to the clinic. We pass a row of burnt out shops where the owners refused to pay protection money and were closed down and then looted. We pass huge graffiti that is dark and evil and the one features the gangster icon, Tupac Shakur. We pass a dog in a gutter that she says has been lying there for two days. It is still twitching.

"There is a malaise here," says Mariette, "as if this whole community is suffering from depression. I've worked in Gugulethu and it's not like this." She's frustrated, desperately wanting things to change but not knowing how to go about it.

I remember Isah's words: "Manenberg is *mos* Manenberg. You get robbed with a knife at your throat just getting bread. It's disgusting. It's not the way to live."

A week later I join another TB Care social worker at a factory in Bofors Circle, Epping. She's Ursula Poggenpoel, a no-nonsense woman with a sound grasp of the Flats vernacular. For 30 minutes she has a bunch of workers listening closely to her even though it's lunch time and they've been working all morning and they'd much rather be having a smoke and eating their lunch and joking among themselves.

She picks on the smokers first and soon no one's smoking any more. Not that she's criticised them, merely told them one or two things about the state of their lungs. Then she runs through the TB symptoms: coughing, tiredness, hot flushes, irritability, weight loss, spitting up blood. She starts talking about alcoholism: what she calls Friday night alcoholism, weekend alcoholism, or day-on-day alcoholism.

She mentions the quantities of liquor bought for weekend parties. Astounding quantities. She mentions places like Jesus and Hoender where supplies can be acquired once Friday's stocks have run out. She talks about fishermen who go away for the weekend with more booze than food. Some of the men squirm with embarrassment. They nudge one another like little boys caught out. They know she's got their number.

Ursula breaks into Flats Afrikaans. She describes wasted weekends. Weekends not only of drink but of dagga and Mandrax, and anything that can be smoked. She talks about men "earthing" after they've smoked, and some of the workers slap their thighs and wipe their hands over their faces, bashful, almost guilty that they've been exposed. And in their own language.

Yet Ursula doesn't criticise, merely states matters bluntly. She talks about TB and its treatment bluntly too. I've had it described to me five times in the last few days but listening to Ursula is like hearing it for the first time and it's not nice. I look at the faces of the men: they're concentrating, they're listening to her.

After the session she says to me: "This factory's really enlightened. They've had two cases who've been cured and now there's one guy on medication. The supervisor acts as a care supporter and gives him the tablets every morning. It's good. Nobody panics. Nobody gets fired. The client gets help and we stop the disease from spreading."

We talk for a while before she leaves and she tells of her maternal grandfather who was so colonial English he insisted on high tea with cucumber sandwiches and of her paternal grandfather who was Boer Afrikaans. "My family's all so wonderfully mixed up," she laughs, "so mixed."

"Actually," she says, "you could say I grew up white" — and she uses the term as a synonym for middle-class. "Home, church, school, family, a very closed circle. I was 18 before I got to know about the Cape Flats."

However, she learnt quickly about Hanover Park and Manenberg and Mitchells Plain while doing her nursing training at Victoria Hospital in Wynberg. "I got to see what was happening then. All the drink and dagga. I saw my friends doing that too. It's sad. Awful." Then her face clears. "But I wouldn't change this job for anything. It's an absolute challenge. I really enjoy it." A pause. "Although there are some days when it's difficult getting out of bed. But then we all feel like that, don't we?" She chuckles.

And with that Ursula, who loves music and pasta and walking in Kirstenbosch, drives off.

There's one thing she told the workers that must be repeated: "Listen guys, if you've going to sleep around, use condoms. If you get TB we can cure it, even if you 'earth' every day. If you get HIV we can't."

It echoes what her colleague Ria Grant said: "There's a problem with HIV and TB in Cape Town. It's going to decimate people. It's going to have a huge impact on the city."

LAST KISS: At the Brooklyn TB hospital Eugene Samson is kissed by his granny, Amina Hartman, four days before he died. Samson died on August 17, a month after his girlfriend Tanya gave birth to his daughter Andrea. His death was unexpected, even though he had been moved to the sickbay days before because he was having difficulty sleeping.

HE'S NOT HEAVY: Mourners carry the coffin of Sidney Christians, wasted by disease before his death, during his funeral in Elsie's River.

'But I wouldn't change this job ... it's an absolute challenge. I really enjoy it'

A HELPING HAND: Christine Ndude is a voluntary worker and sangoma. She works at Hout Bay clinic because she wants to help heal the sick.

DEATHLY LINK: Nomfundo Memani is a social worker who says that the link between TB and HIV is

'Then we will be able to speak openly of our situation'

(91) CT 27/5/99

Continued from Page 13

is no time to be moralistic about this one — we've got to do something to start saving lives."

(To be fair to Cape Town's politicians who have adopted an Aids pledge committing themselves to an active campaign against the disease, Grimwood's frustrated comments are aimed more specifically at the Department of Health. Cape Town is the only city in the country to have signed a pledge.)

To Annamaria, Ashraf Grimwood is an angel. He helped her come to terms with the disease, he helps her now in the low times. To Ashraf, Annamaria's story is a cautionary tale, a grim reminder that this virus can go everywhere.

It was on a Saturday morning at the end of summer that I met Annamaria: A cloudy day after a hot week with a slight north-wester stirring at the curtains. Her house was wide open. A sliding door gave on to the lawn. From the sitting room I could see through the kitchen to the green back yard.

The hall and [illegible]

"I have decided that the best way to go about it is to

then I look at my blood, my blood that used to be the stuff that kept me alive, and I think, inside that blood is a virus that I can't see but one day, probably within the next 12 years, it's going to kill me. It's very difficult getting used to this. It's very difficult knowing that if I nick myself my friends first have to rush for their gloves before they can help me put on a plaster."

Annamaria's story was an extraordinary tale of human travail and, as agreed, I sent her a copy of what I'd written and received the following e-mail (which has been edited and shortened):

"Dear Mike — Sorry I have taken so long to get this off to you but I have spent many hours and days trying to, firstly, sort out my feelings about it, and, secondly, trying to put it all into some form of coherence for you to work with.

