PARLIAMENT
OF THE REPUBLIC OF SOUTH AFRICA

THE RIGHT OF ACCESS TO HEALTH CARE FOR INMATES IN DETENTION

PART 1. CURRENT FRAMEWORK FOR OVERSIGHT

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Publisher: Parliament of the RSA

September 2016

Contents

LIST OF ABBREVIATIONS

ACHR:	American Convention on Human Rights
ART:	Antiretroviral Therapy
ARV:	Antiretroviral
BMI:	Body Mass Index
CCPCJ:	United Nations Commission on Crime Prevention and Criminal Justice or Crime Commission
CMC:	Case Management Committee
CPT:	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CSPB:	Correctional Supervision and Parole Board
CSA:	Correctional Services Act
DCS:	Department of Correctional Services
DoH:	Department of Health
FDC:	Fixed Dose Combination
GP:	Gauteng Province
HCT:	HIV Counselling and Testing
ICCPR:	International Covenant on Civil and Political Rights
ICCV:	Independent Correctional Centre Visitors
ICESR:	International Covenant Economic, Social and Cultural Rights
EC:	Eastern Cape

Ecosoc:	UN Economic and Social Council
FS/NC:	Free State and Northern Cape
JICS:	Judicial Inspectorate of Correctional Services
KZN:	Kwazulu-Natal
LMN:	Limpopo, Mpumalanga and North-West
LTBI:	Latent TB Infection
MPAB:	Medical Parole Advisory Board
MOU:	Memorandum of Understanding
NSP:	National Strategic Plan on HIV, STIs and TB
PAJA:	Promotion of Administrative Justice Act 3 of 2000
PHC:	Primary Health Care
PPP:	Public Private Partnership
RD:	Remand Detainee
SLA:	Service Level Agreement
SMR:	Standard Minimum Rules
STI:	Sexually transmitted infections
TB:	Tuberculosis
UDHR:	Universal Declaration of Human Rights
UN:	United Nations
WC:	Western Cape
WHO:	World Health Organisation

LIST OF TABLES

LIST OF FIGURES

Chapter 1
INTRODUCTION

"Health is a human necessity; health is a human right."[1]

'*The government has an obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or a lingering death. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose*'[2]

1.1 BACKGROUND

The Constitution of South Africa, 1996 guarantees that 'everyone, (including arrested, detained and accused persons), has the right to have access to healthcare services.'[3] It places an obligation on the State to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.'[4] The Constitution also makes provision that: 'Everyone who is detained, including every sentenced prisoner, has the right… to conditions of detention that are consistent with human dignity, including at least, to exercise and the provision, at the State expense, of adequate accommodation, nutrition, reading material and medical treatment'.[5] In line with this prescript, the Correctional Services Act (No. 111 of 1998) makes provision for health care services for inmates incarcerated in correctional centres. In addition, South Africa is a signatory to a number of international instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), amongst others, and is therefore required to provide access to health care for inmates and persons in detention.

The right of access to health care for inmates is enshrined in statutes and international instruments, but does this necessarily mean that all inmates and persons in detention actually have access to adequate health care in South Africa?

This paper is part of a two stage examination of how health care is being implemented in correctional centres. This paper forms Part 1 and provides a contextual framework within which the implementation of health care can be examined. Part 2 focuses on recommendations made by the relevant oversight bodies to improve health care service provision in correctional centres. Part 2 includes recommendations for follow up by Parliament.

In exercising its oversight role over the Executive, Parliament becomes an effective agent in monitoring health care at correctional centres and in promoting improved health care standards.

[1] James Lenhart (n.d.).
[2] Justice Thurgood Marshall
[3] Section 27(1)(a).
[4] Section 27(2).
[5] Section 35(2)(e).

These two papers used together can ensure the increased systematisation and effectiveness of parliamentary oversight particularly by the Portfolio Committee on Justice and Correctional Services and the Select Committee on Security and Justice.

1.2 CHAPTER OUTLINE

The paper is divided into seven chapters:

CHAPTER 1 **INTRODUCTION**	Provides an overview of the purpose of the paper and outline of the main contents of each chapter.
CHAPTER 2 **OVERVIEW OF HEALTH CARE SERVICES FOR INMATES**	Provides an overview of the status of health care provision in South African correctional centres. There are 236 active correctional centres populated by 154 648 inmates of which 44 236 are remand detainees and 110 412 are sentenced offenders. The average national overcrowding rate is 29.7%. The health needs of inmates are the responsibility of the Department of Correctional Services (DCS) with the support of the Department of Health (DoH). Some of the most prevalent health conditions in correctional facilities include respiratory conditions such as tuberculosis (TB) and pneumonia, seasonal virus infections, and cancers, amongst a host of other ailments, which include mental illness. Many of these conditions are easily transmissible especially given the number of overcrowded facilities. The shortage of professional health care staff, especially doctors, exacerbates this problem.
CHAPTER 3 **MENTAL HEALTH CARE, TUBERCULOSIS AND HIV AND AIDS**	Focuses on three critical health care areas in the context of the correctional services environment, namely mental health care, TB, and HIV and AIDS. Services targeted at TB, and HIV and AIDS have received focused attention by the DCS, particularly in recent years. Less attention is placed on the area of mental health.
CHAPTER 4 **INTERNATIONAL AND REGIONAL INSTRUMENTS**	Provides a contextualised understanding of the key international human rights treaties and bodies that monitor the healthcare available to inmates. Many of the specific principles and standards incorporated within the non-binding instruments have found expression in international and domestic case law. Jurisprudence on key areas of prison health demonstrate consistency between the principles and standards articulated in United Nations (UN) resolutions and judgements of international courts and human rights treaty bodies. It would thus suggest that instead of being non-binding, in many instances these guidelines have become minimum legal requirements for governments to meet. The Basic Principles for the Treatment of Prisoners include that prisoners shall have access to health services available in the country without discrimination on the grounds of their legal situation. The UN Principles of Medical Ethics state that health personnel working with prisoners have a duty to provide them with the same quality and standard of treatment as afforded those who are not imprisoned or detained. Three successful applications were made by prisoners to the African Commission on Human and People's Rights, an independent body that

	monitors State compliance with the African Charter. In these cases, the Commission's approach was that State's obligations to fulfil the right to health is greater, as the health and well-being of persons in custody are completely dependent on the actions of the authorities. Similarly, the UN Human Rights Committee has been critical of poor standards of prison medical care in a number of cases, as it too, holds the State party responsible for the care of persons in custody. Preventative, mental and environmental health care are all provided for under various instruments. Medical care for women and children is specified as they have special medical needs (such as access to a gynaecologist or paediatrician respectively). Merely providing general health services would therefore be insufficient. The lack of qualified medical staff, equipment and medicines has also been highlighted. Similarly, issues relating to informed consent and the right of prisoners to refuse treatment or medical testing are discussed. There is thus consensus in domestic and international law that the State has the obligation to protect the lives and well-being of people held in custody.
CHAPTER 5 **SOUTH AFRICAN LEGAL AND POLICY FRAMEWORK**	Deals with the legal and policy framework. The Correctional Services Act (No. 111 of 1998) and the accompanying regulations are described and include the following key regulations governing the right of inmates to access adequate health care which must include: • Universal accessibility. • First-level contact clinic-based health services to enable the inmate population to acquire, maintain and promote health care. • Screening for communicable, contagious or obscure diseases as defined by the National Health Act (No. 61 of 2003, as amended) and the recording of the presence of such diseases. • Cells which conform to the required specifications in terms of floor space, lighting, ventilation etc. Inmates suffering from mental or chronic illness or whose health status will be affected detrimentally or whose health status poses a threat to other inmates if detained in a communal cell must be detained separately on request of the Correctional medical practitioner or registered nurse.
CHAPTER 6 **RESPONSE OF THE COURTS**	Highlights lessons from case law. The DCS is constitutionally bound to provide adequate medical treatment to inmates; and there is evidence that the DCS failed to comply with its own Standing Orders including screening, examination and isolation which could have effectively reduced the risk of infection and contagion of a disease like TB. The *Lee* case, in particular, highlighted routine violations of various aspects of the right to health and as a result of this case the DCS reports that TB management in correctional centres is receiving greater attention.[6] However, concern is raised at how DCS intends to address the fundamental challenges such as overcrowding and poor infrastructure, which are key contributors to the spread of contagious diseases such as TB.

[6] Department of Correctional Services (2013a).

CHAPTER 7 **MEDICAL PAROLE**	Deals with medical parole, which has received considerable media coverage in recent years. In 2011/12 the Judicial Inspectorate for Correctional Services (JICS) reported that 5% of inmates that applied for medical parole had died before a decision could be made.[7] Only 20 medical releases were granted during that year. A new medical parole regime came into effect in 2012 which intended to make the process more transparent and fair. The JICS found that the medical staff was, (in many cases), not aware of the amended provisions.[8] For the period 2013/2014 the JICS again noted that inmates had died whilst waiting for their application for medical release to follow the DCS's administrative processes. The DCS reported that fifteen (15) applications from sentenced inmates and one (1) application from a remand detainee were in process.[9] The JICS found this figure to be low and held that much effort by both DCS and JICS is required to ensure that administrative processes are more efficient.

[7] JICS (2012).
[8] JICS (2014).
[9] JICS (2014).

Chapter 2

OVERVIEW OF HEALTH CARE SERVICES FOR INMATES

This chapter provides an overview of correctional centres and the inmate population in these centres. It also provides information on the status of health care provision at correctional centres in the six regions of the DCS.

2.1 OVERVIEW OF CORRECTIONAL CENTRES AND THE INMATE POPULATION

There are 236 active correctional centres across South Africa.[10] These correctional centres differ vastly in terms of size, structure and accommodation capacity.[11]

The centres are clustered in the six (6) regions across South Africa operated by the Department of Correctional Services. These regions are: Eastern Cape (EC) Region; Gauteng (GP) Region; Western Cape (WC) Region; KwaZulu-Natal (KZN) (Region); Limpopo, Mpumalanga and North-West (LMN) Region; and the Free State and Northern Cape (FS/NC) Region. There are a number of management areas within each of these regions and between 26 and 48 correctional centres in each management area. The following table provides a breakdown of management areas and correctional centres per region.

Table 1: Correctional centres as per DCS management area

Region	Management Area	Active Centres	Temporary closed centres	Total number of centres
EC	6	44	1	**45**
GP	8	25	1	**26**
FS/NC	7	49	0	**48**
KZN	7	40	2	**42**
WC	10	42	0	**42**
LMN	8	36	3	**38**
PPP centres[12]				**2**
Total	**46**	**236**	**7**	**243**

Source: Annual Report of the Department of Correctional Services, 2014/15

The table above reflects that there are two hundred and forty-three (243) correctional centres across South Africa (of which 236 are active and 7 are temporarily closed for renovations) distributed amongst the six (6) regions. There are forty-six (46) management areas in total. The Western Cape Region has the most management areas (10) in South Africa, followed by the Gauteng Region (8) and the Limpopo, Mpumalanga and North-West Region (8). The Eastern Cape Region has the fewest management areas (6).

[10] Department of Correctional Services (2015a).
[11] Mathabathe (2014).
[12] Public-Private Partnership centres

The table also shows that the FS/NC Region has the most active correctional centres (49) followed by the EC (44), WC (42) and KZN (40).

Nine (9) of these 243 facilities are for women only, fourteen (14) are for youth, and one hundred and twenty nine (129) are for men. Ninety two (91) facilities accommodate women in a section of the general prison population (and thus are unisex).[13]

The total capacity of correctional centres is 118 154, with 25 000 places reserved for remand detainees (RDs).[14] At the end of March 2014, the total prison population was 154 648 of which 44 236 were remand detainees and 110 412 were sentenced offenders.[15] The overcrowding rate was 29.70%.[16] It is noted that the overcrowding rate differs from one correctional centre to another. The following table lists the correctional centres with the highest rates of overcrowding at the end of March 2015.

Table 2: Correctional centres with the highest rates of overcrowding (March 2015)

Correctional centre	Lock-up	Capacity	Occupancy
Polokwane	1407	539	261%
Grootvlei Med A	1960	890	220%
Thohoyandou Med B	466	219	213%
Mdantsane	1194	582	205%
Allandale	682	342	200%
George	1098	563	195%
Graaf-Reinett	116	63	184%
Sada	462	261	177%
Makhado	574	324	177%
Kgosi Mampuru II Central	2728	1563	175%

Sources: Annual Report of the Judicial Inspectorate for Correctional Services, 2014/15

The table above provides information related to centres with more than hundred percent occupancy rate. Accordingly, Polokwane has the highest occupancy rate (261%) followed by Grootvlei Med A (220%), Thohoyandou Med B (213%), Mdantsane (205%) and Allandale (205%). The table further shows that, Graaf-Reinett is a very small centre with a capacity to accommodate only 63 offenders but it had a total of 116 offenders resulting in an occupancy rate of 184%.

Table 3: 2013/14 sentenced inmate population

Male adults	Male Youth[17]	Male Children[18]	Female Adults	Female Youth	Female Children
81 132	26 203	233	2 235	607	2

Source: Annual Report of the Judicial Inspectorate of Correctional Services, 2013/14

The table above provides a breakdown of the sentenced offender population in 2013/14. By far, the highest number of inmates in South African correctional centres are adult males (81 132) followed by male youth (26 203) and female adults (2 235). Male adults thus constitute 73% of the total sentenced inmate population followed by male youth who constitute 23% of the total sentenced inmate population. Female adult inmates constitute only 2% of the total sentenced inmate population, while female youth constitute 0.5% of the total sentenced inmate population. In the 2013/14 financial year, there was a total of 235 children (both males and females) incarcerated in correctional centres, which constituted 0.2% of the sentenced population.

[13] Jules-Macquet (2014).
[14] Jules-Macquet (2014).
[15] Judicial Inspectorate of Correctional Services (2014).
[16] Department of Correctional Services (2014a).
[17] The White Paper on Corrections (2005) defines youth as offenders between the ages of 18-25 in correctional facilities.
[18] Children are defined as under the age of 18 years.

Table 4: 2013/14 remand detainee population

Male Adults	Male Youth	Male Children	Female Adults	Female Youth	Female Children
25 346	17 683	176	663	363	5

Source: Annual Report of the Judicial Inspectorate of Correctional Services, 2013/14

The table above shows that male adults constitute the majority (57%) of the total remand detainee population in correctional centres across the country. This is followed by male youth (40%) and female adults (1.5%). In 2013/14 there were only five (5) female children in remand detention under the age of 18 compared to 176 male children over the same period.

2.2 PROVISION OF HEALTH CARE SERVICES FOR INMATES

2.2.1 Management and cooperation

Health care services in correctional centres are there to promote the health of inmates and remand detainees, identify inmates with health problems, assess their needs and deliver treatment or refer to specialists as appropriate. The majority of health care services and programmes in correctional centres are of a primary health care nature. The health care services in the Department of Correctional Services are managed under the Directorate: Health Services.

Directorate: Health Services

The Directorate: Health Services has the following seven (7) core functions in the Department of Correctional Services:

1) Provide legislative and policy guidelines regarding the provision of health care, pharmaceutical, nutritional, personal and environmental hygiene services in Correctional Centres
2) Design the minimum health care package for Correctional Centres guided by the principles of primary health care and the district health model
3) Establish correctional clinics, in-patient facilities, pharmacies and kitchens
4) Ensure the delivery of a comprehensive package of primary health care services
5) Resource management and mobilization
6) Liaison with relevant internal and external stakeholders with regard to health care provision, nutrition, personal and environmental hygiene issues
7) Advice the Department on health care, nutrition, personal and environmental hygiene matters.[19]

Department of Health

The Department of Health (DoH) and the Department of Correctional Services have signed a Memorandum of Understanding (MoU) in the following regions:

- Gauteng
- Eastern Cape
- Western Cape; and
- Free State and Northern Cape.

[19] http://www.dcs.gov.za/Services/Health%20Services.aspx

In the Limpopo, Mpumalanga and North West Region there is no formal MoU between the two Departments. However, a working relationship exists whereby inmates are referred to access health care services at the Department of Health facilities. In the KwaZulu-Natal Region there is also no MoU between the two Departments. However, a Service Level Agreement (SLA) was developed by the KwaZulu-Natal Region and forwarded to the KZN Department of Health but to date, there has been no progress on the matter.[20]

The Department of Health assists the DCS with the following services, among others, in the regions of DCS:

- Eastern Cape: The training of nurses in various programmes offered by DoH and referral of sick offenders when the service is not available in DCS.
- Gauteng: DoH provides technical support pertaining to all services and programmes rendered within correctional health facilities for efficient Primary Health Care services delivery.
- Western Cape: The training on primary health care and other health related conditions.
- KwaZulu-Natal: DoH provides all types of services and programmes which are generally accessible to the public.
- Limpopo, Mpumalanga and North West: No assistance is received from DoH for primary health care services on site. Inmates are referred for secondary and tertiary health care services to DoH facilities.
- Free State and Northern Cape: The training of health care professionals on various health care programmes; monitoring and evaluation on services rendered; HIV counselling and testing; TB screening and testing; and dental services.[21]

COMMENT AND QUESTIONS

Relationship with the Department of Public Works

- How is DCS working with the Department of Public Works to improve conditions in correctional facilities to reduce the spread of disease?

Relationship to the Department of Health

- What is the response of the DCS and DoH to the findings of the Joint Review of the HIV, TB and PMTCT Programmes (2013) which recommended that the DoH assume greater responsibility over the provision of health care in DCS facilities?

- The DoH has twice published draft Regulations Regarding Communicable Diseases – most recently in April 2010 – but the regulations have not yet been promulgated. The draft Regulations propose certain requirements which must be met before the state can apply for a court order to compel a person to be forcibly isolated and treated without their consent.[22] Only after these conditions are met may a health care worker apply to the High Court to have someone forcibly isolated.[23] Are there any outstanding regulations such as

[20] Department of Correctional Services (2015b).
[21] Department of Correctional Services (2015b).
[22] The disease or health risk must be one that has previously been determined to be hazardous to the public health (such as Ebola or drug-resistant TB) • The state must first attempt other measures besides forced isolation and treatment to prevent the spread of the disease • There must be a determination that forced isolation or treatment is the most justifiable course of action to prevent the spread of the disease and what the compulsory measure is likely to entail • It must be highly likely that, without intervention, the disease will be spread to others.
[23] Minister of Health of the Province of the Western Cape v Goliath and Others 2009 (2) SA 248 (C).The Minister of Health applied in the Cape High Court to compel four patients who had drug-resistant tuberculosis (XDR-TB) to be forcibly isolated at Brooklyn Chest Hospital until they were no longer infectious to the community. The court order held that the patients could be isolated against their will, using international precedent regarding isolation of patients with TB and the provisions of section 7 of the National Health Act (NHA) allowing for treatment without consent of the patient. Unfortunately, the court did not consider the requirements in section 9 of the NHA.

those on human resources, communicable diseases[24] and primary health care services which must be finalised?[25] Why is there a delay in finalisation?

Department of Correctional Services

- The DCS obtained permission from DoH to procure medicines through DoH pharmaceutical contracts. Feedback is still required on permission to procure medical related items through medical related contracts.
- Does the DCS participate in the Government Community Service programme for pharmacists?
- Screening on admission has improved but still needs improvement. For example KZN reports that 86% of all new admissions were screened during 2014/15.
- Why have all Correctional Centres not established infection control committees?
- Whether officials are held accountable when the standing orders and regulations are not applied.

2.2.2 Health Care personnel

Table 5: Medical and Health Personnel per region

Region	DCS nurses	DCS doctors	DoH doctors	Pharmacist	Dentists
FS/NC	106	4	5	4[26]	30[27]
LMN	113	1	30	3[28]	
WC	131	2	25	5[29]	10[30]
KZN	113	19[31]	0[32]	8[33]	0
EC	123	1	30[34]	10[35]	
GP	122	2	19[36]	2[37]	6[38]

Source: DCS responses to Parliamentary information request: healthcare service, 2015b

The table above provides information related to medical and health personnel per DCS region. The table shows that DCS has a very limited number of doctors nationally (30) in their establishment. This number is supplemented by sessional doctors from the Department of Health (109) who visit correctional centres on certain days of the week. KZN has the highest number of doctors (19) employed by DCS as compared to other regions. In addition to doctors, DCS has a total number of 708 nurses on their establishment nationally. On International Nurses Day in 2016, it was reported that there are 843 full-time nurses on the DCS establishment.[39]

In addition, it must be noted that this case is largely limited to the specific facts presented to the court. There have also been no subsequent cases dealing with either section 7 or section 9. http://www.siberink.co.za/userfiles/file/NHA_ebook.pdf

[24] 'Communicable disease' means a disease resulting from an infection due to pathogenic agents or toxins generated by the infection, following the direct or indirect transmission of the agents from the source to the host.

[25] The National Health Act : A Guide (2nd Edition) http://www.siberink.co.za/userfiles/file/NHA_ebook.pdf

[26] Data does not separate DCS and DoH Pharmacists

[27] This includes sessional dentists and DoH dentists

[28] This includes both DCS and Community Pharmacists

[29] Data does not separate DCS and DoH Pharmacists

[30] Dentists provided by DoH

[31] This includes 2 sessional and 17 permanent doctors

[32] No information provided on DoH doctors

[33] This includes 2 permanent and 6 community service pharmacists

[34] This includes 20 sessional doctors and 10 from DoH

[35] This includes 3 pharmacy assistants, 2 community service, and 5 permanent pharmacists

[36] Sessional doctors

[37] DCS pharmacists

[38] This includes 2 permanent and 4 sessional dentists

[39] SANews (2016).

Vacancies in health care professional personnel has been an ongoing problem within the Department of Correctional Services. The following are the 2013/14 figures in this regard:

- There are a total of 103 approved posts for psychologists of which only 78 are filled. In the 2013/14 financial year, the vacancy rate for psychologists was 24.3%.
- There are a total of 993 approved posts for professional nurses and only 860 are filled. In 2013/14 financial year, the vacancy rate for professional nurses was 13.4%.
- There are a total of 602 approved posts for social workers and only 505 are filled.[40] In 2013/14 the vacancy rate for social workers was 16.1%.
- The Annual Report of the Department of Correctional Services does not provide information on the employment and vacancy rate for doctors in the Department of Correctional Services.[41]

Table 6: Vacancies per region (2015)

Region	Nurses	Doctors	Dentists	Pharmacists
FS/NC	18	-[42]	-[43]	-[44]
LMN	24	5	0	5
KZN	42	1	-[45]	1
WC[46]				
EC	35	-[47]	-[48]	-[49]
GP				

Source: DCS Responses to Parliamentary information request: Healthcare services, 2015b

The table above provides information related to vacancies for health care professionals in DCS regions. For nurses, the highest vacancies are visible in KZN (42), followed by LMN (32) and EC (28). With regards to doctors, the highest vacancies are visible in LMN (5) whereas in KZN there is only one (1) vacancy. The table further shows that with regard to dentists, there was no vacancy at LMN. For pharmacists, there were five (5) vacancies at LMN while KZN only had one (1) vacancy.

Table 7: Ratio of medical professional per inmate

Region	Nurses	Doctors	Dentists	Pharmacists
FS/NC	1:220	1:5 818	1:802	1:5 818
LMN				
KZN	1:246	1:14 242		1:14 246
WC	1:164	1:14 409		1:5 763
EC	1:131	1:18 549		1:4 638

[40] Department of Correctional Services (2014a).
[41] Department of Correctional Services (2014a).
[42] Information provided states that positions filled but there is no mentions as to how many positions there are.
[43] No information is provided with regard to dentists
[44] No information is provided with regard to pharmacists
[45] No information is provided with regard to dentists
[46] Information provided does not specify each category of personnel.
[47] No information is provided with regard to doctors
[48] No information is provided with regard to dentists
[49] No information provided with regard to pharmacists

GP	1:380	-[50]	-[51]	-[52]

Source: DCS responses to Parliamentary information request; Healthcare services, 2015b

The table above provides data relating to the ratio between offenders and medical professionals in the Department of Correctional Services. The highest ratio is reported in EC at 1 doctor per 18 549 inmates. The lowest ratio for doctors to inmates is reported for FS/NC at 1 doctor per 5 818 inmates. The ratio for nurses is much lower country wide ranging from a high of 1 nurse to 380 inmates in Gauteng to a low of 1 nurse for every 131 inmates in the Eastern Cape.

