The Politics of Prison Nursing and HIV/AIDS at Pollsmoor Maximum Security Prison 1990-2008

University of Cape Town

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Department of Historical Studies, Faculty of Humanities

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NZZLES001

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Abstract

The Politics of Prison Nursing and HIV/AIDS at Pollsmoor Maximum Security Prison 1990-2008

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The purpose of this thesis is to examine histories of prison nursing and the management of HIV/AIDS at Pollsmoor Maximum Security Prison. South Africa is a country with a high HIV prevalence, with rates of infection being especially notable among prisoners. Extant studies of HIV/AIDS in prisons in South Africa have largely focused on inmates' experiences of receiving healthcare services in prisons. Focusing on the years 1990 to 2008, the thesis offers a social history of prison nursing over time with a focus on nurses' workplace experiences in dealing with HIV/AIDS in their patients. By investigating prison nurses' everyday realities, the thesis finds that they experience challenges because of experiencing a fraught dual-system dynamic as employees of the Department of Correctional Services (DCS) who also collaborate with those based at the Department of Health (DOH). The former also tends to prioritize security over inmates' access to quality healthcare. The thesis draws upon a range of sources, including 20 oral history interviews (16 with prison nurses, two with clinical practitioners, and two with non-clinical health practitioners from the NGO TB/HIV Care); prison laws and policies, and DCS annual reports. It reaches several conclusions, such as outlining how factors such as gangs, prison violence (including sexual assault), transactional sex, substance abuse, and overcrowding affect prisoners' vulnerability to infection and their uptake of HIV prevention services provided by the nurses. Concluding in 2008, this thesis captures the significant role played by NGOs and health activists who advocated for inmates' access to effective HIV prevention and treatment services. It describes how legal activism catalyzed the provision of antiretrovirals (ARVs); this, alongside the work of NGOs such as HIV/TB Care, dramatically improved nurses' ability to provide HIV prevention and treatment services.

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1: Map of Pollsmoor Maximum Security Prison in 1990.

List of Abbreviations/ Glossary

ADIS - Acquired Immune Deficiency Syndrome

ARVs- antiretroviral drugs

ART – antiretroviral therapy

Care means the provision of services and programmes aimed at enhancing and maintaining the social, mental, spiritual, health, and physical well-being of inmates.

Constitution - means the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996)

Correction - means the provision of services and programmes aimed at correcting the offending behaviour of sentenced offenders to rehabilitate them.

DCS - Department of Correctional Services

DOH – Department of Health

HIV - Human Immunodeficiency Virus

I**nmate** - means any person, whether convicted or not, who is detained in custody in any correctional centre or remand detention facility, or who is being transferred in custody or is enroute from one correctional centre or remand detention facility to another correctional centre or remand detention facility.

L**GBTQIA -** Lesbian, gay, bisexual, transgender, queer, intersex, and asexual

Medical practitioner - means a medical practitioner as defined in section 1 of the Health Professions Act, 1974 (Act No. 56 of 1974)

Medical treatment - means treatment, regimen or intervention prescribed by a medical practitioner, dentist or psychologist as defined in section 1 of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974)

Mother and child unit - means a unit within a correctional centre where provision is made for separate sleeping accommodation for mother and child, as well as a crèche facility, and where the focus is on the normalisation of the environment to promote the child's physical and emotional development and care.

MTCT- Mother-to-child-transmission

NACOSA – National AIDS Coordinating Committee of South Africa

NICRO – National Institute of Crime Prevention and Regulation

NGO- non-governmental organisation

Offender - A person who commits an illegal act and is held in a correctional facility after they are found guilty in a court of law

POPCRU – Police and Prisons Civil Rights Union

Professionals - means persons registered under the Nursing Act, 1978 (Act No. 50 of 1978), Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act No. 63 of 1982), Pharmacy Act, 1974 (Act No. 53 of 1974), Health Professions Act, 1974 (Act No. 56 of 1974), and the Social Work Act, 1978 (Act No. 110 of 1978)

RDF- Remand Detention Facility

Registered nurse - means a person registered as a nurse under section 16 of the Nursing Act, 1978 (Act No. 50 of 1978), and excludes any reference to the "nursing auxiliary" and "enrolled nurse", enrolled under the provisions of the said section.

SAMDC – South African Medical and Dental Council

STDs – Sexually Transmitted Diseases

South African Nursing Council (SANC) - means the statutory body that regulates the profession of nursing in South Africa in terms of the Nursing Act, 2005.

TB – Tuberculosis

Unsentenced offender - means any person who is lawfully detained in a correctional centre and who has been convicted of an offence, but who has not been sentenced to incarceration or correctional supervision.

USAID – United States Agency for International Development

UNAIDS – United Nations Programme on HIV/AIDS

VMMC – Voluntary Medical Male Circumcision

WHO - World Health Organization

Chapter 1: Introduction

This thesis explores the lived experiences of prison nurses and the management of HIV/AIDS at Pollsmoor Maximum Security Prison from 1990 to 2008. Nurses working in South African correctional facilities have a long history navigating a fraught dual-system dynamic between the Department of Health (DOH) and the Department of Correctional Services (DCS), in a context where security priorities supersede inmates' access to quality healthcare. This has compromised nursing practices, limiting access to essential healthcare resources typically available in external clinics. Ethical conflicts abound as nurses struggle to reconcile patient-centered care with security-driven policies. Consequently, administrative burdens – extensive reporting and court testimony – divert nursing time from direct patient care. This policy discordance hinders healthcare delivery, disproportionately affecting HIV-positive inmates. The rift between DOH and DCS policies effectively constrains nurses' ability to provide comprehensive healthcare services within prisons.

It is in this context that a strong case can be made for the historicization of HIV/AIDS in nursing prisons. Although the existing literature does an excellent job of narrating histories about life in prison post-1992 when the Prisons Act No 8 of 1959 was amended; Article 44 (1) (f) of the (Prisons Act of 1959) created an effective legal obstacle to the publication of any information about prison conditions or the experience imprisonment.[1] Therefore, the experiences and everyday realities of correctional nurses, and their role and contribution in managing HIV/AIDS inside correctional facilities are under-examined in the literature. This thesis addresses this gap by primarily using oral history to document and analyse the everyday lived experiences, politics, and management of HIV/AIDS at Pollsmoor prison. In particular, it offers a social history of prison nursing drawing on oral history interviews with nurses. This allows for their perspectives and voices to be heard on HIV/AIDS prevention and treatment in correctional facilities.

Research Focus: Problems and Issues Explored

To examine nurses' experiences providing HIV prevention and treatment services at Pollsmoor prison, we need to understand the broader issues they faced, such as how the Department of

[1] Gready, Paul. "Autobiography and the 'power of writing': political prison writing in the apartheid era." Journal of South African Studies 19, No. 3, 1993, 489-523. 491.

Correctional Services (DCS) policies influenced the workplace conditions they faced over time. Here is important to explore how the transition from apartheid to democracy impacted their roles and responsibilities. In terms of this, it is worth describing how the policies and legislation were implemented since the transition period influenced the healthcare service delivery at Pollsmoor prison. One of the critical policy changes was the demilitarization of the prison system, which affected nurses in the day-to-day operation of nursing in prison, the recruitment of new nursing staff, and the training and retention of the nursing staff. In turn, the project also focused on ethical dilemmas nurses faced following the demilitarization of the prison system.

In the thesis, I examine the role of NGOs and health activists in highlighting the absence of sexual healthcare in prisons during the rise of HIV/AIDS. The research also dealt with how the outbreak of HIV/AIDS affected the provision of healthcare services at Pollsmoor prison. It also explored how nurses have responded to this epidemic. Finally, it looked at how nurses have provided healthcare services to inmates-patients in a dedicated AIDS unit at Pollsmoor prison. In addition, to learn more about prison nurses' everyday experiences, the research set out to examine their experiences of working conditions at the prison, including the relationships between prison nurses and prison wardens and inmates at the prison, especially as their patients. Finally, it also set out to describe their narratives about their careers in terms of career choice and trajectory, and their relationship with the profession as a whole.

Methodology

The primary sources this thesis draws on consist of oral history interviews with nurses employed at Pollsmoor prison, including clinical and non-clinical practitioners from the TB and HIV Care NGO. Twenty interviews were conducted in total, sixteen with nurses working at Pollsmoor prison clinics and two with clinical practitioners, and two with non-clinical practitioners from TB and HIV Care. Most of the interviewees were health professionals with different years of experience in a correctional facility. Their tenure at Pollsmoor prison ranged from two to twenty-two years, providing different perspectives on the politics of prison nursing and managing HIV/AIDS at Pollsmoor prison. Notably, the interviewees were black and coloured men and women of different ages speaking isiXhosa and Afrikaans as their first languages. While the interviews were conducted in English, interviewees were given the freedom to respond in their preferred language whenever they wished to. The interviews were qualitative and had scheduled semi-open-ended questions which allowed the nurses to reflect on their experiences and gain insights into their lived experiences and the management of

HIV/AIDS at Pollsmoor Prison between 1990-2008. Many of the interviews were conducted in person in the Pollsmoor prison boardroom, far from where the inmates are held, preventing me from having any contact with them (which was not necessary as they were not participants in the study). Of the interviews, only four were conducted telephonically, namely, those with clinical and non-clinical professionals from TB and HIV Care.

As prison can be a dangerous environment, whenever I conducted interviews at Pollsmoor, I carried my identity document and permit issued by the DCS, as well as the access card given to me by the area commissioner of the correctional facility. To ensure my safety when visiting the clinics inside each Centre, sick bay, and prison cells to look at nurses' working conditions and inmates' living conditions, I was accompanied by the head of nursing, Mr. Hlophe, and two prison wardens who were briefed about my research project. The data collected from the interviews assisted in analysing the implementation of DCS policy for HIV/AIDS in the late 1990s to 2008 and provided primary insights from the nurses' voices on the daily challenges they faced in managing HIV/AIDS at the prison.

Before engaging with the nurses, I had a meeting with all five Head of Centres and the Area Commissioner at Pollsmoor to explain my research study, its aims, objectives, methods, and outcomes. At the start of each interview, all participants were similarly briefed. All participants agreed to the interviews being recorded and transcribed by signing a consent form. They were informed that participation in this research study was voluntary and that they could withdraw at any time. They were also informed that the information they had provided up to the point of withdrawal would not be used in the write-up on this thesis or any project. The confidentiality of the interviewees was maintained throughout the research process, including the interviews themselves, the transcriptions and data analysis, and the thesis itself. Each interviewee was informed that they did not have to respond to questions they were uncomfortable answering.

All sixteen nurses interviewed for this research are employees of the Department of Correctional Services (DCS) and, as such (at their request), the names of fourteen of the nurses remain confidential; as such, I have given them pseudonyms. Two nurses were comfortable with their identities being revealed in the thesis: Mr Hlophe (the head of nursing at Pollsmoor prison) and Sister Fefe (who is retiring at the end of 2024). One in-house doctor (Dr Johnson) and William Smith, a pharmacist, were also comfortable with their names being used. The interviewees who were not staff of DCS at Pollsmoor from TB and HIV Care also gave consent for their names to be used in the research.

Oral history provided a rich and dynamic way of approaching this research project. Linda Shopes argues that oral history interviews are significant sources of new information about the past and its interpretive perspectives.[2] Also, interviews have played a significant role over the past decades for social historians, providing information about the everyday life of 'ordinary people' and their thoughts that are not recorded in traditional sources. Similarly, Paul Thompson and Joanna Bornat argue that oral history is a method of giving history a new dimension and can open new areas of inquiry within the production of new history.[3] In the context of this thesis, where the is little documentary evidence of the histories of prison nurses, the use of oral history has been pivotal in accessing the lived experiences of nurses working at Pollsmoor.

However, it is important to acknowledge that, as with other types of primary sources (such as archival documents, books, newspapers, articles, and written reports), oral history interviews are complicated forms of evidence. Because of this, it is important to be critical in terms of biases, selectivity, and distortion. When conducting oral interviews, one has to be aware of how one, as the researcher, is shaping the process. As Lynn Abrams argues, "Although similar questions are asked when looking at oral testaments and archival material, humans cannot be analyzed in the same way as the latter, and the dialogical process needs to be acknowledged."[4] Robert Perks and Alistair Thomson also support the use of oral history and argues that oral history contributes to the historical records the experiences and perspectives of groups of people who might have been 'hidden from history, perhaps written about by social observers or in official documents, but only rarely preserved in persona papers or scarps of autobiographical writing.[5]

Although oral history has proven to be useful in capturing particular kinds of histories (especially social history), some challenges and concerns come up when it is used, such as the positionality of interviewees and interviewers. Moreover, race, age, gender, sexuality, and socio-economic background all shape the way participants see their world and their histories. Also, oral history is largely dependent upon people's memories, and some important information could be missing due to memory loss and people not wanting to share their traumatic experiences. As such, the positionality of the insider/outsider needs to be carefully

[2] Shopes, Linda. "Oral History." The SAGE handbook of qualitative research. 2011. 451-465. 457.
[3] Thompson and Bornat Joanna. "The Voice of the Past: Oral History." Oxford, Oxford University Press. 2017. 29.
[4] Abrams, Lynn. *Oral History Theory*. New York: Routledge, 2012. 18.
[5] Perks, Robert, and Thomson, Alistair. The oral history reader. Rutledge, 2015. Ix.

considered because of the different advantages and barriers each presents. Being an insider, the interviewer may be too close to the subject and, therefore, interviewees provide little details, or in some cases, the interviewer might be too close to the subject to remain objective. The interviewer being an outsider raises issues relating to age, gender, sexuality, language, and trust. However, being an outsider can provide the interviewees with the opportunity to elaborate further on providing details about their experiences.

Establishing a trusting relationship between the interviewer and the interviewees is important when a researcher is conducting oral histories because it influences interviewees' willingness to share, or not share, information. In my case, I also presented my research aims and objectives, informed them that interviews would be recorded. I also mentioned that the study will be submitted to the Department of Correctional Services (DCS) for approval by the Commissioner of Correctional Services before publication. This is outlined in the ethical approval letter I received from DCS to conduct research at the prison (this is attached as an appendix at the end of this thesis). The letter led some of the nurses to be suspicious of the project. To generate trust, I shared my experiences conducting a similar research project entitled: "Nursing on the Inside Life Histories, Stories and Experiences of prison nursing in Johannesburg Correctional Centre 1992-2021" for my honours' degree in History at the University of the Witwatersrand. The nurses began to ask more questions about the study, and I outlined how other nurses from Johannesburg Correctional Centre perceived the study and whether there were any consequences for them in participating in the study.

In the case of this research, I occupy both an insider and an outsider position. I am an outsider because I do not have personal experience of apartheid, or working inside a correctional facility with inmates, or providing healthcare services. Also, given my extensive research experience from Johannesburg Correctional Centre, I occupy an insider position because I have gained knowledge and experience about how nurses in different centres of the correctional facility work, and experience in establishing relationships with correctional nurses for my research. Moreover, I occupy an insider position because I understand how to adhere to the Department of Correctional Services (DSC) ethics and correctional facility rules and regulations.

In addition to oral history interviews, the thesis also draws on sources, including documents related to the prison establishment, management, and daily operation of prison clinics. I consulted archival documents held at the University of Cape Town's Historical Papers, South African Historical Archive (SAHA), and Prison Annual Reports issued by the Department of

Correctional Services. I also read government laws, legislations, and acts from the apartheid and democratic eras. Documentary sources from DCS were significant because they provided HIV statistics and insights on DCS and government positions on HIV/AIDS in correctional facilities from the late 1990s to 2008. Finally, medical journals and newspapers were also used to learn more about the state of healthcare at Pollsmoor, and relevant events related to healthcare and nurses at the prison.

The field work for the oral history component of the research was conducted from 20 September to 3rd October 2024. Official permission to conduct field work at Pollsmoor prison was obtained after four months of negotiating with the National Department of Correctional Services. After communication through emails and phone calls, DCS reviewed my previous application granted in 2022 for my research project, the Johannesburg Correctional Centre, and I was provided with a conditional letter. Therefore, I had to follow up with DCS telephonically and through email. Eventually, I was permitted to commence with field work at Pollsmoor under the following condition:

> You are required to submit your final report to the Department for approval by the Commissioner of Correctional Services before publication (including presentation at workshops, conferences, seminars, etc.) of the report.

After receiving the approval letter, field work commenced after DCS National had informed the regional office to notify the Area Commissioner at Pollsmoor prison about my approval letter.

The inclusion of non-nursing professionals, such as a medical doctor, a pharmacist, and four employees from the NGO TB HIV Care, was intentional and necessary to provide a more non-biased, comprehensive understanding of the management of HIV/AIDS at Pollsmoor prison in the late 1990s to the early 2000s. Dr Johnson was interviewed because she is the long-standing in-house doctor at Pollsmoor prison and her involvement in the prison's HIV/AIDS response, having worked at Pollsmoor since the early 2000s. Before the establishment of the Ubomi Clinic in 2008, nurses were not permitted to manage HIV/AIDS treatment within the prison; instead, only doctors were allowed to do so.

Dr Johnson's insights help contextualize the shifting policies and practices surrounding HIV/AIDS care at Pollsmoor prison, especially during a period when nurses' roles were heavily restricted. Similarly, William, a pharmacist who has also worked at Pollsmoor prison since the

early 2000s, was included in the study because of his essential role in ensuring continuity of treatment, explaining the importance of medication adherence and different kinds of medication and their side effects to inmates, and overseeing nurses medication storage and distribution an often overlooked but critical aspect of the management of HIV/AIDS in prisons.

Moreover, four staff members from TB HIV Care, an NGO operating within Pollsmoor prison since 2007, were interviewed. Two of them are professional nurses who work in partnership with DCS-employed nurses, while the other two are non-clinical staff involved in health education, sensitisation workshops for DCS staff and inmates, HIV testing, counselling, and linkage to treatment. Their inclusion reflects the significant role that external partners played in the early 2000s in supplementing the healthcare system within correctional facilities, especially in offering services not provided directly by DCS, such as voluntary medical male circumcision, distribution of condoms, and peer education.

The Project's Rationale

This thesis is socially relevant as it speaks to the need for the adoption of human rights-based approaches to the provision of health care (in the case of this thesis, that related to HIV/AIDS) in South Africa's prisons. A civilised and humane society demands that when the state takes away the autonomy of an individual by imprisonment, it must assume the obligation to see to the physical welfare of its inmates.[6] In South Africa, the rights of all detained, accused, and arrested people are recognised and protected in various legal instruments. For instance, section 12 (1) of the Correctional Service Act No. 111 of 1998 stipulates that:

> The Department must provide, within its available resources, adequate health care services, based on the principle of health care, to allow every prisoner to lead a healthy life.[7]

It also states that, "(4) (a) Every prisoner should be encouraged to undergo medical treatment necessary for the maintenance or recovery of his or her health".[8]

This act further acknowledges the specific health needs of female offenders and states that mothers and their children held in prison facilities should be provided with access to healthcare. Section 20 (1) states that "A female prisoner may be permitted, subject to such conditions as

[6] The Supreme Court of Appeal of South Africa Judgment, Lee v Minister of Correctional Services, 2012. 13.
[7] Correctional Services Act 111 of 1998.
[8] Correctional Services Act 111 of 1998.

may be prescribed have her child with her until such child is five years of age".[9] In particular, section (2) stipulates that "The department is responsible for food, clothing, health care, and facilities for the sound development of the child for the period that such child remains in prison".[10]

In addition, the health of inmates is addressed in Section 35 (2) (e) of South Africa's Final Constitution of 1996, which obliges the Department of Correctional Services (DCS) to ensure 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, exercise and the provision at the state's expense of adequate accommodation, nutrition, reading material, and medical treatment.[11]

This clause points to the obligation of the DCS to provide health care to inmates. By implication, the health care provided in prisons should be consistent with that provided to other citizens by the state.

Most of the literature on correctional facilities in South Africa focuses on inmates or warders, for example, the 1994 Human Rights Watch report.[12] When nurses or doctors have featured in such texts, it is through descriptions of the experiences of inmates about their illnesses and about the services provided to them by nurses. There is a big gap in the literature in terms of the voices of prison nurses themselves. Therefore, the significance of this research is to document the experiences of prison nurses.

This thesis deals with nurses' experiences providing health care to prisoners living with, and affected by, HIV/AIDS since the early 1990s: for this reason, it is worth discussing the history of the epidemic in South Africa.[13] Human Immunodeficiency Virus (HIV), when left untreated, can progress to Acquired Immunodeficiency Syndrome (AIDS). HIV attacks a person's immune system, making them vulnerable to 'opportunistic' infections. When a person is

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[9] Correctional Services Act 111 of 1998.
[10] Correctional Services Act 111 of 1998.
[11] Constitution of the Republic of South Africa Act 108 of 1996.
[12] Sargiacomo, Massimo. "Michel Foucault, Discipline and Punish: The Birth of the Prison: Allen Lane, London, 1997, Trans. By Alan Sheridan." (2009): 269-280. 271.
[13] Simelela, N, P. and Venter, W, D, F. "A brief history of South Africa's response to Aids." South Africa Medical Journal, Volume. 104, No. 3, 2014. 248-251. *A brief history of South Africa's response to AIDS: history of HIV in SA - Progress towards the Millennium Development Goals (journals.co.za). 284. Accessed: 31 March 2024.

diagnosed with AIDS, they have at least two or more "opportunistic infections."[14] The "viral load" (number of HIV viruses) present in an HIV positive person increases when the infection is not managed through treatment. Consequently, untreated HIV positive people with high viral load can easily transmit the virus to others through "anal, oral, or vaginal intercourse, from mother to child before or during birth, tattooing, piercing and injecting drugs."[15]

The HIV/AIDS epidemic in South Africa was first reported in 1982 and has since spread at an alarming rate, making the country the global epicenter of HIV infections. In 1982, the first case of AIDS in South Africa was reported in a gay man who contracted the virus while in California, United States. Later that year, 250 random blood samples were taken from homosexual men living in Johannesburg, of which a startling 12.8% were infected with the virus. [16] However, instead of prompting a comprehensive response, the apartheid government targeted "homosexual" men as spreaders of this deadly, mysterious disease. This was particularly the case among those who had many sexual partners and had financial means for international travel. The apartheid government's homophobia framed AIDS in South Africa as a disease of immoral and devious gay men; consequently, they failed to adopt an effective and comprehensive response to the epidemic during its infancy. HIV infections also began to spread in the general heterosexual population and high-risk environments such as prisons, which were overcrowded, and where many prisoners lacked access to adequate healthcare (especially if they were black).

In the late 1980s to the early 1990s, the government failed to implement effective strategies to curb the spread of HIV/AIDS, such as HIV/AIDS awareness, the use of condoms, and "safe sex" education.[17] Cichocki Mark has also explained that because the country was amid the dismantling of apartheid, the HIV/AIDS problem was, for the most part, largely ignored by the apartheid government because of the racist, homophobic, sexist, and stigmatizing view they

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[14] Pienaar, P, J, J. "AIDS and the criminal justice officer. *Acta Criminologica: African Journal of Criminology & Victimology*. 1989: 88-92. 89.

[15] Goyer, K, C. "HIV/AIDS in Prison: The Public Policy Challenge for South Africa." MA Thesis, University of Natal, Durban. 2001. 38.

