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Dr. Ashok Kumar
Deputy Director General
Revised National TB Control Programme
Central TB Division (MoHFW)
Government of India
Nirman Bhawan, Block 'C'
Maulana Azad Road
New Delhi – 110108

Sub: TDR TB patients to be isolated in TB sanatorium

Dear Sir,

We write to you as Lawyers Collective HIV/AIDS Unit, a public interest group of lawyers working on HIV, law and human rights. Our work includes policy research and advocacy, undertaking strategic litigation and providing free legal services to persons living with/affected by HIV/AIDS, sex workers, persons dependent on drugs and LGBT persons. We also extensively work in the area of access to affordable medicines and treatment.

According to media reports, in light of recent identification of Totally Drug Resistant Tuberculosis (TDR TB), the Government of Maharashtra is considering the idea of isolating TDR TB patients in a sanatorium. We are writing to express concern over this measure as it is violative of the fundamental rights of TB patients and in fact can potentially subvert India's TB programme. We urge the government not to react on the basis of fear, and instead to formulate a patient – friendly response, modeled on scientific and evidence-based treatment delivery models which are proven and accepted both domestically and internationally.

Forced isolation of TDR TB patients in sanatoriums will be violative of the International human rights framework as well as the Fundamental Rights guaranteed under the Indian Constitution

The rights to liberty, autonomy and freedom of movement have been enshrined as basic human rights in the International Convention on Civil and Political Rights and International Convention on Economic, Social and Cultural Rights and as Fundamental Rights under the Indian Constitution (Articles 21 and 19). Confining TDR patients in TB sanatoriums amounts to violation of the fundamental and human rights of liberty, autonomy and freedom of

movement. Although these Fundamental Rights can be curtailed in the interest of public health, the restrictions must nonetheless meet standards of legality, evidence-based necessity, proportionality, and gradualism. Under both International Law and Constitution of India, restrictions on human rights in the name of public health must, *inter alia*, at a minimum, be:

- strictly necessary in a democratic society to achieve the objective;
- the least intrusive and restrictive available to reach the objective;
- based on scientific evidence and neither arbitrary nor discriminatory in application; and
- of limited duration, respectful of human dignity, and subject to review.

Forced isolation in sanatoriums does not meet the test of evidence-based necessity. Limitations are only permissible if strictly necessary to achieve a given objective. Ambulatory and community-based treatment models for MDR and XDR TB have been successfully implemented in a number of settings – ranging from Lesotho to Latvia, Estonia, Georgia, Peru, the Philippines, Nepal and the Russian Federation – without having to resort to extraordinary measures that infringe on patients' human rights. Even India has been following a robust DOTS programme which negates the need to isolate patients. Since patients in India are not refusing treatment and since ambulatory or community-based treatment programmes provide a viable alternative to wholesale forced isolation, forced isolation is not strictly necessary to achieve public health goals.

Forced isolation does not meet the test of proportionality. Although protecting the general public from drug-resistant TB is clearly a legitimate objective, right to autonomy and liberty and freedom of movement are also important fundamental individual rights. Reliance on compulsory detention, especially when less intrusive and less restrictive, proven and internationally accepted treatment delivery alternatives are available, is not consistent with human rights principles and violative of Fundamental Rights of TB patients.

Forced isolation in TB sanatoriums has the potential to subvert the TB programme

Only those programmes which are respectful of the rights of patients have been successful in achieving treatment goals and furthering public health. The HIV/AIDS programme has taught us that the only way to prevent the spread of HIV is by respecting the rights of those infected with HIV and those most vulnerable to it. TB treatment is a long process – extending from 6-9 months to upto 2 years. Some of the patients can be the sole bread winners of their families and will naturally worry about their family if they are isolated. In fact, many patients may die in isolation without seeing their families. The South African experience of forced isolation of TB patients has shown that patients are unwilling to be quarantined and have tried to escape repeatedly. Forced isolation of TB patients in sanatoriums will drive the epidemic underground, as it will discourage people from getting tested and diagnosed with drug resistant TB for fear of isolation. People who may have drug resistant form of TB may shun health services and go beyond the government's

intervention and the government will have no control over the spread of drug – resistant TB in the general public.

Forced isolation will not prevent transmission of drug resistant TB, better infection control measures will

Diagnosis of TDR TB takes a long time. There is a lack of laboratory facilities to effectively and quickly diagnose drug-resistant TB. This means that the time when the patient is without any treatment and most infectiousness, she/he is a potential source of widespread infection. Once the diagnosis is made and treatment is started, the infectiousness comes down. So the patient will not be isolated when she/he is most infectious but isolated once treatment starts and infectiousness comes down. Instead of relying on isolation, the government should concentrate on WHO recommended TB infection control measures, which will reduce risk of transmission in both household and hospital settings.

WHO does not recommend isolation of drug resistant TB patients

WHO recognizes that managing drug resistant TB must be balanced with the patient's rights and dignity. The WHO recommends that "Patients with MDR-TB should be treated using mainly ambulatory care rather than models of care based principally on hospitalization." "The benefit of reduced transmission can only be expected if proper infection control measures are in place in both the home and the clinic. Potential exposure to people who are infectious can be minimized by reducing or avoiding hospitalization where possible, reducing the number of outpatient visits, avoiding overcrowding in wards and waiting areas and prioritizing community-care approached for TB management."(Guidelines for programmatic management of drug-resistant tuberculosis, 2011 update; page 26).

The 2008 WHO guidelines for drug-resistant TB urge national TB control programmes to adopt and support community based care in national plans, as this can enable outpatient treatment of drug-resistant TB and also reduce hospital costs. WHO has noted that "although early in the history of drug – resistant TB treatment, strict hospitalization of patients was considered necessary, community-based care provided by trained lay and community health workers can achieve comparable results to strict hospitalization and in theory, may result in decreased nosocomical spread of the disease."

Forced isolation of drug-resistant TB patients is not a feasible option for India

TB is endemic in India, where reportedly 8 out of 10 people will have the TB germ. Under the circumstances, forced isolation of drug – resistant TB patients will turn out to be a colossal logistical and administrative nightmare.

In the light of all the above, we urge the government not to rely on the 'isolation model', when less intrusive treatment delivery measures are available, which are respectful of rights of patients, are evidence-based, less expensive, more effective and proven internationally.

We further urge the government to have a consultation with TB Patient groups and civil society groups, in particular, the TB-HIV groups, to discuss the appropriate government response to tackle drug-resistant TB.

We look forward to a constructive dialogue between government and civil society groups on this issue

Thanking you

Sincerely yours'

Anand Grover
Project Director
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New Delhi

CC:

1. Shri P.K. Pradhan, Secretary Health, MoHFW
2. Shri Suresh Hirayanna Shetty, Minister of Public Health and Family Welfare, Maharasthra
3. Sri Jayant Kumar Banthia, Principal Secretary (Health and Family Welfare), Maharashtra
4. Major Dr. Pradeep Gaikwad, State T.B. Officer, Maharashtra