2.2.3 Health Care facilities and services

The DCS is obliged to provide access to primary health care services on a 24 hour basis. Ideally these services should include:

- Promotive and preventive health services (health education);
- Curative services for acute minor ailments, injuries, communicable and non- communicable diseases;
- Referral for secondary and tertiary levels of care; and
- Continuity of care after release. Patients needing secondary and tertiary levels of health care are referred to external health facilities, mainly those of the Department of Health (DoH).[53]

Health care delivery in DCS is also rendered in accordance with the DoH's legislation, policies and guidelines.[54] Clearly, close collaboration between the two Departments is critical to ensure the provision of adequate health care services to inmates.[55]

The DCS reports that there is at least one Primary Health Care (PHC) clinic per correctional centre and one in-patient facility / sickbay with beds ranging from 5 – 120 per management area.[56] An in-patient facility is defined as a facility that has been established for the purpose of accommodating inmates that are ill or recovering from postoperative procedures and cannot be accommodated in the general cells whilst on treatment. This facility does not meet the requirements for being classified as a hospital.[57]

Primary Health Care (PHC) Programmes and Services in the Department of Correctional Services

The DCS provides inmates and remand detainees who are incarcerated in correctional centres with a variety of health care services and programmes including but not limited to the following:

- Preventative and promotive health services;
- In-patient facilities
- Isolation facilities for management of communicable disease
- Basic PHC equipment available e.g. ear, nose and throat sets, blood pressure machine
- ARV Clinics

[50] Data provided states that there is one medical officer per Regional Hospital
[51] No data provided
[52] No data provided
[53] Department of Correctional Services (2015b).
[54] Department of Correctional Services (2013a).
[55] CSA Section 12 (1) and Regulations - definitions
[56] Department of Correctional Services (2013a).
[57] Department of Correctional Services (2013a).

- 24 hour access to nursing services
- Youth and adolescents health care services
- Medical male circumcision
- Health promotion and disease prevention
- Pharmaceutical services
- Mental health care services
- Provision of medico legal services (as a result of rape, sodomy, death, suicides and assaults);
- Basic rehabilitation;
- Basic oral and dental health care;
- Infection control;
- Counselling services;
- Referral services.[58]

Services available on admission and on release

The following services are available to inmates on admission and on release:[59]

- TB screening and testing
- Screening for diabetes
- STIs
- Psychological problems
- Intoxication
- Current injuries
- Chronic illness
- All offenders who are on treatment and released are referred to the nearest PHC clinic
- On release, offenders are provided with a 1 month supply of treatment
- Patients are also followed up to monitor the progress and to get the final outcome on the patient.

COMMENT AND QUESTIONS

- Despite their small numbers, female prisoners have specific needs, in respect of menstruation, pregnancy, child birth and childcare. In 2010, South Africa signed the "UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)" which are international guidelines for the treatment of women in prisons. One of the provisions stipulates: "Preventive health-care measures of particular relevance to women, such as Pap smears and screening for breast and gynaecological cancers, will be offered to women prisoners on an equal basis with women of the same age in the community".[60] Does DCS have a policy framework to ensure a standard of care is available for female prisoners which is equitable with that available in the community?

2.2.4 Diseases

A number of diseases confront inmates in correctional centres across the country. According to the DCS, the most prevalent of these conditions includes the following:

[58] http://www.dcs.gov.za/Services/Health%20Services.aspx
[59] Department of Correctional Services (2015b).
[60] http://www.iol.co.za/news/south-africa/women-in-prison-ignored-and-neglected-1.1658349#.VLd709KUeb8

- Seasonal viral infections;
- Mental health conditions;
- Neurological conditions (epilepsy);
- Cardiovascular conditions;
- Respiratory conditions (e.g. Tuberculosis, pneumonia, asthma, bronchitis);
- Ear, nose and throat conditions;
- Gastrointestinal conditions (e.g. ulcers, gastritis);
- Muscular skeletal conditions;
- Cancer; and
- Skin conditions.[61]

2.3 HEALTH CARE TARGETS IN THE STRATEGIC AND ANNUAL PERFOMANCE PLANS

The Strategic Plan and Annual Performance Plan of the Department of Correctional Services focus on two key areas namely TB and HIV/AIDS. The objective is to provide inmates with HIV and AIDS and TB with services to improve life expectancy. The Annual Performance Plan highlights the following targets:

Table 8: Targets in the APP (2011/12-2015/16) and extent of achievement

Strategic Indicator	2011/12	2012/13	2013/14	2014/15	2015/16
Target: Percentage of inmates on ART	49%	51%	94%	95%	96%
Extent of achievement: Percentage of inmates on ART	43%	65%	95.70%	97.02%	No information
Target: TB cure rate	No historical data	No historical data	75.2% sentenced inmates 52% remand detainees	80%	85%
Extent of achievement: TB cure rate			75.22% sentenced 52.1% remand detainees	83.08%	No information

Sources: Annual Reports of the Department of Correctional Services, 2011/12-2014/15

The table above provides data relating to two targets and the extent of their achievement for both TB cure rate and access to ART over a five-year period (from 2011/12-2015/16). Information in relation to access to ART shows that there has been a substantial increase on the target from 49 per cent (in 2011/12) to 96 per cent (in 2015/16). At the same time this data also shows that the extent of achievement for this target also sharply increased from 43 per cent (in 2011/12) to 97 per cent (in 2014/15).

The table also shows that the target for the TB cure rate only started in 2013/14 where the target was 75.2 per cent for sentenced offenders and 52 per cent for remand detainees. In that specific financial year (2013/14) this target was met. In 2014/15, this target was increased to 80 per cent and it was slightly exceeded (83.08%).

[61] http://www.dcs.gov.za/Services/Health%20Services.aspx

2.4 BUDGET AND EXPENDITURE IN HEALTH CARE

The budget for the provision of Health Care in the Department of Correctional Services resides in Programme 4: Care. Programme 4 provides 'needs-based health care and services aimed at maintaining the well-being of inmates in the Department's custody'. Programme 4 has three sub-programmes: Health Care Services, Nutritional Services and Hygiene Services. The sub-programme which is of particular relevance to health care service provision is sub-programme: Health Care Services.

Table 9: Expenditure in Care Programme (2009/10-2013/14)

Financial year	Adjusted appropriation R'000	Virement R'000	Final appropriation R'000	Actual expenditure R'000	Variance R'000
2009/10	1 584 058	(25 399)	1 558 659	1 548 739	9 920
2010/11	1 756 956	(4 245)	1 752 711	1 682 259	70 452
2011/12	1 858 016	(129 057)	1 728 959	1 728 959	-
2012/13	1 871 871	(147 381)	1 724 490	1 668 873	55 617
2013/14	1 617 008	182 165	1 799 173	1 799 173	-
Total	**8 687 909**		**8 563 992**	**8 428 003**	**135 989**

Sources: Annual Reports of the Department of Correctional Services (2009/10-2013/14)

The table above shows that actual expenditure in the Care Programme in the Department of Correctional Services grew from R1.5 billion (in 2009/10) to R1.8 billion (in 2013/14). The Department could not spend (underspending) a total amount of R136 million in three of the five years (2009/10, 2010/11 and 2012/13). However, in 2011/12 and 2013/14 the Department managed to spend 100% of the allocated budget of the Care Programme.

Table 10: Medium-term expenditure estimate for the 2015/16 MTEF for the Care Programme

Financial year	Medium-term expenditure estimate R'000	Percentage increase or decrease from previous year
2015/16	1 796.3	2.89%
2016/17	1 886.6	5.03%
2017/18	2 045.4	8.42%

Source: 2015 Estimates of National Expenditure

The table above shows a positive trend in the increase of allocation to the Care Programme over the medium term. The allocation is expected to increase from R1.8 million (in 2015/16) to R2 million in 2017/18.

Table 11: Expenditure in Health Care Services sub-programme in 2012/13 and 2013/14[62]

Financial year	Adjusted appropriation R'000	Virement R'000	Final appropriation R'000	Actual expenditure R'000	Variance R'000
2012/13	638 319	(39 546)	598 773	584 311	14 462
2013/14	657 221	(29 424)	627 797	627 797	-
Total	**1 295 540**	(68 970)	**1 226 570**	**1 212 108**	**14 462**

Sources: Annual Reports of the Department of Correctional Services (2009/10-2013/14)

[62] There are the only two years reflected due to a change in sub-programme structure.

The table above illustrates expenditure on health care services specifically, as reflected in the Health Care Services sub-programme. If one totals up spending in this sub-programme for the two financial years (2012/13 and 2013/14) the Health Care sub-programme spent R1.2 billion out of adjusted appropriation of R1.3 billion. The expenditure pattern of this sub-programme has improved from an under-spending of R14.5 million in 2012/13 to 100 percent expenditure in 2013/14. It should be noted, however, that in both years funds were shifted out of this sub programme as virement. R40 million was shifted out of the Health Care sub-programme in 2012/13 and R30 million was shifted out in 2013/14.

Table 12: Budget allocation for Care Programme in 2014/15

	2013/14 (R'000)	2014/15 (R'000)	Nominal % changes
Programme 4: Care	1 617.0	1 747.2	**8.05%**
Sub-programmes			
Nutritional Services	825.6	923.2	**11.82%**
Health Services	**657.2**	**694.0**	**5.60%**
Hygienic Services	**134.2**	**130.1**	**-11.7%**

Source: Estimates of National Expenditure for 2014

According to the table above, the overall allocation for Care programme in 2014/15 was R1.7 billion which constitutes an 8 per cent increase when compared to the allocation of the previous financial year (2013/14). This allocation is shared amongst three sub-programmes namely: Nutrition Services (R923 million); Health Services (R694 million); and Hygienic Services (R130 million). As can be seen from the table, the biggest share of the allocation went to Nutrition Services (R923 million) which has been increased substantially by 11.82 per cent as compared to the previous financial year (2013/14).

2.5. SUMMARY OF KEY CHALLENGES IN THE PROVISION OF HEALTH CARE

The Department of Correctional Services faces a number of challenges in providing health care to inmates in correctional facilities. Key amongst these challenges are:

- Inability to recruit and/or retain health care professionals. The high turnover of health care professionals (including nurses, medical practitioners, and psychologists) has been a persistent problem.[63]
- Insufficient custodial officials to accompany inmates (patients) for referral purposes.
- Increase in the burden of diseases in correctional centres which are becoming increasingly complex to manage.
- Participation of offenders in high risk behaviour and practices.
- High turnover of remand detainees contributes to inadequate management of diseases.
- Lack of proper transport to carry patients to external health facilities.[64]
- Outdated facilities. The facilities do not cater for health care provision at DCS facilities.
- Outdated equipment and shortages of equipment.
- Lack of space. In some centres, store rooms are temporarily used as clinics.
- Suicide attempts using medication issued.
- The design of some facilities relies on artificial ventilation which is not always reliable/operational as opposed to natural ventilation.[65]

[63] Department of Correctional Services (2009).
[64] Department of Correctional Services (2009).
[65] Department of Correctional Services (2015b).

- Overcrowding of correctional centres undermines the rights of offenders to conditions of detention which are consistent with human dignity and also contributes to the spread of diseases especially communicable diseases.
- According to Haggerty, there is generally a lack of HIV-specific medical expertise in prisons, as the poor working conditions and uncompetitive remuneration rates draw doctors to prisons who have little or no first hand expertise in treating HIV in their communities. [66]
- Haggerty also mentions that prisons are mostly concerned with security limiting prison movement and keeping tight control on when and where prisoners are in specified locations. This focus on security is said to negatively impact on the provision of and access to care and treatment. [67]

[66] Haggerty (2000).
[67] Haggerty (2000).

Chapter 3

A FOCUS ON MENTAL HEALTH, TUBERCULOSIS AND HIV AND AIDS

This chapter provides more detailed information on the status of mental health care, and approach to Tuberculosis (TB) and HIV and AIDS care and treatment in correctional centres.

3.1 *MENTAL HEALTH CARE IN CORRECTIONAL SERVICES*

Prevalence: A recent news report stated that the prevalence of mentally ill offenders in correctional centres is 'alarming'.[68] According to this same report, while 3 755 inmates are recorded as mentally ill out of the total prison population, this figure is probably much higher for the following reasons:[69]

- The mental health needs of remand detainees is unknown (unless on admission they provide proof that they are undergoing mental health treatment already). Screening for mental health is only provided to sentenced offenders.
- It is unclear whether all staff that submit the screening process are fully trained to detect mental illness.

A study published in 2012, noted that 'according to prisoners self-report, there was a huge disparity between the prevalence rates of mental disorders as diagnosed by the study and those that were detected and or treated in prisons'.[70] This substantiates the claim that many incarcerated offenders suffer from mental illness without being diagnosed on admission and thus are not being treated.

This study (in which 193 prisoners at Durban-Westville prison were interviewed using a Mini-Neuro-psychiatric Interview, a screening questionnaire and a demographic questionnaire) found that South Africa is in line with comparative international data in the following respects:[71]

- There is internationally a high prevalence of mental disorders amongst incarcerated offenders.
- In this study, the prevalence was also found to be high in that over 55% of sampled offenders were found to have 'Axis 1 disorders'. When substance and alcohol use disorders were excluded, a total of 23.3% were found to suffer psychosis, bipolar, depressive and anxiety disorders.

Insufficient staff within correctional centres to provide adequate professional support to mentally ill offenders has also been identified in the literature as a key concern. The Durban-Westville study notes that '…figures clearly illustrate the gross discrepancy between mental health care needs and services available'.[72]

[68] Mkhwanazi (2015).
[69] Mkhwanazi (2015).
[70] Naidoo,and Mkize (2012).
[71] Naidoo,and Mkize (2012).
[72] Naidoo,and Mkize (2012).

Screening: The following information has been received from each of the six regions of the Department of Correctional Services on the extent of the provision mental health care services in correctional centres.

Table 13: Extent of screening for mental illness on admission per region

Region	Admission processes
FS/NC	All offenders are screened on admission for psychological problems.[73]
LMN	All offenders are screened within 6 hours on admission for general medical problems. Within 21 days a broader observation assessment is completed which includes assessment of mental illness.[74]
KZN	No information is provided on the type of screening that is done on admission, however it is noted that 86% of all new admissions to the region were screened during the year.[75]
WC	Screening on admission not included in response.
EC	Initial screening is completed within 6 hours after admission for health and physical risk assessment. However, comprehensive health screening takes place within 2 weeks after admission and includes screening for mental illness.[76]
GP	All new inmates are screened upon admission and screening covers mental health problems.[77]

Source: Department of Correctional Services (2015b)

All regions (with the exception of the Western Cape which did not respond to this question) reported that offenders are screened on admission for mental illness. However, there is some confusion as to whether this screening occurs immediately on admission (within six hours) or whether this screening occurs later on (within a two to three week period). In addition, it is not clear who does this screening and whether mental health screening is completed by a mental health professional or by general nursing staff. Neither is it clear as to whether all new admissions are screened (both remand detainee admissions and sentenced offenders), though it is likely that this screening is only done for sentenced offenders. In addition, the responses do not clarify whether screening is done for sentenced offenders who have been sentenced to a prison period of under two years (these offenders do not receive treatment plans).

Mental Health Services: The responses include the following information:

Table 14: Mental health services provided per region

Region	Mental Health Services provided
FS/NC	Primary Health Care services- nurse driven Physiological services (Note: presumably, this should read 'psychological services') Psychiatrist's services on side External hospitalisation These services are available at all correctional centres. [78]

[73] Department of Correctional Services (2015b).
[74] Department of Correctional Services (2015b).
[75] Department of Correctional Services (2015b).
[76] Department of Correctional Services (2015b).
[77] Department of Correctional Services (2015b).
[78] Department of Correctional Services (2015b).

	When services cannot be rendered, sessional professionals are used to provide the services.
LMN	One DCS psychologist is appointed at Rooigrond, Klerksdorp and Rustenburg Management Areas. Psychiatric services are provided by Department of Health psychiatrists. Psychiatrists visit the correctional centres in Limpopo to assess the inmates inside the correctional centre clinic. A private psychiatrist is used at Witbank correctional centre. Bethal refers patients for psychiatric assessment to the Witbank correctional centre. [79]
KZN	There are 8 fulltime psychologists located mainly in big centres in all management areas. Pietermaritzburg- Two psychologists Durban Med B- Three psychologists Kokstad- One psychologist Empangeni- One psychologist Ncome- One psychologist Waterval- One psychologist Glencoe area accesses psychological services from other management areas with permanent psychologists and also refers to public institutions. Part-time psychiatrists visit Pietermaritzburg Medium A, Durban Medium B and Ebongweni at least once a week. Other centres refer to these three centres or external public health institution depending on need. Social work services are on site in all big centres. More than 70% of nurses appointed in KZN DCS facilities are qualified in psychiatric nursing. [80]
WC	Psychologists are available on a daily basis. Psychiatrists are available monthly. Social work services are available daily. All services are available at all correctional centres.[81]
EC	Psychologists are available and referral to public institutions occurs for psychiatric services. [82]
GP	Mental health services are available at all correctional centres. Psychologists are appointed by DCS. Psychiatrists offer private services. [83]

Source: Department of Correctional Services (2015b)

None of the regions explicitly identified shortages of professional staff (such as psychologists and psychiatrists) as a problem or a factor that hampers provision of services to inmates with mental illnesses. Though there are discrepancies in the detail of information provided it seems as if generally there is a mix of service provision by DCS, DoH and private specialists:

- Mental health services of some form are available at correctional centres but these may be as basic as social work services or nursing services.

[79] Department of Correctional Services (2015b).
[80] Department of Correctional Services (2015b).
[81] Department of Correctional Services (2015b).
[82] Department of Correctional Services (2015b).
[83] Department of Correctional Services (2015b).

- There are psychologists situated at some of the larger centres many of which are appointed by DCS.
- Psychiatric services are generally provided on a needs basis by the DoH or by private psychiatrists.

Accommodation for inmates diagnosed with mental health problems: The following information has been provided by DCS:

Table 15: Accommodation for inmates with mental health problems

Region	Accommodation
FS/NC	Mentally ill offenders are housed in separate cells. There is a challenge in that not all correctional centres have separate cells for mentally ill offenders.[84]
LMN	Inmates that are not psychotic are housed with other inmates. DOTS are implemented to ensure compliance with taking prescribed treatment. Serious cases are referred to mental health care institutions for further management. Inmates returned back from external health facilities are housed in the in-patient facility. Unstable or violent offenders are housed in single cells in the clinic under supervision of the health care personnel while awaiting to be assessed at DoH mental health institutions.[85]
KZN	There are isolation cells where psychotic, suicidal patients are kept under observation. [86] These cells are not always available at all correctional centres.
WC	Inmates diagnosed with mental health problems are separated from other inmates. Single cells are available for isolation purposes. These are available at all facilities. [87]
EC	Adequate accommodation for inmates diagnosed with mental illnesses are only available in regional in-patient facilities (hospital). Other facilities are not suitable for accommodating this category of inmate. [88]
GP	Inmates diagnosed with mental illnesses are accommodated in single and communal cells depending on the severity of agitation. Arrangements for admission at designated mental health care institutions for observation or treatment are made through the courts or as per referral in terms of the Mental Health Act. [89]

Source: Department of Correctional Services (2015b)

Many of the regions noted that they were unable to accommodate offenders with serious mental illnesses that require accommodation in single or isolation cells, mainly due to a shortage of these single cells.

[84] Department of Correctional Services (2015b).
[85] Department of Correctional Services (2015b).
[86] Department of Correctional Services (2015b).
[87] Department of Correctional Services (2015b).
[88] Department of Correctional Services (2015b).
[89] Department of Correctional Services (2015b).

COMMENT AND QUESTIONS

- Inmates deemed “State Patients” continue to be held in correctional facilities. An urgent call is made to the Department of Health at national and provincial level to make available premises at which these vulnerable inmates can be kept and treated.
- Remand Detainee ‘State Patients’ are particularly vulnerable. This category is detained indefinitely and there is no established process for their management within the remand detention facilities. The processes highlighted in the Mental Health Act only apply to those detained or transferred from remand detention institutions to Mental Health Establishments managed by the Department of Health.
- Isolation cells are not always available at correctional centres.
- The majority of unnatural deaths in correctional centres occur as a result of suicide. This is a strong indication that there is an obvious and urgent need for adequate mental health care services to be provided in all correctional facilities. Has the DCS created a tool to assess suicide risk?

It seems from the responses from the regions that there is an established process and requirements for screening on admission (within 6 hours) followed by a more detailed screening over a period of two to three weeks after admission. More clarity is required on the following:

- Are the screening requirements applicable to admissions for both remand detainees and sentenced offenders (or do they only apply to sentenced offenders)? What are the resulting risks?
- While a number of regions have responded that they screen for mental health problems on admission, does this screening occur in the initial 6 hours after admission period or within the two to three week period after admission? What are the resulting risks?
- Are sentenced offenders who are sentenced to imprisonment for less than two years screened?
- What are the implications for the health and safety of the individual concerned, other inmates, and staff if this screening for mental health problems occurs only in the two to three week period after admission?
- Who undertakes this initial mental health screening- a professional trained in mental health or the general health care staff?
- Despite the response that all new admissions are screened by the regions it is not in fact clear that this is indeed the case. KwaZulu- Natal region reports that 86% of new admissions underwent a health care screening (and states that this is a marked improvement from previous years). Each region should report on:
    - What percentage of new admissions underwent a general health care screening within the first 6 hours of admission?
    - What percentage of new admissions underwent a general health care screening within three weeks after admission?
    - What percentage of these screenings included an assessment of mental health/mental illness?

A key question is whether there are adequate services provided to mentally ill offenders in each of the regions. It is clear from the responses provided by the DCS that a range of different services are offered in the different regions. However, it is not clear as to whether there are critical problems in the provision of these services. Again, a key concern is the fact that it is likely that remand detainees receive no support at all.
More information could be requested from the regions on:

- What are the shortages experienced in professional service provision (psychologists and psychiatrists) and what impact this has on the ability of the region to provide effective mental health care for mentally ill offenders?
- What percentage of nursing staff is trained in psychiatric services and is this sufficient?

The inability to accommodate inmates with diagnosed mental illness that require to be separated from other inmates is the one problem that is openly acknowledged by a number of regions. The implications of the inability to house these inmates separately would have serious implications for the safety of the agitated inmate, other offenders as well as correctional officers and staff.

3.2 TUBERCULOSIS (TB)

3.2.1. Global TB overview

In the 20 year period since the World Health Organization began to focus on TB as a notifiable infection, there has been about 78 million cases that were recorded while 66 million of them were successfully treated.[90] In 2014, the surveillance system measured an increase of TB notifications since 2007, showing drastic improvement in TB detection and treatment. In 2013, the treatment success rate for people newly diagnosed with TB globally was estimated at 86%, a level that has been sustained since 2005 due to improved global strategies that enhance the surveillance and reporting systems for the highly infected countries. The global strategies on TB, the focus on it and the improvement in social determinants has resulted in a substantial reduction of new TB cases of about two-thirds (63%) of the 9.6 million people estimated to have contracted the disease in 2014.[91]

The year 2015 marked the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals which both demonstrate and underscore the global commitment towards the eradication of TB. Furthermore, the shift from the Stop TB Strategy to the End TB Strategy is pronounced in 2015 which again shows deliberate undertakings to cease the TB epidemic. Despite these policy advances at global level, TB remains one of the world's biggest threats. For example in 2014, TB is recorded as been accountable for: [92]

- Over 1.5 million deaths
- Being a number 1 killer amongst people infected with HIV
- 9.6 million people globally estimated to have contracted TB in 2014 comprising of:
    - 5.4 million men
    - 3.2 million women
    - 1.0 million children.

3.2.2 TB in South Africa

[90] World Health Organization (2015).
[91] World Health Organization (2015).
[92] World Health Organization (2015).

The total number of people infected with TB in South Africa was estimated to be 380 000 in 2014 making South Africa the third most affected country in the world after India and China.[93] Moreover**,** the number of new TB cases in South Africa shows the rate at which the disease is spreading, though it has decreased from 900 incidents per 100,000 per population in early 2000 to 834 per 100,000 per population in 2014.[94],[95] Nevertheless, the prevalence of TB in South Africa is a major concern. The high HIV prevalence in in the country is an additional challenge because people living with HIV are 20 to 30 times more likely to contract TB than those without the infection.[96]

3.2.3 TB in correctional centres

In response to the *Lee* judgement[97], the DCS reports that TB management in correctional centres is receiving greater attention.[98] This is in accordance with the National Strategic Plan for HIV, STIs and TB 2012/16 as well as the Guidelines for Management of TB, HIV and STD's in Correctional Centres (2013).[99] It was reported in 2015 that the Department of Health is to launch a programme to test 150 000 inmates in 242 correctional services facilities for Tuberculosis (TB), and have stated that "every single person in correctional services facilities will have to be screened for TB. We will also screen the families of those who have tested positive."[100] The programme was launched on 24 March 2015 - on World TB Day.

However, according to Professor Robin Wood, a correctional facility such as Pollsmoor remains an ideal space for TB to spread: 'Conditions prevailing in Pollsmoor Prison are extremely conducive to the ongoing transmission of TB, including drug-resistant TB. Crowding, long lock-up times up to 23 hours per day, and inadequate ventilation result in prisoners re-breathing contaminated air for prolonged periods of time.'[101]

It is not clear how the DCS intends to address fundamental challenges such as overcrowding and poor infrastructure which are key contributors to the spread of contagious diseases such as TB. A 2011 study using a mathematical model explored the interaction between incarceration conditions and TB control measures, and found that the risk of TB transmission in communal cells was as high as 90% per annum. [102]

TB infections and cure rate: A total number of 2 564 inmates received treatment for TB in correctional facilities in the 2013/14 financial year. The breakdown per region is as follows[103]:

- Free State/Northern Cape: 164
- Western Cape: 673
- KwaZulu-Natal: 704
- Eastern Cape: 320
- Gauteng: 539

[93] World Health Organization (2014a).
[94] World Health Organization (2014a).
[95] World Health Organization (2014a).
[96] Medical Brief (2015).