"I have many misgivings about what you wrote and feel that there seems to be a misunderstanding about the message I tried to convey to you during our interview, and what was actually perceived by you. I obviously did not stress

life as well. Having found him, I got married, but unfortunately after a very short period of bliss, I lost him. I truly thought at the time that I was dealing with the loss and grief quite well — but in truth this was not the case.

"His death left me very vulnerable to the advances of an unscrupulous fortune hunter who was HIV positive and fully aware of this fact. He found it unnecessary to inform me of this before sex and before marriage, as this would obviously not have been in his best interests. What followed was a marriage of deceit, lies and hidden agendas, bringing me only misery and sadness.

"2. It did not take long for me to realise that I had made a terrible mistake by marrying him and very soon the abuse, violence and temper tantrums started. After a few months it became unbearable to remain with him and I informed him that I intended to divorce him. Later, once he was out of my life, out of my home, I learnt that I was HIV positive. This news was given to me without ceremony by my GP who, weeks earlier, had done a routine blood test for me f[illegible]

and what it was doing to my body.

"I also went through a stage of seeking miracle cures and hoping that I would be the one that would find a way, that I would be the one who would experience the miracle of spontaneous remission — that I would wake up one morning and it would have disappeared. But I knew that this was just fantasising.

"I then went on a mission to find the right doctor, one who would not only have an indepth knowledge of the disease, but who could treat me in a way that I would have absolute faith in his advice. This was not an easy task. Fortunately I found Ashraf Grimwood. To me he is an angel.

"I am very grateful to my family — whose unconditional love and support have been incredible and wonderful and have helped me more than they can ever know — and to my close friends. I know they love and stand by me.

"4. Once I had found my doc-

"I hope that they will realise that the disease can come their way

that I had not tapped before. Suddenly there was no time to sit around and bewail my lot.

"6. My hopes are that people become more educated about this disease and learn to show more tolerance — then we will not have to feel like lepers. I hope that they will realise that the disease can come their way as easily as it came mine. That it is not a punishment for bad behaviour. That it is not common to any one colour, creed, sexual orientation, or social status. Then we will be able to speak openly of our situation, our fears and needs, and seek help and healing without fear and trepidation. We will no longer have to walk in shame for something that is not in our power to change. We will no longer have to feel ostracised from our own society and be outcasts and looked upon with mistrust and revulsion.

"7. If I am to be remembered when I am gone, I would like it to be as a person who detested and fought ignorance wherever and whenever I could. That I turned

the green back yard.

The hall and the sitting room were tastefully furnished: Italian floor tiles, comfortable couches, pale restful pictures — a sense of well-being. A CD of soft jazz was playing.

Annamaria sat on a couch opposite me. She was dressed in black jeans and a light black jersey. She wore a discreet silver chain round her neck.

She looked healthy. She was enthusiastic and easy to talk to and life rushed in her like a mountain stream.

Yet, at a recent talk she gave a young man sat looking at her as if she were death itself. There are people who won't shake her hand. Who won't drink from her cups. Who, in a medieval sense, have cast her out of society.

"These days," she said at a point well into our conversation, "I have frequent nosebleeds and

about it is to re-tell my story."

by you. I obviously did not stress or come across clearly about what it was that I expected from this deal, and somewhere along the line, we became misaligned. I related to you my whole dreadful tale, in all its graphic detail, only in the hope that it would give you some background, and an idea of where I was coming from, of who I am. I had no idea you would use the story so graphically.

"I have decided that the best way to go about it is to re-tell my story. I thought the best way to do this was to put it down in point form.

"1. I was a very easygoing, and sometimes in fact an irresponsible adult. Nothing much fazed me or surprised me. I would go so far as to say that I was reasonably cynical about life and its inhabitants, but also naively trusting. I thought I knew it all, and viewed life as a game.

"I became successful in business rather late in my life, and also found my perfect mate late in

me without ceremony by my GP who, weeks earlier, had done a routine blood test for me for an insurance policy. When I went to her I had no suspicion that I might be positive.

"My initial response was absolute disbelief and denial. This was followed by despair and grief of such magnitude that suicide was constantly on my mind. It took me more than two years to come to terms with these feelings of great sorrow, fear, anger and sometimes hatred. Finally I have come to an uneasy truce and acceptance of my situation.

"3. My fears were many. Primarily I had to take each day as a challenge — it was a fight for me to get through the hours. Among my many other fears were how to tell my family: How would they deal with it? Who to tell? What were people going to say? Would my friends reject me?

"I was also completely consumed with a fear of the actual disease and, of course, of dying. I became obsessed with learning about the disease

"4. Once I had found my doctor and was doing well both mentally and physically I started asking all the major questions about life that my previous existence had never queried. In my quest for these answers I came to a realisation that, as awful as the disease is, it comes with some awe-inspiring gifts. My senses have been heightened. I have learnt to live one day at a time. I have found a path of faith in Buddhism that has brought me a serenity of spirit and a joy of life that I never new existed.

"5. Filled and armed with this knowledge and understanding, I have felt driven to share it with others who are in the same boat in an attempt to lift them out of that terrible dark chasm of pain, anger and despair. To try to make them realise that the disease is not the end of one's life, but only the end of one stage of life and the beginning of another. Through these efforts I found that I had talents and strengths

come their way as easily as it came mine."

rough ignorance wherever and whenever I could. That I turned my negative situation into a positive one and that I never gave up on myself."