[16] South African History Online towards a people's history. A History of Official Government HIV/AIDS Policy in South Africa. "The HIV/AIDS Crisis Emerges: Responses of the Apartheid Government A History of Official Government HIV/AIDS Policy in South Africa | South African History Online (sahistory.org.za) Accessed: 10 October 2024.

[17] Simelela, N. P. and Willem Daniel Francois Venter. "A brief history of South Africa's response to AIDS: history of HIV in SA-Progress towards the Millennium Development Goals." *South African Medical Journal*, 2014, 249-251. 249.

held.[18] While political unrest dominated the media, HIV/AIDS began to take a stronger hold, especially among gay men and black people.[19] Between 1990 to 1994, the was a drastic increase in the number of heterosexual infections, including with pregnant women transmitting HIV to their infants (referred to as mother-to-child transmission, or MTCT). The HIV prevalence in pregnant women increased from 0.8% to 7.6% between 1990 and 1994.[20] The HIV/AIDS crisis seriously affected black people, who were already disadvantaged by the policies of apartheid, and they had inadequate access to healthcare services, especially in the Bantustans.

Tragically, from 1998 to 2008, the end year of my research, former President Thabo Mbeki articulated “HIV denialism”, which hindered the roll-out of anti-retroviral drugs (ARVs).[21] AIDS denialism consisted of questioning the causal link between HIV and AIDS and claiming that anti-retroviral drugs were ineffective and lethally toxic; this was all contrary to the evidence-based scientific consensus.[22] Mbeki’s denialism became evident when his Presidential Advisory Panel on AIDS included both scientists who denied orthodox views on the disease and those who followed a mainstream approach. It was also in evidence in the speech he gave at the opening of the 2000 International AIDS Conference held in Durban, South Africa.[23] Mandisa Mbali argues that the adoption of denialist views by prominent government figures such as Former President Thabo Mbeki and his Health Minister Manto Tshabalala-Msimang, denialism prevailed and informed and influenced the government’s HIV/AIDS policies, which excluded a roll-out of ARVs.[24] It is in this context that little government attention was given to HIV/AIDS in prisons. Here we must also note that a large majority of inmates were young, black men from impoverished communities, who were already heavily affected by HIV/AIDS.[25]

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[18] Cichocki, Mark. “History of HIV in South Africa.” Very well Health, The History and Prevalence of HIV in South Africa (verywellhealth.com) Accessed: 10 November 2024.
[19] Cichocki. “History of HIV in South Africa.”
[20] Karim, Salim s. Abdool, Gavin J. Churchyard, Quarraisha Abdool Karim, and Stephen D. Lawn. “HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response. *the Lancet*, 921-933.
[21] Simelela and Venter. “A brief history of South Africa’s response to Aids.” 249.
[22] Mbali, Mandisa. “AIDS Discourses and the South African State: Government denialism and post-apartheid AIDS policy-making.: Transformation: Critical perspective on Southern African 54, no. 1. 2004. 104-122. 104.
[23] Mbali. “AIDS Discourses and the South Africa State.” 104.
[24] Mbali. “AIDS Discourses and the South African State.” 104.
[25] Goyer, K, C. “Prison Health is Public Health HIV/AIDS and the case for prison reform.” *Institute for Security Studies*. South Africa Crime Quarterly No. 2 November 2022 23-26. HIV / AIDS and the case for prison reform: prison health is public health (journals.co.za) Accessed: 31 March 2024.

Literature Review

This dissertation draws on and speaks to historical literature about the development of the penal system, prison nursing, and HIV/AIDS in South Africa. In addition, because it deals with contemporary history, it has also been informed by social science research dealing with access to healthcare in a context of high HIV prevalence. There is a substantial amount of literature available on South African correctional facilities, which largely focuses on: prison gangs; violence; prison experiences of political prisoners during apartheid; and issues of overcrowding inside correctional facilities. Heinrich Veloen's master's dissertation is entitled "The Numbers Gang in South African Correctional Facilities: Reflections on Structures, Functions and Culture."[26] It explores key factors of the Number gangs in South African prisons. It draws upon his own experience (of 26 years) as a warden at Pollsmoor Prison. His paper presents an account of the histories, structures, and operations of prison gangs. In addition, the Department of Correctional Services regularly issues annual reports, providing information about the current state of prison facilities. These reports also document the number of inmates in all prison facilities and highlight the pressing issues of overcrowding and strategies employed to address these issues. They do not, however, address prison nurses and their everyday lives in the workplace.

On the other hand, William Luyt and Nicolien Du Preez have explored the experiences of female inmates at Johannesburg Correctional Centre and produced recommendations on how the healthcare treatment policy of female inmates could be addressed.[27] They examine the incarcerated women's attitudes about HIV/AIDS risk, prevention, and treatment. They have recommended that policymakers consider the disparate healthcare needs of male and female offenders, with specific reference to sexual and reproductive health. In addition, they show how female offenders' vulnerability to HIV infection is greater because of gender inequality, stigma, and discrimination.[28]In addition, they state that urgent reforms are necessary to enhance female offenders' HIV/AIDS awareness through targeted education, behaviour-change communication programs, and confidential voluntary counselling and testing programs.

[26] Veloen, Heinrich. "The Numbers Gang in South African Correctional Facilities: Reflections on Structures, Functions and Culture. MA Thesis, 2022.

[27] Luyt, Willem and du Preez Nicolien. Managing Integrated Women After Establishing Their Knowledge Levels of HIV and Aids: A case study of the Johannesburg Female correctional center. Southern African Journal of Criminology. 2015. 106-124.

[28] Luyt, William and du Preez, Nicolien. Managing Integrated Women After Establishing their knowledge levels of HIV and AIDS: A case study of Johannesburg Female Correctional Centre. South African Journal of Criminology. 2015. 106-124. 120.

Additionally, they recommend that antiretroviral therapy (ART) access should be consistently provided to HIV-positive inmates.[29]

Healthcare in South Africa's correctional facilities has, broadly speaking, been researched over the past twenty years, including that related to tuberculosis and HIV/AIDS transmission. K C Goyer's Master's dissertation titled, "HIV/AIDS in Prison: The Public Policy Challenge for South Africa," explores the history of the establishment and development of prisons in South Africa.[30] It also looks at HIV transmission, prevention, and treatment, including tuberculosis, Hepatitis C, and HIV/AIDS prison policies, and it contains policy recommendations. Similarly, Judith van Heerden's (1996) thesis entitled 'Prison Health Care in South Africa: A Study of Prison Conditions, Health Care and Medical Accountability for the Care of Prisoners', explores the quality of health care and conditions of imprisonment in South Africa in the late 1980s.[31] It highlights critical gaps in South Africa's prison healthcare system in the mid-1990s, emphasizing the need for structural reforms, enhanced medical services, and strengthened accountability. Van Heerden argues that the role of District Surgeons, doctors, and nurses in prison is controversial because of the ethical dilemma they are faced with as state employees operating in both the Department of Health (DOH) and the Department of Correctional Services (DCS). She further suggests that the is a strong need for a policy change to separate the clinical duties of doctors and nurses in prison from DCS to DOH, fully deliver healthcare, and establish an unambiguous line of function.[32]

Linda Lydia Manyathi's thesis 'The effects of sentencing HIV-positive offenders to imprisonment' explored the shortcomings Criminal Law Amendment Act 107 of 1997 inside harsh overcrowded South African prisons and their impact on health and HIV prevention and care.[33] Linda Manyathi focuses on how overcrowding further enables gang activities within correctional centres, because violent conditions influence inmates to join gangs who protect them in exchange for sexual favours and tattoos, which involve contaminated blades. This exposes other inmates to HIV infections, and those who are already

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[29] Luyt and du Preez. "Managing Integrated Women After Establishing their knowledge levels of HIV and AIDS." 212.

[30] Goyer, K, C. "HIV/AIDS in prison: the public policy challenge for South Africa." PhD dissertation, 2001.

[31] Van Heerden, Judith. "Prison Healthcare in South Africa: a Study of prison conditions, healthcare, and medical accountability for the care of prisoners." MA Thesis, University of Cape Town, 1996.

[32] Van Heerden, Judith, "Prison Healthcare in South Africa: a Study of prison conditions, healthcare, and medical accountability for the care of prisoner," MA Thesis, *University of Cape Town*, 1996. 205.

[33] Manyathi, Linda Lydia. "The effect of sentencing HIV-positive offenders to imprisonment." PhD dissertation, 2016.

infected become re-infected.[34] Manyathi further proposes solutions to the issue of HIV/AIDS in South African prisons by exploring measures that have been implemented in prisons in the United States to curb the spread of HIV. The thesis emphasises the significance of mandatory HIV testing, HIV education in prison, segregation of HIV-positive inmates, distribution of anti-retroviral drugs to all HIV-positive inmates, and nutrition for ARVs to work more effectively.[35]

Finally, Christine Lindquist's Ph.D. thesis entitled "Health Behind Bars: Utilisation and Evaluation of medical care among jail inmates" deals with prisons in the United States and explores inmates' experiences of higher levels of chronic and acute physical health problems, which increase the utilization of health services in correctional institutions.[36] During her research, she explored the physical health status of 198 males and females incarcerated in a large county jail located in a medium-sized Southern city in the United States.[37] While her findings provide significant information about the health status and disease experienced by inmates, little detail is included about the health care services offered or the personnel providing these.

The overall provision of health care during the apartheid period was also of relevance in historiographically framing the research for this thesis. Laurel Baldwin-Ragaven, Leslie London, and Jeanelle De Gruchy have explored the role of healthcare professionals during the period, highlighting the ethical dilemmas they faced.[38] They further examine how the apartheid laws and policies limited the autonomy of healthcare workers, including doctors and nurses. Although the autonomy of healthcare professionals was limited, some healthcare professionals resisted apartheid and advocated for universal and human rights-based quality healthcare. However, they do not delve deeply into the histories of prison nurses' daily duties and ethical dilemmas. Although nurses working in prisons are described in the book as having had limited autonomy to resist apartheid injustices in prison, as they were employed by the Department of Correctional Services (DCS) and while also part of the Department of Health (DOH).

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[34] Manyathi, Linda Lydia. "The effect of sentencing HIV-positive offenders to imprisonment." PhD dissertation, 2016. 5.

[35] Manyathi. "The effect of sentencing HIV-positive offenders to imprisonment." 40.

[36] Christine Lindquist, "Health Behind Bars: Utilization and Evaluation of Medical Care among Jail Inmates," *Journal of Community Health* 4 (1999): 285.

[37] Lindquist. "Health Behind Bars: Utilization and Evaluation of Medical Care among Jail Inmates". 285.

[38] Baldwin-Ragaven, Laurel. London, Leslie. and De Gruchy, Jeanelle. "An ambulance of the wrong colour: Health professionals, human rights and ethics in South Africa. Juta and Company Ltd, 1999.

The literature discussed above serves as evidence that the is vast knowledge in South Africa about the historiography of prisons. There is, however, a limited amount of literature relevant to prison nurses' experiences; more specifically, there is a need to specifically explore the politics of prison nursing and HIV/AIDS as experienced by the nursing staff who provide care to HIV-positive inmates inside correctional facility clinics. This is something this thesis addresses

The history of the penal system in South Africa

In order to understand Pollsmoor today, we have to situate it in the broader history of prisons in South Africa. In many societies in the past, those found guilty of violating social mores were punished in different ways according to acceptable sanctions. Offenders of social mores were often historically penalized in the form of slavery, banishment, and physical assault, which often resulted in the death of the offender.[39] South African prisons historically operated in ways influenced by the ideas of the 17th-century Dutch judicial practices of the punishment of criminals and the British criminal laws.[40] Under Dutch rule in the Cape, convicted criminals were physically punished, held in chains inside the Dutch East India Company's slave lodge, and forced to perform public work. The detention of criminals only became possible after the establishment of the Fort and the Castle.[41] When the British took over the Cape from the Dutch at the beginning of the nineteenth century, some forms of harsh, cruel punishment of prisoners were relaxed and replaced with "incarceration for a fixed period proportionate to the heinousness of the offences."[42]

In the colony of Natal, which was established in 1843, there are no records of prisons until the establishment of a brick building in 1849 (with ten communal cells), which was later extended to 206 by 1907 due to the increase in the number of offenders.[43] Therefore, this high increase in the number of offenders in Natal resulted in them being overcrowded, with unhygienic prison cells and no classification of offenders. As in the Cape, offenders generally suffered from corporal punishment with a cane, which was later replaced by a whip, in which no trace of

[39] (Van Heerden, "Prison Healthcare in South Africa," 3.
[40] Singh, S. "The historical development of prisons in South Africa: A penologocial perspective. Department of History University of KwaZulu-Natal. (2005). 25-38. 15.
[41] Singh. "The Historical development of prison in South Africa." 18.
[42] Singh. "The Historical development of prison in South Africa." 18.
[43] Singh. "The Historical development of prison in South Africa. 19.

reform existed "because of the lack of scientific knowledge of crime causation and inadequate facilities in the existing institutions".[44]

The first prison in the Orange Free State was established after 1854 in Bloemfontein, and the number of prisons since then kept on increasing to about thirteen in 1873. The first prison of the Transvaal was built in Pretoria in 1865, and by the end of 1893, there were already 33 prisons in the Transvaal under British rule.[45] These prisons followed the British system, and they were no different from those of Cape and Natal; they were overcrowded and operated according to their localized internal systems. One of the biggest prisons in Johannesburg was the Fort.

In a nutshell, prisons in South Africa before the formation of the Union of South Africa used cruel forms of punishment, including whipping of prisoners, forced hard labour, solitary confinement, and dietary punishment, placing heavy restrictions on access to food, and who were provided was of poor quality. There was no one uniform way to regulate prisons - each prison had its own rules and regulations with little reference to the rehabilitation of prisoners.[46]

Of particular relevance to this thesis (given its focus on HIV/AIDS in prisons) is the history of all-male mining compounds: about these, Isak Niehaus argues that in the mining compounds male-male sexual relations were closer to being heterosexual marriages, because they provided the man with the opportunity to become a husband, engage in sexual relations, marry, and provide for his household.[47]

For example, Shangaan miners paid lobolo (bridal wealth) to the brothers of their wives and slaughtered a goat, which formalised their marriage for the duration of their employment contract in the mines. Also, the husband would provide for his wife through buying the wife clothes, shoes, food, and give his wife allowances each month end. Husbands were able to provide for their wives because they were seniors and earned more than their wives. Most marriages took place during public holidays and were strictly hierarchical, and seniority predicted sex roles. Being a husband exaggerated a man’s masculinity and enabled him to be a ‘real man’.

[44] Singh. “The Historical development of prison in South Africa. 19.
[45] Singh. “The Historical development of prison in South Africa. 19.
[46] Singh. “The Historical development of prison in South Africa.” 18.
[47] Niehaus, Isak. “Renegotiating masculinity in the South African Lowveld: narratives of male-male sex in labour compounds and in prisons.” African Studies 61, no.1, 2002, 77-97. 78.

Changes within the South African prison system began to take shape after the creation of the Union of South Africa in 1910, where plans were made for a single system that would regulate the operation of prisons across the country. The first attempt at creating a single prison system in South Africa was the Prisons and Reformatories Act (Act 13 of 1911) and the formation of the Department of Prisons.[48] Following these attempts, the courts heard more cases about prisons in the country, and they came to rule on the rights of prisoners. As a result, there was a change in terms of how prisoners were treated in prison, and the system of 'parole' was introduced, whereby prisoners would be released from prison before they finished their sentence due to their rehabilitation. Racial segregation of prisons, which had emerged in the colonial era, continued in the Union of South Africa and was further entrenched. Nevertheless, as Singh points out, although there were talks about rehabilitation during this period, "…these prisons were not designed to cater for the rehabilitation of offenders but [were] foremost places of punishment..."[49]

With mass urbanization in the 1920s and 1930s, ideas around penal reform began to emerge in South Africa. A closer study of policies relating to prison development and reform during this period has been important to my study to learn more about how such reforms influenced the introduction of healthcare facilities and access to nursing in South African prisons.

It is also important to focus on the late 1990s and the early 2000s, which saw national and international concern raised around the conditions of health care in prison, caused by the HIV/AIDS pandemic, which claimed millions of lives in South Africa. In South African prisons, by 31 December 1999, there were 2,600 registered cases of HIV and 136 cases of Aids, and 1360 cases of tuberculosis.[50] In response to these shocking statistics, the Department of Correctional Services (DCS) reported that there were about 3,427 cases within the reporting period, which means that from December 1999 to 31 March 2000 (three months), there was an increase of 691 cases in HIV/AIDS infection.[51] Likewise, I reviewed policy developments relating to prison reform and access to healthcare in the post-apartheid era, to learn about the

[48] Singh. "The Historical development of prison in South Africa." 21.
[49] Singh. "The Historical development of prison in South Africa." 21.

development of healthcare facilities and access to nursing in South African prisons during this period.

Historicising Pollsmoor Maximum Security Prison

Pollsmoor Maximum Security Prison has been described as having a "modern face with a primitive heart," and Nelson Mandela, the first black South African president, was once held there.[52] It is located in Cape Town in the southern suburb of Tokai. The site where Pollsmoor prison is located has historically served many different purposes, ranging from farmland "Poll's Moor" farm to grow vegetables, to a Grand Prix racetrack in 1937. It was also used as a military camp during the Second World War.[53] The first buildings of Pollsmoor prison were constructed in the late 1940s to house farm labourers and prisoners brought in from Roeland Street Prison in Cape Town because there was overcrowding.[54] By 1959, Polls Moor land was officially reported as being solely for prison use.

The present hard grey concrete building complex of Pollsmoor Prison was built during the early 1960s at the height of apartheid. Therefore, the architectural design of this prison represents the apartheid system of racial separation in the incarceration of offenders.

[52] Filippi, Natacha. Deviance, Punishment, and Logics of Subjectification during Apartheid: Insane Political and Common-law Prisoners in a South African Gaol. (Journal of Southern African Studies, Volume, 37, Number, 2011). 627-643.
[53] Pettit, Kirsty. "Imprisonment of the Human Body: Reforming the System and Lives through Architecture (using Pollsmoor)." MA Thesis, University of Cape Town, Cape Town. 2022. 14.
[54] Pettitt. "Imprisonment of the Human Body." 14.

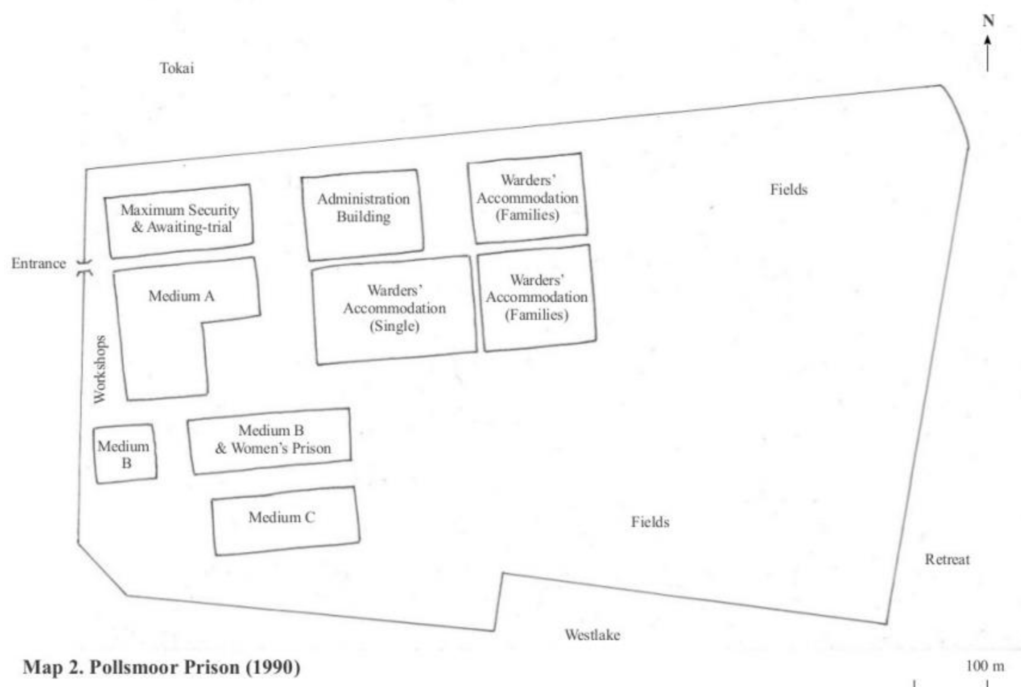

Figure 1: Map of Pollsmoor prison in 1990.

As it stands, Pollsmoor prison has five demarcated facilities: a remand detention facility for awaiting trial prisoners; Medium A, Medium B, and Medium C, which house sentenced offenders; and the juvenile and female prisons.[55]

In 2011, the Baby Mother Unit (BMU) was established to house all pregnant female offenders, mothers, and their babies. This includes a large one-story house with a garden, a picket fence, a kitchen, and a shared bedroom.[56] Mothers and babies are allowed to stay in this unit until the latter turns two years old. This unit has an inside playground area with toys and picture books. Even though it is a few streets away from the maximum-security central Pollsmoor facility, it is surrounded by the houses of correctional officials and nurses. In this unit, nurses provide maternal medical services to mothers and their babies. They assist pregnant offenders giving birth in cases of emergency. In addition, they vaccinate newborn babies, arrange for mothers to see a doctor outside the correctional facility system, and work with social workers to ensure the successful provision of primary healthcare services to mothers and babies.

[55] Constitutional Court of South Africa, "Report: Pollsmoor Correctional Centre – Remand Centre and Women's Centre. Pollsmoor-Prison-Report-23-April-2015-Justice-Edwin-Cameron-FINAL-for-web.pdf.pdf (concourt.org.za) Accessed: 20 March 2024.

[56] Mellow, Diana. "Inside Pollsmoor's special baby-mother unit". News 24 11 October 2016. Inside Pollsmoor's special baby-mother unit | News24 Accessed: 29 March 2024.

During apartheid, inmates at Pollsmoor prison were categorised according to age, gender, race, class, and behaviour. In line with the Classification and Separation of Prisoners' clause of the Prison Act No.8 of 1959:

> 23. (1) (a) Men and women prisoners shall be detained in separate parts thereof and in such manner, as far as possible, as to prevent those of one sex from seeing, conversing, or holding any communication with those of the other sex.[57]
>
> (b) As far as possible, white and non-white prisoners shall be detained in separate parts thereof and such a manner as to prevent white and non-white prisoners from being within view of each other.[58]

Therefore, all white male inmates- those awaiting trial, juveniles, and those who had been sentenced- were separated from 'non-whites', and held in a different section of the same prison, at Medium C. In the early 1990s, women represented ten percent of Pollsmoor's prison population.[59] Consequently, all female offenders were housed in the same building at the Female Prison, but white female offenders were held in single cells. White inmates received more lenient treatment from correctional officials, which included more visits, the quality of toiletries, food, bedding, clothing, and better health services.[60]

During apartheid, discrimination at Pollsmoor prison was not limited to inmates. It was further institutionalised across the correctional services' staff, including nurses. All 'non-white' prison nurses were outranked by white nurses, who were given better pay, promotions, rewards, and fewer responsibilities. There were more black inmates than white, and black nurses had to attend to and treat a large population of sick inmates compared to white nurses, who were only responsible for the treatment and care of the few white inmates. Black nurses were also required to learn fluent Afrikaans so that they could communicate with white prison officials.