[98] Department of Correctional Services (2013a).
[99] Department of Correctional Services (2015b).
[100] http://www.sanews.gov.za/south-africa/new-tb-programme-prisons-mining-towns
[101] http://www.sanews.gov.za/south-africa/new-tb-programme-prisons-mining-towns
[102] Johnstone-Robertson *et al.* (2011).
[103] Department of Correctional Services (2015b).

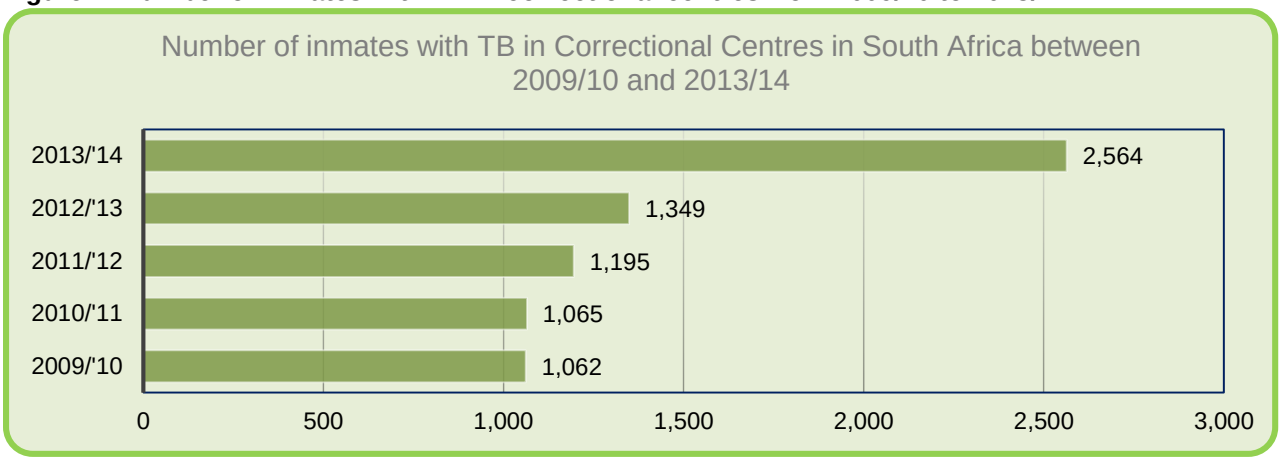
- Limpopo, Mpumalanga and North West: 164

In 2013/14 the TB cure rate in regions was as follows[104]:

- Free State/ Northern Cape: 80%
- Western Cape: 69%
- Eastern Cape: 82%
- KwaZulu-Natal: 63.4%
- Gauteng 84%
- Limpopo/Mpumalanga/North West 86%

Figure 1 below depicts the number of inmates infected with TB (including MDR and XDR) in all the regions from 2009/10 to 2013/14.

Figure 1: Number of inmates with TB in correctional centres from 2009/10 to 2013/14



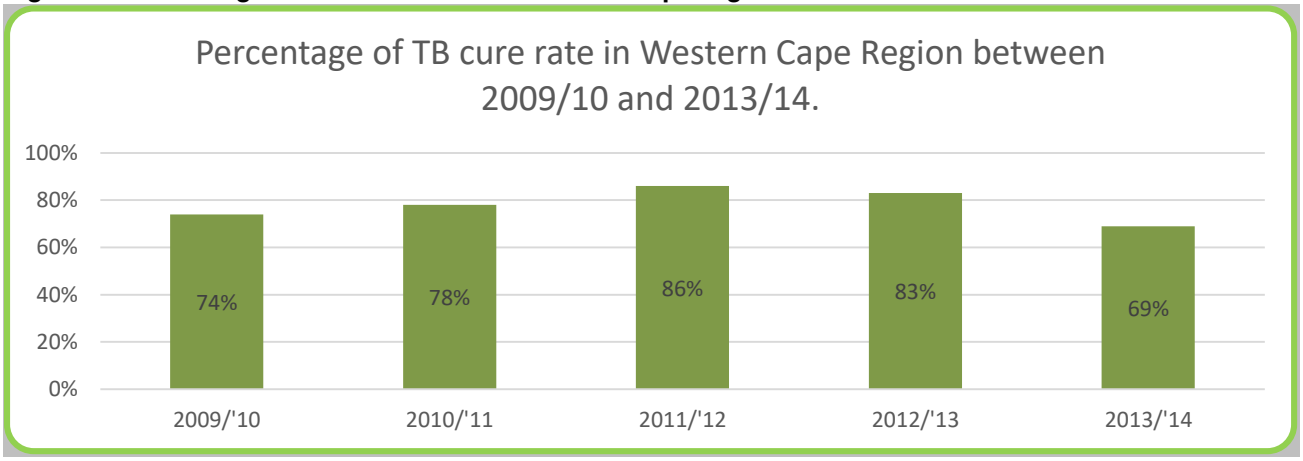
Source: Department of Correctional Services (2015b).

The TB cure rate is considerable though it varies across the regions. For example, in the Western Cape, the percentage of cure rate ranges between 74% in 2009/10 to 69% in 2013/14 financial year. The Free State/Northern Cape region has no records of TB cure rate for 2009/10 and 2011/12 while in 2012/13 the cure rate was 65% and higher in 2013/14 at 80%. In Limpopo, Mpumalanga and North West region, the percentage for 2009/10 and 2011/12 was not consolidated. However, the cure rate for 2012/13 stood at 78% and in 2013/14 stood at 86%. In this region, the challenge mentioned was that some inmates got lost from the system when discharged by the courts, while others upon their release did not continue with treatment with public health facilities. In the Eastern Cape region, the cure rate in 2009/10 was 65% and in 2013/14 was 82%. In 2009/10, the TB cure rate in the KwaZulu-Natal region was 36.5% which is the lowest of all other regions, but it did improve in 2013/14 to 63.4%.

The two graphs below compare the cure rate of two regions namely the Western Cape and Eastern Cape. The objective is to demonstrate that though the treatment is given there is more innovation needed to encourage adherence and reduce the drop-out rate of ex-inmates when they are discharged from the correctional centre. Figure 2 shows the Western Cape region's cure rate for the period 2009/10 to 2013/14.

[104] Department of Correctional Services (2015b).

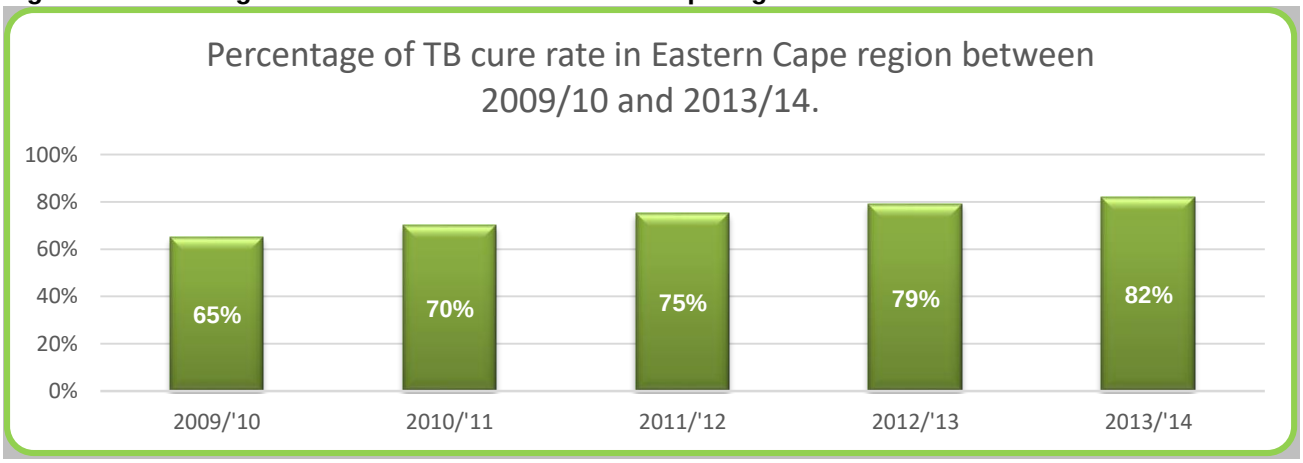
Figure 2: Percentage TB cure rate in the Western Cape region between 2009/10 and 2013/14.



Source: Department of Correctional Services (2015b).

With reference to figure 2, the cure rate in the Western Cape region is reflected as having fluctuated over the period of 5 years with 2013/14 depicting a decline to 69% which is 6% lower as compared to the 74% recorded in 2009/10.

Figure 3: Percentage of TB cure rate in the Eastern Cape region between 2009/10 and 2013/14.



Source: Department of Correctional Services (2015b).

In reference to figure 3, the TB cure rate in the Eastern Cape region shows a steady increase which demonstrates a positive trajectory to reaching a 100% cure rate. The reasons for the defaulters as mentioned earlier is the drop out of ex-inmates when they are discharged from the correctional centre. It is unclear why the Eastern Cape region has shown this steady improvement in cure rate while the Western Cape region has not.

Treatment and access to Gene-Xpert machines: According to the DCS, all offenders are screened for TB on admission to a correctional facility. Screening for TB should take place within six hours of admission, during each encounter with health care professionals as part of primary health care services, bi-annually and on release.[105]

[105] Department of Correctional Services (2015b).

A number of programmes are available in correctional facilities to deal with TB and these include the following:[106]

- Health education on TB
- Comprehensive health assessment of inmates within 24 hours of admission
- HIV counselling and testing for inmates diagnosed with TB
- Initiate HIV and TB positive patients on CPT
- Orientation of TB symptoms
- Provision of TB programmes
- Referrals to TB specialists in TB hospitals
- Treatment and isolation until cured
- Screening of DCS officials for TB disease and LTBI.

The Department of Correctional Services has made it now mandatory to screen all incoming inmates. Six (6) state-of-the-art machines known as Gene-Xpert were handed over to Pollsmoor Correctional Centre by the then Deputy President Kgalema Motlantle in 2013. These machines are able to reduce the time needed to diagnose the presence of TB from about six (6) weeks to two (2) hours, thereby allowing medical staff to treat patients sooner, stop the disease from spreading and improve the efficacy of Government's TB Control Programme.[107]

On a regional basis:

- The Free State/Northern Cape region has over 45 correctional centres with only Groenpunt Correctional Centre having an onsite Gene–Xpert machine. The other centres have access to the equipment at the Department of Health.
- The Limpopo, Mpumalanga and North West region has 41 correctional centres with only one centre namely Barberton Medium-A with a Gene-Xpert machine onsite. The other 40 correctional centres access the Gene-Xpert machine at the National Health Laboratory Service.
- The same approach is in the Eastern Cape region where one facility namely St. Albans has an onsite Gene-Xpert machine, while 39 access the equipment through the DoH in the province.
- The KwaZulu-Natal region has 50 correctional centres and five of them have an onsite Gene-Xpert machine while the other 45 centres access the machine off-site.
- The Western Cape region and 42 correctional centres. Two correctional centres in the Western Cape, namely Overberg and Pollsmoor, have Gene–Xpert.

COMMENT AND QUESTIONS

- Has additional funding has been made available for TB management and treatment following the *Lee* judgement? If so how much has been budgeted over the medium and longer term?
- The Department of Health launched a programme in March 2015 to test 150 000 inmates in 242 correctional services facilities for Tuberculosis (TB), "every single person in correctional services facilities will have to be screened for TB. We will also screen the families of those who have tested positive. "We are talking of 150 000 inmates in 242 correctional services facilities." The DoH and DCS should report on

[106] Department of Correctional Services (2015b).
[107] http://www.sanews.gov.za/south-africa/govt-takes-battle-against-tb-prisons-mines

the specifics of this programme in terms of budget, projected costs and a detailed implementation plan specifying milestones and indicators.

- Do Heads of Correctional Centres participate in Provincial TB control 'war rooms'?
- Does the DoH work with the Minister of Police to manage TB in police holding cells and to avoid the interruption of treatment when people are arrested? If not, why not?
- Does DCS integrate anti-retroviral treatment and TB treatment and if so, how?
- Do all correctional facilities facilitate activities such as adherence support groups for inmates?
- Prior to release, are offenders on TB therapy advised as to the location of TB clinics in their area? If a released offender chooses a particular clinic is that clinic notified to expect the patient.
- Do all correctional centres keep an electronic TB register, if not why not?
- Has the National Task Team on TB in prisons conducted donor-funded baseline assessments to determine levels of infection control and health care services at prisons?
- What are the plans for rollout of additional Gene-Xpert machines? How many are there in total to date, and how many more are required. What are the costs? How have the Gene-Xpert machines improved TB case finding and treatment?
- The DCS response (through the development of targets and timeframes) to the National Strategic Plan (NSP) for HIV, STIs and TB: 2012-2016 confirms that inmates and staff of correctional facilities are at higher risk for both HIV and TB and provides that the DCS:
  - Will implement a number of interventions to decrease transmission of HIV and TB in correctional facilities.[108]
  - Must ensure the provision of appropriate prevention and treatment services, including HIV, STI and TB screening, prompt treatment of all inmates and correctional services staff, ensuring continuum of care through proper referrals, and enforcement of laws and policies to prevent sexual violence in prison settings, including the use of newly developed screening guidelines to identify inmates who are vulnerable to sexual violence.
- The extent to which the 2013 Guidelines for Management of TB, HIV and STD's are being applied uniformly in all correctional centres?
  - Have the guidelines been enabled by an implementation plan and a budget.
  - Whether the DCS has a plan in place to address infection control and overcrowding in prisons, which is linked to the NSP targets?
  - The extent of improved collaboration between the DCS, DoH and researchers to establish levels of MDR TB in prisons and the role of prisons in fuelling the TB epidemic outside prisons.

3.3 HIV AND AIDS

3.3.1 Global HIV overview

Since the discovery of HIV over three decades ago, there has been more than 78 million people globally that have contracted it while an estimated 39 million people have died as a result.[109] However, the epidemic's proportion globally is uneven across the countries and its socio-economic effects are experienced differently.[110] In general, developed countries have significantly lower HIV

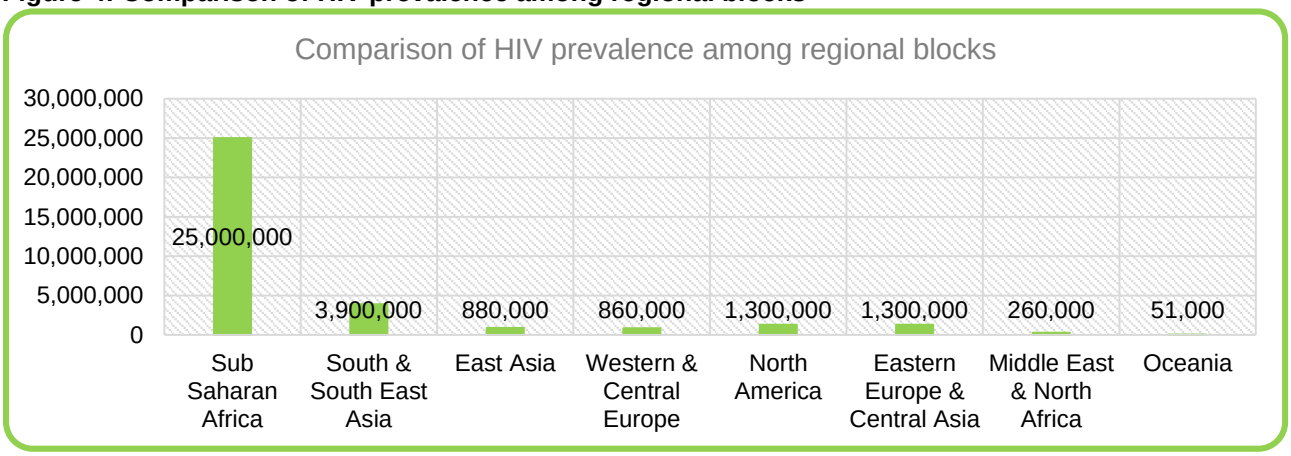
[108] http://www.sahivsoc.org/upload/documents/National_Strategic_Plan_2012.pdf
[109] WHO (2015).
[110] WHO (2015).

prevalence compared to developing countries as many developing countries lack adequate resources to confront the disease and provide ideal primary healthcare to keep people safe and healthy. In 2014, the number of people considered to have been living with HIV globally was about 35 million, while 2.1 million people were newly infected, and 1.5 million people were estimated to have died of AIDS related infections worldwide.[111]

Furthermore, in 2013, the disease showed a continuous trend of uneven proportion across the regional blocks with Sub-Saharan Africa showing a substantial prevalence compared to other regions.[112] On the other hand, the TB prevalence globally continues to increase compromising gains the international community has made in reducing the spread of this deadly airborne infection. By 2014, one third of the world's population was estimated to be infected with TB, while in the same year 9.6 million people around the world became sick with this disease. About 1.5 million TB-related deaths worldwide were recorded in the same year. Given its link to HIV, it is a leading killer of people who are HIV infected.[113]

Figure 1 below depicts the HIV prevalence in eight regions with Sub-Saharan Africa showing 25 million people living with HIV.

Figure 4: Comparison of HIV prevalence among regional blocks



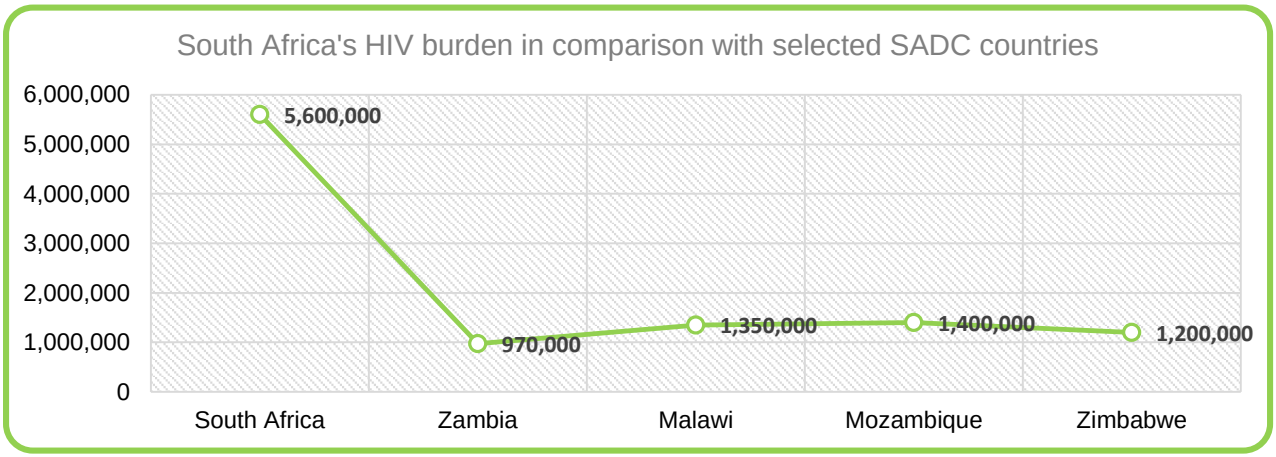
Source: Joint United Nations Programme on HIV/AIDS (2013).

3.3.2. HIV in South Africa

South Africa is purported to be one of the heavily impacted country in the world with an estimated 5.6 million people living with HIV.[114] In 2013, South Africa's HIV prevalence was triple that of Malawi which was at 1.3 million and far more than some of its SADC countries.[115] Figure 2 below compares South Africa's HIV prevalence with selected SADC countries.

Figure 5: South Africa's HIV prevalence in comparison with selected SADC countries

[111] WHO (2015).
[112] Joint United Nations Programme on HIV/AIDS (2013).
[113] Joint United Nations Programme on HIV/AIDS (2013).
[114] Joint United Nations Programme on HIV/AIDS (2013).
[115] Joint United Nations Programme on HIV/AIDS (2013).



Source: Joint United Nations Programme on HIV/AIDS (2013).

3.3.3. HIV in correctional centres

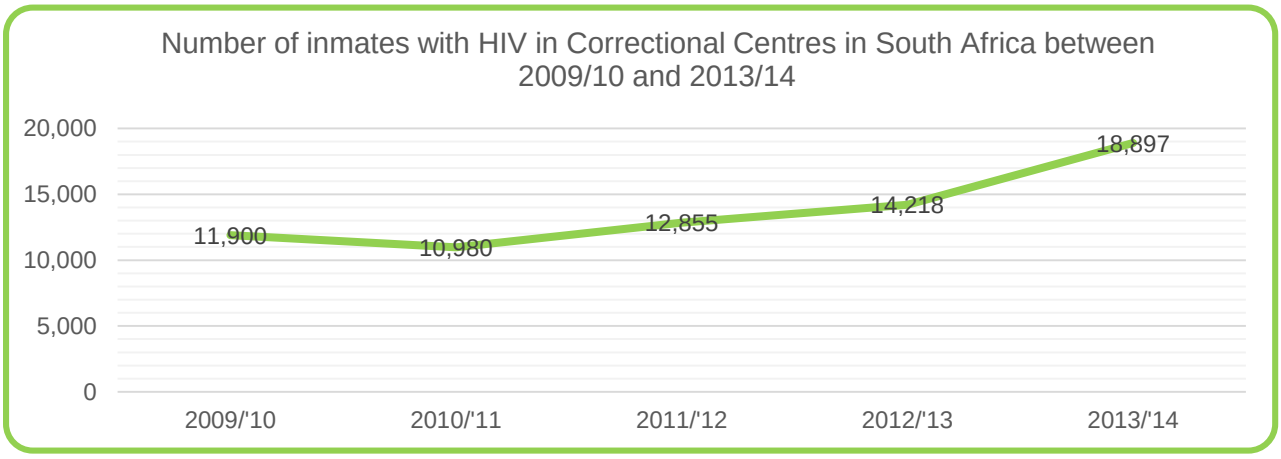
Prevalence: International partners namely the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), and civil society organisations like Treatment Action Campaign (TAC) as well as the Department of Health (DOH) and the Department of Correctional Services (DCS) agree that inmates are one of the vulnerable groups highly susceptible to HIV. However, the total number of inmates estimated by the DCS to be infected with HIV is disputed by civil society groups, such as the Civil Society Prison Reform Initiative, and the Inspecting Judge of Correctional Services. To this end, the Department of Correctional Services reported an HIV prevalence rate of 3% in 2009, while the Civil Society Prison Reform Initiative and the Inspecting Judge of Correctional Services estimated the prevalence to be between 40-60% of all offenders during the same year.[116]

The 2008/09 and 2009/10 Annual Reports of the DCS do not demonstrate how the 3% prevalence was determined. They however, underscore that its estimates were unrealistically low. Given this acknowledgement by the DCS, the Institute for Security Studies and the Inspecting Judge of Correctional Services dispute this estimate on the basis that the DCS has inadequate staff to produce the credible estimates on the prevalence of HIV amongst the inmates. Another study conducted by Lim'uvune Consulting in 2007, commissioned by DCS, reached over 10,000 inmates nationwide and found an HIV prevalence of 19.8%.[117] According to this study, 94% of the infections were among male inmates, who constitute 98% of all incarcerated persons.[118] These results are significantly high but also do not reveal the accurate picture because it only covered selected correctional facilities with a substantial cohort of inmates reported to have declined participation in the study.[119]

During the 5 year period covering 2009/10 and 2013/14 the number of inmates confirmed to have contracted HIV in all regions is reflected on the figure 6.

Figure 6: Number of inmates with HIV in correctional centres in South Africa between 2009/10 to 2013/14.

[116] Civil Society Prison Reform Initiative (2008).
[117] Department of Correctional Services (2008).
[118] Joint United Nations Programme on HIV/AIDS (2013).
[119] World Health Organization (2015).



Source: Department of Correctional Services (2015).

Figure 6 depicts a challenging picture of increased infection despite interventions being made. As shown, in 2009/10 the total number of inmates who were confirmed as having HIV is 11 900 while in 2012/13 and 2013/14 it increased to 14 218 and 18 897 respectively.

In the 2013/14 financial year the Department of Correctional Services tested a total of 98 580 inmates for HIV/AIDS. The breakdown of regions is as follows[120]:

- Free State/ Northern Cape: 10 457
- Limpopo, Mpumalanga, Northern West: 12 678
- Western Cape: 39 258
- Eastern Cape: 11 033
- KwaZulu-Natal: 14 051
- Gauteng: 11 103.

