

## Write B24!

**To the Editor:** No one knows how many people die due to HIV-related causes in South Africa every year. According to the latest statistical release, HIV is the 9th leading underlying cause of death in the country.<sup>1</sup> This is hard to believe. Research has shown that only about 25% of all deaths related to HIV are notified as such<sup>2</sup> – either ‘HIV’ as an underlying or contributing cause of death is left out completely, or a euphemism for HIV is recorded instead. These euphemisms (e.g. immunosuppression, retroviral disease), although widely accepted by medical professionals, cannot be classified as HIV by the ICD-10 coders at Statistics South Africa, who may only code what they see.<sup>1</sup>

Why don't doctors write HIV on death notification forms? Factors contributing to this phenomenon include the misconception that one is not allowed to write HIV on the form, and issues around confidentiality.<sup>3</sup> The two-page BI-1663 death notification form was created in 1998 *inter alia* to allow for HIV to be recorded on the second page, which is supposed to be sealed before being handed to the family. However, no mechanisms exist to protect the confidentiality of this document: official Department of Health guidelines allow for the completion of sections on the second page by Home Affairs officials and funeral undertakers.<sup>4</sup> The concern that the cause of death of the deceased may be revealed to the next of kin and/or other third parties is therefore justified.

This notwithstanding, there rests an ethical and legal obligation on the certifying practitioner to complete the death notification form ‘honestly and fully’.<sup>5,6</sup> Omitting the real underlying cause or stating incorrect causes amounts in reality to falsifying a legal document, bearing the penalty of a fine or imprisonment or both.<sup>6</sup> Yet the HPCSA ethical guidelines also require practitioners to consider whether the effect of disclosing medical information of the deceased will cause distress to or benefit the next of kin.<sup>5</sup>

This ethical conflict may be resolved by simply writing B24, the ICD-10 code for ‘HIV disease unspecified’.<sup>7</sup> The use of this code to denote the underlying cause of death on the notification form fulfils both the legal and ethical requirements – it protects the deceased's confidentiality and at the same time ensures that the national statistics are accurately transcribed.

If this practice is implemented by practitioners countrywide, it will surely result in a substantial improvement in the quality of our HIV mortality statistics. Write B24!

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## Millions of ‘snips’ will harm millions of men

**To the Editor:** I was alarmed by the headline: ‘Millions of “snips” will bolster our health system’ in Chris Bateman's summary of presentations at an October 2009 AIDS/TB meeting of ‘global researchers’ in Cape Town.<sup>1</sup> As an American man with an interest in bodily rights, I find it offensive to hear the traumatic and sexually crippling amputation of the most erogenous portion of a boy's or man's penis described as comparable with snipping off the protruding end of a fingernail. Current gold-standard medical ethics and human rights preclude such a notion. If Bateman has good reason to assume that this word choice might harmonise with the views of subscribers to the *SAMJ* (many of whom are doctors, public health officials, and scientists), I am doubly alarmed that such attitudes may be widespread among the very people who have the power to activate the multinational male circumcision (MC) rollout described in this report.

It is unfortunate that Kelly Curran's grinning face appears directly beneath the headline, almost as if the ‘snips’ word choice were hers – an impression that is reinforced by the fact that her apparent delight in the many ‘health benefits’ of circumcising millions of Africans is featured throughout the article, supported by the ‘incredible excitement’ about the MC rollout expressed by Professor Francois Venter. Lost in all this excitement is the fact that circumcision does not fully prevent HIV/AIDS. In fact, circumcision may even help to spread AIDS from men to women if the use of condoms (a much more humane and effective solution) comes to be neglected because of the dulling of sexual sensation that occurs when men (or baby boys) are circumcised.

It is even more unfortunate, I believe, that no one appears to have been invited to defend the foreskin at this meeting. If such a person had been allowed to speak, it might have been clearer to attendees that the MC rollout that has been proposed, whether or not it diminishes cases of HIV/AIDS in Africa, will damage the joys of manhood for male Africans on a scale comparable with the anti-foreskin campaign that unfolded in my homeland over the last century. My guess is that most, if not all, of the men who are urging MC in Africa were circumcised as infants. As Ronald Goldman, author of *Circumcision: The Hidden Trauma*, has said, such men ‘don't know what they're missing’. In fact, in my view, there is an inherent conflict of interest in allowing anyone who has grown up circumcised to make decisions about whether or not it is in the best interests of anyone else to lose his foreskin. Similarly, circumcising nations such as Israel and the USA have had a suspiciously disproportionate influence in developing studies and influencing policies aimed at encouraging universal

circumcision in Africa as the solution to the terrible scourge of HIV/AIDS.

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1. Bateman C. Millions of 'snips' will bolster our health system. *S Afr Med J* 2009; 99: 840-844.

## Mental health services for HIV/AIDS patients versus ARV services for mentally ill HIV/AIDS patients

**To the Editor:** I fully support the call made by Andersen and Seedat,<sup>1</sup> and would like to add another dimension to the challenges posed by HIV/psychiatric co-morbidity. Apart from the psychiatric complications caused by the infection, an increasing number of – especially – the young adult psychiatric population, with chronic disorders such as schizophrenia and bipolar disorder, present with co-morbid HIV infection. Owing to the adverse socio-economic backgrounds of most public sector patients, combined with the increased socio-economic vulnerability of chronic psychiatric patients, the HIV-positive chronic mental health care user (MHCU) is the most disadvantaged of the disadvantaged! The understandably rigorous prerequisites for ARV therapy hinder access by MHCUs to ARV treatment: they may be homeless, rejected by their families, or lead nomadic lives owing to their mental condition. These factors make identification of a 'buddy' a major challenge. Their mental condition may pose limitations on their ability to engage in the mandatory educational programme preceding commencement of treatment, or cognitive impairment from the mental illness and/or the HIV infection may diminish their capacity to give informed consent.

Finally, those with an 'organic' psychosis or HIV dementia may respond suboptimally to standard psychotropic

interventions, yet be unable to access the very medication that could assist in their recovery. Special provision needs to be made in the ARV roll-out policy to cater for these patients, who may engage in risky sexual behaviour because of illness-related impairment in judgement, or themselves be 'soft' targets for sexual assault. While some may argue that a 'special' policy for MHCUs adds to discrimination and stigma, I believe that such 'discrimination' can better serve the interests of this vulnerable clinical population. Policy should facilitate MHCU access to ARV treatment, taking into consideration the challenges posed by mental illness on the consent and participation process, and make provision for active community-based worker support to facilitate adherence to both psychotropic and ARV treatment. Dedicated psychosocial support for these patients at clinic and community level, and perhaps offering a 'combined' clinic where their unique needs and challenges can be addressed, are avenues worthy of exploration.

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1. Andersen LS, Seedat S. Mental health services for HIV/AIDS patients are long overdue (Editorial). *S Afr Med J* 2009, 99: 796.

**Lena Andersen replies:** There is no question but that mental health services for HIV/AIDS patients are urgently needed. Recognising this is the easiest part. Developing and implementing services that cater to the entire spectrum of psychiatric needs is an enormous and complex undertaking that will require the constructive input and teamwork of many people, departments and organisations. Ramlall highlights an important issue that needs to be considered in the roll-out process. I encourage the mental health community to continue this dialogue in order to identify and address all the relevant dimensions of the problem.