In the early 1990s (the beginning of the period focused upon in this thesis), as apartheid was being dismantled, there were extensive reforms to the prison system of South Africa. In 1990, all South African prisons were deracialized, including Pollsmoor prison. This meant that inmates were categorised according to the duration of their sentences, gender, and age, rather

[57] Prison Act No.8 of 1959.
[58] Prison Act No.8 of 1959.
[59] Filippi, Natacha. "Deviances and the Construction of a 'Healthy Nation' in South Africa A study of Pollsmoor Prison and Valkenberg Psychiatric Hospital c. 1964-1994". PhD Thesis, University of Oxford. 2014. 52.
[60] Filippi. "Deviances and the Construction of a 'Health Nation' in South Africa." 51.

than by their race. As a result, all nurses and medical professionals in prison were expected to attend to all inmates' healthcare needs. In the same year, Nelson Mandela, who was also once incarcerated at Pollsmoor Prison, was released from prison together with other political leaders. Additionally, the amendment to the Prisons Act No. 8 of 1959, to the Prisons Amendment Act 92 of 1990, led to the abolition of apartheid in the prison system.[61] A driver of change during this period was the Police and Prison Officers Civil Rights Union (POPCRU), whose members took to the streets to raise their grievances, which included, but were not limited to, the ill-treatment of prisoners, such as conducting full-body searches involving nudity.[62] As described in the following section of this chapter (describing the project's rationale), a human rights-based approach to incarceration became enshrined in post-apartheid South African law.

Today, inmates at Pollsmoor prison are locked in either single or communal cells of a dormitory type. Single cells are used for different purposes, such as separating inmates deemed vulnerable to sexual abuse, LGBTQ+ people at high risk of discrimination, violence and sexual abuse, elderly and juvenile offenders, and requiring protection; isolation for disciplinary purposes and to segregate inmates deemed to be violent or disruptive and those who have contagious sicknesses.[63] Owing to the issue of overcrowding, single cells that measure approximately sixty square feet which are designed for one inmate are then used to lock two to three inmates, which indicates overcrowding. Even though communal cells vary in size, there is overcrowding in all five parts of Pollsmoor prison. Many of these cells have no beds, so inmates sleep on mats that are rolled up during the day.[64] In these cells, there is no privacy, and not all inmates have lockers for private possessions, such as their food, toiletries, and medication. Inmates locked in communal cells share one toilet with twenty to thirty inmates in total, depending on the side of the cell and the number of inmates held there. As a result, many communal cells have terrible odours because of bad ventilation, overcrowding, and insufficient natural light. These conditions pose a high risk for inmates to contract HIV/AIDS, tuberculosis, and asthma, which are some of the illnesses treated by nurses in the prison.

Nurses at Pollsmoor prison provide primary healthcare services to: all females and males, including awaiting trial and sentenced offenders (both able-bodied and disabled); juveniles;

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[61] Singh, S. "The historical development of prison in South Africa: A penological perspective." New Contree, No. 50 (2005), 1-38. 29.

[62] "Recognise POPCRU." South Africa Labour Bulletin, Vol, 17 No. 6. 70-17. LaNov93.pdf (southafricanlabourbulletin.org.za) 70. Accessed: 20 March 2024.

[63] Africa Watch Prison Project. Prison Conditions in South Africa. New York; Human Rights Watch. 1994. 14.

[64] Africa Watch Prison Project. 15.

mothers and babies; inmates who are over the age of 65 years, and those who are mentally ill. In line with section 6 of the Constitution of South Africa on admission to Pollsmoor prison, all inmates are medically examined by the nurse on duty before they are allowed to mix with the general prison population: this has to occur within 24 hours of admission.[65] However, this practice is often not adhered to as some inmates are admitted after nurses have gone off duty, and inmates spend the first night in communal cells. Although there are nurses who work night shifts, nurses' daytime work shift starts at 7 am and ends at 4 pm during the week. To enable the nursing and prison warden staff to leave work at 4 pm, inmates are locked in their cells at approximately 2 pm after they have received lunch and dinner, which are served simultaneously. In cases of emergencies and life-threatening injuries as a result of assault, drug overdoses or suicide, and self-harm, nurses provide hospital referrals. In addition, nurses at Pollsmoor assist pregnant inmates to give birth during emergency labour. In the provision of healthcare services to inmates, nurses at Pollsmoor work together with the prison medical doctors, social and spiritual workers, pharmacists, psychologists, and psychiatrists as part of ensuring the physical and mental health and well-being of inmates.[66]

Gangsterism is a large feature of Pollsmoor prison life, just like any other correctional facility in South Africa. The historical origins of gangs in South Africa can be traced back to the late nineteenth to the early twentieth century in Johannesburg. Here, we can note the role of Mzuzephi Mathebula, known as "Nongoloza", who was a leader of the then biggest gang in Johannesburg, the Ninevites.[67] Nongoloza's gang lasted for almost twenty years, and at its peak in the early twentieth century, it had almost one thousand members. They were known for robbery and the exchange of stolen goods. His gang gained prominence in the mining compounds and prisons of Johannesburg. The Ninevites gang collapsed in 1912 when Nongoloza turned away from his gang and formed an alliance with prison officials. However, by the time Nongoloza's gang collapsed, other leaders of his gang and other gangs had established themselves inside prisons, and they began recruiting new members. By the 1930s, many young black men were arrested in terms of the racist laws of South Africa, and they moved in and out of prisons. This meant that gang culture influenced by the Ninevites became established in almost all prisons in South Africa. Today, such gangs (institutions founded by

[65] The Judicial Inspectorate for Correctional Services, Annual Report for the Period 01 April 2015 to 31 March 2016. 55.
[66] Annual Report Department of Correctional Services 2022/2023. 41.
[67] Steinberg, Jonny. Nongoloza's Children: *Western Cape prison gangs during and after apartheid*. Braamfontein: Centre for the Study of Violence and Reconciliation, 2004. 1-64. 4.

Nongoloza) persist at Pollsmoor prison in the form of both the 26s, 27s, and 28s (known as number gangs) and newer gangs such as the Air Force and the Big Five.[68]

These contemporary gangs all communicate using secret codes, and they have unique symbols, gestures, signs, and tattoos. Most, if not all of them, call each other "Gazilami" (an isiZulu word meaning 'of the same bloodline'); they have different rankings with specific hierarchies and responsibilities.[69] New inmates and non-gang members are called "Mpatha" in isiXhosa or "Franse" in Afrikaans.[70] As in any other South African correctional facility, inmates at Pollsmoor who are not part of a gang suffer from extreme violence and abuse, and they end up joining a gang for protection and for the resources required to survive inside a correctional facility to survive. This means that being part of the gang in this prison is necessary if an inmate wishes to successfully navigate and survive life at Pollsmoor. Unexpected raids of the cells of inmates have revealed dangerous weapons held by inmates, such as knives and other hand-crafted weapons made of toothbrushes, which are used to stab other offenders and correctional officials, including nurses. It is within this highly masculinised and inherently violent environment that prison wardens must maintain control, while prison nurses attend to the healthcare needs of inmates, including the treatment of chronic or infectious diseases, and attend to the health consequences of gang violence and sexual assault.

The development of prisons after 1910

Changes within the South African prison system began to take shape after the creation of the Union of South Africa in 1910, where plans were made for a single system that would regulate the operation of prisons across the country. The first attempt at creating a single prison system in South Africa was the Prisons and Reformatories Act (Act 13 of 1911) and the formation of the Department of Prisons.[71] Following these attempts, the courts heard more cases about prisons in the country, and they came to rule on the rights of prisoners. As a result, there was a change in terms of how prisoners were treated in prison, and the system of 'parole' was introduced, whereby prisoners would be released from prison before they finished their

[68] Hopkins Ruth, "Fear, Force and sex in Sun City," *Mail & Guardian* 29 January 2015, https://mg.co.za/article/2015-01-29-fear-force-and-sex-in-sun-city/, Accessed 10 January 2024.
[69] Schurink, W, J. "The World of the Wetslaners: an analysis of some organisational features in South African Prison," *HomeActa Criminological: African Journal of Criminology & Victimology*, 2 no. 2 (1989), 64.
[70] Kgosana, Rorisang, "How secret communication and codes run prison's Numbers gang one of the crucial aspects of gang life in prison is the secret language called Sabela, which is used to identify a Numbers gang member." Times Live 28 April 2023. How secret communication and codes run prison's Numbers gang (timeslive.co.za) Accessed: 14 March 2024.
[71] Singh. "The Historical development of prison in South Africa." 21.

sentence due to their rehabilitation. Racial segregation of prisons, which had emerged in the colonial era, continued in the Union of South Africa and was further entrenched. Nevertheless, as Singh points out, although there were talks about rehabilitation during this period, "…these prisons were not designed to cater for the rehabilitation of offenders but [were] foremost places of punishment..."[72]

With mass urbanization in the 1920s and 1930s, ideas around penal reform began to emerge in South Africa. A closer study of policies relating to prison development and reform during this period has been important to my study to learn more about how such reforms influenced the introduction of healthcare facilities and access to nursing in South African prisons.

Literature on the history of prison nursing in South Africa

The current literature on the development of penal systems in South Africa in the seventeenth, eighteenth, and nineteenth centuries tells us very little about the health care received by prisoners. Considering the harsh conditions of incarceration and a worldview that saw imprisonment as punishment and deprivation, the healthcare needs of prisoners may have often not been considered at all. Likely, fellow inmates, prison wardens, and possibly slaves or servants of those incarcerated provided what little care might have been received. A schema for this may be provided by Clare Anderson's book *Convicts in the Indian Ocean: Transportation from South Asia to Mauritius 1815-1853,* which describes an incident in a convict camp on the island, where a Eurasian woman and her daughter fell ill. Initially, it was suggested that a slave attend to them; however, the Governor was opposed to this, being concerned about recent slave uprisings in the Caribbean.[73]

Similarly, there is very little on the history of nursing in prisons within the key texts on the development of nursing in South Africa. A review of the three key South African nursing histories, Shula Mark's *Divided Sisterhood: Race, Class, and Gender in the South African Nursing Profession* (2001), Grace Mashaba's *Rising to the Challenge: A History of black nursing in South Africa* (1995) and Charlotte Searle's *The History of the Development of Nursing in South Africa, 1652-1960: A Socio-Historical Survey*. (1965), brought up almost no references to nursing in goal, prison, jail, or to convicts or prisoners. The only example is a brief description in Searle's history about a lack of a State Hospital in the Orange Free State,

[72] Singh. "The Historical development of prison in South Africa." 21.

[73] Clare Anderson, *Convicts in the Indian Ocean: Transportation from South Asia to Mauritius 1815-1853* Great Britain: MacMillian, 2000, 50.

leading all "pauper cases requiring hospitalization to be admitted to the gaols."[74] She goes on to state that, "Arrangements were made with the sisters to care for the sick in the gaols in Bloemfontein and Jagersfontein" with the assistance of convict labour – a system which Searle identifies as the "forerunners of the prison nursing service"[75]

A review of the historiography of nursing in South Africa does, however, reveal much about the development of this profession in general, and the dynamics that have shaped it, as well as the long trend or tradition of nursing being feminised. As discussed later (see p.39-41), nurse training's introduction into the university curriculum was a key development from the 1930s onwards. It is also useful to compare the histories of women nurses in Britain and South Africa during the second world war nursing was associated with young middle-class white women seeking respectable occupations. During this period in Britain, women were allowed to enter this profession, which they then came to dominate in large numbers. They were forced to be more highly qualified than their male counterparts, who were proportionately fewer in numbers than female nurses. In some cases, female nurses were forced to leave their careers upon marriage. By 1943, nursing opportunities were open to women of the lower class who had no educational qualifications and who had worked in low-paying jobs such as cleaning and shop assistance. These women were integrated into the nursing field through the introduction of a non-academic, two-year practical training in the skills of bedside nursing.[76]

Nursing leaders and government health officials used films to attract lots of young women into the field of nursing. This strategy was very successful as young women in Britain formed the majority of the cinema-going audience, and a large percentage of these women came from lower social and economic groups. During the post-war years, nursing was made famous in Britain through films, with nurses appearing as background characters, particularly in hospital dramas, which promoted nursing as a career to do away with the public perception that nursing is a 'hard and dirty job.[77] It was through these films that nursing began to be promoted as a 'feminine ideal', which was governed by rule-bound behaviour instead of projecting an image of focused professional skills and technical knowledge. What was very crucial to nursing

[74] Marks, Shula. Divided Sisterhood Race, Class, and Gender in the South African Nursing Profession. The MACMILLAN Press LTD. London: 1994, 147.
[75] Marks, Shula. Divided Sisterhood Race, Class, and Gender in the South African Nursing Profession. The MACMILLAN Press LTD. London: 1994, 147.
[76] Hallam, J. Vocation to profession Changing images of nursing in Britain. *Journal of Organizational and Management,* vol. 15 (2002). 35-47. 37.
[77] Hallam, "Vocation to profession Changing image of nursing in Britain," 37.

authorities during this period was how nurses looked and acted, rather than knowing about patients' care or demonstrating the skills of nursing practice.[78] As a result, nurses were depicted as young white middle-class women who underwent a process of transformation during training, symbolised by donning the traditional nurses' uniform.

During the 1980s, a large shift took place in the nursing profession in Britain, and many traditional stereotypes were broken. This was because nurses began to demand public recognition for their professional training and technical skills. They began to see themselves as more than "serving their patients" but advocating for their patients' rights to health and well-being.[79] In addition, in Britain, the nursing profession began to be populated by young professionals who studied in university classrooms rather than hospital wards. Although such transformation occurred, public perceptions of nursing remained largely negative, and nursing was viewed as a physically demanding and dirty job. This was proven by the study that was conducted in 1999 about young people's perception of nursing, with the overall outcome from the participants 'perceived nursing as a gender-specific, low-status service occupation that involves limited skill.[80] Male nurses continued to be a minority group within this profession; however, they held higher managerial positions compared to the majority of women.[81]

Nursing in South Africa was introduced during the 19th century by colonial settlers. During the early 19th century, Western nursing was not incorporated into black communities; instead, the care of sick people was the responsibility of older black women. Nursing in South Africa was introduced in the mid-nineteenth century through the establishment of the first black public hospital at King Williams Town in 1856.[82] Dr John Patrick Fitzgerald was appointed by Governor George Grey as the district surgeon, and he began recruiting black men to be trained in elementary nursing. The first black nursing aides to be trained in the second half of the nineteenth century were therefore men. The first nurses to arrive in South Africa in the nineteenth century to serve white communities were, however, women – and they were often connected with religious sisterhoods and mission stations.

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[78] Hallam, "Vocation to profession Changing image of nursing in Britain," 37.
[79] Hallam, "Vocation to profession Changing image of nursing in Britain," 43.
[80] Hallam, "Vocation to profession Changing image of nursing in Britain,"43.
[81] Hallam, "Vocation to profession Changing image of nursing in Britain,"43.
[82] Mashaba, Grace. Rising to the Challenge of Change: A History of Black Nursing in South Africa. JUTA & CO, LTD. 1995. 2.

The entry of black women into the sphere of nursing occurred at the beginning of the twentieth century. Black nursing began to be feminised in South Africa in 1902 when Victoria Hospital in the Eastern Cape reopened and the training of women to be nurses was formally acknowledged. In the beginning, the training of black women to become nurses was more of a domestic training than one of nursing. Women accepted for training were grouped into four categories according to their educational qualification.

Class I: Standard V (seven years of schooling)
Class II: Standard VI (eight years of schooling)
Class III: Standard VI plus T3 certificate (nine years of schooling)
Class VI: Standard V plus experiences as a domestic servant [83]

From the above categories only, women with classes III and VI were considered to be nurses. The first black woman to become a qualified nurse in South Africa and Africa at large was Cecilia Makiwane in 1907 after she passed all of her Colonial Medical Council examinations.[84]

During the nineteenth century in South Africa, nursing was primarily linked with women, with only a few men assuming nursing roles. Despite the presence of male nurses, the profession was predominantly perceived as exclusive to women, who fulfilled nurse-like functions. This is a point raised by Grace Mashaba in *Rising to the Challenge of Change A History of Black Nursing in South Africa*: in her book, she argues that even white men who qualified as nurses (according to the Transvaal Medical Council regulation for men) were confined to industries as it was not feasible for women to work in places such as mines.[85] While Mashaba's book provides a good explanation of the history of nursing in South Africa and how nursing became a feminised profession, as I have stressed above, it mentions nothing about nursing in prison. The gendered nature of the nursing profession is something I describe in this thesis.

[83] Mashaba. "Rising to the Challenge of Change." 12.
[84] Mashaba. "Rising to the Challenge of Change." 26.
[85] Mashaba. "Rising to the Challenge of Change." 27.

The divide between university and hospital-based nursing education in South Africa

Since the 19th and early 20th century, religious institutions were predominantly responsible for nursing education in South Africa. The first formal training courses were set up by an Anglican Sister, Henrietta Stockdale, on the Kimberly diamonds in 1877.[86] Nursing entered the university curriculum in South Africa in the late 1930s, and its introduction was not well accepted, as nursing was largely associated with women's domestic work both locally and internationally. Searle argues that:

> "at first universities considered that nursing was not a fit subject for university, but in time as faculties of commerce and departments of social and domestic science were added, the nurses were quick to point out that the attitude of the universities was inconsistent and that nursing was at least as important to the community as "book-keeping" and domestic science, and that it was in fact part of medical science."[87]

Therefore, nursing was introduced as a course in universities in the early 20th century in South Africa. However, there was a shortage of sister tutors and nurse educators, which resulted in a limited number of young women being accepted to study nursing in universities. By 1935, South African Medical Council and the South African Trained Nurses Association (SATNA) came into an agreement that courses for white nurses intending to qualify as sister tutors would be taught at the University of the Witwatersrand (Wits) and University of Cape Town (UCT) and English was the language of teaching and learning.

Charlottee Searle argued that the professional status of nursing has faced a long history of debates where critics have been classified as "semi-profession" in countries such as the United States and New Zealand because of limited university education and its perceived dependency on medicine.[88] However, such opinions were increasingly challenged by scholars such as Ward Darley (1969) and Charlotte Towle (1954) who argued that nursing met the intellectual, ethical, and autonomous criteria of a profession.[89] These debates were particularly relevant in the South African context, where nursing gained statutory recognition as early as 1891, and the 1944 Nursing Act explicitly referred to nursing and midwifery as "professions." The South African

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[86] Horwitz, Simonne. "The nurse in the University: a history of university education for South African nurses: a case study of the University of the Witwatersrand." Nursing Research and Practice 2011, no.1 (2011): 813270. 2.

[87] Searle, Charlotte. The History of the Development of Nursing in South Africa 1652-1960 (A Socio-Historical Survey). Struik, Cape Town. 1965. 64.

[88] Searl, Charlotte. "The criteria for professionalism in nursing in South Africa. "Curationis, 1(1), 4-8. 3.

[89] Searl. "The criteria of professionalism in nursing in South Africa." 5.

Nursing Council (SANC) is the professional body that is entrusted to set and maintain standards of nursing education and practice, which was established by the Nursing ACT, No.45 of 1944, amended by the Nursing Act, No.50 of 1978, and the Nursing Act 33 of 2005.[90]

The incorporation of nursing into university courses in South Africa also contributed to the recognition of nursing as a profession. Although nursing was seen as a high-status career by many black women, and entry to university to study nursing was opened to both black and white women, a minority of black women were admitted to university because applicants were required to have a matriculation certificate and two years of post-basic experience to be admitted.

In 1951, during the early years of apartheid, the University of Natal Faculty of Medicine was established in Durban, known as 'Durban Medical School' or the first "black only" medical institution offering medical qualifications to black, coloured, and Indian people that were recognised by the country's professional medical bodies.[91] Bongiwe Bolani, who was trained as a nurse at King Edward VIII Hospital during the mid-1950s, recalled how African communities viewed black medical students, doctors, and nurses, saying:

> People were proud of them. They were watched very keenly by the communities… People took interest in their personal lives, [They]… became celebrated, and I believed young people who saw them wanted to be like them.[92]

In institutions where the student body was exclusively black, Venessa argued that a minority of black female students were not accepted because the South African medical profession was deeply gendered in its ideology, discourse, and practices.[93] She continued to highlight that in many medical schools, sexist attitudes were evident in the way lectures were presented to students, stating that it was also reported that some white medical schools' lectures would bring in *Playboy* magazines to class to highlight certain female anatomical features to their students.[94]

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[90] Duma, Sinegugu. "The State of Nursing Regulation." Trends in Nursing, 1(1), 14-24. 14.
[91] Noble, Vanessa. Doctors divided: *Gender, race, and class anomalies in the production of black medical doctors in apartheid South Africa*, 1948-1994. University of Michigan, 2005. 29.
[92] Noble. "Doctors divided". 29.
[93] Noble. "Doctors divided". 277.
[94] Noble. "Doctors divided". 277.