A total number of 18 897 inmates were infected with HIV/AIDS in the 2013/14 financial year. The regional breakdown is as follows[121]:

- Free State/Northern Cape: 2 681
- Limpopo/Mpumalanga and Northern Cape: 4 120
- Western Cape: 2 906
- Kwa-Zulu Natal: 2 346
- Eastern Cape: 2 321
- Gauteng: 4 523

Services and treatment: All regions reported almost a unified basket of services that are offered to inmates as a response to HIV and AIDS. The following are common services rendered:

- HCT screening and testing;
- Counselling and treatment adherence;
- Reporting of side effects;
- Referral system to other service providers;

[120] Ibid
[121] Ibid

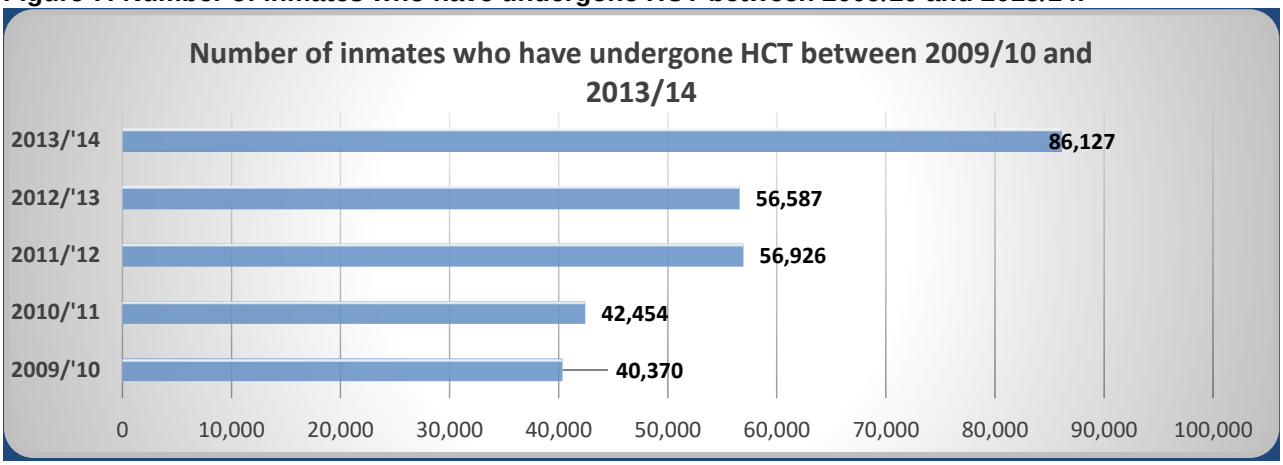
- Support system (social, spiritual and psychological);
- Monthly health education;
- Work-out programme as per requirement.
- Voluntary medical male circumcision;
- Cervical screening;
- Family planning; and
- PMTCT (referral upon discharge).

The Department of Correctional Services provides a number of treatment plans for inmates with HIV/AIDS which includes:[122]

- Supporting post counselling
- Nutritional support according to BMI
- If qualifying, drug readiness classes are offered and the offender is placed on ART
- Provision of Antiretroviral Treatment including Fixed Dose Combination (FDC)
- High protein diet provided to those who meet the criteria
- Medical eligible HIV positive inmates receive Cotromoxazole
- Referrals of ill cases to DoH.

Statistics depict that 40% of inmates or detainees are incarcerated for less than one year and that on average 25 000 of them are released monthly. This results in an average 300 000 of them being released back to the community each year. If they contracted HIV whilst incarcerated – it means they bring it into the community. This demonstrates that HIV does not remain in correctional centres but impacts on people and communities in the general population.[123] In trying to mitigate this problem, the DCS continues to intensify HCT programmes which includes sound counselling on either treatment options and or lifestyle to ensure that clients are better informed. [124]

Figure 7: Number of inmates who have undergone HCT between 2009/10 and 2013/14.



Source: Department of Correctional Services (2015).

Figure 7, demonstrates the vertical trajectory of numbers of inmates who have gone through the HCT programme. There is no explanation of why the the DCS is not reaching a 100% rate of HCT coverage. Outside sources claim that this is because inmates are not coerced to participate but

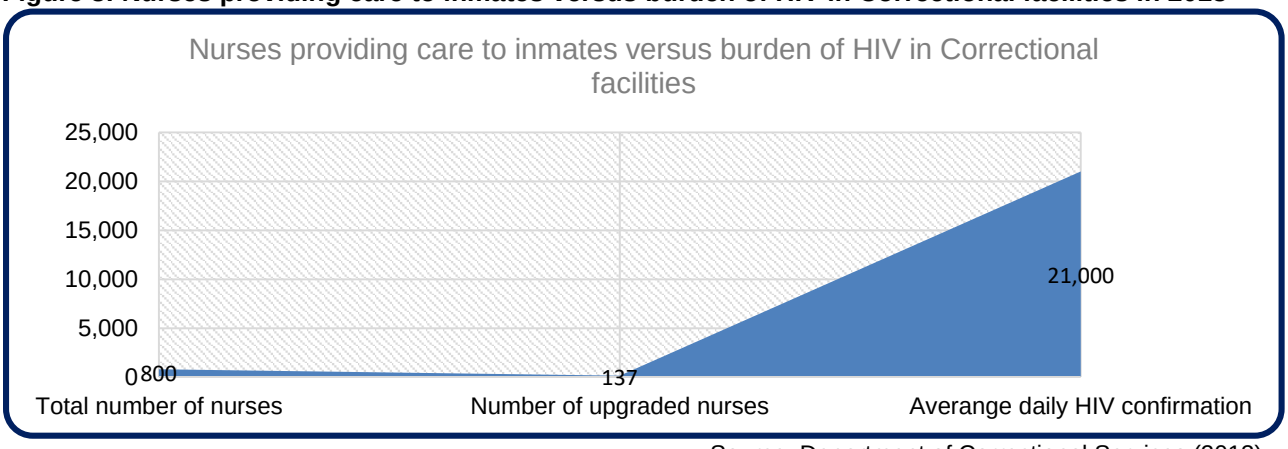
[122] Department of Correctional Services (2015b).
[123] Goyer (2002).
[124] Department of Correctional Services (2015b).

encouraged as it is within their rights to choose otherwise.[125] Another claim is that the DCS has inadequate capacity to undertake HCT for all inmates because of the dynamics of daily exit and daily entry which makes it difficult to successfully manage the HCT programme.[126]

Initiatives have included:

- In pursuit of increasing access to ARVs, the Department of Correctional Services in partnership with the Department of Health has shifted from accrediting sites for anti-retroviral (ARV) to ensuring that all correctional facilities depending on the scale and resources provide antiretroviral treatment to all affected inmates. This initiative is implemented as per 2013 *Guidelines for the Management of Tuberculosis, Human Immunodeficiency Virus and Sexually-Transmitted Infections in Correctional facilities.* These guidelines, prescribe that inmates should be screened for TB, HIV and STIs upon entry into the facility to ensure that treatment is commenced immediately, where it is deemed required.[127]
- The number of inmates on ARV treatment increased from 5 066 (in 2012/13) to 15 417 (in 2013/14)[128]
- The Department has intensified its HIV testing and counselling through the assistance of external partners and as a result, the number of inmates tested for HIV increased from 76 202 (in 2012/13) to 107 415 (in 2013/14).[129]
- Nurse-initiated Antiretroviral Therapy (NIMART):
  The DCS employs a task-shifting approach with its nursing staff to ensure that the prescription of medicines is not only done by doctors but the trained and accredited nurses. The upgrading of nurses is done to ensure that nurses prescribe ART medication to inmates who after diagnosis and relevant interventions require such for treatment. Figure 11 compares the employed nurses, the upgraded nurses to qualify for offering ART and the number of inmates being confirmed HIV positive daily in correctional facilities.

Figure 8: Nurses providing care to inmates versus burden of HIV in Correctional facilities in 2013



Source: Department of Correctional Services (2013)

[125] Goyer (nd).
[126] Goyer (nd).
[127] Department of Health (2013).
[128] Department of Correctional Services (2014a).
[129] Department of Correctional Services (2014a).

Factors contributing to the spread of HIV amongst the inmates in Correctional facilities: In the South African context, prison gangs, corruption, inadequate human resources, policy directives like lock-down and overcrowding are some of the serious problems confronting the system.[130] This subsection discusses some of these challenges in the context of HIV and AIDS in correctional facilities.

- **Prison Gangs:** Various studies claim that the prison system is infested with gangs who claim territorial influence accompanied by absolute power and abuse.[131] Accordingly, this trend manifests itself in various forms namely in perpetuating violence amongst the vulnerable inmates and detainees.[132] Common trends of violence include denying new entrant inmates and detainees' meals, exerting physical violence and sexual assault. Sexual assault is the common route of sexually transmitted infections amongst inmates and the culture of prison violence under the disguise of gangsterism perpetuates incidences of HIV.

  The commonly known gangs in South African correctional facilities are the 26s and 28s. They are both synonymous with high-risk behaviours in relations to the spread of HIV. For example membership in both gangs includes tattooing, which normally entails using one instrument for a group. Another risk behaviour amongst the gangs is the initiation process which entails violent attacks on each other. This violent practice is considered critical in both gangs in terms of ranking or seniority in the gang and, given that seniority is premised on amongst other factors, the extent of exerting violence and brutality on the other inmates, the risks for the spread of HIV are significant.

- **Inadequate human resources and lock-up policy**: The DCS has acknowledged the shortage of human resources as one of its challenges in executing its objectives.[133] The significance of inadequate human resources is linked to lock-up policy directives which compel correctional officials to subject inmates to a lock-up allowing minimal or skeleton staff for patrol and subjecting inmates to a non-movement and non-productive position. The lock-up policy directive is intended to send inmates into their cells, and communal spaces until the next morning.[134] Because the correctional officials are minimal, this creates prime opportunities for sexual perpetrators to commit assaults with no intervention of guards. This creates opportunity for sexual offences being committed, which exacerbate the spread of various STIs including HIV.

- **Overcrowding**: Post-1994 the prison population in South Africa increased from 111 090 to 180 000 inmates in 2003. This increase made South Africa the country with the largest prison population in Africa and the ninth in the world. The prison population has been reduced to around 159 241 inmates in 2015. However there is insufficient space available and in 2015 there was only bed space for 120 000 offenders**.**[135] Overcrowding compromises various elements of human dignity and institutional objectives. For example; it undermines basic rights to privacy, recreational activities, education, health, hygiene and rehabilitation. It causes violence, tension and anxiety leading to weakened immune system and high probability of tuberculosis and HIV. It

[130] Goyer (nd).
[131] Ayade (2010).
[132] Ayade (2010).
[133] Department of Correctional Services (2013b).
[134] AIDS Law Project and the Treatment Action Campaign (nd).
[135] Department of Correctional Services (2015).

effects the correctional facility's ventilation system leading to increased susceptibility to various illnesses with sanitation being compromised.[136]

COMMENT AND QUESTIONS

The DCS encounters various challenges that impede it from achieving its objectives in line with international and national instruments including constitutional provisions guaranteeing the rights of inmates to be protected from harm and risks of HIV. The following are some of the challenges:

- Inadequate nurses trained in Primary Health Care to provide essential service including prescribing medicines such as ART;
- Inadequate key skills such as counsellors, psychologists, pharmacists, doctors and nurses to assist in mitigating the spread and vulnerability of inmates to HIV;
- Ambiguous policy in terms of roles and responsibilities by the DoH and Provincial Departments of Health with regards to Correctional health care issues;
- Overcrowding;
- Gang culture; and
- Unbecoming behaviour of some of DCS officials, which perpetuates crime, violence and vulnerability to STIs and HIV of inmates.

The National Strategic Plan directs government on interventions to be taken to prevent the spread of STIs and HIV. It also explicitly highlights inmates as part of the vulnerable population for HIV and TB infections. Subsequently, the DCS and DoH have begun to provide measures to determine the state of health of inmates and detainees with regards to HIV and TB. In facilitating this intervention, it is essential for both DCS and DoH to upscale their reach to all inmates unlike now where not all inmates are getting an opportunity to be screened due to DCS' capacity.

- Abuse and violation of inmates and detainees by some DCS officials contradicts the DCS' policies and human rights of inmates. To counter this, it is cardinal for DCS to consider the reports submitted to it by various partners which report on the occurrence of these incidences.
- Various studies by DCS partners report on the prevalence of sexual violence amongst male inmates, which are seldom considered. Given the implication of this phenomenon to HIV, and the rights of inmates, it is important for the DCS to equip its officials on managing sexual violence amongst inmates and detainees.
- Overcrowding poses significant complications to the DCS objectives and risks to inmates and detainees. To manage this challenge, it is crucial for the DCS to continue to explore various best practice systems in other countries that balance justice against the offender and respect the rights of the inmate, especially in the context of prison violence, TB and HIV.
- Various factors exacerbate the vulnerability of inmates to HIV and STIs such as the prevalence of gang culture, shortage of medicines, and lack of privacy for inmates to store and take medication as well as susceptibility to TB. These factors either compromise detainees and inmates to contracting HIV and or worsen their HIV status to an advance HIV, making their immune system unresponsive to opportunistic infections. In the context of meeting international, regional and national legal prescripts,

[136] AIDS Law Project and the Treatment Action Campaign (nd).

it is vital for the DCS to resolve these issues and ensure that factors likely to jeopardise detainees' and inmates' health rights are eliminated.

- Prisoners who know their status and have access to ARVs may be discouraged from taking medication for fear of social isolation or abuse. Concealing their medication from fellow prisoners or prison officials is difficult when prisons are overcrowded. The lack of privacy in prisons means that prisoners receiving ARV find it difficult to conceal their status from prison officials or other prisoners. Prisoners miss their medication because they do not want to stand in line to receive it, and often conceal their HIV status from other prisoners. What strategies are being implemented by DCS to overcome such challenges? Do inmates have access to support groups, exposure to regular education programmes focusing on stigma, and peer counselling, which have been shown to be key ingredients of any effective prison HIV and AIDS policy.
- While the courts have used their powers to enforce the rights of prisoners in terms of the Constitution, specifically their right to medical treatment, the state needs to adopt a holistic approach when providing ART for prisoners. Prisons should not offend the values of the Constitution by failing to provide support for the treatment for HIV and AIDS in South African prisons – beyond the mere provision of ART. This failure can be overcome by providing comprehensive HIV and AIDS care and prevention, treatment of opportunistic infections, access to nutritional supplements, access to palliative care and compassionate release.

Chapter 4

INTERNATIONAL AND REGIONAL INSTRUMENTS

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest standard of health conducive to living a life in dignity[137]

In 1948, the World Health Organisation (WHO) developed and promulgated the understanding of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or sickness'.[138] This definition, part of the WHO Constitution, was updated in the 1986 Ottawa Charter for Health Promotion to include other facets of health as a resource for everyday life, not the objective of living, and health is a positive concept emphasizing social and personal resources, as well as physical capacities.[139] The WHO Constitution further affirms that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition.' Over time, this recognition was reiterated, in a wide array of formulations, in several international and regional human rights instruments, which include:

- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Universal Declaration of Human Rights
- American Declaration on the Rights and Duties of Man
- European Social Charter
- International Covenant on Economic, Social and Cultural Rights
- African Charter on Human and Peoples' Rights

This chapter explores the health rights of prisoners as defined by the WHO, and the mechanisms that have been used to ensure the rights of persons in detention to realise the highest attainable standard of health. It examines this right as articulated within United Nations and regional human rights treaties, non-binding or so-called soft law instruments from international organisations and the jurisprudence of international human rights bodies. In so doing, it examines the approach to prison health of the United Nations human rights system and its various monitoring bodies, as well as the regional human rights systems in Europe, Africa and the Americas.

4.1. INTERNATIONAL HUMAN RIGHTS LAW

This section explains and contextualise the key human rights treaties and bodies that have examined questions of right to health. International human rights law is a consensually based system of treaty law. In ratifying a human rights convention, a state pledges to respect, protect and fulfil the rights it enshrines, and participate in the system(s) of independent monitoring and adjudication the treaty sets out.

[137] UN Committee on Economic, Social and Cultural Rights (2000).
[138] WHO (1948)
[139] The Ottawa Charter for Health Promotion, Ottawa, (1986).

According to Lines there are four systems of international human rights law, falling into two distinct categories. The first is the United Nations system, which itself contains two distinct elements: the Treaty System and the Charter-based System.[140]

4.1.1. Treaty-Based System

The treaty-based system is based on nine core international Conventions. However, for the purpose of this paper, only six will be outlined as they make provisions for detained persons. These include:[141]

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment
- Convention on the Elimination of All Forms of Discrimination against Women
- Convention on the Elimination of All Forms of Racial Discrimination
- Convention on the Rights of the Child.

In defining specific human rights protections, each treaty establishes a committee of independent experts (known as a ‘‘treaty body’’) that monitors the progress of states towards meeting the obligations enshrined in the treaty. The UN Human Rights Committee, for example, monitors the national implementation of the International Covenant on Civil and Political Rights. The Committee on the Rights of the Child monitors the implementation at country level of the Convention on the Rights of the Child, and so on. The Committees are expected to fulfil this mandate through a periodic reporting function, in which countries that have ratified the given treaty must submit a report to an independent expert committee every three to five years and have their human rights record under that treaty reviewed. The underlying principle of the periodic reporting process is one of ‘‘constructive dialogue’’ rather than criticism or confrontation. Following each of these periodic reviews, the committee in question will issue a report, called its Concluding Observations, on the state’s progress, noting areas of good implementation and also recommendations for improvement.

In addition, Lines further states that each committee is mandated to interpret the terms of treaty for which it is responsible in order to provide guidance to states in fulfilling their treaty obligations.[142] These are typically done in the form of General Comments, which are in essence detailed commentaries on how the committee interprets the scope of the right or treaty article in question. Some of the independent committees, most notably the Human Rights Committee, are also empowered to consider individual complaints or ‘‘communications’’ from persons who allege to have suffered human rights violations.

Unlike court decisions, none of the recommendations of UN human rights treaty bodies are binding, and there is no direct enforcement mechanism. Rather, the political weight of the treaties themselves is their strongest asset, as all states have agreed the same terms. Lacking any enforcement powers, the independent committees rely on the good will of states to comply with their recommendations.

4.1.2. Charter-Based System

[140] Lines (2008).
[141] The United Nations Human Rights Treaty System: Fact Sheet No.30. Rev 1.
[142] Lines (2008).

On the other hand, the Charter-based system is based on the Charter of the United Nations. Articles 1 and 55 state that the aim of the UN is to promote fundamental respect for human rights, and which creates the principal organs of the United Nations. This system consist of two primary bodies known as the UN General Assembly and the Economic and Social Council. The UN General Assembly is comprised of all UN member states, and is the chief policy-setting body in the UN. It plays a key role in setting standards and codification of international law. Human rights treaties and declarations are adopted at the General Assembly.

The work of the General Assembly is divided among a number of committees. The Third Committee deals specifically with social, humanitarian and cultural issues, including human rights. It considers reports from the human rights ''Special Procedures' and considers draft human rights conventions and resolutions. A primary UN body in this context is the Human Rights Council, the most senior political entity in the UN system dealing specifically with human rights, and a subsidiary of the General Assembly. It is made up of 47 UN member states, and was created in August 2006 to replace the Commission on Human Rights.

Among the mandates of the Human Rights Council is to oversee the Special Procedures. These are independent experts, known as Special Rapporteurs and Working Groups, established to monitor and investigate specific human rights issues. Special Rapporteurs will have either a thematic (e.g. the Right to Health) or a country-specific mandate. They may make country visits on the request of the relevant government, and may also receive individual complaints from victims of human rights abuses. In addition to the UN human rights system, there are also three regional human rights systems: the European system, the Inter-American system and the African system.

The most recent of the regional human rights system is the African system, in which the fundamental treaty is the African Charter on Human and Peoples' Rights. The treaty body created by the Charter to ensure its provisions are promoted is the African Commission on Human and People's Rights. Like the UN human rights committees, the African Commission has a periodic reporting function under which states parties must submit a report every two years detailing the actions they have taken to realise and promote the rights enshrined within the Charter. In addition, the African Commission may also consider individual complaints of alleged human rights violations. Recently, an additional protocol to the African Charter was adopted, creating an African Court on Human and People's Rights. [143]

The standards established in human rights treaties are not ones imposed upon states from the outside. In dualist systems like South Africa, each national government must, using its own domestic legislative process, choose whether or not to ratify a human rights treaty before the terms of that treaty are enforceable within that country. In this sense, ratifying a human rights treaty is similar to ratifying a trade agreement or an arms control agreement. Unless and until a government ratifies the treaty, it cannot be considered a party to that treaty, or bound by its terms. National governments therefore must provide consent via their own independent political processes before they are bound by the terms of a human rights treaty. However, once providing this consent, states have a legal obligation to uphold the protections and standards the treaty articulates.

International treaties, including international human rights conventions, are best conceptualised as contracts between states. The articles in the convention set out the treaty obligations, which are essentially the terms of the agreement. These obligations are owed by states that have ratified the treaty to the other states that have also ratified the treaty. However, unlike most international treaties, in which states enter into commitments regarding their inter-governmental relations and behaviour, human rights treaties enshrine protections for individuals rather than countries.

[143] The African Court on Human and Peoples' Rights (the Court): established by virtue of Article 1 of the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights, (the Protocol) which was adopted by Member States of the then Organization of African Unity (OAU) in Ouagadougou, Burkina Faso, in June 1998. The Protocol came into force on 25 January 2004 after it was ratified by more than 15 countries.

Under international human rights law, when a state violates an individual's rights as defined within an international treaty, it is in effect breaching its contract with the other states parties to protect that person's rights. The reason that states owe their treaty obligations to each other is because only states are subjects of international law. The individual is merely the subject of the agreement.

4.2. THE RIGHT TO HEALTH OF PRISONERS WITHIN INTERNATIONAL HUMAN RIGHT TREATIES

All human beings, including prisoners, have certain unalienable rights, which are acknowledged by internationally recognised instruments and mechanisms. Subsequent to the Second World War, human rights have been quantified and set down in treaties and conventions. It was in 1948 when the United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR). Subsequently, two covenants were adopted, the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant Economic, Social and Cultural Rights (ICESCR). These two covenants state that prisoners have rights, even when they are deprived of liberty in custody. In addition to these, the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Committee also makes provision for health rights of prisoners.

Universal Declaration of Human Rights (UDHR): After the World War II, the establishment of the United Nations together with primacy afforded in the UN Charter to the promotion of human rights signalled a new era, with the UDHR epitomising the organisation's fundamental values. In its preamble, the Charter stresses the founders' determination to shield succeeding generations from the scourge of war and reaffirm faith in fundamental human rights and in the dignity and worth of human person. The drafters of the Charter further sought to promote social progress and better standards of life in larger freedom. The Charters' concern with confined persons' rights is grounded in both the promotion of human rights and its affiliation with social development. in this regard, Article 55(b) of the UN Charter stresses the organisations' concern with solutions of international economic, social, health, and related problems; and international cultural and educational co-operation, whilst paragraph (c) provides that the UN shall promote universal respect for, and observance of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion. According to Abels (2012) these provisions are not precise in their formulation, in that they do not define human rights or social development programmes. There are many UDHR provisions that are relevant to the health rights of prisoners. In this respect, Articles 2 and 7 prescribes equal treatment and prohibit discrimination in any status, Article 3 protects the rights to life, liberty, and security of person, and Article 5 prohibit torture and cruel, inhuman or degrading treatment or punishment.

When the United Nations adopted two major Covenants, the ICCPR and the ICESCR, in 1960, an international 'Bill of Rights' came into existence.

International Covenant on Civil and Political Rights: Of particular importance to the rights of prisoners is Article 10(1) of the ICCPR, which expressly provides that 'all persons deprived of their liberty shall be treated with humanity and with respect for their inherent dignity of the human person'. State parties should not by any chance underestimate this provision. First, the ICCPR is binding in all State parties. Second, the notion of human dignity lies at the heart

of all human rights.[144] Article 10(1) appears to constitute an argument for a holistic approach towards all aspects of confinement from a human rights perspective. It is argued that 'pursuant to such an approach, the more general human rights, i.e. not only those dealing with detention situation, find application in the 'prison sphere' including for example, the right to life, privacy, family life, personal integrity, effective remedies, and the prohibition of slavery and forced labour'[145]. Furthermore, it is important to note that all paragraphs of Article 10 place positive duties on member States. The recognition of positive duty simply means that prison authorities are obliged for the actual realisation of health rights of prisoners.

International Covenant Economic, Social and Cultural Rights: The ICSECR recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. The word 'everyone' includes prisoners. The right to health, including mental health, extends to prisoners and other persons held in detention. For instance, States parties to the ICESCR are under an obligation to 'respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventative, curative and palliative health services'.[146] It is argued that a large portion of jurisprudence dealing with prisoner's rights to health deals with the right to access to medical treatment. It should also be noted that there are complaint mechanism under the ICESCR, the jurisprudence of treaties body generally tends to focus on the various articles in other international instruments including, for example, the right to life and the right to freedom from torture, cruel, inhuman or degrading treatment in the ICCPR.

A review of the jurisprudence shows that international tribunals and courts have frequently recognized and extended protection to prisoner's right to access medical treatment. For example, in *Williams v. Jamaica* (Communication No. 609/1995, U.N. Doc. CCPR/C/61/D/609/1995 (1997)) at [6.5], the Human Rights Council concluded that 'the author did not receive any or received inadequate medical treatment for his mental health condition while detained on death row. This situation constitutes a violation of articles 7 and 10, paragraph 1, of the Covenant, since the author was subjected to inhuman treatment and was not treated with respect for the inherent dignity of his person'.