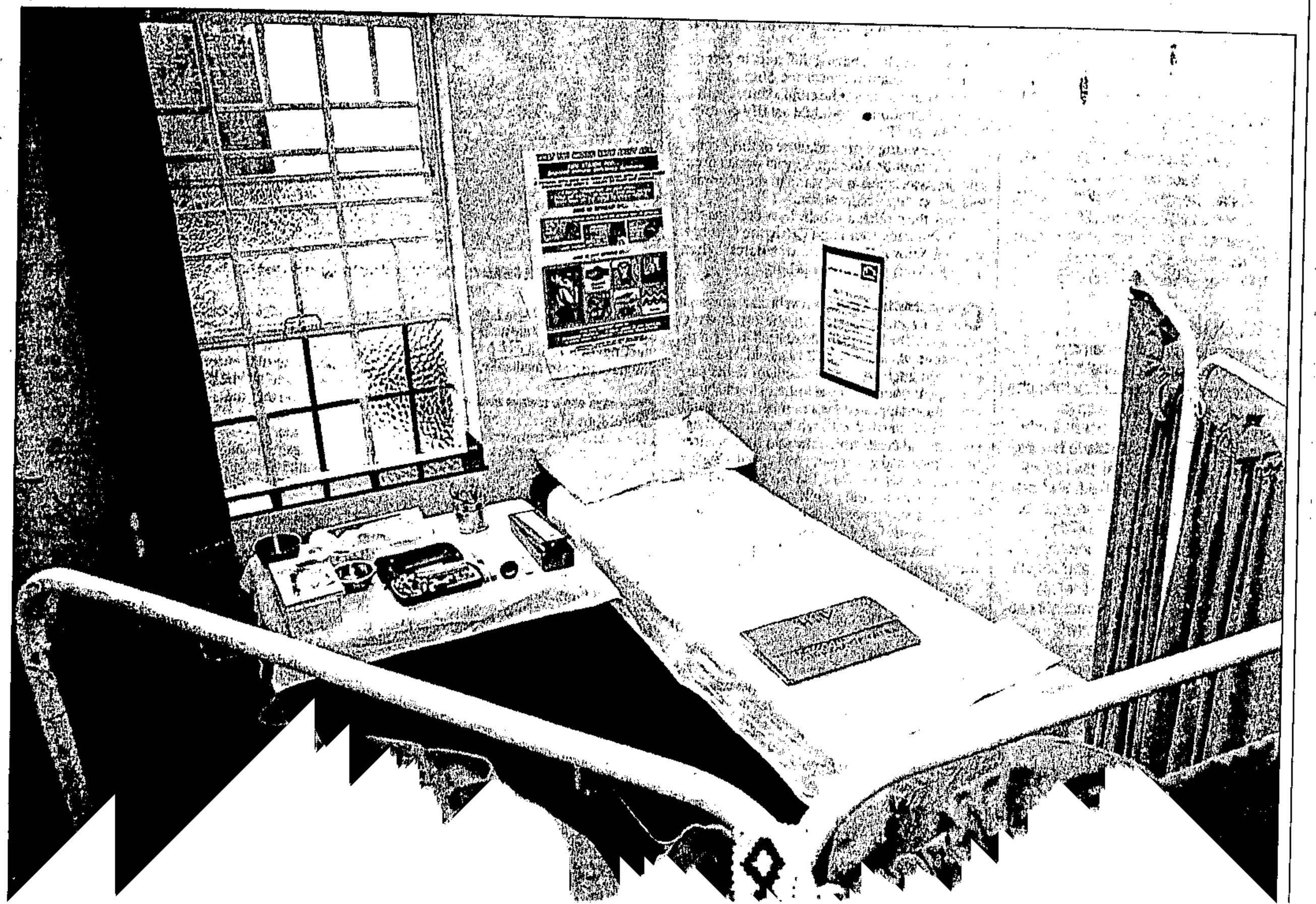
Annamaria concluded her e-mail by saying: "I think everything that you need to say about me is contained in this summary and this is how I would like to see the story told. It is not stereotyped or depressing, and hopefully serves a purpose: one of hope."

A last image from the original interview: As I left her house Annamaria waved from the stoep, her dog jumping at her, her cats waiting to be fed. In my mind, out of all the poignant things she said, was the phrase: "From now on I'll start getting ill."

She said this pragmatically, without sentiment, merely wishing to convey that she had reached a critical stage in the disease. I could not imagine what it would be like to say such a thing.

Vital statistics

- In some areas of the Western Cape 40% of TB patients are children. The "norm" is 10%.
- Children get TB from adults. About 40% of TB cases will contract HIV, the virus that causes Aids.
- Those who are HIV positive have a 30% higher chance of getting TB because their immune systems have been weakened by the HIV virus.
- About 3,5-million South Africans are HIV positive.
- The only country with a higher number of HIV infected people is India at 4 million. South Africa's population is 40m. India's population is 200m.
- At present 8% of South Africa's population is HIV positive. This is projected to increase to 25% over the next decade.
- Many of these people will be civil servants and professionals — the sort of people vital to the functioning of a modern economy.
- "We can see the tidal wave coming but there is no political will, let alone a clear overall strategy," says Dr Ashraf Grimwood, chairperson of the National Aids Council of South Africa.



A PLACE OF HELP: Dr Ashraf Grimwood's surgery in Chapel Street, Woodstock, is where many people come for help on HIV and Aids infection.

On the wall is a framed copy of the HIV/Aids Sectoral Pledge signed last year by mayor Nomaindle Mfeketo and executive committee chairperson Saleem Mowzer committing the city to carry out work programmes for the prevention of HIV/Aids, to care for people with HIV/Aids and to implement an anti discriminatory HIV/Aids practice.

PATIENCE: Children wait for the nurses at the Hout Bay Clinic. Many of the children who attend the clinic have TB and the clinic has an interesting holistic approach to some of the challenges that TB and HIV infection present. *PICTURES: DAVID HENNING*

A baby cries in low, insistent anguish ...

A baby cries in low, insistent anguish ...

(91) CT 27/5/99

In brief

TB and HIV respect no one. In fact social workers suspect that the incidence of TB among the middle class white and black population is growing but that the stigma attached to the disease keeps it hidden. Similarly people who contract HIV feel they have suddenly become outcasts. Most take a long time before they tell their family and friends. Like those who suffer from TB, they feel burdened not only by the disease but by the stigma. Yet no matter how educated or street-wise you are TB and HIV are an everyday part of our world — especially in Cape Town.