During apartheid, many black female nurses were trained at segregated nursing training schools such as Baragwanath Hospital in Johannesburg and Groote Schuur Hospital in Cape Town. Unlike in universities, student nurses trained in these hospitals received a stipend and did not pay for tuition or accommodation.[95] This encouraged many poor black women who could not afford tertiary education to pursue nursing. For example, Harriet Gwebu, who trained at Baragwanath during the late 1960s, said, "Nursing was my second choice. My first choice was teaching, but my parents could not send me to university, so I went for my second choice… where we got paid (while training)."[96] Although several state hospitals in South Africa offered nursing training to black women at no cost, this free nursing training came at a greater expense to these young black women, who, after finishing high school, had to move far away from their families. Those who came from rural areas for training at Baragwanath Nursing College were forced to adapt to new urban living and work environments, under much more disciplinary and stricter applied, racially divided conditions. Noble quotes an interview with Dr. Mfanyana J. Ndlovu, based at Durban Medical School, having said, "They were making rules for us; the nurse behaves like this; the nurse must dress like this and like that".[97] Although nursing training was free at Baragwanath and Groote Schuur, there was a high dropout rate because of pregnancy during training, and young nurses had difficulties adjusting to the strict hospital rules and environment, including failure in exams due to a lack of language ability.[98] In addition, Helen Sweet has argued that the institutional separation between universities and hospital-based training entrenched a dual system that reinforced inequalities within the nursing profession.[99] University-trained nurses, often white and English-speaking, were given higher status, while black hospital-trained nurses were subjected to more rigid, militarized regimes of control.[100] This was also evident in mission hospitals like McCord Hospital in Durban, which, despite being one of the few institutions to train and empower Black nurses actively, operated within a complex web of Christian duty, racial paternalism, and institutional segregation. As Parle and Noble show, McCord was simultaneously a site of innovation, resistance, and constraint, offering Black women a rare path into professional nursing while also reinforcing

[95] Horwitz. "Baragwanath Hospital, Soweto". 122.
[96] Horwitz. "Baragwanath Hospital, Soweto". 126.
[97] Horwitz. "Baragwanath Hospital, Soweto". 79.
[98] Horwitz. "Baragwanath Hospital, Soweto". 77.
[99] Sweet, Helen, "Nursing and Empire: The Training of Nurses in Colonial Natal, 1880-1920. Journal of African History, 45(3), 393-416. 395.
[100] Sweet. "Nursing and Empire." 398.

certain gendered and racialised hierarchies in the guise of moral discipline and missionary care.[101]

Engaging with key literature on the history of nursing in South Africa

As discussed above, two vital sources that have focused on the history and development of nursing in South Africa are Charlotte Searle's *The History of the Development of Nursing in South Africa 1652-1960* and historian Marks Shula's *Divided Sisterhood Race, Class, and Gender in the South African Nursing Profession.* Charlotte Searle was trained as a nurse and obtained her nursing diploma from the University of the Witwatersrand. Her text gives extraordinary detail and insight into the history of nursing in South Africa. Searle explores the history of women in nursing, medicine, and health care from the early years of the Cape to the twentieth century.[102] She also focuses on the legislation that affected Nursing in South Africa with specific reference to the Orange River colony, the Transvaal Colony, and the Union of South Africa up until the formation of the Nursing Act No. 45 of 1944 and Act No. 69 of 1957.[103]

In her book, Shula Marks unpacks three important factors that have shaped the nursing profession in South Africa over time, namely race, class, and gender.[104] These factors are of paramount importance to the dissertation as they are something I explore in nursing within the prison context. Marks argues that race largely shaped the nursing profession in South Africa, as in Britain and the United States. She argues that in nursing, with its journey towards professionalisation, female nurses fought to gain control of nursing from the male medical profession, establishing professional nursing associations and fighting for representation on the state medical council.[105] In the first chapter of her book 'But Why Nursing?' Marks makes it clear that her book is largely concerned with the politics of nursing in South Africa and how its professionalisation was reinforced over the years and she argues for a focus on the ways it was shaped by the divisions of South Africa in terms of race, class, and gender.[106] In a similar

[101] Julie Pearl and Vanessa Noble, The People's Hospital: A History of McCord's, Durban, 1890s-1970s, Pietermaritzburg, Natal Society Foundation, 2017. 130.
[102] Searle, Charlotte. The History of the Development of Nursing in South Africa 1652-1960 (A Socio-Historical Survey). Struik, Cape Town. 1965. 64.
[103] Searle. The History of the Development of Nursing in South Africa. 229.
[104] Marks, Shula. "Divided Sisterhood Race, Class, and Gender in the South African Nursing Profession." The MACMILLAN Press LTD. London: 1994. 9.
[105] Marks, Shula. "Divided Sisterhood Race, Class, and Gender in the South African Nursing Profession." The MACMILLAN Press LTD. London: 1994. 9.
[106] Marks. "Divided Sisterhood." 13.

vein, Julie Parle and Vanessa Noble have shown how mission hospitals such as McCord Hospital became key sites where Black women were trained as nurses under religious, racial, and gendered structures, spaces that simultaneously enabled professionalisation and reproduced hierarchical control.[107]

The history of HIV/AIDS in South Africa

This thesis discusses nurses' experiences with HIV which when left untreated, can progress to AIDS. This virus attacks a person's immune system, making them vulnerable to opportunistic diseases and infections. So, when a person is diagnosed with AIDS, they have at least two or more opportunistic infections.[108] For a person to know their HIV status, an HIV test is performed by health professionals using blood, urine, or saliva. Results from the test display the presence of HIV antibodies cells that are produced by the body to fight the virus. The "viral load" (number of viruses) of an HIV positive person increases when the virus is not managed through treatment. Consequently, untreated HIV positive people with high viral load can easily transmit the virus to other people. HIV is transmitted in many ways including but not limited to "anal, oral, or vaginal intercourse, from mother to child, before or during birth, tattooing, piercing, and injecting drugs."[109]

The HIV/AIDS epidemic in South Africa, was first reported in 1982 and has since spread at an alarming rate, rendering the country the global epicenter of HIV infections. In 1982, the first case of AIDS in South Africa was reported in a gay man who contracted the virus while in California, United States. Later that year, 250 random blood samples were taken from homosexual men living in Johannesburg, of which a startling 12.8% were infected with the virus. [110] However, instead of prompting a comprehensive response, the apartheid government targeted gay men as spreaders of this deadly, mysterious disease.[111] The apartheid government's homophobia framed HIV/AIDS in South Africa as a disease of immoral and devious gay men, consequently, preventing a comprehensive response against HIV/AIDS

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[107] Julie Pearl and Vanessa Noble. The People's Hospital: A History of McCord's. 129.

[108] Pienaar, P, J, J. "AIDS and the criminal justice officer. *Acta Criminologica: African Journal of Criminology & Victimology*. 1989: 88-92. 89.

[109] Goyer, K, C. "HIV/AIDS in Prison: The Public Policy Challenge for South Africa." MA Thesis, University of Natal, Durban. 2001. 38.

[110] South African History Online towards a people's history. A History of Official Government HIV/AIDS Policy in South Africa. "The HIV/AIDS Crisis Emerges: Responses of the Apartheid Government [A History of Official Government HIV/AIDS Policy in South Africa | South African History Online (sahistory.org.za)] (10 October 2024).

[111] Gevisser, Mark, and Cameron, Edwin. Defiant desire. Taylor & Francis. 1995. 11.

during its infancy.[112] This allowed HIV/AIDS to spread more quickly in the general heterosexual population and high-risk environments such as prisons, which were overcrowded, and a lack of access to effective HIV prevention services.

In the late 1980s to the early 1990s, the strategies that were implemented to curb the spread of HIV/AIDS, such as the provision of condoms, "safe sex" education, were hindered by stigma and discrimination.[113] Cichocki Mark also explains that because the country was amid the dismantling of apartheid, the HIV/AIDS problem was, for the most part, largely ignored by the apartheid government.[114] While political unrest dominated the media, HIV/AIDS began to take a stronger hold, both in the gay community and among black people in general.[115] Between 1990 to 1994, there was a drastic increase in the number of heterosexual infections, with pregnant women transmitting HIV to their infants. The HIV prevalence increased in pregnant women from 0.8 0.8% to 7.6% between 1990 and 1994.[116] The HIV/AIDS crisis seriously affected black people who were already disadvantaged by the policies of apartheid and who lacked adequate access to healthcare services, especially those living in the Bantustan.

It is also important to focus on the late 1990s and the early 2000s, which saw national and international concern raised around the conditions of health care in prison, caused by the HIV/AIDS pandemic, which claimed millions of lives in South Africa. In South African prisons, by 31 December 1999, there were 2,600 registered cases of HIV and 136 cases of Aids, and 1360 cases of tuberculosis.[117] In response to these shocking statistics, the Department of Correctional Services (DCS) reported that there were about 3,427 cases within the reporting period, which means that from December 1999 to 31 March 2000 (three months), there was an increase of 691 cases in HIV/AIDS infection.[118] Likewise, I reviewed policy developments relating to prison reform and access to healthcare in the post-apartheid era, to learn about the

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[112] Grundlingh, Louis. "HIV/AIDS in South Africa: A case of failed responses because of stigmatization, discrimination and morality, 1983-1994. New Contree, 46. 55-81. 61.

[113] Simelela, N. P. and Willem Daniel Francois Venter. "A brief history of South Africa's response to AIDS: history of HIV in SA-Progress towards the Millennium Development Goals." *South African Medical Journal*, 2014, 249-251. 249.

[114] Cichocki, Mark. "History of HIV in South Africa." Very well Health, 05 May, 2020 The History and Prevalence of HIV in South Africa (verywellhealth.com) Accessed: 10 March 2024.

[115] Cichocki. "History of HIV in South Africa."

[116] Karim, Salim s. Abdool, Gavin J. Churchyard, Quarraisha Abdool Karim, and Stephen D. Lawn. "HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response. *the Lancet*, 921-933.

development of healthcare facilities and access to nursing in South African prisons during this period.

The history of AIDS activism

This thesis shows how, in the post-apartheid era, AIDS activists successfully pushed for the roll-out of ARVs in South Africa's prisons in ways that vastly improved nurses' experiences of managing the disease in their prisoner-patients. AIDS activism has a longer trajectory in South African history. Gay activists and homosexual organizations, including the Gay Association of South Africa (GASA), took the issue of HIV/AIDS seriously, even though they were challenged by extreme homophobia and racism.[119] In the 1980s, when HIV/AIDS was strongly associated with homosexual men, gay activists such as Edwin Cameron played an important role defending the rights of people living with HIV/AIDS. From the late 1990s, to combat HIV/AIDS-related stigma and discrimination, gay activists such as Cameron, Simon Nkoli, and Zackie Achmat began to speak openly about their HIV status. According to Mandisa Mbali, early gay HIV/AIDS activists were "patient activists" as some of them were HIV-positive and others were affected by it, having lost loved ones to the condition.[120] In response to the growing rates of HIV/AIDS infection in the country, civil society formed the National Advisory Group (Networking HIV/AIDS Community of South Africa (NACOSA) to advocate for a comprehensive national AIDS strategy. In 1992, NACOSA facilitated an important meeting to discuss and develop South Africa's National Aids Plan, bringing together representatives from the National Party's Ministry of Health, the African National Congress, and the United Democratic Front. In 1994, when the African National Congress (ANC) came into power with Nelson Mandela as the first black president of the Republic of South Africa, the National Aids Plan was adopted within three months of President Mandela's office, endorsed by the then incoming Minister of Health, Dr Nkosazana Dlamini Zuma.[121]

[119] Gevisser, Mark. "A different fight for freedom: A history of South African lesbian and gay organization from the 1950s to 1990s." In Defiant desire, 14-86. Rutledge, 2013. 59.
[120] Mbali, Mandisa. "The treatment action campaign and the history of rights-based. Patient-driven HIV/AIDS activism in South Africa. In Democratising Development, 213-243. Brill Nijhoff. 2005. 227.
[121] Butler, Anthony. "South Africa's HIV/AIDS policy, 1994-2004: How can it be explained?" African Affairs, 591-614. 593.

The formation of the Treatment Action Campaign (TAC) and the 2006 Westville Correctional Center inmate lawsuit to access ARVs

On 1998 December 10, on International Human Rights Day, the Treatment Action Campaign (TAC) was formed in Cape Town by Zackie Achmat, after the death of Simon Nkoli, a South African gay rights and anti-apartheid activist, who died from AIDS-related complications.[122] In 1998, the cost of ARV first-line medication (AZT, 3TC, NVP, DDI, AND D4T) was R450 ($64) per month.[123] Therefore, TAC aimed to widen the access of anti-retroviral drugs for prevention of mother-to-child transmission (MTCT), post-exposure prophylaxis (PEP) after sexual assault, and for use in combination drug therapy.[124] As a movement formed in post-apartheid, TAC used the newly formed political and democratic constitution of South Africa to achieve its aims. Mandisa Mbali argues that TAC builds on the advocacy work of the late 1980s and early 1990s anti-apartheid gay rights activism, such as the emphasis on universal human rights-based discourse and early openness of gay activists about their HIV status, including Simon Nkoli, Zackie Achmat, and Edwin Cameron.[125]

In 2001, TAC was successful at pressuring 41 international pharmaceutical companies to abandon their lawsuit against the South African government preventing them from passing on the amended Medicines Act of 1997; article 15 of this law gave the South African government the right to allow compulsory licensing and parallel importing, which is the importing of cheaper generic version of patented drugs from countries that do not comply with the international trade agreements, namely, the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement.[126] During the court cases, TAC supported the South African government by mobilizing local and international activists' support and global public opinion in favour of the government. Using multiple campaign strategies, including mobilizing people to campaign for the right to healthcare using a combination of human rights education, HIV treatment, demonstration, and litigation.[127] The withdrawal of the lawsuit against the South African government led to the introduction of generic competition in ARV production, and the

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[122] Martin, Yasmine. "'Now I Am Not Afriad': Queer Utopias and Transnational Solidarity." Journal of Southern African Studies, 46(4), no4. 2020. 673-687. 685.

[123] Heywood, Mark. "South Africa's treatment action campaign: combining law and social mobilization to realize the right to health. Journal of Human Rights Practice 1, No. 1, 2009, 14-36. 24

[124] Mbali, Mandisa. "Gay AIDS activism in South Africa prior to 1994. From social silence to social science: same-sex sexuality, HIV & AIDS and gender in South Africa." 2009. 238.

[125] Mbali. "Gay activism in South Africa prior to 1994." 238.

[126] March, Patrick. "Compulsory Licensing and the South Africa Medicine Act of 1997: Violation of Compliance of the Trade Related Aspects of Intellectal Property Rights Agreement," New York Law School Journal of International and Comparative Law 21, No. 1, 2001, 109-126. 109.

[127] Heywood. "South Africa's Treatment Action Campaign." 17.

prices of ARVs significantly dropped from R450 ($64) in 1998, when TAC was formed, to less than R300 ($42) per month in 2007.[128]

In 2002 TAC began pressuring the South African government to adopt a National Treatment Plan to roll out anti-retroviral combination drugs therapy in the public sector, shortly after its victory when the constitutional court, arbiter of the constitution, declared the government's failure to provide a comprehensive programme to prevent mother-to-child transmission (PMTCT) of HIV "unreasonable and unconstitutional" and order the government to supply the ARV nevirapine to prevent transmission of the virus by mother to newly born children.[129] Since its establishment in 1998, TAC has grown in size, scope of activities, and funding. By 2003, TAC had full-time employees, administration, and donor-funded programmes. Most of its funding came from the church aid programmes (such as Bread for the World) and Atlantic Philantrophies, a United States based private foundation, they did not accept any donations from the South African government, pharmaceutical companies, and USAID because "it is seen to promote the interest if the US government."[130]

South African prisons, including Pollsmoor prison, have been said to be a breeding ground for opportunistic diseases, which tend to shorten the progression from initial HIV infection to full-blown AIDS.[131] Although inmates have a history of receiving medical care in prisons, in the early 2000s, HIV-positive inmates had no access to anti-retroviral treatment inside prisons, including those who qualified for treatment according to the government guidelines recommending that patients start ARV treatment once their CD4 count drops below 2000.[132] In 2006, TAC and the AIDS Law Project (ALP) assisted fifteen HIV-positive inmates from Westville Correctional Centre, to pressure the Department of Correctional Services (DCS) to remove barriers those inmates (and other qualifying inmates) from accessing ARV treatment in prison, in a lawsuit *EN and Others v The Government of South Africa and Others*.[133] This litigation marked a significant change and improvement in the management of HIV/AIDS in prison, and it is discussed in detail in chapter three on NGOs and the management of HIV/AIDS

[128] Heywood. "South Africa's Treatment Action Campaign." 18.
[129] Friedman, Steven, and Mottiar, Shaun. "A rewarding engagement? The treatment action campaign and the politics of HIV/AIDS." Politics & Society 33, No. 4, 2005, 511-565. 514.
[130] Friedman and Mottiar. "A rewarding engagement." 517.
[131] Singh, Shanta. "Prison inmate awareness of HIV and AIDS in Durban, South Africa. Sociological bulletin, 57, No. 2, 2008, 193-210. 205.
[132] Singh. "Prison inmate awareness of HIV and AIDS in Durban." 205.
[133] Muntingh, Lukas, and Mbazira, Christopher. "Prisoners right of access to anti-retroviral treatment." 2006. 14.

at Pollsmoor prison. The chapter deals with the involvement of NGOs, health activists, and social movements in the management of HIV/AIDS in prison.

Understanding gender, MSM, sex, and sexuality in prison

Historically, same-sex desire inside South African correctional facilities has been largely ignored, and the existence of men having sex with men (MSM) has been denied, and they have been punished by the Department of Correctional Services (DCS). In apartheid South Africa, same-sex desire and male rape victims were criminalised, demonised, and not even acknowledged. The Immorality Amendment Act of 1969 strictly regulated sex between men and adjusted sexual offences by men to girls, through the amendment of the Immorality Act of 1957, which was renamed the Immorality Amendment Act of 1988, called the Sexual Offences Act 1957.[134] The amendment specific to sex between men was Section 0A of the 1957 Act, stating:

> A male person who commits with another male person at a party an act which is calculated to stimulate sexual passion or to give sexual gratification shall be guilty of an offence.
>
> For subsection (1), 'a party' means any occasion where more than two persons are present.[135]

This law further stated that people who are in same-sex relationships could be imprisoned for up to two years.[136] Still, in post-apartheid South Africa, before 1998, anal or oral sex between men was a crime even though it was consensual. As a result, the distinctions between consensual same-sex and violence inside and outside correctional facilities became blurred. Criminalisation of same-sex and homophobia in South Africa largely contributed to sex among inmates being one of the least understood subjects because of the persistent stigma and taboo associated with same-sex desire and rape. Even after more than twenty years of these laws being scrapped, their legacy still lives on.

Gear argues that in the early 2000s, after the decriminalisation of same sex in South Africa, DCS did not have clear policies on male-to-male sex and sex crimes.[137] Correctional officials,

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[134] da Costa Santos, Gustavo Gomes. "Decriminalising homosexuality in Africa: lessons from the South African experience." Downloaded from the Humanities Digital Library. 2013. 313- 338. 317.
[135] Da Costa Santos. "Decriminalising homosexuality in Africa." 317.
[136] Da Costa Santos. "Decriminalising homosexuality in Africa." 317.
[137] Gear, Sasha. "Behind the bars of masculinity: male rape and homophobia in and about South African men's prisons." Sexualities 10, no.2. 209-227. 215.

including nurses and inmates, became confused about what was allowed and not allowed. As a result, the was a division between correctional officials and inmates on whether same sex sexual encounters in prisons were officially prohibited or allowed in terms of the South African constitution.

Not all men who engage in sexual activity with other men define and understand themselves to be gay: this is also the case in prisons. It is for this reason that public health researchers developed the term men who have sex with men (MSM) in 1992, to capture a range of male-male sexual behaviours and avoid characterisation of the men engaging in these behaviours by sexual orientation (homosexual, bisexual, heterosexual, or gay) or gender identity (male, female, transgender, queer).[138] MSM includes gay-identified men, heterosexually identified men who have sex with men, bisexual men, male sex worker who can have any sexual orientation, men engaging in these behaviours in all male settings, such as prisons, and the rich and wide array of traditional identities and terms for these men across cultures and subcultures.[139]

MSM have a higher rate of contracting HIV/AIDS and other sexually transmitted infections. UNAIDS considers gay men, MSM, sex workers, transgender people, people who inject drugs, prisoners, and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to healthcare services.[140] MSM around the world and in South Africa have been disproportionately affected by HIV/AIDS due to a combination of structural, biological, social, and behavioural factors that increase their vulnerability to HIV infection.[141] The risk of HIV/AIDS infection is higher inside correctional facilities because of inmates' high-risk behaviours, including unprotected and unlubricated anal sex, rape, sharing of unsterilized tattooing equipment, and injecting drugs, all of these risk behaviours are discussed in detail in chapter 2, which deals with the nurses' experiences in managing HIV at Pollsmoor Prison.

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[138] Bearer, Chris. Baral, Stefan D. Van Griensven, Frits. Goodreau, Steven M. Chariyalertsak, Suwat. Wirtz, Andrea L. Brookmeyer, Ron. "Global epidemiology of HIV infection in men who have sex with men." The Lancet 380, No. 9839, 2012, 367-377. 367.

[139] Beyrer. Baral. Van Griensven. Goodreau. Chariyalertsak. Wirtz. and Brookmeryer. "Global epidemiology of HIV infection in men who have sex with men." 367.

[140] UNAIDS Global AIDS Monitoring. "HIV and gay men and other men who have sex with men." 2024. https://www.unainds.ord=g Accessed: 15 January 2025.

[141] Rispel, Laetitia Charmaine, Carol Ann Metcalf, Allanise Cloete, Vasu Reddy, and Carl Lombard. "HIV prevalence and risk practices among men who have sex with men in two South African cities. JAIDS Journal of Acquired Immune Deficiency Syndromes, 2001, 69-76. 69.

Referring to the present day, the nurses from Pollsmoor prison interviewed for this research acknowledged that male inmates are having sex with other male inmates inside their prison cells, whether it was consensual or coerced. In addition, some male offenders were secretly and openly in romantic sexual relationships with other male offenders. All these male offenders involved with other male offenders were reported by nurses to have considered themselves as 'straight' men and not gay. One of the participants, Sister Fefe, mentioned during the interview that some inmates were open to her about their sexuality and sex life, and they requested couple testing and condoms, although romantic relationships among inmates were not allowed in DCS. Nevertheless, according to the nurses interviewed, not all inmates felt free to talk about their sexuality and sex life at Pollsmoor prison, especially those who had been sexually abused in their cells.

Sex and gender in prison and the mining compounds

Hegemonic constructions of gender that prescribe conformity with the 'heterosexual matrix' play a significant role in defining gender into categories that exist in opposition to each other (ie, "man versus woman").[142] This includes all hierarchical relationships where a man is looked upon as the leader or head of the house and the woman is subordinate. At Pollsmoor prison, as in the mining compounds of Johannesburg, gender is defined according to this framework whereby an inmate who is 'new and younger in most cases' and has sex with another inmate, whether coerced or consensual, is referred to as a 'woman.' This makes the inmate who dominates and penetrates during sexual intercourse a 'man' and the one who receives penetration a 'woman', in ways which bear similarity to mine marriages in mining compounds (discussed above).

In prison, a typical path for a male offender to become a 'Wyfie/women' is through accepting food given by another inmate: in most cases, the inmate giving another inmate food, protection, or drugs belongs to a gang ruling the cell. By accepting these prison 'luxuries', the offender gets himself into a debt that has to be paid back through sex at night.[143] Most inmates, who become Wyfie/women, are new offenders who have no idea of prison cultures and traditions. As in the mining compounds, Gear argues that according to dominant inmate culture, 'marriages' are the 'correct' place for sex to occur because 'men' penetrate, and 'women' are

[142] Gear, Sasha. "Behind the bars of masculinity: male rape and homophobia in and about South African men's prisons." Sexualities 10, no.2. 209-227. 214.
[143] Gear, "Behind the bars of masculinity." 217.

their passive receivers.[144] Van Onselen argues that in the mining compounds black men were denied the right to family life, as a result, homosexuality played its part, but not in a western cultures but as a an expression of personal sexual 'preference', because of the deprecation experienced within the confines of a 'total institution.'[145] Similarly, Dunbar Moodie argues that homosexual 'mine marriages' were superficial marriages, where the subordinate had to play the 'feminine' part.[146] Moodie argues that since traditional marriages were not romantic or compassionate relationships, and people were marrying to build an '*umuzi*'. Mine marriages allowed a younger man to accumulate more money to pay *lobola,* bridal wealth, and build 'umuzi' or increase their cattle and maintain their families and social status back at home. [147]Achmat has questioned this point of view, arguing that these new forms of power were established because of colonialism, and men became no longer bound to their reproductive functions to secure wealth and status.[148] He continues to state that mining compounds and correctional facilities became a new environment for sexual desire, where non-reproductive sex attained new validity.

According to the nurses interviewed, another motive for prisoners to engage in same-sex relationships is transactional. Transactional sex is influenced by the balance of power in prison and the desire for protection from other offenders. The inmates who engage in sexual activity sometimes do so for food, cigarettes, drugs, toiletries, and money. Gear warns about transactional sex in prison, saying that, "the line between coercion and consent can be particularly blurred in prison…largely because of the commodification of sex in that context (where sex is exchanged for any number of necessities or luxuries)."[149] The inmates who engage in transactional sex at Pollsmoor prison include both offenders who have sexual relations with people of the same sex and define their sexual orientation as gay or bisexual. By contrast, some offenders understand themselves to be heterosexual but engage in transactional same sex intercourse in prison for survival.