UN Convention on the Elimination of All Forms of Discrimination against Women: In respect of women in detention, the right to health of women is specifically protected under the UN Convention on the Elimination of All Forms of Discrimination against Women,[147] which obligates governments to take all appropriate measures to eliminate discrimination against women in the field of health care, including those related to family planning for women under Article 12. As this language refers only to primary health care services, the Convention's conception of the right to health is much less comprehensive than that found in the Covenant on Economic, Social and Cultural Rights. However, as women's rights to health are included under the universal right enshrined in the Covenant, it has been suggested that the Convention's language reflects an intent to highlight only those health-related areas where women need additional protection. This is particularly relevant for incarcerated women. The UN Special Rapporteur on Violence against Women, in her 1999 report on women's prisons in the United States, noted women clearly have special medical needs, and that the mere replication of health services provided for male prisoners is therefore not adequate.

[144] Van Zyl Smit (2005).
[145] Van Zyl Smit (2005).
[146] CESCR, general comment No. 14, at [34].
[147] The Convention on the Elimination of All Forms of Discrimination against Women was adopted by the United Nations General Assembly, On 18 December 1979. Entered into force as an international treaty on 3 September 1981.

UN Convention on the Rights of the Child: The right to health for children and adolescents is enshrined within the UN Convention on the Rights of the Child. While the Convention enshrines a holistic and comprehensive right to health consistent with the approach of the WHO Constitution and Covenant on Economic, Social and Cultural Rights, the Committee on the Rights of the Child, the independent expert body which monitors state compliance with the obligations under the Convention, understands the concepts of health and development more broadly than being strictly limited to the provisions defined in the relevant articles. This would suggest that the right to health of children and adolescents places increased obligations on countries, due to the age and vulnerability of young people.

4.3. REGIONAL DEVELOPMENTS ON HEALTH RIGHTS OF PRISONERS

In addition to the international developments outlined above, prisoners' rights have increasingly found recognition and protection at the regional level. This section of this paper focuses on three regions, namely; Europe, Africa, and the Americas.

Europe

In the context of Europe, large numbers of (legally non-binding) recommendations have been adopted promulgating standards in the penitentiary field, including the European Prison Rules. Such recommendations may be adopted on matters on which the Committee of Ministers has agreed on a common policy. In addition, a number of (binding) conventions have been adopted, including the European Convention on the Supervision of Conditionally Sentenced or Conditionally Released Offenders and the Convention on the Transfer of Sentenced Persons and its Additional Protocol.

Within the European context, a treaty that protects the health rights of persons deprived of liberty is the European Convention for the Prevention of Torture and inhuman or Degrading Treatment or Punishment, which entered into force in 1989 and which established the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (better known as the CPT). The CPT is mandated to visit any place where persons are being deprived of their liberty, in order to examine the treatment afforded in such places, in a bid to prevent ill-treatment in the future. The CPT is not a judicial body and was not established to identify breaches of detainees' *rights ex post facto*. In this regards, the CPT has noted that the Commission and the Court have as their primary goal to ascertain whether breaches of the European Convention of Human Rights have occurred. By contrast, the CPT's tasked is to prevent abuses, whether physical or mental, of persons deprived of their liberty from occurring; it has its eyes on the future rather than the past.

Africa

Unique among the regional systems, the African system enshrines a holistic protection of the right to health within its primary human rights instrument. The African Charter on Human and Peoples' Rights guarantees the right to enjoy the best attainable state of physical and mental health under Article 16. The African Charter also requires that states parties take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. Within the African system, the right to health of prisoners has also been engaged under the right to life and the prohibition of cruel, inhuman or degrading treatment.

The African Charter on Human and Peoples' Rights prohibits torture in Article 5. Of particular interest also are the 'Robben Island Guidelines, adopted by the African Commission on Human and Peoples' Rights in 2002. These Guidelines promote the ratification by States of international and regional anti-torture instruments and the Sates' co-operation with existing international

mechanisms. In relation to the health rights of prisoners, the Guidelines prescribe the adoption of the rules designed to contribute to the prevention of torture, including such basic safeguards as the right of detainees to notify relatives of their detention immediately after admission, to the right to an independent medical examination and the right to access a lawyer. Furthermore, Guideline 33 stipulates that states should '[t]ake steps to ensure that the treatment of all person deprived of their liberty is in conformity with the international standards guided by the UN Standard Minimum Rules for Treatment of Prisoners'.

Of importance is the Special Rapporteur on Prisons and Conditions of Detention in Africa which is mandated to visit and examine places where people are being detained. The Special Rapporteur may make recommendations to improve conditions of detention and may, if necessary, propose that urgent action be taken.

Americas

In respect of the Americas, various instruments and enforcement mechanisms are worth mentioning. In 1948, the Organization of American States adopted the American Declaration of the Rights and Duties of Man.[148] The Declaration starts by prescribing in Article 1 the right to life, liberty and security of the person. Other rights set forth in the Declaration include those of equality before the law, to protection of family life and one's privacy, to establish a family, to the inviolability and transmission of correspondence, to the preservation of health and to well-being, to education and to a fair remuneration.

The Declaration provides for a plethora of other rights that are relevant in the detention context, including, in particular, Article 25, which provides for the right to humane treatment of all persons deprived of their liberty. The American Convention on Human Rights (ACHR)[149] aims to protect such rights as the right to life, freedom of slavery, personal liberty, fair trial, compensation, privacy, freedom of conscience and religion, freedom of thought and expression, freedom of association, rights of the family and to both equal and judicial protection. Of particular importance in the context of detention is Article 5, which provides for the right to humane treatment. Paragraph 2 of Article 5 states that '[n]o one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment'. It further provides that '[a]ll persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person'.

4.4. DEFINING LAWFUL HEALTH STANDARDS IN PLACES OF DETENTION

Although the right to health of prisoners is broadly protected under human rights norms, exercising these guarantees within the context of prisons is difficult. Apart from being especially vulnerable by virtue of being detained, detainees generally are an unpopular political cause. Consideration of their rights is not normally included in the political process. The health rights of prisoners are therefore rarely a priority for political leaders or the general public. Complicating this situation is the fact that none of the relevant international or regional conventions define humane or inhumane treatment As a result, the generalised language used in the international treaties allows for significant discretion in interpreting standards of humane treatment of prisoners, such as the provision of medical care.

[148] Adopted by the Ninth International Conference of American States, Bogota, Colombia, 1948.
[149] Adopted at the Inter-American Specialized Conference on Human Rights, San José, Costa Rica, on 22 November 1969, entry into force on 18 July 1978.

Although specific entitlements, including health guidelines, are codified in numerous international resolutions and model standards, none enjoys the status of international law, and are rather non-binding ‘‘soft law’’ instruments, which include the following:

- The 1955 UN Standard Minimum Rules on the Treatment of Prisoners,
- The 1979 UN Code of Conduct for Law Enforcement Officials,
- The 1982 UN Principles of Medical Ethics,
- The 1988 UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment,
- The 1990 UN Basic Principles for the Treatment of Prisoners,
- The 1990 UN Rules for the Protection of Juveniles Deprived of their Liberty, and
- The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Means for Women Offenders (the Bangkok Rules).

All the above instruments seek to articulate standards of medical care for persons in detention. Each of these instruments, and therefore the standards they define, has been adopted by the UN General Assembly. While former UN Special Rapporteur on Torture, Nigel Rodley, suggests that instruments such as the Standard Minimum Rules exert a political or moral influence, and others argue that countries have at the very least an ethical obligation to observe such prison health resolutions, none has a binding effect within international law. Ultimately, these are aspirational, rather than prescriptive, standards and guidelines. They articulate neither legally binding norms, nor particularly ambitious or high standards for states to achieve. That said, many of the specific principles and standards incorporated within these nonbinding instruments have found legal expression within international and domestic case law.

The Standard Minimum Rules, for example, has been cited by international human rights bodies in finding countries in violation of prisoners’ rights norms, which clearly illustrates the influential position they enjoy with jurists. The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment has similarly been cited within the international jurisprudence, and used as a basis for defining standards of detention within international law. In recent years, the reports of the European Committee on the Prevention of Torture have been regularly cited in prison jurisprudence of the European Court of Human Rights.

The influence of these non-binding instruments on the judgments of international human rights bodies therefore creates the possibility that the standards they embody might evolve from aspirational targets into accepted legal norms. Indeed, a close review of the jurisprudence on key areas of prison health illustrates a remarkable consistency between the principles and standards articulated in the UN resolutions above, and the judgments of international courts and human rights treaty bodies. This would suggest that, far from articulating non-binding standards, in many cases these guidelines have become accepted minimum legal requirements for governments to meet.

As described in the Basic Principles for the Treatment of Prisoners, prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation. The UN Principles of Medical Ethics state that all health personnel working with prisoners have a duty to provide them with treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

A review of the international jurisprudence demonstrates that the principle reflected in these and other non-binding instruments also reflects the legal minimum standard within international law under economic, social and cultural rights (the right to health), civil and political rights (the right to life, the right to due process, the right to humane treatment) and international humanitarian law (the Geneva Conventions). It is also the consensus view expressed by UN human rights monitors.

The UN Committee on Economic, Social and Cultural Rights has stated explicitly that States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees to curative and palliative health services.

The right to medical care is guaranteed to young persons in prison under the right to health in *Article 24 of the UN Convention on the Rights of the Child*. The Convention details a series of areas in which states are obliged to take action in order to fulfil this right, including the provision of primary health services. Although it has not been a major area of the work of the Committee on the Rights of the Child, the right to health of children and young people in detention has been identified as a concern in several of the Committee's Concluding Observations examining state compliance with the terms of the treaty. The Committee has expressed concern at the lack of adequate basic services such as education and health and called upon the state party to ensure that all children deprived of their liberty have statutory rights to health.

There have been three successful applications by prisoners to the African Commission on Human and Peoples' Rights, the independent body that monitors state compliance with the African Charter, in which countries have been found in violation of the Charter's right to health. In these cases, the approach of the Commission has been that the state obligation to fulfil the right to health under Article 16 'is heightened in cases where an individual is in its custody', as the person's 'integrity and well-being is completely dependent upon the actions of the authorities'.

In the case of *Free Legal Assistance Group and others v. Zaire*[150], it was alleged that the military engaged in a campaign of persecution against members of the Jehovah's Witnesses, including arbitrary arrest and detention. The African Commission found a violation of the right to health on grounds including inadequate medical treatment. In *International PEN and Others v. Nigeria*[151], which concerned the case of human rights activist Ken Saro-Wiwa, the Commission found the government in violation of Article 16 for its failure to provide Mr Saro-Wiwa with hospital care, despite the recommendation of a doctor. This failure caused Saro-Wiwa's 'health to suffer to the point where his life was endangered'. In the most recent of the African Commission cases, *Malawi African Association and others v. Mauritania*[152], a violation of the right to health was again found to include poor medical care. In this case, the Commission noted that several prisoners died due to a lack of medical attention.

The right to medical care of persons in detention is also guaranteed under civil and political rights. The UN Human Rights Committee, for example, has indicated that the right to health of all detained persons is engaged under Articles 6 (the right to life) and 7 (prohibition of torture) of the *International Covenant on Civil and Political Rights,* and the obligation to provide appropriate medical care to detainees is engaged under Article 10 (prohibition of inhuman or degrading treatment). As a result, the Committee has affirmed that state responsibilities under the Covenant include the provision of adequate medical care during detention. It has specified that state obligations to provide medical care to prisoners extends to persons under the sentence of death. Given that even those persons under the most severe penal sanction retain a fundamental right to medical care, it follows that all persons under sentence, or indeed held without charge or in pre-trial detention, must also retain this right.

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[150] Free Legal Assistance Group and Others v Zaire (2000) AHRLR 74 (ACHPR 1995) Communications 25/89, 47/90, 56/91, 100/93, *Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, Les Témoins de Jehovah v Zaire*

[151] International Pen and Others v. Nigeria, African Commission on Human and Peoples' Rights, Comm. Nos. 137/94, 139/94, 154/96 and 161/97 (1998).

[152] Malawi African Association and Others v. Mauritania, African Commission on Human and Peoples' Rights, Comm. Nos. 54/91, 61/91, 98/93, 164/97 à 196/97 and 210/98 (2000).

The Committee has been critical of poor standards of prison medical care in a number of its Concluding Observations reviewing the compliance of states with the obligations in the Covenant. According to the UN Human Rights Committee, the State party by arresting and detaining individuals takes the responsibility to care for their life. The State party remains responsible for the life and well-being of its detainees. It is therefore incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection. This therefore demands the provision of adequate and pro-active medical care. The Human Rights Committee has also considered several individual complaints addressing prisoner medical care under the right to life.

4.5. THE NATURE AND CONTENT OF THE RIGHT OF ACCESS TO HEALTH CARE AS DEVELOPED BY INTERNATIONAL INSTRUMENTS AND JURISPRUDENCE

The right to have medical attention provided to prisoners in a timely fashion is one broadly supported as a legal requirement. Indeed, it is clear from the jurisprudence that medical care for prisoners is only compliant with international law if it is available when needed. According to the Standard Minimum Rules, the medical officer should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his/her attention is specially directed. The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment specifies that medical care and treatment shall be provided whenever necessary. The failure to provide medical treatment to a sick or injured prisoner inevitably and unnecessarily exacerbates his or her pain and suffering, and as such the right to medical care in prisons is also engaged under the prohibition of cruel, inhuman or degrading treatment.

The jurisprudence of the UN Human Rights Committee includes cases where prison authorities have been obligated to provide ophthalmologic and dental treatment, dermatology and treatment for allergies and asthma. This obligation also includes provision of medicines, including medications to relieve pain. The Special Rapporteur on Health has sent a number of individual communications to countries expressing concern over the failure to provide treatment for diabetes, chronic asthma, kidney conditions, a critical heart condition, tuberculosis and dental problems. The Special Rapporteur on Violence against Women has called for timely referrals and easy access to gynaecologists for incarcerated women.

Prison health standards and declarations of the WHO and the World Medical Association state that prisoners must be provided with measures to prevent the transmission of disease. The UN Rules for the Protection of Juveniles Deprived of their Liberty specifies that all juvenile detainees shall receive preventive health care. This agreed medical standard found throughout the non-binding instruments is also reflected as a legal norm in the international case law, one which obligates states to take measures to prevent the spread of disease within prisons.

The Standard Minimum Rules specify that all prisons should have a psychiatric service to diagnose and treat mental illness. The Special Rapporteur on Health has expressed concern that prisoners with mental illness are particularly vulnerable to human rights violations. Indeed, international courts and treaty bodies have articulated clear legal standards for the humane treatment of persons with mental illness in detention. Many of the standards for mental health care in prisons outlined in the non-binding instruments above are reflected within this jurisprudence. Given the unique vulnerability of persons with mental illness in detention, the state's positive obligations to ensure their humane treatment, and to protect their well-being, are heightened.

In addition to medical care and mental health services, a third element affecting then fulfilment of the right to health of prisoners is the environment within the prison itself. Indeed, the issue of healthy or unhealthy living conditions has particular resonance in considering the issue of prisoners' health, as overcrowding, inadequate sanitary conditions and poor quality of food and

water standards are common in prisons worldwide. While such conditions are typically considered to be violations of the right to dignity or humane treatment, they clearly have implications on the right to health.

Overcrowding, lengthy confinement within closed, poorly lit, badly heated and consequently poorly ventilated and often humid spaces are all conditions frequently associated with imprisonment and which contribute to the spread of disease and ill-health. Where these factors are combined with poor hygiene, inadequate nutrition and limited access to adequate health care, prisons can represent a major public health challenge. Keeping prisoners in such conditions expose them to substantial medical risk.

As with medical care and mental health care, questions of environmental health are engaged under economic, social and cultural rights as well as civil and political rights.

According to the *UN Committee on Economic, Social and Cultural Rights, the right to health as defined in Article 12* is: an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, and healthy environmental conditions. Some legal scholars have suggested the right to health, as it has come to be codified, includes not only the right to health care services, but also to the underlying preconditions of health, such as occupational health, environmental health, clean drinking water, and adequate sanitation, a conclusion shared by the Committee on Economic, Social and Cultural Rights and found within the Universal Declaration of Human Rights.

The right to a healthy living environment in prisons is also engaged by *Article 11(1) of the Covenant on Economic, Social and Cultural Rights*, which enshrines the right to adequate housing. As described in General Comment No. 4 of the UN Committee on Economic, Social and Cultural Rights, which provides a detailed and authoritative interpretation of the meaning of Article 11, housing is 'the environmental factor most frequently associated with conditions for disease and inadequate and deficient housing and living conditions are invariably associated with higher mortality and morbidity rates'.

The Committee defines adequate housing to include adequate privacy, space, security, lighting and ventilation, safe drinking water, heating, sanitation and washing facilities, and protection from dampness or other threats to health. All of these factors have particular relevance to the relationship between prison conditions and the health status of prisoners, as the lack of any of these factors has the potential to negatively affect the physical and/or mental health of people in detention. The right to a healthy living environment is also engaged under civil and political rights mechanisms. Some legal scholars have argued that that the right to life inherently includes a requirement to provide the necessary elements for survival, such as food, water and shelter. Such an approach would therefore imply a positive obligation to address environmental health issues under the right to life.

4.6. OTHER ELEMENTS OF THE RIGHT TO HEALTH CARE

The Standard Minimum Rules specify that at least one qualified medical officer will be available in every prison, a requirement also echoed in the European Prison Rules. The Principles of Medical Ethics and Council of Europe Recommendation 1235 (1994) on Psychiatry and Human Rights specify that standards of mental health care must meet acceptable professional standards. A review of the jurisprudence makes clear that prisoners have a right to a professional standard of heath service provided by qualified medical personnel. States that fall short of this threshold in the provision of medical or mental health care risk violating their obligations under international law.

Lack of qualified staff has also been highlighted by UN Special Rapporteurs. The Special Rapporteur on Health has expressed concern where the prison medical clinics are too poorly equipped in terms of staff, equipment and medicines to deal with even basic complaints. Given the vulnerability of persons in detention to coercion, the issue of informed consent to medical treatment and the right to refuse treatment are particularly resonant. Non-binding standards of prison health care are clear that people in prison must provide informed consent before undergoing treatment. The WHO states that prisoners should have access to information on treatment options and the same right to refuse treatment as exists in the community. This includes not only medical and drug treatments, but also undergoing medical testing, such as that for HIV infection. The failure to provide detainees with reasonable quality food or water in sufficient quantity has an obvious negative impact on health.

The Standard Minimum Rules specify that all prisoners shall be provided with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served, as well as drinking water whenever they need it. The failure to provide safe and adequate food and drinking water has been found to contribute to violations of international law in all human rights systems. The failure of the state to provide proper toilet or washing facilities, or clean living conditions, not only negatively affects the health of detainees, but potentially breaches international law.

4.7. THE RECENTLY ADOPTED MANDELA RULES

Sixty years ago, the First UN Congress on the Prevention of Crime and the Treatment of Prisoners (Tokyo, Japan) adopted the Standard Minimum Rules (SMR) for the Treatment of Prisoners which two years later were adopted by the UN Economic and Social Council (Ecosoc), a principal UN organ under the UN Charter. Apart from one amendment in 1977 that added an extra rule, the SMR have remained as originally drafted.

These Rules have been a leading force for the improvement of conditions of detention for persons deprived of liberty. They have influenced national legislation and prison rules in many countries. They have also played an important role in assisting international bodies in interpreting key human rights provisions. Even though the Rules are not of themselves legally binding, they have been invoked by the UN Human Rights Committee, the European and Inter-American Courts of Human Rights and the African Commission on Human and Peoples' Rights, when they have had to decide if detained or imprisoned persons have been treated with respect for their humanity and inherent human dignity and have not been subjected to torture or cruel, inhuman or degrading treatment or punishment.

Nevertheless, after six decades, it was clear that the text needed revision to reflect current penological standards and the evolution of human rights norms. When the General Assembly concluded in 2010 that a review was necessary, it was decided that the process be undertaken by an intergovernmental expert group meeting which, in turn, eventually decided to go for a 'targeted revision', largely with the aim of updating, rather than re-writing the current text. There have been four inter-governmental group meetings, the latest and last taking place in Cape Town, South Africa in March 2015, in the shadow of Robben Island where Nelson Mandela spent many years of his incarceration. The United Nations Commission on Crime Prevention and Criminal Justice (CCPCJ or Crime Commission) adopted the revised Standard Minimum Rules for the Treatment of Prisoners at its 24th session in May 2015.

The revision focussed on nine thematic areas which include, for the purpose of this paper, extensive provisions on healthcare in prisons. Rules 24-35 respond positively to all the issues raised by civil society about medical services, in particular, requiring respect for medical ethics

that, *inter alia*, expect health personnel to provide independent medical care, applying the standards prevailing in the outside world.

The updating of a key set of widely used standards with the adoption of the Mandela Rules by the Crime Commission was a significant milestone for the advancement of prison conditions and treatment of prisoners worldwide.

The resolution was adopted by the plenary of the Crime Commission, sponsored by Argentina, Austria, Brazil, Chile, Ecuador, El Salvador, France, Italy, Lebanon, Mexico, Nicaragua, Panama, Paraguay, Poland, South Africa, Thailand, United States, and Uruguay. It is expected that the resolution will now be put forward by the UN Economic and Social Council for adoption by the UN General Assembly at the end of 2015.

Medical services (Old Rules)	**Health-care services (Updated Rules)**
Rule 22	*Rule 24*
(1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.	1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.
(2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.	2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.
(3) The services of a qualified dental officer shall be available to every prisoner.	*Rule 25*
Rule 23	1. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation.
(1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.	2. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner.
(2) Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.	*Rule 26*
	1. The health-care service shall prepare and maintain accurate, up-to-date and confidential individual medical files on all prisoners, and all prisoners should be granted access to their files upon request. A prisoner may appoint a third party to access his or her medical file. 2. Medical files shall be transferred to the health-care service of the receiving institution upon transfer of a prisoner and shall be subject to medical confidentiality.

Rule 24

The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

Rule 25

(1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.
(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

Rule 26

(1) The medical officer shall regularly inspect and advise the director upon:

(a) The quantity, quality, preparation and service of food;

(b) The hygiene and cleanliness of the institution and the prisoners;

(c) The sanitation, heating, lighting and ventilation of the institution;

(d) The suitability and cleanliness of the prisoners' clothing and bedding;

(e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

(2) The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

Rule 27

1. All prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals. Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide prisoners referred to them with appropriate treatment and care.

2. Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff.

Rule 28

In women's prisons, there shall be special accommodation for all necessary prenatal and postnatal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the prison. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

Rule 29

1. A decision to allow a child to stay with his or her parent in prison shall be based on the best interests of the child concerned. Where children are allowed to remain in prison with a parent, provision shall be made for:

   (a) Internal or external childcare facilities staffed by qualified persons, where the children shall be placed when they are not in the care of their parent;
   (b) Child-specific health-care services, including health screenings upon admission and ongoing monitoring of their development by specialists.

2. Children in prison with a parent shall never be treated as prisoners.

Rule 30

A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary. Particular attention shall be paid to:

(a) Identifying health-care needs and taking all necessary measures for treatment;

(b) Identifying any ill-treatment that arriving prisoners may have been subjected to prior to admission;

(c) Identifying any signs of psychological or other stress brought on by the fact of imprisonment, including, but not limited to, the risk of suicide or

	self-harm and withdrawal symptoms resulting from the use of drugs, medication or alcohol; and undertaking all appropriate individualized measures or treatment; (d) In cases where prisoners are suspected of having contagious diseases, providing for the clinical isolation and adequate treatment of those prisoners during the infectious period; (e) Determining the fitness of prisoners to work, to exercise and to participate in other activities, as appropriate. *Rule 31* The physician or, where applicable, other qualified health-care professionals shall have daily access to all sick prisoners, all prisoners who complain of physical or mental health issues or injury and any prisoner to whom their attention is specially directed. All medical examinations shall be undertaken in full confidentiality. *Rule 32* 1. The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, in particular: (a) The duty of protecting prisoners' physical and mental health and the prevention and treatment of disease on the basis of clinical grounds only; (b) Adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship; (c) The confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others; (d) An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation that may be detrimental to a prisoner's health, such as the removal of a prisoner's cells, body tissues or organs. 2. Without prejudice to paragraph 1 (d) of this rule, prisoners may be allowed, upon their free and informed consent and in accordance with applicable law, to participate in clinical trials and other health research accessible in the community if these are expected to produce a direct and significant benefit to their health, and to donate cells, body tissues or organs to a relative.

	Rule 33 The physician shall report to the director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment. *Rule 34* If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm. *Rule 35* 1. The physician or competent public health body shall regularly inspect and advise the director on: (a) The quantity, quality, preparation and service of food; (b) The hygiene and cleanliness of the institution and the prisoners; (c) The sanitation, temperature, lighting and ventilation of the prison; (d) The suitability and cleanliness of the prisoners' clothing and bedding; (e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities. 2. The prison director shall take into consideration the advice and reports provided in accordance with paragraph 1 of this rule and rule 33 and shall take immediate steps to give effect to the advice and the recommendations in the reports. If the advice or recommendations do not fall within the prison director's competence or if he or she does not concur with them, the director shall immediately submit to a higher authority his or her own report and the advice or recommendations of the physician or competent public health body.

COMMENT AND QUESTIONS

There is consensus in international law that the state has an obligation to protect the lives and well-being of people it holds in custody. It is also clear that prisoners have a right of access to health care, which includes medical care, mental health care and living conditions that do not jeopardise their health or promote disease. International jurisprudence shows clear areas of consensus not only on the nature and content of the right of access to health care, but also on the role of the State and the legal standards it must meet to remain human rights compliant.