Kortliks

TB en HIV het respek vir geeneen. Maatskaplike werkers glo selfs dat die voorkoms van TB en HIV onder die middelklas wit- en swart bevolking aan die toeneem is, maar dat die stigma wat aan beide siektes kleef, mense weerhou daarvan om dit aan te meld. Mense wat HIV kry voel ook dikwels soos uitgewopenes. Baie neem baie lank voordat hulle vriende en familie inlig. Soos die wat ly aan TB, voel hulle slagoffers nie net van die siekte nie, maar ook van die stigma. Dit maak egter nie saak hoe opegvoed of straatslim jy is nie, TB en HIV is deel van ons daaglikse lewe — veral in Kaapstad.

Ushwankathelo

ISIFO sephepha asihloniphi namnye umntu.Oonontlalontle barhanela into yokuba isehlo zesisifo kuluntu olumhlophe nolumnyama oluphila ngokwezinga eliphantsi siyanda kodwa nohlazo abathi babekulo luthi lisigcine sifihlakele esisifo. Ngokufanayo abantu abahlaselwa sisifo sephepha nesika gawulayo bakhawuleza abetyeshelwe banganibani ukunye nabo. Abaninzi babo bathatha lthuba elide phambi kokuba bazise izizalwana nezihlobo zabo ngalengxaki.Njengabo bagula ngesisifo baziva benoxanduva hayi nje sisifo eso kodwa naluhlazo abathi babekulo.Nangoku nokuba ufunde okanye undwebe kangakanani isifo sephepha nesikagawulayo ziyinxalenye yobomi temihla ngemihla kulizwe iphila kulo ngakumbi apha kweli le-Kapa.

THERE are a few young women with their babies in the waiting room of the Hout Bay clinic. They put the children on the floor in a group and fetch them toys from a box. The pre-toddlers play happily and their mothers keep an eye on them and talk about family matters.

Every now and then old men come in and go through the waiting room to a door in a passageway marked with the initials TB. A few moments later they saunter out and head off into the day. Then a women enters the clinic with a baby strapped to her back. She ignores the other mothers, heading for the TB room.

Eventually I hear the baby crying, not a howl but a low insistent anguish. It goes on and on.

In the room with the mother and baby is Christine Ndude. She's been at the clinic since it opened an hour earlier to make breakfast for the TB patients who come daily to receive their medicine. Christine is a voluntary worker, paid a small gratuity by the TB Care Association. She is also a sangoma. She is doing this work because she wants to help, and she wants to heal the sick.

Right now she is having difficulty in getting the baby to swallow the medicine. She's going to have to squirt it down the child's throat with a syringe. Both mother and child are HIV positive. The baby has TB.

"We're seeing more and more of this," comments Nomfundo Memani, a social worker from TB Care Association as we stand in the doorway, looking on. "It's a big problem."

Once the mother and baby have been treated we sit in a back room and Christine tells her story in Xhosa. Nomfundo translates. What unfolds is complex and compelling.

WHENEVER YOU'RE READY: Mothers wait for their turn to see one of the nurses at the Hout Bay clinic.

One of Christine's parents had been a sangoma and, according to tradition, she inherited the "sickness". This first manifested itself in aberrant behaviour when she was 12 years old. She started skipping school, was disobedient to her parents, spent hours with the initiates in the bush. Once she disappeared for a number of days and was found smeared with white mud in a river. She also had beads which she said the ancestors of the river had given her, and carried a bucket that sangomas use. For a few days she vomited badly. Only then did people realise her calling. At home a sheep was slaughtered to give thanks to the ancestors. She was sent to receive instruction from other sangomas but she found it unhelpful because the sort of medicine her patients needed was presented to her in dreams.

"It is a gift from God," she says.

And does it not conflict with Western medicine?

"No," she replies. The TB medicine works. She cannot cure TB sufferers with herbs. But she can use traditional medicines for other uses.

The talk moves to the power of the ancestors. "If the ancestors call you have to go," says Nomfundo. "It doesn't matter if you are in a board meeting, or it is three o'clock in the morning. You have to go immediately."

She says she's always aware of the ancestors. She should sacrifice an animal to them to give thanks for her successes, "but" — she laughs — "I'm too stingy." Nomfundo's successes are singular. While working as a part-time packer at Pick 'n Pay she attended the University of the Western Cape and graduated in social sciences. Pick 'n Pay gave her a bursary for three of her four years.

"It's important to make a sacrifice to the ancestors," she says, "otherwise they may no longer bless my life."

For a moment I can see the tensions in Nomfundo's life. She stares at me and I can't hold her gaze. Then she relents and looks out the window at the far sanddunes.

"You know,' she says, "there are some educated, wealthy black people who die of TB. They are too embarrassed to go to the clinic. They think TB is a sign of poverty. They go to a private doctor and they get the medicine but they only take it until they feel better. Then they get sick again and maybe this time they are drug resistant and they die.

"This stigma is terrible. It is like that with HIV, too."

Again I recall the words of her colleague Ria Grant: HIV and TB are going to decimate people in this city.

This is the story of Annamaria. She is HIV positive. She has been positive for three years. She is a middle-class white woman in her early 50s, a successful businesswoman, vivacious with a pleasingly dark sense of humour.

Annamaria is clearly not part of the HIV stereotype. She is not young and black. But she is part of a statistic that includes 3,5 million South Africans. The only other country with a higher number of HIV infected people is India at 4 million. But then India has a population of 200 million whereas South Africa's is 40 million. As a percentage this country is in an unenviable bracket of its own.

If the situation is bad now, within the next decade the projection is that 25% of the population will be HIV positive. And these people will not be lost in the poverty stricken rural areas. For want of a better term, "these people" could be called the "emerging middle-classes". In other words civil servants, professionals, the sort of people vital to the functioning of a modern economy.

"You'd think," says Dr Ashraf Grimwood, chairperson of the National Aids Convention of South Africa and a Principal Medical Officer for Cape Town, "that given these statistics and projections, there would be extraordinary political commitment towards dealing with HIV. "Instead we get gestures. Nor is there union involvement, or private sector support. We can see the tidal wave coming but there is no political will, let alone a clear overall strategy. There

Continued on Page 14

Pigs to eat hungry kids' biscuits

(90) ST 13/6/99

MZILIKAZI WA AFRIKA

BISCUITS meant for poor schoolchildren are to be fed to prison pigs after the collapse of a feeding scheme which has left 340 000 pupils hungry.