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[144] Gear, "Behind the bar of masculinity." 217.
[145] Van Onselen, Charles. "Crime and Total Institutions in the Making of Modern South Africa: The Life of Nongoloza'Mathebula, 1867-1948. In *History Workshop*, 62-81. Edited Collective, History Workshop, Ruskin College, 1985. 76.
[146] Moodie, Dunbar, T. "Migrancy and male sexuality on the South African gold mines." *Journal of Southern African Studies* 14, No. 2, 1998, 228-256. 249.
[147] Moodie. "Migrancy and male sexuality on the South African gold mines." 249.
[148] Achmat, Zackie. "Apostles of civilized vice": Immoral practice' and 'unnatural voice' in South African prisons and compounds, 1890-1920. Social Dynamics 19, No.2, 1993. 92-110. 105.
[149] Moolman, Benita, "Carceral dis/continuities: Masculinities, male same-sex desire, discipline, and rape in South African prisons. Gender and Behaviour, 2013: 6742-6752. 6746

Section for 'gay inmates' at Pollsmoor Prison Medium A

Gay inmates at Pollsmoor prison qualify to be locked at Medium A, a separate section for vulnerable LGBT inmates commonly known as a 'gay section,' according to one of the nurses during the interview conducted for this research. Mr Hlophe explained that Medium A is divided to house all inmates considered vulnerable by DCS, including gay people, referring to LGBT offenders, inmates above the age of 50 years, and young and juvenile inmates. In addition, he stated that gay people are housed in their section as a measure of protecting them from sexual assault by the general offender population. However, inmates must first come out as gay to any correctional official on duty during the initial intake process (where they are searched and medically screened). It's important to highlight the fact that this process excludes inmates who fear revealing their sexuality because of homophobic stigma and discrimination.

Russell Robinson argues that in correctional facilities construction of gay, bisexual, and transgender identities reveals the hegemony among people who often are thought to constitute a singular, cohesive LGBT community, and this is the case at Pollsmoor prison.[150] For this research, inmates were not interviewed to speak about their experiences in prison and HIV/AIDS healthcare services, and this was because the study focused on the experiences of nurses and their role in managing HIV/AIDS at Pollsmoor prison. Therefore, the interviews conducted with nurses working at Pollsmoor prisons, including interviews with clinical and non-clinical practitioners from TB and HIV Care, revealed a conflation and the interchangeable use of terms such as men who have sex with men (MSM), gay and homosexual, and transactional sex. This conflation points to healthcare professionals, nurses, and doctors at Pollsmoor prison, sometimes limited understanding of inmates' sex lives inside their cells. This can also be linked to inmates not talking enough to healthcare professionals about their sexuality and sex life.

Structure of the thesis and chapter outline

My research includes five chapters that weave together the histories and lived experiences of nurses working at Pollsmoor Maximum Security Prison. The study explores their role and contributions in managing HIV/AIDS inside a correctional facility during several critical moments in South African history, including the transition from apartheid to democracy and prison transformation during the period when AIDS policy was dominated by Mbeki's

[150] Robinson, Russell K. "Masculinity as Prison: Sexuality Identity, Race, and Incarceration." California Law Review, 2011, 1309-1408, 1315.

denialism. Although the histories belong to the fifteen nurses interviewed for this research, their stories have similar themes. The lived experiences, histories, and stories of these nurses not only provide us with a unique understanding of the past, but they also help us uncover the narratives and realities of correctional nurses from their perspectives.

Chapter one serves as the introductory chapter of the thesis, outlining the thesis rationale, broader problems and issues, aims and objectives of the study, methodology, ethics, limitations of the study, literature review, and thesis structure. Chapter two explores the complexities nurses faced when providing healthcare services to inmates operating in two systems, namely, the Department of Correctional Services (DCS) and the Department of Health (DOH), from apartheid to the present day at Pollsmoor prison. It begins by examining the Prison Act No. 8 of 1959, which influenced the provision of healthcare and further institutionalized racial discrimination and segregation. It also reinforced the militarization of prisons. Through careful analysis of this legislation, chapter one reveals how strict apartheid racial laws and militarized prison institutions challenged everyday nursing practices and uncovers how the use of force to maintain order inside correctional facilities, combined with the lack of resources, compromised nurses' ability to meet their ethical obligations. The second half of chapter one discusses how prison reform impacted healthcare professionals and the demilitarization of correctional facilities in 1996. Finally, chapter one investigates nurses' working conditions, mental wellbeing, and their relationship with correctional officials and inmates.

The primary focus of chapter three is on the management of HIV/AIDS at Pollsmoor with specific reference to the late 1990s to the early 2000s during the height of AIDS denialism and in a context where there were significant prison reforms to address the legacies of apartheid including inmates limited access to healthcare services, harsh prison condition, overcrowding and racial disparities in incarceration. This chapter begins with examining the first policy introduced by the Department of Correctional Services (DCS) in response to HIV/AIDS in 1992, and it reveals that this policy was conservative and included forced segregation of HIV-positive inmates: a policy which was later repealed. In addition, this chapter explores four major risk factors for HIV transmission in prison: violence and tattooing; substance abuse; overcrowding; and consensual and coerced sex. Chapter three also explores how nurses experienced challenges in managing HIV/AIDS inside Pollsmoor before the roll-out of combination Anti-Retroviral (ARV) therapy. Finally, this chapter looks at the distribution of ARVs, HIV education, issues of stigma and confidentiality, including the challenges of providing inmates with condoms.

Chapter four explores the involvement of NGOs, HIV/AIDS activists, and healthcare professionals in advocating for inmates' access to HIV/AIDS treatment and care in prison and in the management of HIV/AIDS at Pollsmoor. First, this chapter tracks how the Treatment Action Campaign (TAC) used litigation and campaigns to effectively advocate for access to ARV treatment in South Africa, in a context of Mbeki's denialism. It further explores the realities and difficulties inmates struggled with in accessing HIV treatment and care in the early 2000s by focusing on Pollsmoor and Westville Correctional Centre (WCC) as case studies. The second half of this chapter focuses on changes in the management of HIV/AIDS at Pollsmoor prison, as a result of activist litigation against the Department of Correctional Services (DCS). With insights from the nurses, this chapter shows how HIV-positive inmates' access to healthcare services and nurses' working conditions improved thereafter, with specific reference to: the establishment of Ubomi HIV/AIDS specialized clinic; the provision of HIV/AIDS education and training; capacity building and inmate peer education. Finally, chapter four addresses the issues of cultural and traditional beliefs held by inmates at Pollsmoor prison about Voluntary Medical Male Circumcision (VMMC) and the introduction of Pre-Exposure Prophylaxis (Prep) as a measure introduced to reduce HIV transmission. Finally, Chapter Five concludes the thesis by summarizing key findings and providing possible areas of further research.

Chapter 2: The Dual System of the Department of Correctional Services and the Department of Health

Introduction

This Chapter explores the complexities of nursing in a dual system, examining how the Prison Act No. 8 of 1959, in particular, influenced the working conditions and experiences of nurses at Pollsmoor prison since its passage into law. This piece of legislation allowed for the provision of healthcare inside correctional facilities. It also introduced apartheid laws of discrimination and segregation of race and ethnicity into prisons, in line with the Population Registration Act 1950 (Act No. 30 of 1950). The issues of violence and human rights violations were compounded by the fact that this legislation administered correctional facilities as military institutions and restricted any writing about prison conditions and realities until 1992, when it was amended. The first three sections of this chapter explore the responsibilities and ethical dilemmas of nurses working in a militarised correctional facility during apartheid.

This fourth section of this chapter discusses the issues that came with prison reform for healthcare professionals and the demilitarization of correctional facilities in 1996. As this section and those after show, despite the efforts to reform correctional facilities, Pollsmoor prison infrastructure and resources remain inadequate. This chapter examines the challenges faced by nurses providing healthcare services and managing HIV/AIDS at the RDF (Remand Detention Facility), where gross human rights violations and torture of inmates occurred.

Furthermore, this chapter delves into examining the ongoing dilemmas that arise from working inside a correctional facility clinic that is not conducive to providing healthcare services and where security concerns and healthcare priorities often clash. The presence of security wardens inside consultation rooms continues to undermine an ethical principle faced by health professionals working with people living with HIV (patient confidentiality). Moreover, detailed discussions are included about the training offered to nurses upon assuming employment at Pollsmoor prison. The following sections of the chapter then discuss the induction process, nurses' daily ethical dilemmas, the lack of their professional autonomy, as well as the issue of occupational stress and trauma.

Finally, by examining the historical context and post-apartheid contemporary realities of nursing in this dual system, this chapter sheds light on the persistent challenges faced by nurses at Pollsmoor Prison Clinic in managing HIV/AIDS. One of my findings is that the relationship

between nurses, security wardens, and inmates is influenced by multiple factors, including old prison legislation, prison gangs, and the fear of unpredictable inmates' behaviour.

Nursing in correctional facilities during apartheid

During the apartheid period, nurses were full-time, paid healthcare workers at the Department of Correctional Services (DCS). As DCS employees, they assumed a paramilitary ranking status and were required to salute a 'senior official.' As custodial officers, uniforms formed a big part of everyday reality at work because they symbolized authority and hierarchy, differentiating between correctional officials, nurses, and inmates.[151] Nurses were oriented and trained based on the old colonial and apartheid-influenced DCS ideologies of punishing inmates instead of rehabilitating them. As custodial officers, there was confusion about their caring role, which undermined the situation of trust between them and their inmate-patients.[152] Baldwin-Ragaven, London, and De Gruchy argue that health professionals (nurses, doctors, dentists, and psychiatrists) working in correctional facilities during apartheid found themselves, on many occasions, compromised in following their professional codes of conduct by operating in favour of their employer, DCS.[153]

Nurses acted as a 'middleman' between inmates and doctors because they were responsible for assessing inmates' health status to check if they were 'sick enough' to be referred to a doctor, or if they could treat the inmate themselves. In addition, they were in charge of managing inmates' medication and involved in maintaining and restoring order and discipline through corporal punishment. As stipulated in the Prison Act, No. 8 of 1959 (hereafter the Prison Act (1959), Section 36, "Infliction of Corporal Punishment"):

> Corporal punishment shall not be inflicted before the medical officer has examined the prisoner and has certified that he is in a fit state of health to undergo such punishment... After the prisoner has been certified. By the medical officer to be fit for corporal punishment, the punishment shall be inflicted in private in a prison in the presence of the medical officer. The medical officer shall immediately stop the infliction of any further punishment if it appears to him during the infliction of the corporal punishment that the prisoner is not in a fit state of health to undergo the remainder thereof and shall certify that fact in writing.[154]

[151] Baldwin-Ragaven, Laurel, Leslie London, and Jeanelle De Gruchy. An ambulance of the wrong colour: Health professionals, human rights and ethics in South Africa. University of Cape Town Press. 1999. 82.
[152]. Baldwin-Ragaven, London and De Gruchy. "An ambulance of the wrong colour". 82.
[153] Baldwin-Ragaven, London and De Gruchy. "An ambulance of the wrong colour". 82.
[154] Department of Prison. Republic of South Africa. Prison Act No.8 of 1959. 26 March 1959.

Therefore, during apartheid, when correctional facilities were still operating under military rules, nurses overlooked the conditions that endangered the health and safety of inmates to adhere to the rules and regulations of their employer (DCS). To ensure that the general public was unaware of the realities of health care and issues in correctional facilities, the Prisons Act (1959) strictly controlled any writing and media reports on prison conditions as follows:

> Any person who publishes any false information concerning the behaviour or experience in prison of any prisoner or ex-prisoner or the administration of any prison, knowing the same to be false, or without taking reasonable steps to verify such information… shall be guilty of an offense and liable on conviction to a fine…or to such imprisonment without the option of a fine, and the court convicting any person of an offense…, [can] declare the sketches or photographs and the negatives from which such photographs that were taken to be forfeited to the State.[155]

Racism and discrimination at Pollsmoor prison

During the apartheid period, prison facilities in South Africa operated under a strict military, racist system. Existing racial segregation within prisons was concretised in line with the Population Registration Act, 1950

> In every prison, men and women prisoners shall be detained in separate parts thereof and in such manner as far as possible to prevent those of one sex from seeing, conversing, or holding any communication with those of the other sex; wherever practicable, non-white prisoners of different races shall be separated.[156]

As a result, at Pollsmoor prison, 'non-white'[157] White inmates were held separately and out of sight from one another. All non-white inmates were locked in overcrowded communal cells while white inmates were locked at Medium B, the old white sections with single cells.[158] During apartheid, white inmates at Pollsmoor prison had access to healthcare services, which were much better than those of non-white inmates.

The differential treatment along racial lines also affected health professionals and prison officials. All white medical and prison officials automatically outranked their black colleagues, who were forced to accept the prevailing racist ideology to succeed in the institution. Non-white nurses had to provide medical services to a large population of inmates compared to

[155] Department of Prison. Republic of South Africa. Prison Act No.8 of 1959. 26 March 1959.
[156] Department of Prison. Republic of South Africa. Prison Act No.8 of 1959. 26 March 1959.
[157] I am against the use of this racist term. It is used to reflect the apartheid government policies at the time.
[158] Dissel and Kollapen. "*Racism and Discrimination in the South African Penal System*". 65.

white nurses, who were only responsible for the health services of a few white inmates. In addition, non-white nurses employed at Pollsmoor prison were required to learn to speak and write in Afrikaans so that they could communicate with their white colleagues and the prison authorities. In an interview conducted with Sister Rululu, she reflected on the language-related challenges she faced when she started working at Pollsmoor prison, saying, "The first challenge for me here at Pollsmoor prison clinic was Afrikaans because about 70 percent of the people working here and inmates were speaking Afrikaans."[159]

She also described the challenges she faced while working with people of different races, saying;

> For me, it was a challenge working with other people from different races because, in the Eastern Cape, where I grew up, studied, and worked around one large group of black people. Another challenge for me when I started working here was that inmates came to me, and some of them were illiterate and only knew their home language, Afrikaans; so, I had to learn this language quickly so that I could survive and keep my job here. I then mastered all of their complaints in Afrikaans, even if I mixed them along the way, I ended up knowing exactly what they wanted.[160]

Despite encountering language barriers inside a predominantly Afrikaans and English medium Pollsmoor prison, sister Rululu noted that her isiXhosa language was beneficial to other non-Afrikaans speaking inmates, saying;

> It was also advantageous for some of the black inmates because our clinic was the first one where some of the black inmates could relate to someone speaking a language other than Afrikaans. I was the first black female nurse to work in that clinic in 2008. I also taught my colleagues some basic Xhosa language like (Molo, Tata, Mama, Buti) so that they can communicate with non-Afrikaans speaking prison officials and inmates with respect.[161]

Pollsmoor prison had a residential area for all prison officials, including health professionals working a night shift. Inside the residential area, non-white and white prison officials and nurses lived separately in markedly different standards of houses during apartheid. Non-white nurses and security wardens were prevented from using certain prison facilities, such as the golf course and other recreational facilities that were set aside for the exclusive use of their

[159] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.
[160] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[161] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.

white colleagues.[162] The issue of racism at Pollsmoor prison was not limited to that between black and white workers, but also between coloured and black employees.

Currently, there are many coloured and black people employed in this facility. Amada Dissel and Jody Kollapen argue the reasons behind this, stating that after the period of transition in the DCS, many white employees did not accept the changes and left the service, many on voluntary retrenchment, others on 'stress leave', and others refused to be managed by black or coloured people.[163] When speaking about contemporary racial issues at Pollsmoor prison among nurses and prison officials, Nurse Grey from Pollsmoor prison said in an interview that:

> I don't want to lie, this is the Western Cape, it is its own Republic, it had deep-rooted issues of color. Some of us were trained as nurses in the Eastern Cape, and sometimes we were looked down on because of where we came from and the color of our skin.[164]

He added that racial differences among employees at Pollsmoor prison are noticed and as nurses, they engage in activities to activities and programs to diffuse racial tensions among themselves, saying,

> We then tried to diffuse the elements of looking down on each other because of race by doing activities together, like team building. Also, in terms of placement, because we are in the Western Cape and most of our patients were colored and black, we tried and made sure that the is a colored nurse and a black nurse in each prison clinic.[165]

The transition from Apartheid and the military context

Efforts at prison reform commenced in 1990 when the Department of Prisons was renamed Department of Correctional Services (DCS) with Adriaan Vlok as the Minister of DCS, and he was later replaced by Sipho Mzimela in 1994.[166] Also, in 1990, many political prisoners were released from prison. From 1990-1994, many legislative amendments were passed. Among these were: the removal of any references to racial discrimination, which ended apartheid rule and oppression in correctional facilities; the introduction of legislative provisions on correctional supervision; the establishment of correctional boards and a relaxation of the use of prison labour to enhance commercial activities. Additionally, the first policy to address HIV/AIDS in South Africa was formulated in 1992 and was based on "fear, lack of knowledge,

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[162] Dissel and Kollapen. "*Racism and Discrimination in the South African Penal System*". 22.
[163] Dissel and Kollapen. "*Racism and Discrimination in the South African Penal System*". 47.
[164] Grey Bulelwa Boniswa, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[165] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[166] Muntingh. "An Analytical Study of South African Prison Reform After 1994".100

and prejudice." This policy will be discussed in depth in Chapter 3. With the transition to a new democratic South Africa based on the principles of equality and racial transformation of the prison staff corps, human rights issues became increasingly important between 1990 and 1994. This was evidenced by the staff of the Department being involved in various incidents of industrial actions where the trade union Police and Prisons Civil Rights Union (POPCRU) was frequently at the forefront.[167]

Furthermore, the new 1993 Interim Constitution and the later final 1996 Constitution made the prison system have an entirely new environment, a new set of demands, and fundamentally different operational requirements.[168] In effect, it delegitimized the existing order and called for the transformation of the prison system.[169] Another significant prison reform of post-apartheid was when the Prison Act of 1959 was changed by the Amendment Act 79 of 1996 to:

> Regulate the transformation of the Department of Correctional Service into a non-military institution and for the purpose, to delete certain definitions and to replace or insert certain others; to abolish the Correctional Service Force; to make further provision for the early retirement of Correctional officials; to make further provision regarding canteens at prisons; and to delete the provision in respect of infliction of corporal punishment and detention of judgment debtors; and to provide for matters in connections therewith.
>
> Amendment of section 2 of Act 8 of 1959, as substituted by section 2 of Act 122 of 1991. There shall be a department to be styled the Department of Correctional Services, consisting of (members who shall be known as] correctional officials and who, (a)have been appointed as commissioned officers under section 4; I 0 (b) have been appointed as members, other than commissioned officers, under section 8; and (c) are members of the reserve force in terms of section 9B.[170]

On 1 April 1996, DCS was officially demilitarized. All medical professionals, including nurses, were no longer required to follow strict military rules. Another important change that followed those of de-racialisation and demilitarisation was the replacement of healthcare from military to Primary Healthcare at Pollsmoor prison in 2008, which will be discussed in depth in the following chapter.

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[167] Muntingh. "An Analytical Study of South African Prison Reform After 1994". 111.
[168] Muntingh. "An Analytical Study of South African Prison Reform After 1994". 24.
[169] Muntingh. "An Analytical Study of South African Prison Reform After 1994". 24.
[170] Republic of South Africa, Act 79 of 1996, Correctional Services Second Amendment Act.

Nurses' expectations and induction in the early 2000s

Since 1994, newly hired nurses at Pollsmoor prison have undergone a comprehensive induction process upon commencement of work, facilitated by the head of nursing, who is currently Mr Hlophe. During induction, nurses are taught about prison policies and safety processes. Before they start working in their designated centers, nurses are rotated every week to a different centre to foster familiarity with the facility layout and the work culture in different centres. This induction enables nurses to form relations with their new colleagues from different centers, and transition from the Department of Health (DOH) to the Department of Correctional Services (DCS). Despite acknowledging the significance of the induction, nurses noted that no amount of preparation could fully prepare them to work in prison. Reflecting on her first day at work in the early 2000s, sister Fefe shared feelings of fear, saying,

> On my first day, I was anxious because of the environment and all the stories I had heard before about things in prison and things I saw in prison on television. I also questioned my decision to work here after I saw how things are here.[171]

She continued to say, "After I started working, I got used to it, but with prison, you cannot say you are used to it. Anything can happen here anytime; you just have to look after yourself.[172] Similarly, sister Zamela shared feelings of disappointment in her new workplace comparing the DOH and DCS clinic structure and operation saying, "I was expecting a clinic like that of DOH outside where patients who are sick come, but then I found a clinic inside the prison facility and I just went with the flow."[173] Prince, who was given orientation by Mr Shenge, the former head of nursing, in the early 2000s, recounted his first day inside a correctional facility, admitting that he was overcome by fear, saying;

> When you entered Pollsmoor prison, the was no order back then and inmates were very scary. Mr Shenge tried informing me about the working conditions here at Pollsmoor. He told me that I must not show offenders that I feared them. Instead, I must stand tall and not look afraid, because when they see that you were scared, they will make me a victim of violence. I had to walk tall like I am used to the environment, even though I was scared, I told myself that if I were a woman, I would never work here.[174]

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[171] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[172] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[173] Zamela Ketye -Nangamso, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.
[174] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

Although he described his first day as unpleasant and filled with fear, he thought of working in a correctional facility as a new challenge saying, "I told myself that this is not going to be an easy experience but I applied for this job so it's going to be a learning curve for me."[175] When asked why he had applied for the job in the first place, he explained that employment in DCS offered better pay and more benefits compared to his previous position at DOH. His perspective was echoed by other nurses. Sister Fefe, for example, stated, "The reason I started working here was that I wanted career growth and I could not get that in the clinic I was working at in the Eastern Cape."[176] Similarly, Sister Sibongile added, "The working hours in prison were better for me, and I could spend more time with my family."[177] These statements highlight how economic incentives, professional development opportunities, and encouragement encouraged the nurses working at Pollsmoor prison to seek employment at DCS, despite its intimidating and often difficult environment.