- Lines (2008) bemoans the limitations of leaving the question of prisoner health rights solely within the realm of domestic courts, and suggests that there is a need for vigorous international oversight and enforcement mechanisms to complement domestic human rights advocacy. To that end, he suggests the following:[153]
  - The need to develop a new international instrument, for example, the Second Optional Protocol to the UN Convention against Torture, which would focus specifically on health standards and define the rights of inmates while outlining the State's responsibilities.
  - The definition of cruel, inhuman and degrading punishment under the Convention on Torture could be expanded to include health related matters in prison, with the Committee on Torture taking a more expansive role in monitoring prisoner health rights.
  - Enhancing the mechanisms to enforce state compliance with human rights obligations.
- At a domestic level, these clearly defined international law standards and guidelines should form the basis of parliamentary tools for the national legislature in exercising its oversight role over the Executive.

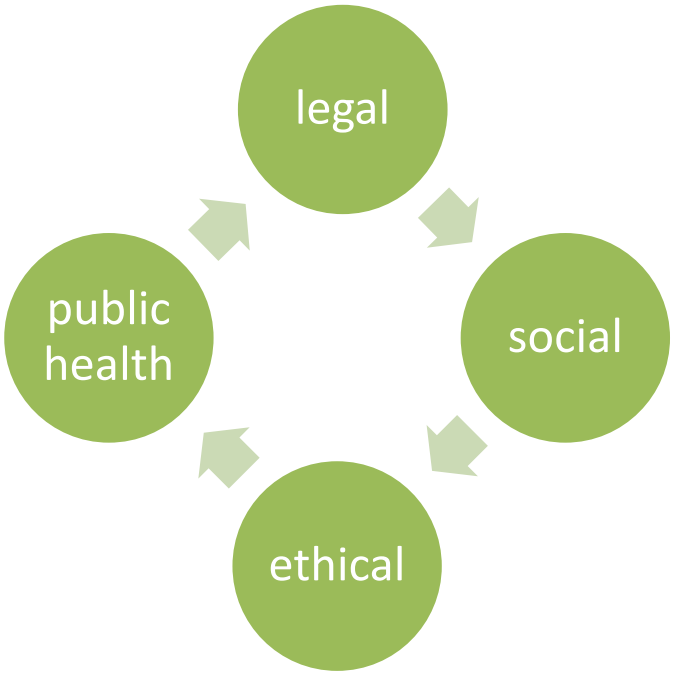
[153]Lines (2008).

Chapter 5

SOUTH AFRICAN LEGAL AND POLICY FRAMEWORK

This chapter briefly outlines key elements of the legal and policy framework in terms of which the Department of Correctional Services must provide health services to inmates.

When the state removes a person's autonomy by detaining that person in a correctional centre it must provide for the welfare of that individual.[154] A key component of welfare is health care. There are a range of legal, ethical, social, and public health reasons why inmates, as wards of the state, should be supplied with adequate health care services.



- **Legal reasons**
  The Constitution, 1996 provides for the right of access to health care services. The Correctional Services Act 111 of 1998, accompanying Regulations and Standing orders are clear about the degree of care which should be provided to inmates.

- **Social reasons**

[154] Lee v Minister of Correctional Services 2013 (2) SA 144 (CC)

The vast majority of inmates will return to society within a few years. Proper health care makes it possible for ex-inmates reintegrating into society to embark on productive activities.

- **Ethical reasons**
  The state has a duty of care. Prisoners are entirely dependent on the staff of prisons and detention centres for all aspects of their daily lives. The provision of adequate health care is a core component of this care. This requires effective methods of prevention, screening, and treatment.

- **Public health reasons**
  Prison health is part of public health. Prisons should not be breeding places for communicable and non-communicable diseases.[155] As a group, prisoners often have higher rates of disease during incarceration due to a combination of poor infection control, overcrowding, poor nutrition, social and behavioural factors, high HIV and TB prevalence and poor access to health care services.

  While the extent of the prevalence of TB and MDR-TB (multidrug-resistant TB) in prisons is unknown, "the Department of Justice and Correctional Services [has] estimated the prevalence in prisons to be between three and seven times that of the general population".[156] The World Health Organisation reports that the transmission dynamics between inmates and broader society play a key role in driving overall population incidence, prevalence and mortality from TB.[157] More than 95 percent of prisoners will return to the community, often carrying significant health burdens and associated costs with them.[158] The health and well-being of staff is equally important. What happens inside prisons does not stay there; it goes home with released prisoners and the staff who work there.[159]

5.1. LEGAL FRAMEWORK

5.1.1 Constitution, 1996

The right to health is fundamental to the physical and mental well-being of all individuals and is a necessary condition for the exercise of other human rights.

For the purposes of this paper the following Constitutional rights in respect of health are key:

(i) Section 27(1)(a) of the Constitution asserts that "everyone has the right to have access to health care services".
(ii) Section 28(1)(c) provides that every child has the right to basic health care services.
(iii) Section 35(2)(e) specifies that detained persons must be incarcerated in conditions of detention that are consistent with human dignity, including at least exercise and to the provision, at State expense, of adequate accommodation, nutrition, and **medical treatment**.
(iv) Section 35(2)(f)(iv) awards a detained person the right to communicate with and be visited by a medical practitioner of the detainee's choice.

[155] World Health Organisation (2014b).
[156] Skosana I, (2015).
[157] World Health Organisation (2014).
[158] Paris (2008). Disease prevention education, vaccination where appropriate, and disease surveillance are basic public health tools that can be used in the correctional setting with public health goals in mind.
[159] Gibbons and Katzenbach (2006).

Moreover, the DCS has general obligations, in terms of section 7 of the Constitution to protect, promote and fulfil the rights enshrined in the Bill of Rights and to ensure that all constitutional obligations are fulfilled diligently and without delay.[160]

Significantly, the Constitution provides that the State is required to "take reasonable legislative and other measures, within its available resources, to achieve the **progressive realisation"** of the right to health care services. Progressive realisation of a right may be understood as follows:[161]

(i) There must be immediate and tangible progress towards the realisation of rights. The fact that progressive realisation introduces an element of flexibility does not imply that states can drag their feet. States have an obligation to adopt a plan of action "within a reasonable number of years" and the timeframe must "be fixed in the plan".

(ii) States cannot pursue deliberate retrogressive measures.

(iii) Special measures for vulnerable and disadvantaged groups need to be put in place. Positive action includes specially tailored measures or additional resource allocation for these groups.[162]

Notably, the right to health cannot be viewed in isolation and is interlinked with other rights, namely, the rights to human dignity, life, non-discrimination, equality, freedom and security of the person (specifically the right to bodily and psychological integrity and not to be subjected to medical or scientific experiments without informed consent), not to be treated or punished in a cruel, inhuman or degrading way, privacy, access to information and the right to an environment that is not harmful to health or well-being.

5.1.2 Correctional Services Act 111 of 1998

The health of inmates is currently the responsibility of the DCS. Health care services should be preventive, promotive, curative and rehabilitative. In terms of section 12 of the Correctional Services Act, 111 of 1998 (CSA):

- The DCS must provide, within its available resources, adequate health care services, based on the principles of primary health care, in order to allow every inmate to lead a healthy life;
    - (a) every inmate has the right to adequate medical treatment but no inmate is entitled to cosmetic medical treatment at state expense;
    - (b) medical treatment must be provided by a correctional medical practitioner, medical practitioners or by a specialist of health care institution or person or institution identified by such medical practitioner except where the medical treatment is provided by a medical practitioner in terms of subsection (3);
- Every inmate may be visited and examined by a medical practitioner of his or her choice and, subject to the permission of the Head of Correctional Centre, may be treated by such practitioner, in which event the inmate is personally liable for the cost of such consultation, examination, service or treatment;

[160] Constitution, 1995 section 235
[161] Chenwi (2013).
[162] Chenwi (2013).

- (a) every inmate should be encouraged to undergo medical treatment necessary for the maintenance or recovery of his or her health;
- (b) no inmate may be compelled to undergo medical intervention or treatment without informed consent unless failure to submit such medical intervention or treatment will pose a threat to the health of other persons;
- (c) except as provided in paragraph (d), no surgery may be performed on an inmate without his or her informed consent, or in the case of a minor, without the written consent of his or her legal guardian; and
- (d) consent to surgery is not required if, in the opinion of the medical practitioner who is treating the inmate, the intervention is in the interest of the inmate's health and the inmate is unable to give such consent, or in the case of a minor, if it is not possible or practical to delay it in order to obtain the consent of his or her legal guardian.

5.1.3 Specific health care responsibilities in terms of the legislation

The CSA and accompanying Regulations (as provided for in section 134 of the CSA) provide that:

- Inmates have the right to **adequate health care** based on the principles of primary health services in order to allow every inmate to lead a healthy life.[163] This means universally accessible, first-level contact clinic-based health services to enable the inmate population to acquire, maintain and promote health.[164]
- Primary health care must be available at least on the same level as that rendered by the State to members of the community.
- Treatment of inmates must be in accordance with binding international instruments.
- Medical care must be provided by suitably qualified persons.[165]
- Every inmate (and cared for child)[166] must **within 24 hours** after admission and before being allowed to mix with the general population undergo a health status examination by either a correctional medical practitioner or a registered nurse.[167] All inmates must be screened for communicable, contagious or obscure diseases as defined in the Health Act and the presence of such diseases must be recorded.[168]
- Upon admission any medical assistance advice or medicine in the possession of an inmate must be recorded. If the inmate is wearing any emergency identification locket or bracelet (for example "Medi-Alert"), this must be recorded and the inmate must be allowed to wear the device unless it poses a security risk.[169]
- An inmate may only mix with the general inmate population after being medically assessed.
- The Correctional centre correctional medical practitioner is responsible for the general medical treatment of inmates. A registered nurse must attend all sick sentenced offenders and remand detainees (including pregnant women and the mentally ill) as often as necessary but **at least** once a day.[170]
- The correctional medical practitioner, environmental health officer or registered nurse must inspect the facility **at least once a month** and report to the National Commissioner about problems concerning environmental health conditions and health related issues.

[163] Section 12 (1) and (2) of the CSA
[164] Regulations 1 (Definitions), 7(1) and (2)
[165] Section 12(2)
[166] Regulations 1 – Definitions - "Cared-for child" means the child that a female inmate is permitted, in terms of Section 20 of the CSA to have with her in Correctional Centre;
[167] As soon as possible after admission every inmate Section 6 (5)(b) of the CSA must undergo a health status examination, which must include testing for contagious and communicable diseases as defined in the Health Act, 1977 (Act No. 63 of 1977)
[168] Section 6(5)(b) of the CSA
[169] Regulation 2(6)
[170] Regulation 7(4)

- Every Correctional centre must make provision for general sleeping and in-patient hospital accommodation.
- The services of a correctional medical practitioner and dental practitioner **must** be available at every Correctional centre.[171]
- Inmates must be held in cells which meet the requirements prescribed by regulation in respect of floor space, cubic capacity, lighting, ventilation, sanitary installations and general health conditions. These requirements must be adequate for detention under conditions of human dignity.[172]
- Inmates suffering from mental or chronic illness or whose health status will be affected detrimentally or whose health status poses a threat to other inmates if detained in a communal cell must be detained separately on request of the Correctional medical practitioner or registered nurse.[173] The National Commissioner may detain inmates of specific age, health or security risk categories separately.[174] [175]
- Each inmate must be provided with an adequate diet to promote good health, as prescribed in the regulations.[176] Such a diet must make provision for the nutritional requirements of inmates whose physical condition requires a special diet. The correctional medical practitioner may order a variation in the prescribed diet for an inmate and the intervals at which food is served, when such a variation is required or medical reasons.[177]
- Every inmate should be encouraged to undergo medical treatment for the maintenance or recovery of his or her health, but no inmate may be compelled to undergo medical intervention or treatment without informed consent, unless failure to submit to medical intervention or treatment will pose a threat to the health of other persons. Surgery may not be performed on an inmate without his or her informed consent except where this would pose a risk to others.[178]
- An inmate may be visited and treated by a medical practitioner of his or her choice in which case the permission of the Head of a Correctional Centre is required before treatment may occur. An inmate will be personally liable for the costs of any such consultation.[179]
- Inmates are not entitled to cosmetic surgery at state expense.[180]
- No inmate may, even with his consent, be subjected to any medical, scientific experimentation or research.[181]
- An inmate may only participate in clinical trials with the permission of the National Commissioner.[182]
- A request by an inmate to donate or receive an organ or tissue must be approved by the National Commissioner.[183]
- In the event of an emergency or if the inmate cannot give consent to medical treatment or an intervention, a medical practitioner may proceed with treatment if he or she believes that the inmate's life is in danger if treatment is not performed.
- Pregnant women in remand detention must have access to pre-intra and postnatal services.

[171] Regulation 7(2) A
[172] Section 7(1) of CSA
[173] Regulation 3(2) (i)
[174] Section 7(1)(d)
[175] Section 7(2)(d) of the CSA
[176] Section 8 (4) of the CSA
[177] Section 8 (1)(2) and (4) of the CSA
[178]Section 12(4)(b) of the CSA
[179] Section 12(3) of the CSA
[180] Section 12(2) of the CSA
[181] Regulation 7(7)
[182] Regulation 7(7)
[183] Regulation 7(8)

- The National Commissioner may detain a person suspected to be mentally ill, in terms of section 77 (1) of the Criminal Procedure Act or a person showing signs of mental health care problems, in a single cell or correctional health facility for purposes of observation by a medical practitioner. The Department must provide, within its available resources, adequate health care services for the prescribed care and treatment of that person.
- The Department must, within its available resources, provide social and psychological services in order to support mentally ill remand detainees and promote their mental health.[184]
- An offender who is certified in terms of Chapter VII of the Mental Healthcare Act 17 of 2002 may not be detained in a Correctional centre and must be transferred to a designated health establishment as defined in section 1 of that Act. Until such transfer, the inmate must be placed under the special care of a medical officer.

5.1.4 Standing Orders

The Standing Orders were compiled in order to give effect to the CSA. Key requirements of the Standing Orders include:

- Screening of all admissions by a registered nurse using a screening form.
- Following screening an examination at the prison health facility within 24 hours.
- Whenever there is a suspicion that a prisoner could be suffering from a communicable, or contagious disease the case must immediately be brought to the attention of the nurse and attending medical officer/practitioner.
- All prisoners with communicable conditions to be isolated in strict accordance with orders of a registered nurse/medical practitioner.
- Minimum permissible floor space.
- Minimum permissible air space.
- Daily and weekly inspections to be conducted to ensure every cell conforms to minimum standards.
- Separate detention of prisoners with a suspected or confirmed diagnosis of TB or other contagious disease.
- Appointment of staff as environmental (health) management supervisors.
- Weekly health education sessions.
- Involvement of external stakeholders in health promotion and disease prevention.
- Each prison to have written orders on infection control which must be monitored and reviewed annually.

5.1.5 National Health Act 63 of 2003

The Act seeks to regulate and ensure uniformity in respect of the National Health Service. Key objectives are to:

- Provide in an equitable manner the population of the Republic with the best possible health services that available resources can afford;
- Set out the rights and duties of health care providers, health workers, health establishments and users.
- Respect, promote and fulfil the rights of;

[184] Section 49D. Mentally ill remand detainees.

- the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;
- children to basic nutrition and basic health care services; and
- vulnerable groups such as women, children, older persons and persons with disabilities.

All health care providers in the public sector must equitably provide health services within the limits of available resources. In terms of health services at non-health establishments and public health establishments other than hospitals the Minister may prescribe minimum standards and penalties for any contravention of or failure to comply with any such standards or requirements.[185]

5.1.6 Mental Health Care Act 17 of 2003

In terms of the Act a 'mental health care user' is a person receiving care, treatment, rehabilitation service or using health services at a health establishment aimed at enhancing the mental health of a user, state patient and mentally ill prisoner.[186] One of the objectives of the Act is to regulate the provision of mental health care, treatment and rehabilitation to mentally ill prisoners.

Every organ of state responsible for health services must determine and co-ordinate the implementation of its policies and measure to ensure provision of mental health care, treatment and rehabilitation promote the right and interest of mental health care users.

If it appears to the head of a prison through personal observation or from information provided that a prisoner may be mentally ill then the head of the prison must ensure an enquiry into the mental health of the prisoner by a psychiatrist or where a psychiatrist is not readily available by a medical practitioner or mental health practitioner.

Such a person must submit a written report specifying the mental health status of the prisoner and a plan for the care, treatment and rehabilitation of that prisoner. This may occur at the prison unless the mental illness is of such a nature that the prisoner ought to be treated in a health care establishment. If this is the case the head of the prison must request a magistrate to institute an enquiry to determine whether such a transfer is appropriate.

The magistrate must commission two mental health practitioners (one must be a psychiatrist, psychologist or medical practitioner with special training in mental health) to make recommendations – either for the transfer of that prisoner in which case the magistrate must issue an order to the head of the prison; or if the prisoner need not be transferred the magistrate must issue an order to the head of prison to take the necessary steps to ensure levels of care and treatment are provided to the prisoner concerned.

The head of the health establishment in which a mentally ill prisoner is detained must ensure a six month review which must set out a plan for further care and the merits of returning the prisoner. This report must be issued to the Review Board, magistrate, administrator and head of prison. Within 30 days of receipt of the report the Review Board must make recommendations. If the head of the health establishment has reason to believe the prisoner has recovered and can be returned to the prison he or she must compile a report and inform the head of the prison and the magistrate.

5.2. POLICY, GUIDELINES, JOINT REVIEW AND WHITE PAPER ON REMAND DETAINEES

[185] Section 43 of the NHA
[186] Definitions of the NHA

5.2.1 Draft National Infection Prevention and Control Policy for TB, MDR-TB & XDR-TB (2007)

The goal of this policy was to help health care facility management and staff minimise the risk of TB transmission in their facilities and other facilities where the risk of transmission of TB may be high due to high prevalence of both diagnosed and undiagnosed TB, such as prisons.

The policy notes that work practice and administrative control measures have the greatest impact on preventing TB transmission. They serve as the first line of defence for (i) preventing TB exposure to staff and patients; and (ii) reducing the spread of infection by ensuring rapid and recommended diagnostic investigation and treatment for patients and staff suspected or known to have TB. This can best be accomplished through the prompt recognition, separation, provision of services, and referral of persons with potentially infectious TB disease.

There are five components to good work practice and administrative controls. They are: (a) An infection prevention and control plan; (b) Administrative support for procedures in the plan, including quality assurance; (c) Training of staff; (d) Education of patients and increasing community awareness; and (e) Coordination and communication with the TB programme.

5.2.2 National Strategic Plan on HIV, STIs and TB (2012–2016)

The DCS forms part of South African National AIDS Council (SANAC), which is the Government's Coordinating Structure for HIV, STIs and TB in the country. The DCS participated in the development of the National Strategic Plan (NSP) for HIV, STIs and TB: 2012-2016. The NSP sets out key strategic interventions in the national response to HIV, STIs and TB in South Africa.

The NSP acknowledges that certain populations are at higher risk of TB infection and re-infection, or progressing from TB infection to TB disease and considers the following groups as key populations for TB: correctional services staff and inmates; children and adults living with HIV; diabetics and people who are malnourished; smokers, drug users and alcohol abusers; mobile, migrant and refugee populations; and people living and working in poorly ventilated and overcrowded environments.

Given that inmates and staff of correctional facilities are at higher risk for both HIV and TB the NSP provides that the DCS:

- Will implement a number of interventions to decrease transmission of HIV and TB in correctional facilities.[187]
- Must ensure the provision of appropriate prevention and treatment services, including HIV, STI and TB screening, prompt treatment of all inmates and correctional services staff, ensuring continuum of care through proper referrals, and enforcement of laws and policies to prevent sexual violence in prison settings, including the use of newly developed screening guidelines to identify inmates who are vulnerable to sexual violence.

5.2.3 Guidelines for the management of Tuberculosis, Human Immunodeficiency Virus and Sexually-Transmitted Infections in Correctional Centres (2013)

[187] http://www.sahivsoc.org/upload/documents/National_Strategic_Plan_2012.pdf

It is clear that correctional facilities are potential areas for spread of airborne infections and the diversity of the population in these facilities justifies the implementation of interventions to mitigate the risk. These guidelines provide standards from a public health perspective which South African Correctional centre authorities should implement to prevent HIV and TB transmission in Correctional centres and to provide care to those most affected by these diseases.

The Guidelines conform that Correctional Services management have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV and TB to inmates and staff alike. There is support for independent research in the field of TB / HIV among South African correctional centre populations to inform successful interventions in Correctional centres in the country.[188]

The Guidelines set out the roles and responsibilities of doctors, nurses and the Regional DCS Programme Manager or Supervisor. The Regional DCS Manager must monitor the implementation of the programmes in Correctional centres and budget for TB and HIV activities. The DCS with the support of the DOH at national, provincial, district and sub-district levels must ensure that the required resources are available to enable relevant staff to operationalize and implement the guidelines.

5.2.4 Joint Review of the HIV, TB and PMTCT Programmes (2013)

The National Department of Health (NDOH) commissioned a Joint Review of the HIV, TB and PMTCT Programmes in 2013. The main purpose of the Review, carried out by a multi-disciplinary team of South African and international reviewers, was to assess progress made, to identify challenges, and highlight best practices. The following was noted by the Review team:

- **Limitations within correctional health services may require the Department of Health to assume greater responsibility and collaboration with DCS in running health services in correctional facilities.** The fact that the DCS has part-time doctors presents significant challenges in mentoring and quality improvement.
- Some of the weaknesses observed in efforts towards greater integration of HIV, TB and Prevention of Mother to Child Transmission (PMTCT) of HIV services are as follows:
    - There is a lack of clear guidance for primary care providers and mechanisms for fast-tracking late presenters and persons who would benefit from referral.
    - There is no combined approach to supportive supervision between HIV, TB and PMTCT.

There is a lack of a systematic approach to TB/HIV/PMTCT programme integration and to monitoring the quality of care provided.

5.2.5 White Paper on Corrections in South Africa (2005)[189]

The White Paper on Corrections in South Africa (2005) provides policy direction for the Department of Correctional Services. The White Paper states that, the safety and health of offenders forms part of rehabilitation. By this, the policy document states the following:

- By its very nature, incarceration can have a damaging effect on both physical and mental well-being of inmates and the Department of Correctional Services is thus obliged to provide for these special needs of inmates in its institutions. This means

[188] http://www.section27.org.za/wp-content/uploads/2013/05/Guidelines-for-the-management-of-Tuberculosis-Human-Immunodeficiency-Virus-and-Sexually-Transmitted-Infections-in-Correctional-Centres-2013.pdf
[189] Department of Correctional Services (2005).

that those providing health care be trained in the specific health needs and health problems encountered in a Correctional centre environment. Inmates must also have the ability to seek health care solutions that are appropriate and attainable in a Correctional centre environment. The responsibility of the Department is not just to provide health care, but also to provide conditions that promote the well-being of inmates and correctional officials.

5.2.6 White Paper on the Management of Remand Detention in South Africa (2014)[190]

The White Paper highlighted certain challenges in respect of provision of health care services to remand detainees:

- Inadequate provision of services to deal with mental health issues and uninterrupted medical care programmes to remand detainees detained in DCS facilities due to perceived short-term stay of detainees.
- Inadequate and poorly maintained facilities make admitting, accommodating and releasing of remand detainees difficult.
- The classification and subsequent appropriate treatment of remand detainees requires detailed information such as an endorsed warrant to reflect categories of remand detainees including: remand detainees detained pending observation at a Mental Health Establishment. These warrants are not always completed.
- Remand Detention Institutions must ensure that policies that address the health of detainees take cognisance of communicable diseases and special outbreaks that threaten the safety and security of remand detainees, personnel and other persons that may have contact with the affected remand detainees. Where the health of the remand detainee means he or she is unable to honour his/her court appearance, the court should be informed timeously.
- Inadequate provisions for RDs placed temporarily in DCS facilities for transfer to Mental Health establishments for forensic assessments.
- A lack of role clarification with regard to the transportation of RDs for forensic assessment and the provision of emergency health services to RDs in court cells.
- Inadequate provision of adequate health care and prescribed care and treatment for the management of RDs who are mentally ill and those RDs who are on chronic medication, from arrest to detention
- The need for protocols to deal with (i) the management of RDs placed in detention institutions pending observation (some wait in a detention facility for more than two years for a bed in a mental health establishment); and (ii) the management of the State Patients: this category is detained indefinitely and there is no established process for their management within the remand detention facilities. The processes highlighted in the Mental Health Act only apply to those detained or transferred from remand detention institutions to Mental Health Establishments managed by the Department of Health.
- Lack of clarification on detention of persons suspected to be mentally ill or persons displaying signs of mental illness in single cells or correctional health facility for observation in line with s77(1) of the Criminal Procedure Act (Act 51 of 1977).

Some elements of the above legal and policy framework have, over time, given rise to legal disputes which have made their way into courts of law, which have, in turn, fleshed out the nature

[190] Department of Correctional Services (2014b).

and extent of the right of access to healthcare for inmates and people in detention. In the next chapter, the emerging jurisprudence in that regard and its implications for the rendering of health care at Correctional centres is discussed in detail.