More than R33-million was spent on the scheme, but in excess of 1 000 boxes of biscuits were left to rot in warehouses because contractors were not paid to take them to 1/563 schools.

North West Health Department spokesman Cornelius Monama said the scheme collapsed because of "cash flow problems".

"We had failed on several occasions to pay contractors who were supposed to supply food to our targeted schools," Monama admitted.

So more than 5 000 pigs at a piggery at Rooigrond near Mafikeng, which supplies pork to Rooigrond Prison and local butcheries, will eat the biscuits.

The boxes of biscuits had sat rotting in storerooms for more than six months.

Monama was unable to say when the programme stopped, but some schools say they have not had food deliveries since the beginning of the year.

At Stadt Primary School near Mafikeng, nine-year-old Cornelia Novolo was astonished to hear that the biscuits, which were supposed to feed her and other primary school pupils, would be given to pigs. She said she and her sister Thandiwe had had only tea for breakfast.

Lebohang Ntsie, the school principal, said most of her pupils had depended on food from the nutrition programme.

Oliteng Mokati, an environmental health inspector for the department, said he decided that the rotten biscuits should be given to the pigs after inspecting them on May 18.

Now the department is pointing the finger of blame at Pieter Joubert, a senior administration officer whose job it was to oversee the programme.

"Joubert was supposed to monitor and inspect the programme and report any problem to his seniors and it seems he has failed to do so," said Monama.

But Joubert said storeroom managers and the contractors were to blame.

Tokyo Tlaletse, the manager of the Tswelelopelo depot in Mafikeng, is adamant that he warned the department six months ago that disaster loomed unless it sorted out its payment with contractors transporting the food.

Contractors have accused Joubert and Adelaide Kaya, assistant director for nutrition, of failing to inform them about the cash flow problem.

This week the department said it hoped to resume its school nutrition programme next month.

Acute shortage of TB vaccine

(91)

JUDITH SOAL
HEALTH WRITER

CT 29/7/99

CAPE TOWN has the highest rate of new tuberculosis infections in the world, but the provincial health department has been warned that the country has run out of the vaccine that protects children against the disease.

At a meeting between provincial health MECs and national Health Minister Manto Tshabalala-Msimang last week, the provinces were told that the supplier of the BCG (bacille Calmette-Guérin) vaccine was having production problems. "The state vaccine institute has experienced machinery failure resulting in a national acute shortage of the BCG vaccine," said Health and Social Services chief Tom Sutcliffe. "It is anticipated that this problem will persist for at least another three to four weeks."

Some state clinics have already run out, others expect to shortly. The shortages are also being felt in the private sector. "It isn't an immediate crisis," said Sutcliffe, "because children won't suddenly get TB if they aren't immunised at birth. They can be immunised any time before they are two."

However, authorities are concerned that parents might not bring their children back to be immunised and the "window of opportunity" will be lost.

Sutcliffe said the national immunisation programme had tried to import the vaccine from Japan, but had encountered problems.

TB drug defaulters risk being locked up

JANET HEARD (91)

ST 1/8/99

SUFFERERS of a life-threatening strain of tuberculosis face being locked up if they habitually avoid treatment.

A senior health official, Dr Ivan Toms, has warned that the law enables medical authorities to "incarcerate" defaulting patients who suffer from the contagious multidrug-resistant tuberculosis, a strain that returns even more resistant than before unless treatment is kept up.

"I have the authority [under the Health Act] to do this in order to protect the community and I am under increasing pressure to consider this," said Toms, who was recently appointed director of Cape Town's health services.

However, a suitable lock-up hospital would have to be found.

The "lock-up" option has been welcomed by MDR TB survivor Franceline Gilla, 25, who over the past 10 years has lost a lung, her mother, father and two sisters to tuberculosis.

"If they don't lock up a person who refuses treatment, then that person is putting others at risk and behaving like a murderer," said Gilla, who was cured of MDR TB this week after more than two years of medication.

"It boils down to addressing the rights of the individual versus the rights of the community," said Toms, stressing that most TB patients were not infectious after just a few weeks of treatment.

Toms also has to deal with frustrated health workers who administer the costly drugs — about R30 000 a patient for an 18-month course.

Brooklyn Chest Hospital's MDR TB co-ordinator, Sister Karen Shean, said: "We have patients who jump fences to escape. It is so frustrating because we know that when they return we will have to start from scratch."

Although TB — which kills more people than HIV in this country — is prevalent in poor, overcrowded areas, it is spreading.

About 2 000 new cases of resistant TB are reported countrywide a year. "This is not a lot, yet it consumes about 20 percent of the TB budget," said Groote Schuur Hospital pulmonologist Professor Paul Willcox.

About one in five patients default on treatment, leading Willcox to agree that "in extreme cases, there is no other way but incarceration".

Killer disease threat to babies

ST 5/9/99 (91)

RANJENI MUNUSAMY

THOUSANDS of babies born since June have not been vaccinated against tuberculosis after the only institute in South Africa to produce a vaccine that prevents the killer disease was forced to stop production. Some of the babies now risk contracting the highly infectious disease, which last year claimed the lives of 5 000 South Africans, or spreading it to other people.

The director of the State Vaccine Institute in Cape Town, Dr Woolf Katz, said production of the BCG vaccine had to be stopped due to an "instability" in the bacteria used in its manufacture.

The institute is the only source of the vaccine in South Africa and hospitals are prohibited from acquiring it overseas.

Hospitals throughout the country have not received the vaccine for about three months, during which time about 284 000 babies were born in South Africa.

With varying levels of stock at each hospital, health authorities are unable to determine how many newborns were sent home without being immunised.

The shortage comes at a time when the Department of Health has declared tuberculosis a top national health priority after discovering that more people in South Africa die of TB than HIV/AIDS. An estimated 140 000 new cases occur annually.

The director of communicable diseases at the Department of Health, Dr Neil Cameron, said private hospitals were most affected by the shortage as they received less stock than state hospitals.

The head of the baby clinic at City Park Hospital in Cape Town, Sister Bridgette Oaks said while the shortage became evident in June, stocks ran out in mid-July.