Failing infrastructure, poor working conditions, and a lack of resources

The present hard grey concrete building complex of Pollsmoor Prison was built during the early 1960s at the height of apartheid. The architectural design of this prison represents the colonial and apartheid system of the punishment of inmates. Parts of this outdated building complex have been repurposed for inmate health services such as clinics, hospitals, and the sickbay. However, the apartheid legacy of violence, punishment of inmates, and the building's old design fail to meet healthcare standards, adversely impacting nurses' working conditions. Mr Hlophe revealed that the current clinic space at the Remand Detention Facility (RDF) for awaiting trial adult male offenders was previously used as a torture space for detainees, saying:

> Before this was a clinic, inmates were chained here and whipped during apartheid. If you can see, there are still holes here on the floor from the removed chains that were used to tie inmates and punish them.[178]

Prince, one of the nursing staff with 22 years of work experience at Pollsmoor prison, reflected on the working conditions in the early 2000s, saying, during those days, the environment was

[175] Mr Hlophe, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[176] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[177] Sibongile Majola, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[178] Sibongile Majola, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

very threatening because every day I had to walk between plus 30 inmates inside a dark prison whose walls were cracking off."[179] Echoing him, sister Sibongile said,

> On my first day, I was shocked when I was told that the clinic is inside the prison where inmates are locked. The place was very scary, old and dirty, I felt like I was being locked inside, and to security wardens opened and locked each gate when I was taken to the clinic.[180]

Despite South Africa's extensive prison reform, the outdated physical infrastructure at Pollsmoor prison remains unchanged, hindering healthcare delivery. Grey mentioned that the old building structure compromises nurses' working conditions and creates an environment conducive to the emergence and spread of diseases, saying,

> In my center, the was water leaking from the roof when it rained, and it always flooded in winter here at Pollsmoor, and you could slip and fall and break your leg or arm; there was water stagnant in some part of the center with mosquitoes around and this created new diseases and more work for us.[181]

Similarly, sister Zamela said, "This building and the infrastructure were very old, and it leaked when it was raining; there was water everywhere, and we had to constantly shift things."[182]

She also revealed the terrible living conditions of inmates, where overcrowding contributes to the rapid spread of diseases among inmates, and horrible smell around the prison, saying;

> The environment contributed a lot to the sickness of the inmates. Inmates' cells were overcrowded and very dirty; they shared beds and sheets. There was a lack of proper cleaning materials in prison cells. The hygiene was very poor, and as nurses, we know that germs like dirty places. As we were challenged by the issue of skin problems, which is caused by poor hygiene. Some inmates did not wash themselves, and others peed in the showers, and eventually, they developed sickness, and the prison smelled very bad.[183]

Additionally, nurses at Pollsmoor prison expressed feelings of frustration due to the challenges they face when reporting maintenance issues, Grey explained that;

> At Pollsmoor, there was the correctional services internal maintenance unit and Public Works responsible for fixing and maintaining the facility infrastructures, but when we reported to the

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[179] Prince Khuthele, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[180] Sibongile Majola, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[181] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[182] Zamela Ketye -Nangamso, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[183] Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

internal unit, we were referred to Public Works, and Public Works referred us back to them a cycle that never ended.[184]

He continued to say,

> What frustrated us the most was that we were required to submit an annexure to internal maintenance with the issue and things to be fixed, which we did, and we followed up on them again and again and again until we got tired, but nothing happened.[185]

In response to their frustration and the DCS delays in fixing faulty infrastructure, nurses and doctors at Pollsmoor prison have taken matters into their own hands to fix the broken infrastructure so that they can provide better medical care. However, Dr. Johnson voiced sentiments of marginalization of health professionals at Pollsmoor prison, revealing that despite taking matters into their own hands to ensure that they have a conducive workspace to provide quality healthcare services to inmates, they are removed from their offices without being adequately notified by the facility authorities:

> Initially, there was no space anywhere for the other doctor to work. After a while, he was given a bad condition office, the floor was messed up, and the office was in a bad state; he then arranged for tiling, painting, and cleaning, and when it looked good and nice. He was told by the prison authorities that they want the office to use it. Whereas this office was not occupied for more than three years, but because it was renovated and in good condition it was taken.[186]

Nurses rely on healthcare equipment for proper diagnosis, monitoring, and prompt treatment. However, nurses at Pollsmoor prison were challenged by the issue of the lack of medical equipment, which affected their ability to provide quality healthcare to their patients. Sister Asavela mentioned that health professionals at Pollsmoor prison lacked basic medical equipment that is easily available in the outside clinic under DOH, such as the Hemoglobinometer (HB Meter), a device that is used to measure hemoglobin levels in the blood, used primarily to detect and monitor anaemia and related conditions. In addition, sister Asavela complained about how the DCS uniform was tight and prevented nurses from being flexible and kneeling during medical examinations, saying,

> We always understood that we were working in a correctional facility, we were provided with only two uniforms, and prison is a dirty place. Therefore, we constantly had to wash our uniforms every day. The uniform was not comfortable to kneel in when we examined patients.

[184] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[185] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[186] Dr. Johnson, Pollsmoor Prison, Interview by Nzuza 20 September 2024.

> When we requested to wear our navy-blue nurses' uniform, we were denied and forced to wear the brown DCS uniform, which is not comfortable for us nurses we always have to move.[187]

Moreover, Pollsmoor prison has a shortage of healthcare workers, Grey said.

> DCS took a long time to recruit nurses, and sometimes job posts were frozen for so long that we were expected to deliver quality healthcare. We were expected to report and submit statistics and perform operations, and nursing duties while we lacked nurses.[188]

He continued to say, "Currently at RDF, there are 3200 inmates in the facility and 5 nurses; the ratio of nurse to inmate-patients does not balance as they struggle to meet demands because of the lack of human resources."[189] While the mission of DCS nurses is the same as that of any nurses working at DOH, nurses to provide the best possible care for every patient, nurses at Pollsmoor prison revealed struggling to achieve this goal because DCS only employs professional nurses, who are then expected to do all of the nursing duties that would be shared among general, basic and professionals nurses in DOH. Although nurses at Pollsmoor prison acknowledged working in a resource-constrained environment, when asked if they continue to work there, sister Sibongile said, "What motivated me was that I was at Pollsmoor to make an impact and contribute to the health and rehabilitation of offenders and the thank you sister for saving my live from the patients I received after consultation or giving them medication"[190]

Concerns about DCS nurses' inadequate training

Offenders at Pollsmoor prison are convicted of different crimes, from armed robbery to drug abuse and distribution, human trafficking, sexual abuse, attempted murder, and murder. In addition, this prison has an active gang culture, from number gangs, 26s, 27s, and 28s, and newer gangs, the Air Force and the Big Five.[191] These gangs are notoriously ruthless and secretive, and have unpredictable behavior. Nurses take on the role of primary caregivers, as they are first in line when it comes to inmates' health. They are responsible for providing services to promote the health of inmates and identify, assess, and treat health problems. Considering the nature of the crimes committed by their inmate-patients and gangs, nurses are exposed to a wide variety of occupational hazards. Even though training is important and needed to mitigate these hazards, to ensure nurses' safety and inmates' access to quality primary

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[187] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[188] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[189] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[190] Sibongile Majola, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[191] Hopkins Ruth, "Fear, Force and sex in Sun City", *Mail & Guardian* 29 January 2015, https://mg.co.za/article/2015-01-29-fear-force-and-sex-in-sun-city/, Accessed: 10 October 2024.

healthcare, sister Sibongile revealed that, unlike security wardens who receive compressive training upon hiring, nurses wait months or years before they are taken for training saying, when I got here they did not provide me with any form of training. [192] Echoing her is her sister Asavela, who said,

> When I started working here, I was never taken to a formal induction or training like they did in outside hospitals by the Department of Health; I was taken for training after two years working here.[193]

Similarly, sister Fefe said, “I started working here in 2002, and I was taken to training in Pretoria.” As a result, the training experiences of nurses varied significantly; those who joined the Department of Correctional Services (DCS) in the early 2000s received comprehensive training in comparison to their colleagues who joined the department later. Sister Fefe reflected on her training experience, saying,

> During training, we were taught about the prison systems, and what is expected from us; we also had to do physical training (self-defense) as part of the training. We were taken for firearm training and wrote tests every week for three weeks of training.[194]

She also shared a traumatic accident caused by another nurse because of a traumatic experience they had during the shooting range training, saying:

> During that training, I realized the reality of being a prison nurse, and I told myself that I had come to another world because it was really scary. A nurse next to me during the shooting was crying a lot. We were lined up with our instructors at our backs, who observed us, and when they noticed something wrong, they spoke to us politely and took the firearm away from us. This other nurse who was nursing someone who was shot before joining DCS. When we were shooting, he recalled that patient and started shooting around it was very scary.[195]

Sister Fefe further mentioned that her training was 10 weeks long, in Pretoria in Gauteng, with other nurses from different correctional facilities. They were provided with transportation, accommodation, meals, uniforms, and shoes. Prince, who started working at Pollsmoor prison after Sister Fefe, shared his three weeks of training experience, saying,

> I've worked for about two years before I was taken into training at Kroonstad in the Free State DCS Training College, where they take all the correctional officials. During training, we were

[192] Sibongile Majola, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[193] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[194] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[195] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.

taught about several things, including security, health, self-defense, and different kinds of prison keys.[196]

On the other hand, sister Asavela reflected on her short training experience, saying:

> The formal training (if it was formal) was in 2021. We were traveling from our homes to the training place. During this training, our instructor was someone from Johannesburg. We were combined with other DCS members, including psychologists and social workers; we were taught about the DCS policies and processes, but day three was short as our instructor had to leave for Johannesburg.[197]

The DCS's standard of nurses' training is declining over time and is said to be prioritizing prison policies instead of healthcare. Other nurses interviewed as part of this thesis noted the importance of this training. For example, Grey said:

> During training, we were taught about DCS policies, gangs, and the fact that inmates have unpredictable, manipulative behaviors; I experienced this when I was consulting with an inmate who looked at my watch and said he could get me someone who could get me a nicer and expensive watch. I realized that this is what we were taught about during training inmates' manipulative behavior to try and get officials to do them favors I dismissed him and told him I was not one of those officials; because there are officials here who do favors for inmates and bring them things from outside and withdraw money from outside for them.[198]

Conflicting priorities between security and healthcare

Correctional facilities are regarded as static and hierarchical institutions. They are static because their goals and objectives are "clear and unchanging", and they are hierarchical as their lines of communication are vertical and accompanied by an expectation that junior officials will simply implement the orders handed down by seniors.[199] To maintain order and prevent inmates from escaping. As a result, health professionals (nurses, doctors, and pharmacists), prison officials, and inmates are required to know their position in this hierarchy and obey operational instructions without question.[200]

The 2004 White Paper on Corrections in South Africa stipulates that the Department of Correctional Services (DCS) is obligated to ensure the safety of the public from inmates who

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[196] Prince Khuthele, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[197] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[198] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[199] Muntingh. "An Analytical Study of South African Prison Reform After 1994". 25.
[200] Muntingh. "An Analytical Study of South African Prison Reform After 1994". 25.

pose a threat to them and ensure inmates' safety in custody while enforcing sentencing and justice.[201] It further states that, given the restrictive nature of the correctional centre environment, the security control in a correctional centre has to be tight. To ensure safety, inmates' cells should be regularly inspected, and visitors searched for any items not allowed in the facility.

The health of inmates is addressed in Section 35 (2) of the Constitution, which obliges the Department of Correctional Services (DCS) to ensure 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 exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material, and medical treatment.[202]

This clause points to the obligation of the Department of Correctional Services (DCS) to provide health care to inmates. By implication, this health care should be consistent with that provided by the state to other citizens, while also recognizing the right of individuals in South Africa to access private health care facilities at their own expense, which in the case of inmates can also be limited by security constraints.[203]

In compliance with section 35 of the Constitution, inmates at Pollsmoor prison receive primary healthcare in all five correctional centres. However, the 15 nurses interviewed for this thesis described Pollsmoor prison as an environment primarily focused on security, control, and containment, and not conducive to providing medical care. Sister Asavela noted that strict security measures at Pollsmoor prison restricted nurses' abilities to provide quality health services to inmates, saying;

> At Pollsmoor it was security [rather] than health, we say we are healthcare but in reality, we are not, security took priority here, our time of consultation with inmates was not enough because of security, we spent four hours with inmates doing healthcare services and the other four hours we did administrative work because inmates had to be locked in back, we could not say anything we just obeyed because those were the rule here.[204]

Similarly, sister Zamela said,

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[201] White Paper on Corrections 2004, 76.
[202] Constitution of the Republic of South Africa. Bill of Rights. 1996.
[203] Constitution of the Republic of South Africa. Bill of Rights. 1996.
[204] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.

> Because of strict security here, we worked on a limited time, after 14:00, when inmates were done eating, they were counted and locked away by the "*chief"* (emphasis) security warden, who has to submit the key after and knock off at 3:00 p.m.[205]

Therefore, after the inmates have been locked back in their cell sections, nurses use the remaining hours of their shift for clinic administration work, such as following up on inmates who have been released on parole to ensure they continue with their HIV treatment at their clinic in the community. Also, they follow up on the newly sentenced inmates' medical history and communicate with the outside hospitals to get their medical history to continue with ARV treatment in custody.

In addition, nurses revealed that the strict security process at Pollsmoor prison affects inmates' access to healthcare services. Prince (a nurse) noted that,

> Sometimes, when we asked members to bring inmates to the clinic, the member refused and said they were short-staffed. I cannot leave the other members alone and bring inmates to the clinic. This is sad because the person who suffered at the end of the day was the inmate and we nurses.[206]

As a result, all HIV-positive inmates and those offenders who are on chronic medication receive their treatment from the nurses every morning because they are scared of taking their medication in front of other inmates and end up not receiving their medication for the day. Prince further expressed concerns over Pollsmoor prison's strict security measures compromising nurses' careers, saying;

> When an offender failed to see a nurse and they ended up dead, nurses were the first people to be investigated by DCS and forced to account for things they did not do because of security constraints in prison. When an inmate died because the member refused to bring them to the clinic for us to assess them, and referred them to the hospital if that's the case. The investigation report never states that the member failed to bring the inmate to the clinic, but it states that nurses failed to see the inmate.[207]

As stated above, the rights of all awaiting-trial and sentenced offenders in South Africa are protected in the Constitution, except for those taken away from them by the law.[208] In 2012,

[205] Zamela Ketye -Nangamso, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[206] Prince Khuthele, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[207] Prince Khuthele, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[208] Neethling, J "Dellictual liability of prison authorities for contagious diseases among inmates Lee v Minister of Correctional Services 2011 6 SA 564 (WCC); Minister of Correctional Services v Lee 2012 3 SA 617 (SCA): respray. *Journal of South African Law*, 2013, 177-187. 177

Pollsmoor Prison made headlines when Mr Lee, who was incarcerated in this facility in 1999 for money laundering and was re-incarcerated in 2000, and he spent four years in this facility, became ill and was diagnosed as suffering from pulmonary Tuberculosis (TB). He sued the Minister of Correctional Services for negligence, contending that the correctional authorities negligently failed to take responsible actions to protect him from contracting TB.[209] The court noted that there is a legal duty to provide healthcare services for inmates as part of their constitutional right to conditions of detention consistent with human dignity.[210]

Security not only limits inmates' access to healthcare services and compromises nurses' careers, but it also prevents nurses from accessing medical equipment that would easily be available in the DOH clinics outside. Sister Asavela expressed frustration and desperation, saying, "We are just nurses and I wish someone could listen to us because we want to do our work here and make a change, but security is on our necks." She continued to explain how security at Pollsmoor prison prevents them from accessing medical resources, saying,

> When we requested simple medical equipment, like a drug test, we were told that such is not part of DCS guidelines, and our request was declined, but the reality is that inmates are smoking drugs here, and their test results always come back positive from Victoria Hospital.[211]

The lack of independence of health professionals at Pollsmoor prison

The Van Dam Committee of Inquiry report of 1984 revealed that nurses working in correctional facilities battled with the issue of caring for their inmate-patients and obeying the strict military rules and regulations of the Department of Correctional Services (DCS); The inquiry's report further questioned the authority of nurses in DCS. Five years later, in 1989, a female offender at Pollsmoor prison named Carol Anne Meyers died after she was placed in a straitjacket for 23 hours as a disciplinary measure. At the inquest, the magistrate ruled that the prison authority that was on duty and the nurse were irresponsible and inhumane, and grossly negligent.[212] In 1994, the nurse was found guilty by the South African Nursing Council (SANC) of 'disgraceful conduct' and suspended for five years from the nurses register. In addition, the nurse was convicted of contributing to the death of the offender, failing to respond to the offender's distress when the straitjacket was applied too tightly, and not calling the doctor when the

[209] Neethling. Lee v Minister of Correctional Services. 177.
[210] Lalla, Meera, Unlocking the impact of South Africa's correctional center conditions on inmates' rights." LLM Thesis, University of the Witwatersrand.
[211] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[212] Baldwin-Ragaven, London and De Gruchy. "An ambulance of the wrong colour". 84.

inmate's blood pressure was dangerously low.[213] In her defense, the nurse mentioned that she was ordered by her superior to apply the straitjacket and did not have the authority to remove it; "I did what I had to do. Those were the regulations".[214]

Despite the dismantling of apartheid and the amendment of the Prison Act No.8 of 1959, health professionals at Pollsmoor prison continue to face systematic challenges to their professional autonomy. Nurses raised concerns that strict DCS rules, the area commissioner, and senior authorities at Pollsmoor prison continue to hinder best healthcare practices, reinforce dominant narratives, and undermine their efforts to provide quality healthcare to inmates. Dr. Johnson noted that healthcare professionals at Pollsmoor prison are excluded from significant meetings that affect their everyday health practices, saying,

> We were not treated as professionals; the area commissioner is superior to everyone. When significant people like the national commissioner visited the prison for inspections, only the executive, directors, and the area commissioner were invited to the meetings and made decisions on our behalf.[215]

Grey echoed her, saying, "For years it has been like that. We find ourselves at odds with them, but we always try to say that we are here for their patient."[216] As a result, this top-down approach to decision-making takes away the autonomy of health professionals.

The autonomy of healthcare workers at Pollsmoor prison is undermined by the fact that prison conditions force them to report to the security wardens sensitive inmate-patients' medical information so that they can be transferred to Victoria Hospital. Moreover, the lack of nurses', doctors', and pharmacists' independence at Pollsmoor prison is further exacerbated by the management's dismissive attitudes towards the concerns of healthcare workers. William, a pharmacist at Pollsmoor prison, recalled a situation when his superiors dismissed him when he advised them to remove a clerk who was not registered with the South African Pharmacy Council from working inside the pharmacy, saying;

> They appointed their clerk to help out with the order process. However, because the clerk was not registered with the Pharmacy Council, I specified to them that the person could not sit in

[213] Baldwin-Ragaven, London and De Gruchy. "An ambulance of the wrong colour". 84.
[214] Baldwin-Ragaven, London and De Gruchy. "An ambulance of the wrong colour". 84.
[215] Dr. Johnson, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[216] Grey Bulelwa Boniswa, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.

> the pharmacy. They can work, and they can help out with the orders, but they cannot sit in the pharmacy; they are not allowed to. The superiors said no, the person must be in the pharmacy. So, when the Pharmacy Council came and asked if the person was registered, I said no, and they marked us down as the pharmacy.[217]

As a result of dismissing William, Pollsmoor prison was fined for not adhering to the rules relating to good pharmacy practice as published by the Council in terms of section 35. (2) of the Pharmacy Act, 53 of 1974 that stipulates that:

> Any member of a partnership, society or other association of persons the members of which are not each individually registered as a pharmacist, who uses in respect of such partnership, society or association of persons any name, title, description, symbol or descriptive term…shall be guilty of an offense and on conviction liable to a fine…or imprisonment for a period not exceeding twelve months or to both such fine and such imprisonment.[218]

In addition, William revealed that the grading of the pharmacy at Pollsmoor prison has been dropping to grade C in the last two inspections and raised concerns that the pharmacy might end up being closed. The persistence of these concerns points to the continued lack of professional autonomy among healthcare professionals working inside correctional facilities' clinics, which was suspected by the Van Dam Committee of Inquiry report in 1984.

Nurses' daily ethical challenges

Correctional facilities are notoriously controversial environments to work in, and this causes staff members to become cautious and often obsessive about maintaining records, which may support or even exonerate them should legal proceedings follow any untoward incident.[219] This is the everyday reality of nurses working at Pollsmoor prison as they are challenged by the issue of prioritizing inmate-patient emergencies amidst security lockdowns. Therefore, they keep medical records of inmates in case the need to defend themselves arises. Sister Asavela explained that.

[217] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

[218] Department of the Prime Minister. Republic of South Africa. Pharmacy Act, No. 53 of 1979. 16 October 1974.

[219] Walsh. E. The emotional labor of nurses working in Her Majesty's (HM) prison service. 148.

> We did administration work afternoon when inmates were locked in the sections. We did this work because in my center, we only had awaiting trial offenders, and keeping their medical records is important because we sometimes got called in court to account.[220]

So, inmates' medical records are kept to track their health and patient benefits, for reference during treatment, and measure how well the health system is working, and they can also be used by nurses to protect themselves when they are summoned to appear in court should the need arise or when there is an inmate death-related investigation.

In addition, nurses at Pollsmoor prison were grappling with the issue of providing compassionate care to terminally ill inmates and mentally ill patients. As a result, nurses revealed using the sick bay (a room that can be used as a small ward in DOH) designed for seriously ill inmates to accommodate mental health patients because other inmates refuse to stay with them in the sections, and others are sexually abused. Sister Zamela explained the process of converting the sick bay for mental health patients, saying every center has a sick bay which is meant to keep clients who need to be closely monitored, such as diabetic inmates, and uncontrollable epileptic seizures.[221] She continued to describe this process saying, "those sick bays do not serve their purpose because the situation here forced us to use them for mental health clients because they are many here, and other inmates do not want to live with them and some are raped by gangs".[222]

A large number of inmates at Pollsmoor prison are poorly educated and come from marginalized communities with the lowest social and economic orientation. The National Institute of Crime Prevention and Rehabilitation (NICRO) revealed that an average South African offender has only a grade six education.[223] Nurses at Pollsmoor prison encounter numerous ethical dilemmas each day in obtaining genuine informed consent from patients with limited literacy. One measure implemented by nurses to address this issue was placing an isiXhosa-speaking nurse and an Afrikaans-speaking nurse in each center to mitigate the issue of language barriers and obtain the full consent of inmates.

Furthermore, allocating limited clinical resources is an ongoing day-to-day challenge facing nurses at Pollsmoor prison. This facility has one dentist that serves all five centers; therefore,

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[220] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[221] Zamela Ketye -Nangamso, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[222] Zamela Ketye -Nangamso, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[223] Mokoele, Matata J. "Benefits of correctional education in South Africa: Implications for adult inmates as a group with special needs. In International Pre-Conference, 2013. 151-256. 152.

nurses have to choose which inmate to prioritize in a facility where many inmates are using crystal meth known as Tik due to the "ticking" sound it produces when smoked.[224] Sister Zamela revealed that inmates at Pollsmoor prison are suffering from drug-related sickness, saying,

> They did use drugs and get very sick from those drugs. We were dealing with people without teeth because of a drug called Tik, people who always come to the hospital for stomach problems because of withdrawal symptoms, and people with damaged intestines due to the use of drugs.[225]

Cape Town, where Pollsmoor prison is located, is classified as the Tik capital of South Africa, with 98% of methamphetamine patients seen across the country coming from the city.[226] Inmates use this drug as a recreational stimulant or to cope with being in prison, and it can be snored, swallowed, injected, or smoked.[227] Sister Asavela noted how the use of drugs by offenders jeopardizes their security, and they constantly have to be on the lookout for danger in addition to providing medical care, saying,

> The substances that they smoked affect us so badly. There was a case when a nurse was almost assaulted by an inmate who was so high on drugs, and we could tell by the way that inmate was talking that they were very high on drugs. They were shouting and being violent towards the nurse.[228]

In addition to the ethical dilemmas of nurses having to choose which inmate to prioritize due to limited resources, nurses are challenged with the issue of defending themselves when inmates who are under the influence of drugs attack them. Prince described this ethical dilemma by saying;

> As the big guy I am, when an inmate attacks me and I hit back, I will be prosecuted by the state for beating an inmate without recognizing that he is the one who started, so we constantly had to think of ways of removing ourselves from situations when inmates attacked us, which were unpredictable.[229]

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[224] Naidoo, Sudeshni. "A closer look at how crystal meth attacks gums and teeth", The Conversation 17 October 2018, A closer look at how crystal meth attacks gums and teeth Accessed: 10 October 2024.
[225] Zamela Ketye -Nangamso, Pollsmoor Prison, Interview by Nzuza 20 September 2024.
[226] Naidoo, "A closer look at how crystal meth attacks gums and teeth".
[227] Naidoo, "A closer look at how crystal meth attacks gums and teeth".
[228] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[229] Prince Khuthele, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.