Chapter 6

RESPONSE OF THE COURTS TO THE PROVISION OF HEALTH CARE SERVICES FOR INMATES

'*While the primary task of translating the health-related rights in the Constitution into a lived reality for the people of South Africa rests with the legislature and executive, these rights are also justiciable, meaning that courts have a say in the manner in which the rights are understood and implemented*.'[191]

The Constitutional Court held in the case of Government of the RSA v Grootboom that measures aimed at the progressive realisation of socio-economic rights have to be reasonable 'both in their conception and their implementation'.[192] These measures have to be balanced, flexible and inclusive, and have to cater for short, medium and long-term needs, but especially for the needs of those 'whose needs are most urgent and whose ability to enjoy all rights therefore is most in peril'. Legislative measures have to be 'supported by appropriate, well-directed policies and programmes implemented by the executive'.[193]

6.1. SELECTIVE CASE LAW

The four court cases which are discussed below illustrate the evolution of the courts engagement with the right to health care for inmates.

- **S v Makwanyane 1995 (6) BCLR 665 (CC)**

The Constitutional Court (CC) affirmed that although dignity may be impaired by imprisonment, a prisoner does not lose all his rights on entering prison.

According to Chaskalson JP, even though imprisonment is a severe punishment, prisoners nevertheless retain all the rights to which every person is entitled to under the Constitution subject only to the limitations imposed by the prison regime. This includes a right to adequate health care.

- **Van Biljon v Minister of Correctional Services 1997 (4) SA 441 (C)**

Four HIV-positive prisoners, who had previously received ARV treatment outside of prison challenged DCS' failure to provide AZT, (at that stage the most widely-used anti-retroviral treatment for HIV/AIDS). At that time, anti-retroviral medication was not yet generally available to patients in the South African public health care system. The prisoners relied on section 35(2)(e) of the Constitution, which determines that detained persons have a right to the provision of adequate

[191] Pieterse (2014).
[192] Government of the RSA v Grootboom 2001 (1) SA 46 (CC) para 42.
[193] Government of the RSA v Grootboom 2001 (1) SA 46 (CC) para 42.

medical treatment at state expense.[194] In response the Minister argued that the provision of ARV's was beyond the resources of the prison.

Brand J, was of the view that the four prisoners were entitled to the treatment at Government expense because:

(i) AZT was at that stage the most effective anti-AIDS medicine on the market
(ii) the offenders were unable to privately procure medical treatment
(iii) the offenders were dependent on the state to provide treatment and
(iv) in respect of HIV-positive prisoners the state owed a higher duty of care due to the overall conditions in prisons and the increased risk of opportunistic infections.

The Court found that the failure to provide the drug to the applicants infringed section 35(2)(e) of the Constitution. Significantly, in emphasising the term 'adequate' in the Constitution, the Court observed that **medical treatment for prisoners does not have to be the 'best available' or even 'optimal', but must be equivalent and comparable to the treatment afforded to those outside the prison setting**.

The Court dismissed the argument that budgetary constraints generally absolved the state from treating HIV-positive prisoners, holding that the state had failed to show that it could not afford to provide the prescribed treatment to the applicants in the current case. The Court found that the question of whether a particular form of medical treatment could be regarded as 'adequate' in terms of the Constitution had to be decided with reference to, amongst other factors, its cost in relation to its effectiveness. Since there was no less expensive but sufficiently effective treatment available at the time, and since the state could not show that it could not afford to provide the two applicants with the treatment, it was held to fall within the scope of the applicants' entitlement.

The Department was ordered to provide the first and second applicants with the prescribed treatment. However, the Court dismissed the similar application by the third and fourth applicants, to whom AZT had not been medically prescribed, and expressly limited the effect of the order to the first and second applicants.

Given the limited reach of the order in Van Biljon, it did not make a perceivable impact on policies pertaining to access to anti-retroviral medication in prisons to the extent that similarly situated but unrepresented prisoners were unable to benefit from the order. This stunted its impact on the policy environment pertaining to health care provision in prisons, where anti-retroviral treatment only became generally available several years later.

However, Van Biljon highlights important considerations pertaining to the cost-effectiveness of particular forms of treatment. The Court dismissed an argument that budgetary constraints generally absolved the state from treating HIV-positive prisoners, holding that the state had failed to show that it could not afford to provide the prescribed treatment.

- **N v Government of Republic of South Africa 2006 (6) SA 543 (D)**

This case had a more significant impact. It also dealt with the challenges of access to, and provision of, ARVs for prisoners. Following the Treatment Action Campaign decision, a National Treatment Plan for HIV/AIDS, in terms of which prisoners were entitled to receive anti-retroviral treatment, had been proclaimed. However, implementation of the Plan by the Department of Correctional Services was lacking. The TAC and Aids Law Project accordingly took legal action, on behalf of a

[194] Pieterse (2014).

group of prisoners at Durban's Westville Correctional Centre who were unable to access treatment at the prison, despite qualifying for it in terms of the Plan.[195]

The prisoners had attempted to access ARVs via regular channels but this failed. The Court held that **the DCS was legally and constitutionally bound to provide adequate medical treatment to prisoners who need it (in terms of section 35(2)(e) of the Constitution)**. Moreover, the Court found that section 237 of the Constitution requires all constitutional obligations to be performed diligently and without delay. The treatment and medical care afforded to the applicants and other similarly situated prisoners was neither adequate nor reasonable. Unnecessary delays in treatment of prisoners seriously compromised their health status.

The DCS was ordered, with immediate effect, to:

(i) Remove the restrictions preventing the qualifying prisoners from accessing ARV treatment at an accredited health facility; and
(ii) Provide ARV treatment in accordance with the Operational Plan to the qualifying prisoners at an accredited public health facility.

However, it took two further court orders for the state to comply with this initial judgment. The state's non-compliance with the order was found to be in contempt of court signifying a 'grave constitutional crisis' and 'serious threat' to the separation of powers.

A further deadline for implementation of the original order was issued and complied with. Subsequently, the Department engaged with the applicants on the broader implementation of the National Treatment Plan in prisons.[196]

In an interesting shift from Biljon the Court in this case noted that an order which did not take into consideration the plight of other similarly situated prisoners would result in continued denial of access to ARV treatment and consequently an infringement of their constitutional rights.

- **Lee v Minister of Correctional Services 2013 (2) SA 144 (CC)**

Mr Lee was diagnosed with TB after three years of incarceration. After his release in 2004 he instituted an action for damages against the DCS in the High Court for harm suffered as a result of his contracting TB in prison. He argued that the responsible authorities failed to take adequate steps to protect him against the risk of TB infection.

The High Court upheld the claim and held that the evidence tendered established that TB could be curtailed through by introducing certain measures including:

(i) Early identification of persons who are deteriorating and who may accordingly become vulnerable to contracting TB;
(ii) Early diagnosis of the disease; and
(iii) Effective treatment and proper nutrition. [197]

The law does not demand a state institution or employer to "guarantee" absence of risk. **The prison authorities only had to take reasonable steps to protect Mr Lee**. What reasonable prison authorities should have done depended on the following: medical best practice, security

[195] Pieterse (2014).
[196] N v Government of Republic of South Africa 2006 (6) SA 543 (D
[197] Lee v Minister of Correctional Services [2011] JOL 27141 (2011 (6) SA 564) (WCC)

issues, financial resources, personnel, space, the prevalence and incidence of the disease. The High Court suggested the following:

- Proper screening of incoming inmates, inclusive of a physical chest examination;
- Separating those who had or were suspected of having TB or were obviously undernourished and vulnerable to TB;
- The provision of adequate nutrition to those who were undernourished and otherwise vulnerable to TB;
- Regular and effective screening of the prisoner population, inclusive of examinations by means of x-rays and/or physical chest examinations by means of a stethoscope, to identify possible TB infection; and
- Isolation of infectious inmates and effective implementation of the dots 36 system over the prescribed period of time.

The Minister appealed to the SCA which upheld his appeal.[198] Although the Appeal Court agreed with the High Court that the prison authorities at Pollsmoor did not take reasonable steps to prevent and curb the spread of TB the Court was of the view that Mr Lee had not proved that his TB infection was as a result of negligence by the prisons authorities.

The matter then went to the Constitutional Court which had to consider whether the applicant's detention and Correctional Services systemic failure to take preventative and precautionary measures caused the applicant to be infected with TB. It was factually agreed that the Pollsmoor Correctional Centre was notoriously congested and the responsible authorities relied on a system of inmates self-reporting their symptoms upon admission to the prison and during incarceration.

The Court held a prisoners right to bodily integrity (in line with section 12 of the Constitution which provides no person, including detainees and prisoners may be treated or punished in a cruel, inhumane or degrading manner) must be respected and inmates must be treated in a manner consistent with human dignity. Moreover, the CSA obliges the authorities to provide adequate health care services.

The Court found it was possible for the authorities to implement reasonable, adequate and cost-effective measures to prevent and curb the spread of TB.[199] The DCS must execute its duties in accordance with the purposes of the Act which include detaining all inmates in safe custody whilst ensuring their human dignity and providing adequate health care services for every inmate to lead a healthy life. The rule of law requires that all those who exercise public power must do so in accordance with the law and the Constitution.

According to the Constitutional Court the duty on Correctional Services authorities to provide adequate health care services, as part of the constitutional right of all prisoners to "conditions of detention that are consistent with human dignity", is beyond dispute.[200] Nor is it disputed that in relation to Pollsmoor the responsible authorities were aware that there was an appreciable risk of infection and contagion of TB in crowded living circumstances.[201] Being aware of that risk they had **a duty to take reasonable measures to reduce the risk of contagion**.[202]

6.2. LESSONS FROM THE CASE LAW

[198] Minister of Correctional Services v Lee [2012] 2 All SA 586 (2012 (3) SA 617) (SCA)
[199] Roux- Kemp (2013).
[200] Lee v Minister of Correctional Services 2013 (2) SA 144 (CC)
[201] Para [59]
[202] Para [59]

The courts have affirmed:

- Inmates retain all the rights to which every person is entitled to under the Constitution subject only to the limitations imposed by the prison regime.
- The DCS is constitutionally bound to provide adequate medical treatment to inmates.
- The DCS has a duty of care in respect of all inmates and there are consequence for failure to fulfil this duty adequately.
- The DCS has been "pertinently aware" of the crisis of TB in prisons for many years yet failed to take reasonable measures to reduce the risk of the spread of the disease.
- The DCS has a duty to take reasonable measures to reduce the risk of the spread of TB.
- There was evidence that the DCS failed to comply with its own Standing Orders. The kind of screening, examination and isolation required in terms of the Standing Orders could have been effective in reducing the risk of infection and contagion of a disease like TB.[203]
- A person in whom TB has progressed from "dormant" to "active" will not always immediately show symptoms. The symptoms may manifest only as the disease progresses hence the courts acknowledged the importance of implementing an effective and comprehensive TB prevention, diagnosis, treatment, care and support programme.

The Lee case, in particular, highlights routine violations of various aspects of the right to health and raises the possibility of future claims against the DCS for other negative health consequences resulting from constitutionally unacceptable prison conditions.

COMMENT AND QUESTIONS

- The DCS must execute its duties in accordance with the Constitution and the CSA (along with the Regulations and Standing Orders) which include detaining all inmates in safe custody whilst ensuring their human dignity and providing adequate health care services for every inmate. Despite the existence of a comprehensive legal and policy framework, the case law reveals clear failings on the part of the state and highlights significant gaps in the provision of health care services to inmates.
- While the DCS contends that it is taking a more aggressive stance towards healthcare provision in correctional centres, especially in respect of tackling high levels of TB, following the Constitutional Court finding in the Dudley Lee matter, studies by civil society organisations show that under-staffing, overcrowding and inconsistent treatment of disease in prisons remain a serious cause for concern.

[203] Para [61]

Chapter 7
MEDICAL PAROLE

This chapter briefly outlines the current legislative framework governing medical parole and the role of the Medical Parole Appeal Board and other role players in the medical parole application process. It also illustrates, by way of three case studies, the challenges in the medical parole process and makes recommendations to the Department and Parliament on selected issues to consider regarding the current the medical parole regime.

A number of inmates currently receiving health care are eligible for medical parole which, in the absence of a definition in the CSA, can be described as the conditional release from prison of an inmate on medical grounds.

Originally medical parole was intended as a 'compassionate' gesture for those inmates who were terminally ill in order for them to die a dignified death outside prison in the company of their families. Before the amended s79 of the CSA came into effect in 2012, the conditions for granting medical parole were often applied so narrowly that many deserving inmates were refused medical parole. The absence of a clear policy on medical parole resulted in an arbitrary, inconsistent and uncertain medical parole process. A decision of the Parole Board to refuse medical parole was final as the CSA lacked an appeal mechanism and only allowed for a very limited review process by the Parole Review Board.[204] The only other option left was to approach the court for relief.

The new medical parole regime that came into effect in 2012 was intended to make the process more transparent and fair.

7.1. STATISTICS[205]

7.1.1. Regional Statistics 2009 up to the latest date in 2011

This section contains information on data **before** implementation of the amended section 79 of the Correctional Services Act in 2011.

Table 16: Number of inmates who applied for, were granted and denied medical parole (2009-2011)

Regions	Number of applications				Granted				Not Granted			
	2009	2010	2011	Total	2009	2010	2011	Total	2009	2010	2011	Total
Eastern Cape	5	3	1	**9**	5	2	0	**7**	0	0	0	**0**
Free State and	7	10	7	**24**	5	9	5	**19**	1	1	2	**4**

[204] Dano (2011a).
[205] Department of Correctional Services (2015b).

Northern Cape												
Gauteng	56	29	29	**114**	17	21	13	**51**	17	5	5	**27**
KwaZulu-Natal	26	28	9	**63**	22	21	5	**48**	4	2	0	**6**
Limpopo, Mpumalanga, Northwest	14	13	6	**33**	12	6	4	**22**	2	3	1	**6**
Western Cape	9	15	15	**39**	9	14	13	**36**	0	1	1	**2**
Total	**117**	**98**	**67**	**282**	**70**	**73**	**40**	**183**	**24**	**12**	**9**	**45**

Medical parole applications granted

- In 2009 a total of 70 out of 117 applications were granted (59.8 per cent).
- In 2010 a total of 73 out of 98 applications were granted (74 per cent).
- In 2011 a total of 40 out of 67 applications were granted (59.7 per cent).

Applicants who died before / after medical parole hearing

Between 2009 and 2011, 32 applicants died before their medical parole applications were heard.

- Of the 12 applicants who died in 2009, the majority (11) were from the Gauteng region and one was from the Free State / Northern Cape region.
- Of the nine applicants who died in 2010, the majority (four) were from the KwaZulu-Natal region, three were from the Limpopo / Mpumalanga / North West region, while the Eastern Cape and Gauteng each had one applicant who died before their medical parole applications were heard.
- In 2011, Gauteng once again had the majority (five), of the 11 applicants who died, followed by KwaZulu-Natal, Limpopo / Mpumalanga / North West and the Western Cape.

Reasons for denying medical parole

Between 2009 and 2011 the Western Cape and KwaZulu-Natal were the regions with the most refusals of medical parole applications. The Department was requested to provide reasons for the granting or refusal of medical parole between 2009 and 2011.The Eastern Cape, KwaZulu-Natal and Gauteng regions did not provide any reasons for medical parole decisions made during this period, while the Limpopo / Mpumalanga / North West region indicated that refusals were in respect of those applications that did not meet requirements, without elaborating which requirements were not met. One applicant from the Free State / Northern Cape region was refused medical parole in 2010 because he or she 'responded well to medication', while two others were refused medical parole in 2011 because one had no support system and the other applicant's condition improved.

The DCS stated that the applications that were not recommended for medical parole were those that did not meet the criteria in the amended Correctional Services Regulations 29A. No further information is provided. It is not clear whether this actually means instances where medical parole were denied. Regulation 29A lists the medical conditions in respect of which medical parole can

be applied for. However, the amended regulations were promulgated on 25 April 2012 and could not have applied to applications between 2009 and 2011.[206]

According to the Department no inmates were denied medical parole because the Board was of the view that they would not be able to access the medical care they require post release. However, this was the reason for refusing medical parole in one case in 2011 in the Free State / Northern Cape region.[207]

Applicants who died after they were denied medical parole

The Department only lists the one person who died in 2011 in the Eastern Cape after his application for medical parole was denied. In the absence of reasons why medical parole was not granted in respect of the Eastern Cape applicant, what his medical condition was at the time of application, the cause of death and how long after his application and decision he died, it is impossible to draw conclusions in this regard.

7.1.2. Regional statistics 2012 up to the latest date in 2015

This section contains information on data **after** implementation of the amended section 79 of the Correctional Services Act in 2011.

Table 17: Number of inmates who applied for, were granted and denied medical parole (2012-2015)

Regions	Number of applications				Granted				Not Granted			
	2012	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
Eastern Cape	13	10	12	**0**	6	4	3	**0**	3	4	0	**0**
Free State and Northern Cape	12	9	4	**0**	6	3	3	**0**	6	2	1	**0**
Gauteng	14	10	11	**3**	5	4	2	**0**	3	4	3	**1**
KwaZulu-Natal	23	17	19	**2**	8	3	9	**-**	14	13	6	**2**
Limpopo, Mpumalanga, Northwest	16	8	8	**2**	1	1	2	**-**	11	7	2	**0**
Western Cape	20	26	21	**3**	7	15	7	**-**	11	5	2	**0**
Total	**98**	**80**	**75**	**10**	**33**	**30**	**25**	**0**	**48**	**35**	**14**	**3**

Number of medical parole applications

Between 2012 and 2014 the Western Cape, KwaZulu-Natal and Limpopo / Mpumalanga / North West were the regions with the most medical parole applications. The number of medical parole applications countrywide dropped steadily between 2012 and 2014, from 98

[206] GG 35277. Regulation Gazette No. 9739. Government Notice R323. 25 April 2012. Correctional Services Act, 1998 as amended. Promulgation of Correctional Services Regulations with amendments incorporated.
[207] Department of Correctional Services (2015b).

to 80 and then 75, respectively, after which it nose-dived to only 10 applications in 2015 (as at 9 June 2015, the date on which statistics were provided by the DCS).

Medical parole applications granted

- In 2012 only 33 out of 98 applications were granted (33.8 per cent).
- In 2013 only 30 out of 80 applications were granted (37.5 per cent).
- In 2014 only 25 out of 75 applications were granted (33 per cent).
- As at 9 June 2015 three of the 10 applications received in 2015 were denied and seven were pending.

Apart from a brief reference to three apartheid-era detained who applied for medical parole, the 2014/15 Annual Report of the Department of Correctional Services tabled in September 2015 provides no other information on medical parole applications / releases. The gap in information regarding medical releases is unacceptable and needs to be addressed in future annual reports.

Reasons for denying medical parole

Between 2012 and 2014 the Western Cape, KwaZulu-Natal and the Limpopo / Mpumalanga / North West were the regions with the most refusals of medical parole applications. The Department was requested to provide reasons for the granting or refusal of medical parole in this period.

KwaZulu-Natal and Gauteng did not provide any reasons for medical parole decisions made during this period, while the Eastern Cape, Limpopo / Mpumalanga / North West and Western Cape regions indicated that refusals were in respect of those applications that did not meet requirements, without elaborating which requirements were not met. In the Free State / Northern Cape region (a) six applicants were refused medical parole in 2012 because they were 'foreigners without [a] support system', (b) one medical parole application was converted to 'normal parole' in 2013, while one applicant was transferred and (c) the refusal in 2014 was because the applicant 'responded well to medication'.

Applicants who died after they were denied medical parole

According to the DCS, since the implementation of the amended s79, only one inmate 'was denied medical parole because the Medical Parole Board was of the view that he would not be able to access the medical care required, post release'.[208] This possibly referred to the application in June 2014 by Xolile Mngeni (convicted for his part in the high-profile murder case of Shrien Dewani) who had terminal brain cancer. Mngeni died four months later, after his application for medical release was denied because he would not be able to access the required medical treatment if released.

7.2. JUDICIAL INSPECTORATE REPORTS RELATING TO MEDICAL PAROLE[209]

The Section 85 of the CSA established the Judicial Inspectorate of Correctional Services (JICS) is an independent office under the control of an Inspecting Judge who is mandated to

[208] Department of Correctional Services (2015b).
[209] Judicial Inspectorate of Correctional Services (2015).

inspect Correctional Centres and report on conditions in and the treatment of inmates in Correctional Centres. The mandate of the JICS is aimed at preventing human rights violations through the monitoring of mandatory reporting systems and maintaining an independent complaints system. The latter is facilitated by Independent Correctional Centre Visitors (ICCVs) who record inmate complaints directly and must also be given access to prisoner complaints lodged with the Head of a Correctional Centre.

Complaints relating to medical parole for the period 2010 to 2015

Table 18: ICCVs complaints relating to medical parole (2010-2014)

2010/11	2011/12	2012/13	2013/14	2014/15
822	851	2 316	950	2 370

The 2011/12 JICS Annual Report indicates that ICCVs received 29 or four percent more complaints (851) relating to medical release in 2011/12 compared to the 822 complaints registered in 2010/11.[210] According to the Report, 19 percent of Heads of Correctional Centres registered requests for medical parole in 2011/12. Of these applicants, 26 percent were refused and 5 percent died before a decision was made.[211]

In 2012/13, complaints to ICCVs in respect of medical parole escalated by 172% to 2 316 but then surprisingly decreased by 1366 or 59 per cent in 2013/14.[212] The reasons for the sharp decrease warrants further investigation as the Department indicated to JICS 'that the total medical releases for 2013 /2014 were 20... [this] figure is low and...much effort is required by the Department and [JICS] to ensure that the administrative processes are fluid and efficient'.[213] In terms of information provided by the Department on 9 June 2015, however, there were 25 medical releases in 2013/14. The 2013/14 Annual Report notes that: 'the broadening of the opportunity to be favourably considered for [medical parole] is a further area that requires attention...our inspections...found that the medical staff was, in many cases, not aware of the amended provisions'.[214]

JICS further observed 'during its verification of natural deaths that inmates had died whilst their application for medical release was still being processed following the Department's administrative processes.'[215]

In 2014/15 ICCVs dealt with a total of 2 370 complaints relating to medical parole. When a complaint that was brought to the relevant officials by ICCVs is not resolved within the prescribed 14 days, a formal complaint, called a Record of Consultation (RoC), is filed. If still unresolved, the matter is referred to the JICS Legal Services Unit. In 2014/15 the Legal Services Unit dealt with 128 medical release complaints.

7.3. LEGISLATIVE FRAMEWORK GOVERNING MEDICAL PAROLE

[210]. Judicial Inspectorate of Correctional Services (2015).
[211] Judicial Inspectorate of Correctional Services (2015).
[212] Judicial Inspectorate of Correctional Services (2014).
[213] Judicial Inspectorate of Correctional Services (2014).
[214] Judicial Inspectorate of Correctional Services (2014).
[215] Judicial Inspectorate of Correctional Services (2014).

Following the public outcry in 2009 over the Parole Board's controversial decision to release Shabir Shaik on medical parole, the Minister of Correctional Services ordered a review of the medical parole policy. The review of the Medical Parole Regulatory Framework under section 79 of the CSA, was finalised and its findings released in 2010. The outcome was a new policy under the Correctional Matters Amendment Act 5 of 2011 that came into effect in April 2012; and that also established the Medical Parole Advisory Board (MPAB) to consider medical parole applications.

7.3.1 Medical parole requirements prior to 2012

Section 79 of the Correctional Services Act provided for correctional supervision or parole on medical grounds. In terms thereof:

> 'Any person serving any sentence in a prison and who, based on the written evidence of the medical practitioner treating that person, is diagnosed as being in the final phase of any terminal disease or condition may be considered for placement under correctional supervision or on parole, by the Commissioner, Correctional Supervision and Parole Board or the court, as the case may be, to die a consolatory and dignified death.'

The requirement that an applicant for medical parole had to be in his or her 'final phase of any terminal illness' was quite contentious as many medical doctors admitted that it was difficult to certify when a patient reached this stage. They were therefore reluctant to recommend medical parole.

Apart from the above provision in s 79, the Act contained no other reference to medical parole and did not clarify who could initiate the medical parole application process itself. Regarding parole generally, only the Minister or Commissioner of Correctional Services could refer a matter to the Parole Review Board.

The DCS also did not have a policy framework governing medical parole; nor adequate resources (including medical personnel and funds) to provide medical services in its correctional facilities in general, and to terminally ill or mentally and physically incapacitated inmates in particular.

7.3.2 Medical parole effective 2012

Both the CSA and the regulations were amended to standardise the medical parole process and make it more transparent. In terms thereof, the treating doctor assesses the applicant and makes a recommendation to the MPAB (comprising 10 medical doctors) to assess the evidence independently. The MPAB may call for additional information and test results, and examine the applicant in person to assess his or her health before providing an independent report and recommendation to the Correctional Supervision and Parole Board (CSPB). The CSPB makes a decision in respect of all medical parole applicants, except those serving life sentences ('lifers'). In respect of lifers the CSPB makes a recommendation to the Minister of Justice and Correctional Services for a decision.