"At that time, only two clinics in Cape Town had stocks left over. But since then we have not been immunising the babies. We have informed the mothers to keep contacting us and the minute we get stock, we will begin immunising the babies again," Oaks said.

Stocks at most Durban hospitals were also depleted in July. Sister Lorraine Kronik of St Augustine's Hospital said no babies born since then had been immunised.

Cameron said provincial depots should begin receiving the BCG vaccine within the next few weeks.

He said the Department of Health was not "overly concerned" that babies were not being immunised as they could still be vaccinated when they visited their local clinics.

But a spokesman for the South African National Tuberculosis Association, Jackie van Rensburg, said the shortage was "quite serious", especially among poor people in rural areas.

She said although the vaccine did not offer complete immunity against TB, it posed some resistance to the spread of the disease. Babies who are taken home without being immunised could therefore be infected or spread the disease to others.

"With declining socio-economic standards in South Africa, fewer families are able to offer children good nourishment, which makes the onset of TB much quicker."

"The disease is also more predominant in rural areas, where there are not many clinics and mobile clinics visit only a few times a year," she said.

The Medical Research Council's Dr Bernard Fourie said the risk of newborn babies contracting TB was "fairly high", especially if they were in direct contact with people who had the disease.

"The risk increases the longer they do not get the vaccine. There has to be a system of tracing back the newborns who did not receive the vaccinations because this could become a serious problem if it is completely forgotten," Fourie said.

More than 80 000 babies to get new TB vaccine

(91)

Sowetan 7/9/99

By Bhungani Mzolo
Health Reporter

MORE than 80 000 babies will be vaccinated against tuberculosis (TB) as from today after health authorities approved the latest vaccine.

Weekend reports said thousands of babies born since June had not been vaccinated against tuberculosis because the State Vaccine Institute was forced to stop production last year.

Newborn babies are normally given doses of the BCG vaccine to immunise them against tuberculosis.

Director of the institute Dr Woolf Katz said yesterday he had sent 85 000 vaccine doses to the Department of Health and hospitals, and clinics could begin to immunise babies.

"I will send batches of doses every week until there is enough to vaccinate all children," he said.

Katz said the reason there was no vaccine supply for the past three months was because of stringent regulations set up by the World Health Organisation.

"I was not prepared to send the vaccine if it was not potent, safe and effective, as the bacteria was unstable," he said.

The Medical Research Council said yesterday it did not believe the country was facing a crisis as a result of the absence of the vaccine since June.

The MRC's Dr Bernard Fourie said although babies received BCG at birth, they were checked again after three months to find out if they had been vaccinated.

However, he said babies who did not receive the vaccine ran the risk of becoming infected with the TB bacteria if they were living with people infected with the diseases.

Fourie said special care was needed for babies who were not immunised.

"Babies will only contract TB if their mothers or caretakers have the disease," he said.

Fourie said it was estimated that 15 000 new TB cases occur in South Africa annually. Nearly 5 000 people were thought to have died of TB last year.

Biochip could tackle tuberculosis

BD 28/10/99 (91)

Researchers have high hopes for a 'biological' computer chip which might become widely used in medicine

WASHINGTON — US and Russian researchers say they have developed a biochip — a biological version of the computer chip — that would help to diagnose drug-resistant forms of tuberculosis in human beings.

The chip would be important for helping to fight a renewed spread of the ancient disease, but also proved that biochips could be used widely in medicine, the researchers said. Developed by teams at the US energy department's Argonne National Laboratory in Chicago and the Russian Academy of Sciences' Engelhardt Institute of Molecular Biology in Moscow, the chips can carry out thousands of biochemical reactions at the same time.

"This will be their first test in the realm of real-world medical diagnostics," said Harvey Drucker, associate director of the Argonne laboratory.

"We chose tuberculosis for the tests because new drug-resistant strains have sprung up and can easily spread to the whole world. If we can quickly identify specific strains, it will help doctors to prescribe the best treatments quickly and possibly help prevent a worldwide epidemic."

About 8-million people worldwide become infected with tuberculosis every year and 3-million die of it. The World Health Organisation said strains resistant to more than one drug were on the rise. Current tests take weeks or months to find which strain a patient has.

The Argonne-Englehart biochip is a glass slide carrying as many as 10 000 tiny gel pads, each serving as a kind of miniature test-tube. Attached to each gel pad is a short strand of DNA from a drug-resistant strain of tuberculosis.

DNA normally comes in two strands, and these pair up in a specific way. The biochip works when a single strand of the DNA from the tuberculosis strain being tested is laid down. If it matches up right, the test is positive for drug-resistant tuberculosis. Yet researchers need to do many more tests. "It'll take years to get to the market," Drucker said. "Since tuberculosis is becoming a global epidemic, urgent steps must be taken to speed up the process." — Reuters.

'ONE OF WORST NUTRITION DISEASES'

ET 5/10/99

New strategy to curb vitamin A deficiency

(90)

AS EARLY AS 1994 it was found that one in three children under the age of six in SA suffers from serious vitamin A deficiency. The problem persists, writes **GUSTAV THIEL.**

THE Association for Dietetics in South Africa (Adsa) and the Nutrition Information Centre of the University of Stellenbosch (Nicus) are working together on ways to solve the problem.

To kickstart their efforts, the importance of vitamin A in people's daily diet is one of the central themes of next week's National Nutrition Week.

Its theme is Youth Against Hunger.

Vitamin A is especially important for good vision and for protecting the body against infection, as well as in ensuring adequate growth and development.

The amount of vitamin A in food is commonly expressed in International Units (IU) or Retinol Equivalents (RE).

RE is a unit developed to standardise measurement of the variable vitamin A activity of different vitamin A sources.

According to Irene Roberts from Nicus, vitamin A is essential for the health and well-being of people, particularly children.

Roberts said Vitamin A deficiency is one of the most significant nutritional diseases among children.

"Each year, both established and marginal forms of vitamin A deficiency may contribute toward 1,3 to 2,2 million preventable deaths from infections in children younger than five years," Roberts said.

Apart from infections, according to Nicus, vitamin A deficiency is also one of the main causes of blindness among children.