Stress and burnout in nurses at Pollsmoor prison

Correctional facilities are a stressful environment to work in. Published reviews related to nurses in correctional facilities identified occupational stressors, including security prioritization, conflicts, fear, job demands, burnout, stress, and trauma.[230] In the interviews conducted for this thesis, health professionals at Pollsmoor prison revealed suffering from high levels of stress because of working in resource-constrained clinics, their low levels of professional autonomy, and a lack for recognition of healthcare workers in DCS Sister Anele stated, "This place stresses us a lot, many younger nurses do not last more than three years in DCS: we are always making farewells."[231] Similarly, Prince mentioned that nurses at Pollsmoor prison are faced with devastating pressures and demands because of the shortage of healthcare workers in prison, saying;

> We are working, but honestly speaking, many nurses have left Pollsmoor. If I can count them, they are more than the nurses we currently have here in prison. Some did not even manage to finish two years because the environment was not conducive.[232]

Nurses articulated how working within a resource-constrained environment perpetuated high levels of stress and anxiety for them. Sister Anele went on to elaborate on her feelings of frustration by saying, "I don't know why I am still here when it is hard to get simple medical resources: in DOH, I will not be suffering like I am here."[233]

Nurses' stress levels at Pollsmoor prison are further exacerbated by the fear of danger and violent attacks from inmates. Sister Majola recalled experiencing anxiety after finding out about the crime of the inmate-patient she was examining, saying: “I could not cope after I was told that the man I was busy examining in the consultation room was a serial murderer who killed many people”.[234]

Other nurses noted that they preferred not knowing about the crimes committed by their inmate patients to avoid feelings of anxiety. Moreover, nurses at Pollsmoor prison revealed symptoms of suffering from occupational and post-traumatic stress because of violent attacks by inmates.

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[230] Guardiano, Megan, Paul Boy, Grigoriy Shapirshteyn, Lisa Dobrozdravic, Liwie Chen, Haiou Yang, Wendie Robbins, and Jian Li. “Working Conditions and Wellbeing among Prison Nurses during the COVID-19 Pandemic in Comparison to Community Nurses”. International Journal of Environmental Research and Public Hleath19, no.17: 10955

[231] Anele Dlamini, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

[232] Prince Khuthele, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.

[233] Anele Dlamini, Nurse, Pollsmoor Prison, Interview by Nzuza 20 September 2024.

[234] Sibongile Majola, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.

Sister Asavela recalled a traumatic situation when she was attacked by an inmate with her colleague and how that affected their mental health, saying;

> At some point, my colleague and I were held hostage by this one inmate who was very aggressive at the passage, and we locked ourselves in, as the inmate tried to break the door down and became violent toward us. This was a very traumatic experience for both of us. This incident took place on Saturday, and on Monday, we were taken to the Employees Assistance Programme (EAP), a service that was provided by the government. We then had to go back to work even though we were not ready to go back to work yet. We then decided to use our own money to go see our doctors. We had a follow-up with this EAP with the government psychologist, and we were then discharged. We used our own money to seek psychological health to be mentally well.[235]

The long-lasting trauma and stress experienced by nurses at Pollsmoor prison have devastating effects on their well-being and the quality of healthcare provided to inmates. These stresses affect nurses' ability to provide optimal care to all sick, including those who are HIV-positive inmate patients. Stress further decreases nurses' empathy and compassion for their inmate-patients, affecting their ability to pay attention to details because they fear inmates' unpredictable, violent behaviors.

The relationship between correctional officers, authorities, and nurses

At Pollsmoor prison, security wardens are responsible for taking inmates from their cells to the clinic. During medical emergencies, inmates first report to security wardens, who then move the offender from the sections with his or her colleagues to the hospital to receive medical care. They are also responsible for ensuring the safety of both inmates and medical professionals during consultation. When nurses were asked about their relationship with security wardens, they reported having a difficult relationship, fuelled by feelings of being controlled and disrespected, which limits their will to provide adequate medical health service to offenders. Sister Asavela described the relationship, saying, "Our relationship is good… We call inmates 'patients', they call them *"Bantiti"* (inmates), to them they are criminals."[236] She also noted that nurses' relationship with security wardens is fragmented because some security wardens refuse to uphold the confidentiality of inmates-patients' sensitive medical information, saying;

> Our relationship with the security warden was also affected by the issues of a lack of privacy. There was no privacy in prison; we understood that it was also for our safety that they were

[235] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[236] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.

> there during consultation with inmates. But that does not mean that when they go back to lock the inmates, they must start disclosing inmates' sensitive medical information; We hear them in the corridors saying this *Bantiti* (inmate) is HIV or that TB "*Bantiti*. Also, when our patients come to the clinic, they complain about their status being disclosed.[237]

In addition, sister Sibongile raised concerns about security wardens occasionally jeopardising their safety and preventing them from seeing their patients, saying,

> Before we get to inmates, there is a middleman, a security warden. They sometimes place our lives at risk. Here we are dealing with patients with different sentences and profiles. Sometimes, we would be dealing with a very high-profile inmate, and you find that the middleman responsible for our safety is very negligent.[238]

She reflected on the day she expressed feelings of frustration towards a security warden who jeopardized her safety while she was providing medical care to a high-profile inmate, saying,

> He left me alone. I asked him Would you leave your wife with this offender, His facial expression said it all that he would not. Every time, we must remind them to sit with us inside the consultation room.[239]

As a result, nurses' endless reminder to security wardens to do their work affects their relationship because nurses get frustrated when their security is jeopardised.

The relationship between nurses and inmates

Pollsmoor Prison is a maximum-security prison commonly known as a C-Max prison in South Africa. C-Max prisons aim to regulate extreme gang behaviors and awaiting-trial offenders with high escape risk. Inmates locked in C-Max prisons are those people convicted of very serious or high-profile violent crimes, including robbery, murder, drugs, and sexual offenses.[240] Deborah Drake argues that inmates locked in maximum-security prisons are cast as 'dangerous others' or 'evil monsters' and every aspect of a C-Max prison life is viewed through the filter of security: This notion of otherness creates a relationship of 'us versus them' between correctional authorities (security wardens, nurses, doctors, heads of centers) and inmates.

This oppositional notion plays out in today's nurses and inmates' relationships at Pollsmoor prison. When nurses were asked about their relationship with inmates, some described having

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[237] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[238] Sibongile Majola, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[239] Sibongile Majola, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024
[240] Drake, Deborah. "The dangerous other in maximum-security prisons. Criminology & Criminal Journal, 11 (4), 2011. 367-382. 375.

a professional nurse and a patient relationship, like sister Asavela said, "My relationship with inmates is fine, I do not have a problem with them. I work at the admission center, I am a nurse, they respect that and they are my patients, and I respect them."[241] Therefore, there is a strictly defined line between inmates and nurses at Pollsmoor prison. On the other hand, older nurses mentioned having a more open, empathetic motherly relationship with offenders, despite their sentences. Sister Deliwe stated that,

> I had a very good relationship with the inmates; they are my children, and I love my naughty children. Wherever I went, they would call me Mama. I don't even know their names, but I am good at remembering their faces.[242]

She continued to describe her relationship with inmates, saying, “I think my relationship was influenced by my late husband, who was a pastor: for me, my clients are human, and this is what I always say to the wardens, to treat inmates like people.”[243] Similarly, sister Rachel said

> Some of these inmates are young, and they do not have mothers, and when they see us, they see mothers, and I treat them with love and care. As a result, they can open up to us about their health issues. In our consulting rooms, we spend lots of time doing parenting and psychological work for inmates.[244]

Conclusion

In conclusion, this chapter has highlighted the challenges nurses face working within a dual system of the Department of Correctional Services (DCS) and the Department of Health (DOH) at Pollsmoor Prison. The implementation of apartheid militarised policies and legislation about correctional facilities forced segregation and violence and involved nurses in the torture and punishment of inmates instead of providing quality healthcare services. The transformation of correctional facilities that took place in the 1990s marked a significant improvement in nurses taking a more active role in the healthcare of inmates. Despite prison transformations, deracialisation, and demilitarization, nurses still lack autonomy in correctional facilities, security is still prioritised over healthcare in DCS, and nurses experience dilemmas and

[241] Asavela Sodinga, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[242] Deliwe Khumalo, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[243] Deliwe Khumalo, Nurse, Pollsmoor Prison, Interview by Nzuza 20 October 2024.
[244] Rachel Abrahams, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

challenges between their roles about health and security. The next chapter describes how this has influenced nurses' provision of HIV prevention and treatment services over time.

Chapter 3: The management of HIV/AIDS at Pollsmoor Maximum Security prison

Introduction

This chapter explores the complex issue of HIV/AIDS at Pollsmoor prison. Although HIV was recognized in South Africa from the early 1980s, it wasn't until 1992 that a policy was created for correctional institutions. This policy was conservative, and it included forced segregation of HIV-positive inmates, which was later reversed. The chapter explores three major risk factors for HIV transmission at Pollsmoor prison: violence and tattooing, substance abuse, and overcrowding. Consensual and coerced sex in Pollsmoor prison have contributed to a high transmission rate, though precise numbers are still undetermined. The violent environment inside inmates' cells hampers the provision of necessary services, and overcrowding exacerbates poor health outcomes, as defined by the WHO.[245]These issues are compounded by the fact that many inmates are Black and come from poor backgrounds, and they are already at high risk of HIV infection.

The chapter will also examine the challenges of managing HIV at Pollsmoor before the advent of ART (antiretroviral therapy). The introduction of the Ubomi Clinic in 2008, a specialized HIV/AIDS clinic, streamlined care and made management easier. Before this, both staff and inmates sought HIV care at the nearby Victoria Hospital, raising concerns about privacy and confidentiality, which are also addressed in the chapter. Since the introduction of the Ubomi Clinic, the health services detainees receive obtain upon admission to the prison and the ways in which ART is administered to both awaiting trial and sentenced inmates have changed. The following sections of the chapter discuss the distribution of ARVs and education by a dedicated team of professionals, as well as the issues of confidentiality.

Finally, the chapter addresses the persistent stigma and discrimination within the facility. Stigma is often perpetuated by patriarchal structures within gangs. Stigma is driven by fear of the unknown. The last section highlights the challenges of providing condoms to prisoners, how this was initially denied by the Department of Correctional Services (DCS), and eventually accepted and has become standard practice.

[245] World Health Organization. Guidelines on HIV Infectious and AIDS in Prisons. Geneva: World Health Organization, 1993. 5.

HIV/AIDS in prison

The first policy to address HIV/AIDS in the South African prison system was formulated in 1992, the "Management Strategy: AIDS in Prisons", and it was based on 'fear, lack of knowledge and prejudice'.[246] All HIV-positive inmates in the Department of Correctional Services (DCS) were isolated from the general prison population. Those who were suspected of having HIV were separated not only from the general prison population but also from HIV-positive inmates until a nurse performed an HIV test. According to this policy, HIV-positive inmates were segregated from other inmates. High-risk inmates were those convicted of sexual crimes, injecting drug users, and people who had sexual contact whilst in foreign countries, identified with high rates of HIV-infection at 10% or more of the population.[247] All high-risk inmates were referred to a nurse to be tested. According to the policy paper, test results were to be kept confidential but had to be reported to the head of the prison centre.[248]

South Africa's Department of Correctional Services (DCS) policies on HIV/AIDS in prison evolved slowly from the mid-1990s, prompted by World Health Organization (WHO) guidelines criticizing segregation of HIV-positive inmates. In 1994, the DCS policy on HIV was amended to conform to international guidelines, developed at the World Health Organization (WHO) convention in Geneva in 1993. WHO regulations specified that:

> Compulsory testing of prisoners for HIV is unethical and ineffective and should be prohibited. Voluntary testing for HIV infections should be available in prisons, together with adequate pre- and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support should be available when prisoners are notified of test results and in the period following.[249]

The World Health Organization (WHO) guidelines further stipulated that segregation, isolation, and restrictions on occupational activities, sports, and recreation were not considered useful or relevant in the care of HIV-infected people in the community, and that the same attitude should have been adopted towards HIV-infected inmates. Decisions on isolation for health conditions should have been taken by medical staff only, and on the same grounds as for the general public. HIV-infected inmates should have had equal access to workshops and

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[246] Goyer K C. "HIV/AIDS in Prison: The Public Policy Challenges for South Africa" MA Thesis, University of Natal. 2001. 105.
[247] Goyer. "HIV/AIDS in South African prisons". 105.
[248] Goyer. "HIV/AIDS in South African prisons". 196.
[249] World Health Organization. Guidelines on HIV Infections and AIDS in Prisons. Geneva: World Health Organization, 1993. 5.

to work in kitchens, farms, and other work areas, and to all programmes available to the prison population.[250] It also stipulated that information on inmates' HIV status and medical treatment should be kept confidential and recorded in files available only to health professionals. The provision was made that offenders' health information be shared with the prison manager or judicial authorities when the information would assist in the treatment, but only when the inmate gave full consent.

It further stipulated that female offenders, including those who were HIV-infected, should have received services specifically designed for their needs, including information on the likelihood of HIV transmission from mother to child or through sexual intercourse. Since female offenders may have engaged in sexual intercourse during detention or release on parole, they should have been enabled to protect themselves from HIV infection, for example, through the provision of condoms and skills in negotiating safer sex. Counselling on family planning should have also been available. However, no pressure should have been placed on female inmates to terminate their pregnancies. Women should have been able to care for their young children while in detention, regardless of their HIV status.[251]

This policy change resulted in the desegregation of HIV-positive and "high-risk" inmates, and all inmates were no longer forced to test for the infection with the virus during admission in prison, and they had the right to choose to test whenever they wanted to test, or when the District Surgeon recommended.[252] As stipulated in the WHO guideline, "Decisions on the need to isolate or segregate prisoners (including those infected with HIV) should only be taken on medical grounds and only by health personnel, and should not be influenced by the prison administration."[253]

In addition to revising the earlier policy of segregation, the amendment also introduced several programmes implemented at provincial correctional facility levels. First was the introduction of STI clinics in all correctional facility hospitals.[254] These clinics were managed by nurses and provided counselling, testing, and treatment. Nurses were also responsible for providing inmates with information about STIs. In addition, nurses were obligated to check the conditions

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[250] World Health Organization. Guidelines on HIV infections and AIDS in Prison. 6.
[251] World Health Organization. Guidelines on HIV infections and AIDS IN Prison. 8.
[252] Goyer. "HIV/AIDS in South African prisons. 197.
[253] Goyer. "HIV/AIDS in South African prisons. 197.
[254] Goyer, K, C., Saloojee, Yusuf. Richter, Marlise and Hardy, Chloe. "HIV/AIDS in Prison: Treatment, Intervention, and Reform, A Submission to the Jail Commission." On behalf of the AIDS Law Project and the Treatment Action Campaign. 30.

of inmate-patients who were living with HIV/AIDS, and organize their diet supplements and consultations with psychologists, social workers, medical specialists, and other professionals.[255]

In order to assist with the implementation of these new policies, the Department of Correctional Services (DCS) stated that each province had to appoint a member of the nursing staff to act as Provincial HIV/AIDS Coordinator. At Pollsmoor prison, sister Rululu Ntombizandile, known as sister Fefe, was appointed as the HIV/AIDS Coordinator. The responsibilities of the HIV/AIDS Coordinator were to train inmates and correctional officials about universal precautions, monitor STI clinics, arrange information sessions for both officials and inmates on the policy change, and organise the distribution of condoms.[256] In addition, the HIV/AIDS coordinators were responsible for liaising with AIDS counsellors in every correctional facility in the province, and identifying and training AIDS counsellors for those correctional facilities that did not have HIV/AIDS counsellors.[257]

HIV/AIDS: Risk behaviours at Pollsmoor prison

In South Africa, this disease has had a long track record of disproportionately affecting more of the black population, due to the economic and social disadvantages they have faced. In the late 1990s, young black women between the ages of 20 to 24 were the most vulnerable group; by contrast, the prevalence of HIV/AIDS among black men peaked at age 25 to 29, with one-third infected with HIV.[258] Inmates were greatly affected by HIV/AIDS, and a large number of inmates in all South African prisons, including Pollsmoor prison, are from poor communities with high rates of unemployment and crime. A study conducted by the Judicial Inspectorate in 1999, which examined post-mortem reports, concluded that 90% of deaths in South African prisons were AIDS-related.[259] The culture of prisons in South Africa was conducive to high rates of HIV transmission, including unprotected sexual intercourse, the use of intravenous drugs (IV drugs), and contaminated cutting instruments and tattooing.

[255] Goyer. Saloojee. Richter and Hardy. “HIV/AIDS in Prison”. 30.
[256] Goyer. Saloojee. Richter and Hardy. “HIV/AIDS in Prison”. 31.
[257] Goyer. Saloojee. Richter and Hardy. “HIV/AIDS in Prison”. 31.
[258] Goyer. HIV/AIDS in South African prisons. 63.
[259] Goyer. HIV/AIDS in South African prisons. 66.

Sexual risk factors: Violence and consent

The presence of gangs (the 26s, 27s, 28s, known as number gangs and the Air Force and Big Five) at Pollsmoor prison contributes to an elevated risk of HIV transmission.[260] In this facility, gangs dominate the entire prison as they recruit new members, organise their activities, and conduct a reign of terror.[261]. They control the allocations of cells, the distribution of food, the active drug trade, and much of the sexual activity. Consequently, a victim of sexual abuse at Pollsmoor prison is believed to have been converted into a "woman". To keep rape victims silenced they are shamed, threatened and physically abused by gang members into stop them from reporting rape. This was confirmed in the interviews conducted for this thesis, for instance, Nurse Prince observed that gangs are the spreaders of HIV/AIDS at Pollsmoor prison, mentioning that,

> Things that spread HIV here are this number, number thing, new arrivals we tested HIV-negative come in here, they join the numbers, and we cannot run away from the fact that they have sex with each other voluntarily and involuntarily, and when they test again, they test HIV-positive.[262]

Sister Zamela echoed this statement, stating, "The reason for the increased number of HIV-positive inmates here is this gang behaviour that one needs a wife. How do you have a wife when you are all men?"[263]

Health professionals at Pollsmoor prison acknowledged that inmates are sexually active. Dr Johnson mentioned that;

> People do whatever they want, they have a different sexual orientation, and if you are homosexual and it's who you are, who am I to stop you from what you are or your sexual preference? I cannot say do not have sex.[264]

[260] Hopkins Ruth, "Fear, Force and sex in Sun City", *Mail & Guardian* 29 January 2015, https://mg.co.za/article/2015-01-29-fear-force-and-sex-in-sun-city/, Accessed: 10 January 2022.

[261] Gear, Sasha. "Behind the Bars of Masculinity: Male Rape and Homophobia in and about South African Men's Prisons. *Centre for the Study of Violence and Reconciliation, South Africa*, Vol 10(2), (2007), 209-277. *Behind the Bars of Masculinity: Male Rape and Homophobia in and about South African Men's Prisons (sagepub.com) 216. Accessed: 01 October 2024.

[262] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

[263] Zamela Ketye -Nangamso, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

[264] Dr Johnson, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author. (I do not agree with the term 'sexual preference')

Similarly, Sister Fefe shared that some of her inmate patients openly shared about their sexual and romantic relations, saying;

> They were free to talk to me about their relationships in prison, some told me about being in a same sex relationship with other offenders within the correctional facility. Some would come in and tell me I have found somebody, and they will request HIV couple testing.[265]

Although this shows that not all sexual interactions among inmates at Pollsmoor prison are non-consensual, a great number of inmates at Pollsmoor report to the nurses that they have been sexually assaulted. Nurse Prince mentioned that a sufficient number of his patients inform him during consultation that they have been forced to engage in anal sex saying, "chief they raped me or something happened last night".[266] Consequently, the alarming prevalence of rape in Pollsmoor prison, as mentioned by the nurses as linked to the increasing incidence of HIV/AIDS.

Other risk factors: Violence, tattoos, and substance abuse

The use of contaminated cutting or piercing instruments and injecting drugs has been known to cause HIV infection among inmates. Nurses revealed that inmates inside the proclaimed high maximum security Pollsmoor prison are using drugs. Sister Sibongile said, "The substances that they smoke affect us so bad because outside they smoke drugs, and even in prison, they still smoke drugs. I do not know how they still smuggle them inside the prison."[267] Echoing her, Dr Johnson stated that drugs at Pollsmoor prison are smuggled by inmates, visitors, and other correctional officials. She recalled when inmates boasted to her about having drugs in their section, saying,

> Some inmates would tell us that they had a tik drug party yesterday, then there are those who we find them okay today, and the following day they are completely off and have to be rushed to the hospital.[268]

[265] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.
[266] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza, 20 September 2024, Transcription Possession of Author.
[267] Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[268] Dr Johnson, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

As a result, nurses at Pollsmoor have noted the intersection between drugs and HIV transmission among inmates. When they are high on drugs, they are involved in physical fights, resulting in open wounds and blood exposure, increasing the risk of HIV transmission.

An integral part of the prison subculture is the incidence of rudimentary tattooing by inmates on other inmates.[269] One of the many health and safety risks associated with the transmission of HIV in prison. Nurses noted that when inmates join a gang, they are tattooed with a symbol specific to the gang they joined. Sister Asavela noted that:

> We did not know much about gangs and their culture as nurses; security wardens were the ones who knew more about gang-related activities here. But we knew that they tattooed each other using the same machines and pens that were not sterilized, which placed them at high risk of contracting HIV because some of them could clinically see symptoms of HIV, and when we encouraged them to test, they refused and shared tattooing instruments with their blood.[270]

Nurses mentioned being overwhelmed by work due to gang-related fights in the early 2000s. Sister Asavela recalled when a clinic had to be shut down and she could not attend to inmates who had to collect their HIV-treatment that day because of gang stabbings saying:

> Numbers fighting and stabbing inflict the number of patients that we saw daily. If the gangs had fought with each other on the 26 and the 28, they would all end up in the clinic the next morning. There was a day where by the were sixteen casualties for us, all three nurses, which meant that the clinic had to come to a standstill that day because the was a stabbing which made us work hard.[271]

Nurses complained that gang-related fights affect their morning routine of giving HIV-positive inmates medication, to inmates who struggle to take their medication inside their section because of the fear of stigmatisation by other inmates and gang members.

Unhygienic and overcrowded offenders' cells

Overcrowding in prisons compromises inmates' security, which leads them to seek protection from gang members in exchange for sexual favours. At Pollsmoor prison, overcrowding leads to violence among inmates fighting over limited resources such as beds, lockers, and food.