Section 79 and other provisions and regulations governing medical parole

Section 79 of the CSA was amended by the Correctional Matters Amendment Act 5 of 2011.[216] This was followed by an amendment of the applicable Regulations which were promulgated on 25 April 2012.[217]

In terms of the Long Title of the Correctional Matters Amendment Act 5 of 2011, its aim was to *inter alia* 'provide for a new medical parole system; [and] clarify certain provisions relating to parole'. Under the new system, an offender or someone acting on the offender's behalf, can bring an application for release on medical parole. Previously, only the medical practitioner treating the offender (in many cases the prison doctor) could apply.

The other main changes brought about by the amendments are that (a) the list of medical conditions for granting medical parole was broadened; (b) the MPAB was established to consider medical parole applications; (c) medical parole cannot be cancelled if there is an improvement in health after release on medical parole; (d) medical parole decisions can be reviewed and (e) a revised medical parole application process was established. These changes are discussed in more detail below.

- **The list of medical conditions for granting medical parole was broadened**

The placement of an offender on medical parole is no longer restricted to inmates in the final phase of a terminal disease or medical condition, but also includes physically or mentally incapacitated inmates whose conditions severely limit their daily activities or self-care.

The amended CSA and the Regulations contain a list of infectious and non-infectious diseases from which it is clear that the person applying for medical parole (a) has a very short time left to live (for example, due to '[m]alignant cancer stage IV with metastasis[218] being inoperable or with both radiotherapy and chemotherapy failure'), or (b) is unable to perform everyday activities due to (i) a severe decline in memory or other thinking skills (for example, dementia) or (ii) because of physical incapacity as a result of injury, disease or illness (for example, severe disabling rheumatoid arthritis). According to the regulations the MPAB may also consider any other unlisted condition if it applies with the principles contained in s79 of the CSA.

- **The Act establishes a Medical Parole Advisory Board to deal with medical parole applications**

The MPAB was established with a view to strengthen the general policy on parole and correctional supervision. Its 10 members (10 doctors) were appointed on 23 February 2012 to consider the submitted reports of all inmates who applied to be released on medical grounds.

The main function of the MPAB in terms of s79(3) of the CSA is to 'provide an independent medical report to the National Commissioner, Correctional Supervision and Parole Board or the Minister, as the case may be, in addition to the medical report' submitted with the medical parole application. Section 79 further provides that a medical practitioner or the MPAB can also obtain a written medical report from a specialist medical practitioner. In terms of the CSA they can also examine

[216] Dano (2011a).
[217] GG 35277. Regulation Gazette No. 9739. Government Notice R323. 25 April 2012. Correctional Services Act, 1998 as amended. Promulgation of Correctional Services Regulations with amendments incorporated.
218 National Cancer Institute (2015).

the applicants themselves, in addition to asking for any additional reports relating to an applicant's health.

- **Medical parole cannot be cancelled on grounds of improved in health**

The CSA is very explicit about the fact that improved health is not a ground on which medical parole can be revoked.

- **Review of medical parole decisions**

Medical parole decisions can be reviewed by the Correctional Supervision and Parole Review Board, the Minister, the President and the court.

In terms of s77 of the CSA the Correctional Supervision and Parole Review Board can review decisions of the Correctional Supervision and Parole Board. It must then either '(*a*) confirm the decision; or (*b*) substitute its own decision and make any order which the Correctional Supervision and Parole Board ought to have made' and the reasons for its decision.

S78 provides that the Minister can review parole decisions in respect of offenders serving life sentences. Although the section does not expressly refer to medical parole in terms of s79, it is inferred as he or she makes decisions in respect of medical parole applications of inmates serving life sentences. If the Minister refuses to grant parole or day parole he or she can make recommendations in respect of treatment, care, development and support of the sentenced offender which may contribute to improving the likelihood of future placement on parole or day parole. Where the Minister refuses or withdraws parole or day parole the matter must be reconsidered by the Minister, on advice of the National Council, within two years.

In terms of s82 of the CSA, in addition to the power to 'pardon or reprieve sentenced offenders', the President may 'authorise the placement on correctional supervision or parole of any sentenced offender, subject to such conditions as may be recommended by the CSPB under whose jurisdiction such sentenced offender may fall or, in the case of a person serving a life sentence, by the Minister' and 'remit any part of a sentenced offender's sentence'.

The court can be approached in terms of the Promotion of Administrative Justice Act 3 of 2000 (PAJA).

- **Medical Parole application process**[219]

In terms of s79(2) of the CSA, an application for medical parole must be lodged in the prescribed manner, by (i) a medical practitioner; or (ii) a sentenced offender or a person acting on his or her behalf. However, such an application will not be considered if it is not supported by a written medical report recommending placement on medical parole. The written medical report must include, amongst other things, the provision of (a) a complete medical diagnosis and prognosis of the terminal illness or physical incapacity from which the sentenced offender suffers; (b) a statement by the medical practitioner indicating whether the offender is so physically incapacitated as to limit daily activity or inmate self-care; and (c) reasons as to why the placement on medical parole should be considered.

[219] Department of Correctional Services (2014c).

The court confirmed in the 2014 judgement in *Paddock v the Correctional Medical Practitioner St Albans,*[220] that notwithstanding the fact that a medical parole application will not be considered without a medical report, a correctional medical practitioner is not obliged to provide a medical report if he or she refuses to recommend release on medical parole

Under Regulation 29A an inmate's health condition that falls within the list covered in Regulation 29A (5), can be detected as early as the 'health status examination' which must be done when he or she is first admitted to a DCS facility.[221] This health condition must be recorded in the prescribed register.[222] Thus, a correctional services medical practitioner can initiate the medical parole application process by identifying offenders who are eligible for medical parole during the health status examination or thereafter.

An offender or anyone acting on his or her behalf (e.g. a family member or attorney) can apply for medical parole supported by a recommendation by the applicant's own doctor and submitted to the relevant decision maker (for example the Head of the Correctional Centre, National Commissioner or Area Manager) for referral to the MPAB for an assessment. The medical practitioner must do a thorough assessment of the applicant's medical condition, supported by the relevant medical and other reports.

If the MPAB recommends medical parole, the application is submitted to the Case Management Committee (CMC) for an investigation (including obtaining requested medical reports and supporting documents) and recommendation.

The CMC comprises at least three correctional officials and meets 'as often as the National Commissioner may determine'. By 2013 interim CMCs were established in all correctional centres in accordance with s42 of the CSA.[223] According to the regulations the CMC must provide a 'summary of the reasons for a recommendation on a sentenced offender's conditional placement or release to the National Commissioner, Correctional Supervision and Parole Board or the Minister, as the case may be, who decides on the placement or release of an offender'.

In terms of Regulation 29A(7) the MPAB must make a recommendation to the National Commissioner, Correctional Supervision and Parole Board or the Minister, as the case may be', who must consider whether the conditions stipulated in s79(1)(b) and (c) are present. In other words that 'the risk of re-offending is low; and there are appropriate arrangements for the inmate's supervision, care and treatment within the community to which the inmate is to be released'. The CSA stipulates that the Minister must make a decision in respect of those applicants serving life sentences. As mentioned previously, the MPAB provides an independent medical report to the Minister in respect of such medical parole applicants.

The next section sets outs the case studies on selected aspects of the medical parole process.

[220] (2248/2014) [2014] ZAECPEHC 59; 2015 (1) SACR 200 (ECP) (4 September 2014)
[221] Section 6(5) of CSA
[222] Judicial Inspectorate of Correctional Services (2013). A health care survey conducted in 2011/12 indicates that 38 percent of inmates were not examined within 24 hours of admission, 29 percent were not informed of their right to health care; and 54 percent did not receive immediate treatment, constituting a breach of DCS policy.
[223] The Presidency (2013). In March 2012 the Minister held a national work session for correctional supervision and parole boards and CMCs to improve their functioning. In addition, the Medical Parole System has been included in the regulatory framework and operationalised. In 2011/12, 175 members of parole boards and case management committees attended a one-week training session and another 185 attended a follow-up session of two days.

7.4. SELECTED CASE STUDIES

- **Bernard Paddock**[224]

Paddock was serving a twenty years prison sentence in St Albans Medium B Correctional Centre following his conviction in 2005 on charges of murder, robbery and unlawful possession of a firearm and ammunition. In 2014 he approached the Eastern Cape High Court to review the decision of the St. Alban's Correctional Centre medical practitioner not to recommend his release on medical parole. This meant his medical parole application could not be considered by the relevant decision makers (the National Commissioner, CSPB or the Minister). Paddock sought an order directing the Minister to appoint a different medical practitioner to conduct a medical evaluation in terms of s79 of the CSA.

Despite the applicant's long list of ailments which included hearing loss, only being able to walk for short periods with the aid of a crutch in one hand, a severe bladder problem for which a catheter was inserted and severe breathing problems due to TB, the Court held that the applicant could not show that the correctional medical practitioner had failed to apply her mind to his case. Further, that the correctional medical practitioner was not obliged to submit his application for medical parole. The Court clarified that the role of the correctional medical practitioner in terms of s79(1) was to: 'first consider whether or not the applicant's condition satisfied the provisions of section 79 (1) of the Act [*i.e*.] whether the applicant's condition conforms with such requirements before any application for medical parole could be submitted for consideration by the National Commissioner, the Correctional Supervision and Parole Board or Minister, as the case may be. The correctional medical practitioner does not make a final decision but can only make a recommendation to the Medical Parole Advisory Board for its decision'.[225] In the Court's interpretation of s79(2)(b) it 'prevents any application for parole being forwarded to the relevant parole board entity or person contemplated in the said section in circumstances where an application is not supported by a written medical report recommending placement on medical grounds.'[226]

The applicant was however, free to engage the services of a private doctor to examine him and recommend medical parole if that was the conclusion. If such a report accompanies a new medical parole application it would have to be considered by the MPAB and the CSPB.

- In three court cases brought prior to the commencement of the new medical parole policy (*Du Plooy v Minister of Correctional Services; Stanfield v Minister of Correctional Services and Mazibuko v Minister of Correctional Services & Others*), the courts overturned the Parole Board's decision to refuse medical parole to the seriously ill applicants.

- In the *Paddock case*[227], the court stated that in order to establish grounds of review the applicant had to show that 'the decision-maker failed to apply his or her mind to the relevant issues in accordance with the applicable statutory provisions and requirements of natural justice'.[228] In terms of S6 (2) (e)(i)-(vi) of PAJA, an administrative action is reviewable if *inter alia* it was taken 'arbitrarily or capriciously'

[224] *Paddock v The Correctional Medical Practitioner St. Albans Medium B Correctional Centre and others* supra
[225] At par 18
[226] At par 26
[227] (2248/2014) [2014] ZAECPEHC 59; 2015 (1) SACR 200 (ECP) (4 September 2014)
[228] At par a 11 - 12

and was therefore unreasonable.[229] The court made reference to the Stanfield judgment, noting that 'if the decision in question points, on balance, to bad or flawed reasoning and such reasoning was of material or substantial significance in prompting the decision-maker to come to his or her decision, the decision would be invalid and liable to be set aside on review...'.[230.] The court, mindful of the separation of powers, made it clear that it will not interfere with a decision 'that a reasonable authority could make' if it complied with all the requirements of legality and fairness.[231] Because the applicant could not show that the doctor had failed to apply her mind to his case, the application for review was dismissed.

- **Xolile Mngeni**

Mngeni was diagnosed with Metastatic Pinealoblastoma, a rare brain tumour, in May 2011.[232] According to the Medical Report dated 22 November 2012, Mngeni started showing symptoms including headaches, vomiting and double vision in January 2011, but was only seen at Groote Schuur Hospital on 19 May 2011. He subsequently underwent surgery on 9 July 2011 during which approximately 70 percent of the tumour was removed. A subsequent CT scan and spinal MRI showed that the disease had spread and chemotherapy and radiotherapy treatments followed to which he seemed to respond. Although there was 'no available evidence for survival rates', international studies conducted on patients with a similar spread of the disease showed that the two-year survival rate was less than 37 percent.

Mngeni applied for medical parole on 11 June 2014 which was denied. According to the DCS the decision to deny medical parole was based on the consideration of his aftercare (medical treatment) needs. According to the Minister 'there were no appropriate arrangements for Mngeni's supervision, care and treatment in the community into which he would be released,' whereas 'the correctional centre where Mngeni was incarcerated had the necessary resources to provide him with adequate medical assistance'. [233] Mngeni died in prison in October 2014.

Following the Minister's announcement that Mngeni was denied medical parole, social media was abuzz with the question why 'a terminally ill man [serving] a life sentence in prison [was] denied medical parole'.[234]

- **Clive Derby-Lewis**

In 2014, after two unsuccessful medical parole bids, Derby-Lewis's lawyers obtained a High Court order in terms of which the Medical Parole Advisory Board (MPAB) had to consider all the medical reports applicable to Derby-Lewis by December 10, and provide the Minister with a written recommendation by 15 December 2014. The Minister was ordered to consider Derby-Lewis's application for medical parole by 31 January 2015 along with the representations of the South African Communist Party (SACP) and the Hani family.[235]

[229] At par 22
[230] Per Van Zyl J in *Stansfield v The Minister of Correctional Services and Others* 2004 (4) SA 43 (C) at para [102] B-C
[231] At par 13.
[232] Department of Health (2012). Re: Xolile Mngeni: RT2011-1551: GSH73171076. Diagnosis: Metastatic Pinealoblastoma. Updated treatment report 22 November 2012.
[233] Masutha (2014).
[234] Waywell, (2014).
[235] Mail and Guardian (2014).

At the time Derby-Lewis was serving a life sentence in respect of the murder of SACP Secretary-General Chris Hani in 1993. At 78 years old, he was reportedly admitted to hospital in 2014 with 'a range of medical problems', and was diagnosed with terminal lung cancer which was 'inoperable because he is too weak to survive surgery'. According to his lawyers he had 'only months to live'.

On 31 January 2015 the Minister announced that he had denied medical parole to Derby-Lewis due to among other things, questions over the authenticity of his medical reports and the fact that he had stage 3B lung cancer, whereas the Act required stage 4 cancer to qualify for release on medical parole.

Following this, Derby-Lewis's lawyers successfully applied to the North Gauteng High Court to review and overturn the Minister's decision to deny medical parole to their client.[236] They argued that two doctors had diagnosed Derby-Lewis with stage 4 cancer, whereas only one doctor had found that he had stage 3B cancer on which the Minister's decision was based.

The judgement handed down on 29 May 2015 ordered Derby-Lewis's immediately release 'in the name of *ubuntu* and...dignity'.[237] It set out the following background information that informed the MPAB's recommendation to the Minister for Derby-Lewis's release on medical parole:[238]

- The applicant submitted an application for medical parole to the Department of Correctional Services on 2 May 2014. The application was supplemented by the report of his doctor, Dr L.S Fourie. In terms hereof the applicant suffered from lung cancer, heart failure and hypertension.
- The MPAB Chairperson subsequently appointed two members of the MPAB to perform a medical assessment of the applicant, the findings of which were part of the consideration by the MPAB at its meeting on 9 July 2014.
- The MPAB concluded that:
  - The applicant had *Stage IIIB Carcinoma of the Lung, which was inoperable but with no distal spread or metastasis. He was receiving chemotherapy and radiotherapy from a private hospital where he was admitted, that he was halfway through his treatment which he was tolerating well. He was clinically well and able to perform his daily activities and inmate self-care.*
  - *As the Act stipulates that only Stage IV cancers with metastases can be considered for medical parole, the staging of Stage IIIB lung cancer did not qualify. Further, there was no sufficient reliable information on his treatment aims or 'an unequivocal and unbiased assessment' of his prospects.*
  - *An independent team of specialists consisting of an Oncologist, Pulmonologist and Pathologist were appointed to examine the applicant.*
- The applicant's application for ordinary parole of 23 October 2014 was subsequently converted to an application for release on medical parole.
- Derby-Lewis's lawyers later obtained a High Court order in terms of which the MPAB had to consider all the medical reports applicable to Derby-Lewis by 10 December 2014, and provide the Minister with a written recommendation by 15 December 2014.

[236] *Clive John Derby-Lewis v The Minister of Justice and Correctional Services and others* (17889/15) [2015] ZAGPPHC (28 May 2015) at para 16-26
[237] Radio 702 (2015).
[238] *Clive John Derby-Lewis v The Minister of Justice and Correctional Services and others* case number 17889/15 (G) at para 16-26.

- On 2 December 2014 the court ordered that the SACP and Chris Hani's widow's representations in response to Derby-Lewis's medical parole application be filed and that the Minister make his decision on application on 31 January 2015.
- The representations were filed with the Minister on 9 January 2015 but were not presented or served on the applicant's lawyers prior to 31 January 2015.
- The independent specialists and the applicant's own doctor presented their reports and responded to questions by members of the MPAB with regard to their findings (in particular, the staging of the applicant's lung cancer) at a meeting of the MPAB on 14 January 2015.
- Two of the specialists diagnosed the applicant as suffering from Stage IV cancer on the basis of the spread of cancer to the left adrenal gland based on the PET scan performed on the applicant. The other specialist thought that the PET scan was inconclusive that the cancer had spread.
- The MPAB therefore concluded that the applicant's cancer could be staged at least at stage IIIB with a probable but inconclusive spread to the left adrenal gland, and recommended that the applicant be placed on medical parole.
- The Minister, however, denied the placement on medical parole on the grounds that:
  - Derby-Lewis suffered from stage IIIB lung cancer whereas the Act and Regulations stipulated inoperable malignant cancer stage IV with metastasis being or with both radiotherapy and chemotherapy failure to qualify for placement on medical parole;
  - The applicant was not rendered physically incapacitated so as to severely limit his daily activity or self-care.
  - There were no indications to whether the applicant had 'showed any remorse for the crimes committed.'

In terms of s6 of PAJA, the court had the authority for a judicial review of administrative action if, *inter alia*, the administrator (decision-maker) 'was biased or reasonably suspected of bias' and a 'mandatory and material procedure or condition prescribed by an empowering provision was not complied with' and the 'action was taken...because irrelevant considerations were taken into account or relevant considerations were not considered'.

The court found that the Minister had clearly taken the victims' representations into account in reaching his decision but had not been in possession of the applicant's response thereto. While remorse was relevant to the question of re-offending, the Minister failed to consider the evidence presented by the DCS 'which recorded the applicant's expression of remorse on several occasions'. The '*audi alteram partem'* principle and section 6(2)(b) of PAJA mandated service on the applicant of the victims' representations and any other document in the Minister's possession. Failure to serve the representations on the applicant constituted a serious irregularity and that, under the circumstances, the flawed nature of the process adopted by the Minister could not be cured.

Due to the urgency of the matter which was literally a matter of life and death (the applicant was given only six months to live in December 2014) and considering that the court could in exceptional circumstances substitute its own decision for that of a functionary who has a legislative discretion, the court ordered that:

(a) The Minister's decision dated 31 January 2015 in terms of which the applicant was refused medical parole was reviewed and set aside. The applicant was placed on medical parole with immediate effect.

(b) The conditions under which the applicant was to be released on medical parole had to be set by the Parole Board of the Kgosi Mampuru II Prison by 5 June 2015 which was complied with but not made public.

COMMENT AND QUESTIONS

Considering that the new s79 came into effect in 2012 which brought greater clarity regarding who qualifies for medical parole and which factors need to be taken into consideration by the MPB, the decline in the number of medical parole applications between 2012 and 2015 is unexpected — one would have expected medical parole applications to increase. While the amended s79 and the regulations guiding the medical parole application process are meant to ensure that medical parole is not abused as a 'get out of jail free card', there should be measures in place to ensure that there are no barriers to deserving applicants applying for medical parole in the first place. Thus, the reasons for the decline in the number of medical parole applications should be closely interrogated to ensure that where barriers exist (whether unnecessary red tape, inmates not being aware of their right to apply for medical parole or medical staff's ignorance of the amended provisions), they are eliminated.

On average the rate of granting medical parole (34.8 percent) between 2012 and 2014 was quite low. This, of course, is linked to the rate at which medical parole was denied and the reasons therefor. KwaZulu-Natal is one of the regions which not only had the most medical parole applications and refusals, but it also did not provide reasons why medical parole applications were refused. Most likely the reasons are recorded in the department, but the absence of the relevant information makes it difficult to draw conclusions regarding the efficacy, and fairness of, and trends and challenges in the medical parole application process. The same applies to the Eastern Cape and Gauteng regions that did not provide reasons for medical parole decisions, and Limpopo / Mpumalanga/ North West region for not elaborating on which requirements were not met.

The CSA as amended could be considered for review in terms of the following issues:

- **Separate the granting of medical parole from the provision of medical care for the condition(s) in respect of which medical parole is granted**. One of the conditions of granting medical parole currently is that an applicant must be able to access the required health care services to treat his or her condition upon release from prison. Where an applicant cannot meet this condition, medical parole must be denied, as illustrated in the case study of Xolile Mngeni who suffered from brain cancer but was denied medical parole due to concerns over his treatment and care after release.[239]
- This is because the Department of Correctional Services in terms of its mandate, is responsible for providing health care to inmates. Once that person qualifies for medical parole, he or she must be granted such parole. Having granted such parole, the DCS is no longer responsible for that person's continued medical care. That responsibility must then rest with the Department of Health and/or Social Development. Thus, while the state is at all times giving effect to provision in the Constitution regarding the dignity and the provision of adequate health care, it does

[239] At the time of writing the DCS has not yet responded to a list of questions on medical parole which included statistics on the number of inmates that were denied medical parole because of concerns over their access to medical care they require post release.

so by way of different organs or departments of state who are each tasked with a specific mandate. By separating health care from medical parole it will also clear up the perception and sometimes misperception among the public that medical parole is denied to deserving inmates and reinforce the principle that everyone is equal before the law. In addition to the obvious cost saving benefits for the DCS, it would also alleviate overcrowding and ease the burden on its already constrained medical resources.[240]

- **Consider whether an improvement of a person's health after medical parole can be a singular reason for cancelling parole.** One of the recommendations of the review task team in 2010 had been that the granting of medical parole should be reviewable should a medical parolee's health improve after his or her release.[241] This recommendation, however, was not taken up as the amended s79 expressly states that the improvement in a parolee's health following his or her release on medical parole, is not a ground for revoking medical parole. Medical parole can only be revoked if the conditions attached to the granting of medical parole were violated, for example, if the medical parolee re-offended.
- Consider implementing the recommendation of the review task team in 2010 that the granting of medical parole should be reviewable should a medical parolee's health improve after his or her release. As the reason why medical parole was granted (terminal illness resulting in incapacity or imminent death) is no longer present, the person is fit to serve the rest of his sentence in prison, or it can be converted to ordinary parole or another suitable regime recommended by the MPAB. The onus should be on the parolee to show why medical parole should not be cancelled or converted; and he or she must submit medical records and/or be subjected to a medical examination by members of the MPAB or an independent medical practitioner appointed by it to independently verify the medical condition of the parolee.

  Thus consideration could possibly be given to make future medical parole releases subject to regular post-release medical assessments. This is currently the position in California where a medical parolee must be returned to the custody of the department of corrections should his/her health improve.[242] Because of the fact that imminent death or a diminished life expectancy is no longer the only condition for medical release in South Africa, each case would have to be decided on the unique merits and circumstances of the parolee.
- **Clarify the provisions regarding the amendment of the conditions attached to medical parole**. These need not necessarily be as a result of ill health, but could be any condition that affects the medical parolee generally (e.g. change in family situation or income).
- **Public education and promotion of the work of the medical parole board with stakeholders and the general public.** Regular workshops should be held within the department and with outside civil organisations. Training should be done with staff involved in the provision of medical services to ensure they are aware of the amended provisions in s79.
- **Utilise resources provided by private institutions like hospice.** This will assist to help place terminally ill patients with access to needed health care services after release on medical parole.
- **No complainant involvement in MPAB process.** [243]Section 299A of the Criminal Procedure Act 51 of 1977 (as amended) regulates victim involvement in the decisions

[240] See also Justice Policy Institute (2009) which also recommends that elderly inmates should be released on parole when they reach a certain age or due to medical conditions. Elderly persons tend to put more strain on health services in general and need more health care as they get older – this also applies in the prison system. Elderly inmates generally do not pose a danger to society and releasing them will have immediate cost benefits for the corrections department, as well as easing overcrowding.
[241] Bathembu (2010).
[242] reference
[243] Department of Correctional Services (2014d).

of parole boards.[244] However, this is not applicable to medical parole applications as the decision is largely based on a determination of the applicant's state of health in line with the provisions of the amended s79 of the CSA.

- **Elderly inmates:** Due to the large number of inmates serving long term sentences, the number of elderly inmates in the system are increasing and 'ultimately an older prison population will require more health care and other age-related services'.[245] Consideration should thus also be given to release elderly inmates on medical or compassionate parole when they reach a certain age. Apart from relieving overcrowding, there are costs savings incentives for the DCS to release elderly inmates who no longer pose a danger to society.
- **Increasing the channels for review:** Although the Inspecting Judge may inspect and report on the state of correctional services and facilities, including health care services, and the Correctional Services Council advises the Minister on policy and draft legislation, the CSA does not ascribe any powers relating to the review of medical parole decisions to these institutions.

[244] Department of Correctional Services (2014d).
[245] US Department of Justice (2015).

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