An estimated 500 000 children go blind every year because of vitamin A deficiency, and within months of the onset of blindness, between 20% and 70% of these children die.

Vitamin A deficiency occurs mostly in poor countries and a variety of international agencies are looking at ways to co-ordinate efforts to address the problem.

The South African Vitamin A Consultancy Group found in 1994 that one in three children in South Africa do not get enough vitamin A in their diets.

Infants need 420 RE a day before they turn six months, 400 RE between that age and three years, and 500 between three and six years.

Vitamin A is present in the diet in two forms: Retinol and carotenoids. Retinol comes only from animals and carotenoids mainly from bright yellow and orange fruits and vegetables, and dark green and leafy vegetables.

Examples of essential food items include milk, kidney, butter, yellow cheese, sweet potato, carrot, spinach, broccoli, butternut and mango.

The most immediate cause of vitamin A deficiency is through poor diet, but can be worsened by frequent infections like measles, diarrhoea and acute respiratory infections.

The underlying causes of the deficiency in children include breast-feeding for an insufficient length of time, inappropriate complementary feeding practices and low levels of family education.

According to Nicus the basic reasons for vitamin A deficiency are a lack of resources to produce vitamin A-rich foods, failure to consider vitamin A and other micro-nutrient needs in agriculture and health policy-making, little agricultural land, poverty and poor access to markets.

A number of intervention strategies have been formulated and Nicus stresses the importance of educating South Africans.

Strategies include the promotion of breast-feeding, food fortification — which is achieved by adding vitamin A to foods commonly consumed by a community — and the routine provision of high-dose vitamin A supplements.

The ultimate goal of the programme is to eradicate vitamin A deficiency in South Africa and it is hoped it will achieve complete dietary modification.

During National Nutrition Week, which starts on Monday, registered dietitians will answer questions related to vitamin A deficiency.

A national hotline has been set up for this purpose.

The number is (021) 933-1408.

TURNING THE TIDE AGAINST TB

The African solution (91)

South Africa is taking an innovative approach to the problem of tuberculosis, harnessing the power of traditional healers to supervise a cure, writes LAURICE TAITZ

THE heat in the shack next to Caroline Mkhwanazi's house is oppressive. Mkhwanazi, a sangoma, rolls out a grass mat, sits on her haunches and throws the bones. Facing her is 27-year-old Sibusiso Moloi. In Mkhwanazi's right hand is an oxtail whisk — to communicate with the ancestors and drive away evil spirits — and, in a deep voice, she chants in Zulu.

As her pitch rises she says in English: "It is TB. You must go to the clinic."

Mkhwanazi, from Lebohang township in Leandra, Mpumalanga — 110km east of Johannesburg — is one of a group of healers who have volunteered to work with the Department of Health and the South African National TB Association in implementing a strategy for curing tuberculosis.

The Dots strategy — Directly Observed Treatment, Short-course — relies on testing, monitoring an uninterrupted supply of effective medicine and ensuring each TB patient completes a six-month course of treatment.

Dots, which has achieved 95 percent cure rates in countries such as China, Peru and the US, was implemented after a World Health Organisation review of the TB programme in 1996 confirmed that South Africa had one of the worst TB epidemics in the world. But the progress in reaching all health districts has been slow as the Health Department does not have the capacity to do it alone.

Last year, about 180 000 South Africans suffered the debilitating effects of TB, and 12 000 died from it. Caused by bacteria, a TB infection is spread through breathing in infected droplets coughed up by sufferers.

Health officials estimate that if left untreated, one person can infect up to 15 others.

Until Dots, the biggest obstacle to curing TB was the non-compliance of patients with treatment — often because they start to feel better or because of distance from a clinic.

A person diagnosed with TB has to take medication every day for six months. For those who don't, TB can be deadly.

Experts say the development of multidrug resistant strains is increasing, caused by inconsistent or partial treatment of ordinary TB. When drug treatment stops, the body builds up resistance to medication, reducing options for further treatment.

The Health Department says drug-resistant strains can cost up to R25 000 to treat, as opposed to R250 to treat a new infection. At best, only half of those infected with the new strains can be cured.

For years, patients have flocked to *inyangas* — herbalists — and sangomas — traditional healers endowed with spiritual power by the ancestors — in search of help for the coughing, the severe fatigue and the weight loss that are the symptoms of infection.

Sister Emma Mabena, in charge of Leandra Clinic and a member of the Lebohang Santa branch, which opened in June, says: "Patients trust traditional healers more than they trust us. It's only here that the healers say they can't cure TB."

Leandra Clinic lies a block from a busy taxi rank and a marketplace. On Wednesday, it was pension day. People thronged the streets looking at the wares displayed, as Michael Jackson's music blared out of a nearby shack, and goats walked freely. Clay pots lay amid the caged chickens, the fruit and the vegetables. Women sat behind piles of second-hand clothes, weaving straw sweepers.

Lebohang is home to about 250 000 people, and locals estimate unemployment there is as high as 80 percent.

RESTING PLACE: Goats roam freely in Lebohang, where traditional healers and the public health authorities have united to combat TB, which claimed the lives of about 12 000 South Africans last year Pictures: JULANI VAN DER WESTHUIZEN

HEALING HANDS: Sister Emma Mabena, sangoma Caroline Mkhwanazi with Sibusiso Moloi, and patient Zandile Tshabalala

Like Mkhwanazi, *inyanga* Selena Makone has also bought into Dots. For many other traditional healers, the strategy represents a challenge to their authority and a cut in earnings.

Makone says: "We used to say it was *isidliso*, a poison inside or a 'dirty thing'. We would give them something to make them vomit it out. Now we send them to the clinic."

And like Mkhwanazi, Makone is a member of the Traditional Healers Organisation of Africa. They have both completed training in traditional primary health care — in treating sexually transmitted diseases, TB and AIDS.

Her patient, 16-year-old Nkosinathi Mngomezulu, is one of three of her TB charges.

"I support his treatment," says Makone. "Since he was tested I visit him at home every morning. I fetch his medicine from the clinic and make sure he takes his tablets every day.

"After that I mark it here," she says, bringing out the green card on which Mngomezulu's daily treatment is recorded.

Among the herbs, powders and tinctures neatly arrayed on the shelves of Makone's consulting room sits the trademark zip-lock yellow plastic pouch from the local clinic. "I enjoy working with Santa because I am a traditional healer," says Makone. "When you work with the community you want to help them."

Santa was formed 52 years ago in Durban. A non-profit, voluntary organisation, it has built up a network of branches and care groups — responsible for creating awareness, fundraising and providing support to patients and their families — countrywide. The organisation also runs 22 TB hospitals, fully funded by provincial health departments.

Corporate relations manager Jacqui van Rensburg says: "The state hospitals can't do it as cost-effectively. We used to hospitalise TB patients for the full six months, but with Dots that's been cut to two months."

The patients are now sent back into the community to be cared for, she says.

Skills like repairing shoes, vegetable gardening, sewing and even brick-making are taught at the hospitals. Marketing manager John Heinrich says: "Over the years, we've switched from a 'do good' to a community involved organisation."

While patients are in hospital the organisation traces their addresses to ensure the patients can be linked to a clinic and a care group once discharged.

The link between clinics and Santa groups depends on the clinic sisters, says Heinrich.

Mabena says in some areas nurses are resistant to Dots. They feel threatened by the programme's intrusion and the level of commitment required.

She adds: "I did my training in the rural areas, so I enjoy a struggle. I am used to it."

With the increase in HIV infections, TB is on the rise.

Van Rensburg says: "Over the past two years HIV has become a real issue for us, whereas before we were just working with predictions."

Today, nearly half of all patients with TB are infected with HIV. The Health Department says two out of three South Africans are infected with TB germs but most will never succumb to the disease as their immune systems are strong.

In Lebohang, where HIV is a growing problem, Mabena says the response to the opening of the local Santa branch has been overwhelming. "We have 42 volunteers and a waiting list. Now we can trace all the cases that come to the clinic."

Patrick Mbatha, 23, is one of these volunteers. "There is no work here. But I'm happy because I am keeping busy."

With so few work options available — Sasol, the mines or the farms — volunteer work restores a measure of dignity.

Mbatha's story is familiar. After he finished school there was no money for him to further his studies. Bright and energetic, he has been trained to identify the signs and symptoms of TB. With pride, he says he is often referred to as "that TB doctor".

"If someone tells me they know of a patient I go to the home and discuss their condition with them. I look for other people who may be infected in that house."

Mabena says: "The problem is we are surrounded by the mines. There is a lot of pollution, and people still use coal stoves. In some areas of Lebohang there is no water or sanitation." But she is not deterred by the scale of the epidemic. Mabena believes the Dots strategy is starting to show results. "This month we'll discharge five patients who've completed their treatment. Next month we'll go with the volunteers to the farms, to tell them what TB is, how to prevent it, and that it's curable."

She says there is a growing awareness of the problem.

In Lebohang, this is being fuelled by the commitment of a small band of volunteers who are making it their job to seek a cure to an age-old problem.

"A few weeks ago, a patient died, and we attended the funeral with our Santa flag for everyone to see. On Monday, there were queues of people saying: 'I'm coughing.' Now they are bringing themselves. Now they are aware," she say

Soweto hospital at centre of world TB study

ARG 11/12/99 (91)

CLAUDIA MPETA

The Charles Hurwitz hospital in Soweto has become the site for a revolutionary field trial to study the effects of ultraviolet light in containing the spread of tuberculosis (TB).

The technique, ultraviolet germicidal irradiation (UVGI), uses a light bulb to destroy the mycobacteria that transmits TB via the atmosphere before it infects people in the same environment as TB sufferers.

The project is a joint initiative of Eskom and an American-based non-profit research organisation, the Electrical Power Research Institute (EPRI), known here as the South African Centre for Essential Community Services (SACECS).

The centre is also looking at other ways of using electro-technology to improve health and living standards.

Research into the design and use of the UVGI technology has been carried out in homeless shelters in the United States.

"Much remains to be done to determine conclusively whether UVGI air-mixing systems can make a beneficial difference in TB control," said Dr Philip Brickner of the department of community medicine at Saint Vincent's hospital in New York.

"The study in Soweto is significant because if it can be proved that the spread of TB can be reduced in difficult settings then the technology can be applied broadly. Potential benefits for the world family are substantial for developing a creative application of this inexpensive technology to help prevent the airborne transmission of TB."

'Potential benefits of the tests for the world family are substantial'

In 1996 a pilot UVGI programme was launched at the King George V hospital in KwaZulu Natal for problematic TB cases.

"Some intervention had become necessary because health workers had become very anxious about their safety and contracting the disease," said Dr Philip Onyebujoh, head of clinical research at the Medical Research Council.

"The light fixtures are still being used in the hospital. They are now considering buying the mechanically assisted ventilators to help with constant air circulation."

The ventilators help to ensure that all airborne germs come in contact with the lamp and are destroyed.

While TB has always been a major health priority in South Africa it has reached epidemic proportions and continues to rise.

"South Africa is burdened by one of the worst tuberculosis epidemics in the world," said Dr Bernard Fourie, director of the National Tuberculosis Research Programme.

"For every 100 000 people 350 new people are infected every year. That figure is expected to double in the next two to three years if current trends persist."

At one KwaZulu Natal hospital, TB cases increased by 81% between 1991 and 1998.

An alarming trend is the increase of TB that is multidrug resistant, especially among HIV and Aids patients.

TB affects people with HIV more easily because of their weakened immune system.

While strategies are in place through government hospitals and clinics to curb the spread of the disease, Dr Fourie feels people are not aware of the seriousness of the TB problem.

"People should forget about HIV as a separate issue. We need to be talking about a simultaneous commitment to Aids and TB."

According to Dr Edward Nardell of the Harvard Medical School, the focus on protecting health workers is also significant.

"Environmental control such as UVGI is important because TB sufferers cannot always be isolated before they start infecting others."

As well as extending the original experiment in homeless shelters, the new project, which will "switch on" next year, will attempt to determine whether the UVGI technology is safe and cost-effective.