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[269] Goyer. "HIV/AIDS in South African prisons". 72.
[270] Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[271]Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

Nurses at Pollsmoor prison noted that inmates' unhygienic living conditions heightened their susceptibility to infectious diseases such as HIV, Tuberculosis (TB), and dermatological issues. Sister Asavela stated that;

> Inmates' cells were overcrowded, very dirty, and they shared beds and sheets. There is a lack of proper cleaning materials inside prison cells. The hygiene is very poor, and germs like a dirty place.[272]

She further stated that, "as nurses we are challenged by the issue of skin problems which are caused by the poor hygiene scabies, HIV, and TB".[273] Echoing her, Dr Johnson said:

> Some of the common sicknesses here were skin diseases, scabies, STIs, and syphilis. We do a lot of blood tests when we see some skin problems. The hospital did the syphilis test, and it turned out positive. And there seems to be a rise in syphilis here.[274]

Therefore, unhygienic inmates' cells and inadequate personal hygiene contribute to contracting skin issues, which, when combined with gang violent behaviours, unprotected anal sex, drugs and tattooing, significantly increase inmate's vulnerability to HIV infection at Pollsmoor prison.

Management of HIV/AIDS since the late 1990s

In 2008, Ubomi HIV/AIDS Clinic was established at Pollsmoor Maximum Security Prison.[275] The clinic was named by inmates, said sister Fefe, the former HIV/AIDS coordinator at Pollsmoor prison, "I wanted them to be involved because this was their clinic and their involvement was important".[276] Ubomi Clinic was launched through a collaborative initiative between a doctor from Victoria Hospital, TB/HIV Care (a non-profit organisation), the former HIV/AIDS coordinator, sister Fefe, and the nursing staff. As it is near Victoria Hospital, the hospital is used by the prison for inmates' emergencies, and other medical services that are not offered inside the prison clinics. Sister Fefe explained that Ubomi Clinic was established as a measure to mitigate the Victoria community's concerns regarding safety and hospital overcrowding by sick inmates:

[272]Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[273]Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

[274] Dr Johnson, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[275] Ubomi means life in IsiXhosa.
[276] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

> A doctor from Victoria Clinic was interested in starting an HIV/AIDS clinic here at Pollsmoor without being compensated, because community members were scared of inmates accessing treatment in the hospital. We then started the clinic here as a trial. Because at that time I was very new in this facility, it was not an easy task. I worked with some NGO's and the doctor who helped set up the trial clinic here at Pollsmoor.[277]

Before the establishment of the Ubomi HIV/AIDS clinic, Pollsmoor prison had no designated site for HIV/AIDS care. A veteran nurse sister, Rululu, explained that at Pollsmoor prison, healthcare from the late 1990s to early 2000s was 'a parade', stating that:

> Inmates would come to our clinic, stand in line, tell us the medication they wanted, and we would ask them why they wanted it. We gave them medication over the window and wrote down a list of all the inmate patients and the medication we gave them. We only opened files for inmates who were seriously sick.[278]

So, before 2008, all HIV-positive sentenced and unsentenced inmates received medical care from Victoria Hospital because Pollsmoor prison had no HIV/AIDS clinic. Although inmates' HIV testing was voluntary and often occurred when inmates became clinically ill in prison, there was no treatment. Another veteran nurse, Grey Bulelwa, described the hurdles he faced in implementing HIV testing in the early 2000s before access to ARV treatment, adequate HIV/AIDS education, and establishing a clinic at Pollsmoor, saying:

> During a consultation with someone, I say I need to test them, because as a nurse, I can clinically see all the signs of HIV, they shut down and say I cannot test. Some would say, chief, it's better that I test outside than inside prison because in prison, you are HIV-positive, and they stigmatize you.[279]

The lack of adequate knowledge about HIV/AIDS risks and transmission at Pollsmoor prison among inmates and prison officials was met by the absence of protective measures. This allowed the epidemic to spread more in the late 1990s to the early 2000s. Nurse Grey reflected on a memory of losing patients to HIV/AIDS, recalling the heart-breaking experience: "It feels bad when you are losing a patient, and losing someone is very bad and very painful".[280] Back then, in the early 2000s, HIV-positive inmates were referred to Victoria Hospital to start with

[277] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[278] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[279] Grey Bulelwa Boniswa, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[280] Grey Bulelwa Boniswa, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

ARVs when their CD4 count was lower than <200 cells/mm3 in line with the National and World Health Organisation (WHO) Stage 4.[281] As with the general public, asymptomatic inmates who tested positive for HIV in prison or outside at the hospital with a CD4 count higher than 350 did not receive treatment.[282] The former minister of the Department of Correctional Services from 2004 to 2009 also mentioned in her speech that, "it doesn't mean that if you are HIV-positive and the CD4 count is low, therefore you would be granted medical report. It's about sick people, very sick people."[283]

Improved access to HIV/AIDS care at Pollsmoor prison

The management of HIV/AIDS at Pollsmoor prison significantly improved following the establishment of the Ubomi HIV/AIDS Clinic in 2008, and the Department of Correctional Services (DCS) clinic at Pollsmoor prison began providing Primary Health care. Primary Health is defined by the Department of Correctional Services Act No. 111 of 1998 as "universally accessible, first-level contact, clinical-based health services essential to enable the prisoner population to acquire, maintain and promote health."[284] Sister Fefe mentioned that,

> After we were approved to start our own HIV/AIDS clinic here at Pollsmoor, the Department of Health helped us with some training. As the HIV coordinator, I was taken for training and partnered with other prison HIV coordinators around the country, for example, the Johannesburg Correctional Centre HIV coordinator, who guided me on how to set up and manage our own HIV/AIDS clinic in prison.[285]

Following the training sister Fefe received as the HIV coordinator from the Department of Health, she reported that other nurses were taken for training on HIV/AIDS. As a result, nurses began taking a more active role in managing HIV/AIDS and the general health of inmates, especially now that they were providing primary healthcare. William, an in-house pharmacist at Pollsmoor prison, attested to the improvements that came with this training concerning how quickly the treatment now reaches inmates, saying, "We've found ways to get the treatment to inmate patients quicker and more effectively. When guidelines change, we communicate that

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[281] Davies, Natasha ECG, and Alan S. Karastaedt. "Antiretroviral outcomes in South African prisoners: a retrospective cohort analysis. 2012. 1-6. 2.

[282] Plazy, Melanie, Fancois Dabis, Kevindra Naidu, Joanna Orne-Gliemann, Till Barnighausen, and Rosemary Dray-Spira. "Change of treatment guidelines and evolution of ART initiation in rural South Africa: data of a large HIV care and treatment programme." BMC infectious diseases, 2015: 1-8.

[283] Chesen Albertus, "Protecting Inmates' Dignity and the Public Safety: A clinical Analysis of the New Law on Medical Parole in South Africa", Law, Democracy and Development, 2012: 185-189. 185.

[284] Government Notices Department of Correctional Services, Correctional Services Act, 1998. https://www.gov.za/sites/default/files/.gcis_document /.201409/26rg8023gon914.pdf

[285] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

quickly".[286] He further emphasised the benefits that came with primary healthcare and the HIV/AIDS training, saying:

> I think the nurses and the doctors are doing an amazing job of treating HIV/AIDS here. For example, when there were changes in guidelines and first-line treatment was introduced, the department wanted people to shift to this treatment gradually, but our nurses and doctors switched patients quickly, not irresponsibly, but they got inmate patients to understand the benefits of this new treatment.[287]

Management of HIV/AIDS in awaiting trial and sentenced prisoners

Pollsmoor prison comprises three trial facilities catering specifically to awaiting trial inmates: the Remand Detention facility (RDF), provisory known as the 'maximum security prison', the Admissions Centre Medium A, and the Female Prison Awaiting Trial Section. These facilities serve almost every court across the southern Cape Peninsula. RDF is the largest awaiting trial facility for adult males, with over 400 detainees attending court Monday to Friday. The Medium A at the Admission Centre has a separate section for awaiting trial youth, juveniles, adult males, and vulnerable inmates, of whom Mr Hlophe said, "By vulnerable I mean the gays that get abused here in prison, disabled inmates, and older inmates who are 40/50/60 years old."[288]

Upon entry, all awaiting trial convicts at Pollsmoor prison are stripped naked and searched by security wardens in line with Part C of the Correctional Service Act (1998), dealing with Security Safe custody, which stipulates that wardens should:

> 26. (1) (a) search the person of a prisoner, his or her property and the place where he or she is in custody and seize any object or substance which may pose a threat to the security of the prison or of any person, or which could be used as evidence in a criminal trial or disciplinary proceedings.[289]

After the search, a professional nurse (working either at RDF, Admission Centre or Female Prisons awaiting trial section) conducts a comprehensive medical screening, starts with an admission and risk assessment and performs a compulsory Hemo Glucose Test (HGT) to

[286] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[287] William Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[288] Mr Hlophe, Head of Nursing, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[289] Department of Correctional Services, Correctional Service Act, 1998.

known diabetics detainees, and those 40 years and older and pregnant detainees. They also screen and record inmates' chronic disease history (HIV, Hepatitis, TB, HPT, DM, Cardiac, Asthma, Chronic Obstructive Pulmonary Disease (COPD) and identify Epilepsy and Mental Health Care Users (MHCU). This also includes screening for acute problems that require treatment and isolation, and they also perform a comprehensive health risk assessment for foreign national inmates. Nurse Prince described how challenging it is working at RDF, especially on a Monday:

> Screening of inmates here at Pollsmoor differs; for example, Monday is a very hectic day, and I can screen 80 to 90 detainees. I only focus on those new offenders. Keep in mind that those offenders were arrested on Friday, Saturday, and Sunday. And they are being kept there in their police cells. Now they will come in numbers, especially on Monday. I have to attend to them.[290]

All HIV-positive awaiting trial detainees receive their ARV medication from their respective local clinics outside Pollsmoor prison till they are sentenced or released. Nurse Prince explained the way awaiting trial detainees receive their treatment in prison, saying,

> During screening, inmates who are HIV-positive disclosed to me, and I immediately opened a file for them. Our external officials who are collecting medication from outside clinics will go to that particular clinic and say we are here on behalf of so and so, and now, because they are in prison now for security purposes, we would like to get their medication.[291]

Although HIV testing is available for free at Pollsmoor prison, inmates can only test after booking an appointment with a nurse, HIV coordinator, or through TB Care, a non-profit organisation working with HIV/AIDS at Pollsmoor prison (as discussed further in chapter 3). All awaiting trial detainees who test positive for HIV are started on treatment in prison, and when they are released either on bail or found not guilty, they are given a referral letter to continue with treatment outside. Those who are found guilty and are moved to Medium B, C, or the Female Prison sentenced section are also given a referral letter by the nurses to continue with their treatment in prison as sentenced inmates.

Imprisoned people at Pollsmoor prison are frequently reincarcerated after release, moving back and forth between the prison and the outside. Nurses raised a concern that many inmates move in and out of prison and do not take their HIV treatment outside. Sister Asavela noted that, "I

[290] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

[291] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

don't know if inmates get rehabilitated because we get the same people all over again and again and again."[292] Dr Johnson echoed her, saying, "Someone I was seeing yesterday at a female prison knew that she was HIV-positive, and when I asked her where and when she last did you collected your medication, she said four years ago".[293] As a result, nurses complained that defaulting adds more work to them because they now have to start from the beginning, providing counselling, repeat initiation of treatment, and closely monitoring if their patients adhere to treatment. Sister Deliwe emphasised the significance of adhering to HIV medication to her patient inmates, stating:

> I had two pots where I had red and white balls. When they are newly diagnosed, I will explain to them that these are your red blood cells and these are your white blood cells. I will show them if you have not been on medication for three months. Then we look back to the beginning where your CD4 count was low and tell them it's very important that you adhere to treatment because in today's life, you don't have to die any more of HIV anymore because there's medication.[294]

The management of HIV/AIDS in sentenced offenders differs slightly from awaiting trial offenders. Similar to awaiting trial inmates, when inmates are sentenced, they are searched by the security wardens, and nurses conduct a health screening. Sister Sibongile, working at Medium B for sentenced male offenders at Pollsmoor prison, explained this process, saying,

> We did an admission screening of all the newly sentenced inmates from head to toe. We use a comprehensive tool which includes physical examination, whereby we ask the inmates about their health and any chronic condition, so that they have access to medication, for example, for the 20 years they are sentenced here.[295]

Unlike in awaiting trial offenders, HIV-positive sentenced inmates receive their treatment in prison, including those who test positive for HIV in prison. Towards the end of their sentencing, nurses also examine them and test them for any illness and sickness, and those on HIV treatment receive referral letters to outside clinics to continue with their medication.

[292]Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[293] Dr Johnson, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[294] Deliwe Khumalo, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[295] Sibongile Majola, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

The distribution of ARVs and HIV/AIDS education

Pollsmoor prison has one in-house pharmacy that supplies all five prison facilities with medication. It is situated inside the prison premises, opposite Medium A, next to the rehabilitation centre, garment factory. At present, the is one clinical pharmacist and four community service pharmacists. It is tailored to optimise patients' health outcomes, ensuring safety throughout the medical management process and lowering the risk associated with the use of medicines. In addition, they monitor therapeutic drugs for adverse drug reaction management, enter medication reconciliation, and develop medication management plans.

William, a clinical pharmacist, shared insight about the prevalence of HIV/AIDS at Pollsmoor Prison stating that they dispense a significant amount of HIV medication to all five prison clinics "the bulk of our work here is ARV's, TB, and psychotic medication, and we provide the first-line treatment antiretroviral therapy (ART)".[296] William frankly illustrated the situation, saying, "90% of our HIV-positive patients are on the first line treatment, so this is the shift I can do with my eyes closed because the script always comes the same every time nurses request medication."[297]

Nurses observed that many inmate patients detained at Pollsmoor Prison learn of their HIV status in prison. They do not test for HIV outside, and those who test positive for HIV outside do not start their treatment until they are arrested. Therefore, many inmates have poor knowledge about health-related issues. Nurses and pharmacists at Pollsmoor Prison play a crucial role in providing reliable information about the medication inmates are consuming. This helps inmates understand the potential risks, benefits, and uncertainties regarding the specific medication they are taking. William, a clinical pharmacist, mentioned that at least every month, they visit all five prison centres' clinics for inspections:

> We went to different clinics to check on the drugs we supplied, looked at the cardboards where nurses stored the medication, checked the room temperature where the medication stored, checked expiring dates, and checked if the was enough medication in the clinics and informed nurses to return any medication close to the expiring date for it to be disposed properly.[298]

[296] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[297] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[298] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

When HIV medication is consumed at the same time every day, it decreases viral load and transmission. Inside Pollsmoor prison, medical professionals, nurses, doctors, and pharmacists play a crucial role in ensuring that inmates are not only adhering to their HIV medication, but they also understand its side effects. The pharmacist team visits inmates' sections with the permission of the Head of Centre to educate them about their medication and the importance of adhering to any treatment they are taking. William mentioned that,

> as pharmacists, we know better and can explain things better to inmates in terms of medication, and inmates enjoyed seeing new faces besides nurses and doctors, and asked us lots of questions, people they were not familiar with. We concentrated more on ARVs because they had more side effects than any other medication that was given to inmates at the time, and then we moved to TB drugs, hypertension, and other sicknesses.[299]

These education sessions are run every month in all five prison centres, Medium A, Medium B, Medium C, RDF, and Female Prison. They are conducted either in group settings or individual consultation rooms with pharmacists, William stated.

> There were times when we spoke to groups like September it's a pharmacy month whereby we went to all sections of the prison and talking to inmates about vaccines and we would do a group discussion with people who were more at risk like, HIV-positive inmates, hypertensive, diabetic, and other inmate patients in a group of 15 to 20. Explaining to them why it is important for them to get vaccinated, because, as pharmacists, we know better and can explain things better to inmates in terms of medication.[300]

Nurses also conduct similar sessions focused on HIV/AIDS. Their sessions also take place inside the prison sections where inmates are locked. To break the stigma and encourage other inmates to test and adhere to their HIV/AIDS treatment, the voluntary HIV coordinators were appointed. These inmates openly share their status with others during these sessions and talk about their experiences of living with the virus and the importance of adhering to medication. Nurses explained that HIV/AIDS education sessions are conducted in an interactive style to allow inmates to freely ask questions and engage. For example, sister Deliwe recalled an exciting moment when she was educating inmates about HIV medication and the importance of knowing the name of the medication they were taking,

[299] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[300] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.

> When I was teaching them about the first line regime TLD and said whenever anyone wakes you up at night, you must be able to tell them the name of your medication, one inmate made a joke about it and said (TLd-te lekker dronk), and that's what they call it.[301]

Dr Johnson, one of the two in-house doctors at Pollsmoor prison, mentioned that she and her colleagues are not part of HIV-education sessions. However, during consultation with inmate patients, she answers any questions her patients ask, providing them with enough information, limited by the consultation time.

Despite the efforts taken by the nursing staff, pharmacist, and doctors to educate inmates about HIV/AIDS and other illnesses, they raised concerns about the Department of Correctional Services' (DCS) restrictions that prevent them from hosting health educational programs. Sister Fefe recalled some of the difficulties she faced as HIV coordinator in the early 2000s when there was no knowledge about HIV/AIDS in prison, saying,

> With prison, it was very difficult for them to accept someone's proposal. Maybe you know this through your research ethics for security reasons. During that time, there were a lot of people who wanted to come to prison and educate inmates about HIV/AIDS, but they were not approved because of the bureaucracy of the prison.[302]

Other nurses echoed her, saying, "There are a lot of red tapes here in terms of getting approval to get to inmates in the sections."[303] Another nurse stated that,

> Too many restrictions were one of the reasons that I've decided I cannot stay within this department. I'm almost five years here. I'm four years, nine months. But I've just decided I need to shift. I needed to move back to the Department of Health.[304]

Maintaining patient confidentiality in prison

In medicine, the concept of patient confidentiality is highly regarded, and all medical staff are taught about this concept during their education and training. It is also reinforced through major medical ethics, oaths, and codes of conduct. Since the beginning of the HIV/AIDS epidemic, there has been a strong focus by medical governing bodies and personnel on protecting a patient's confidentiality as a measure of protecting them from stigma and ensuring

[301] Deliwe Khumalo, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[302] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[303] Willian Smith, Pharmacists, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 October 2024, Transcription Possession of Author.
[304] Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

personal privacy. In South Africa, the National AIDS Plan adopted in 1994 emphasised the significance of confidentiality. In the same year, the South African Medical and Dental Council (SAMDC) issued a revised guideline for the management of HIV-positive or AIDS patients. These guiding principles strongly pointed out that patients' HIV-test results should be protected at the highest level of confidentiality.[305] Nurses at Pollsmoor prison testified that upholding patient confidentiality is challenging in a space that prioritizes security over health care. Sister Fefe explained that, "it is difficult to uphold the confidentiality of inmates, because inmates are seen with a guard standing next to you, so the issue of confidentiality gets broken there."[306] Similarly, sister Sibongile noted, "We are dealing with different patients with different sentences and profiles, and we require the middle man security wardens to be there at all times."[307]

Mr Hlophe and Sister Fefe (with over two decades of nursing service at Pollsmoor prison) revealed that between 2000-2007, the building structure posed confidentiality issues. Inmates' medical records were stored in one of the three rooms that were used as a clinic inside the prison. When it rained, water damaged some of these documents, and they constantly had to be moved, further compromising patients' confidentiality. This issue persists, as other nurses interviewed mentioned the hardship they face daily in maintaining patients' confidentiality inside the old Pollsmoor prison buildings, noting that they require more equipment and resources. Nurse Prince mentioned that,

> The environment that we were working in was not conducive to protecting inmates' confidentiality, and new nurses did not even finish two years here because of the environment and the pressure we faced.[308]

In addition to the poor infrastructure, nurses revealed that security wardens do not respect inmates' privacy as during a consultation, they are constantly asking questions about inmate-patients sensitive medical information and use that to refer to inmates saying "this *Bantiti* (inmate) is HIV or call that Bantiti (inmate) that is HIV or with TB, the nurses are looking for him, because they are the ones that are brining inmates to us."[309] Despite the challenges posed

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[305] Edwin Cameron, "Confidentiality in HIV/AIDS: Some Reflections on India and South Africa," Oxford University Commonwealth Law Journal1, no. 1 (2001): 35-58. 40.

[306] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

[307] Sibongile Khumalo, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

[308] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

[309] Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

by the environment and inquisitive security wardens, nurses mentioned implementing effective strategies to protect their patients' confidentiality. For example, when they require privacy without jeopardising their security, they make use of a male nurse inside the consultation room without a security warden watching or listening to an inmate's sensitive medical information. They also noted that changing the packaging of HIV-positive inmates' treatment protected them from other inmates finding out that they are HIV-positive. Lastly, they revealed that gang members and other offenders who are HIV-positive and scared of taking their treatment in the section (due to the fear of others finding out and disclosing their status to the entire prison community) they come every morning to take their medication at the clinic, after they have been counted in the prison cells and had breakfast.

HIV/AIDS stigma and discrimination in the correctional facility

Since the beginning of the HIV/AIDS epidemic, people who are HIV positive and those suspected to have the virus have been victims of stigma and discrimination. Stigma challenges the efforts taken to expand testing, prevention, and adherence to treatment. Nurses at Pollsmoor prison noted that HIV/AIDS stigma stops many inmates from HIV testing and accessing HIV treatment. Sister Fefe observed that the stigma in the early 2000s at Pollsmoor was stirred by fear and a lack of HIV/AIDS-related knowledge: "Stigma and discrimination when I started working here was a problem, I tried to partner with NGOs to come and help in educating inmates about HIV/AIDS."[310] She recalled her colleagues assuming that she was HIV-positive because she was an HIV coordinator in 2006 when there was still a lack of knowledge in prison about HIV/AIDS, saying,

> This affected me a lot because many inmates and prison officials, and some nurses did not know about HIV/AIDS during this time. According to some of them, I was also HIV-positive because I was working with HIV.[311]

Sister Fefe also spoke about HIV stigma in prison on her colleagues living with HIV; before the establishment of Ubomi HIV/AIDS Clinic inside Pollsmoor prison nurses, prison officials and inmates who were HIV-positive all collected their treatment at Victoria Hospital; when inmates saw nurses and prison officials at the hospital HIV section, they shared their status with other inmates who would stigmatise them saying;

[310] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[311] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

HIV/AIDS was very stressful at this time it affected both officials and inmates because I was new in this facility it was easier for some other members of staff to come talk to in confidence and tell me that they are HIV positive… some of them were at that time without medical aid and others they will run out of medical aid funds for HIV/AIDS treatment therefore, I spoke with Victoria Hospital for some of the staff members to access treatment there at the same time protecting their confidentiality … Because when they were are going there they were mixed with inmates who were HIV-positive and these offenders when they came back to prison they discussed their status and discriminated against them even though some of them were HIV-positive to.[312]

Sister Zamela attested to the persistence of HIV stigma at Pollsmoor prison as being driven by gang misconceptions that gang members cannot get sick. "The numbers gang members' belief that an *ndoda* (man), who I think is the gang leader, cannot get sick, that is not true".[313] It is not only gang members who have misconceptions about HIV/AIDS at Pollsmoor Sister Zamela pointed out that "Rastafarians, they say that they do not take medication, they use herbs, but they are dying of HIV/AIDS". Similarly, Prince Khuthele, a nurse, noted that stigma at Pollsmoor prison deters HIV positive inmates from attending the clinic to collect their medication and show up for their appointments:

Since the clinic was opened, this stigma is just like outside because when an offender is taken to the Ubomi Clinic, all other offenders will know that the offender is HIV-positive. Then, as nurses, we came together to say Look, guys, we need to do something and disband this Ubomi clinic because it gives a stigma.[314]

Stigmatising attitudes held by both prison officials and inmates at Pollsmoor prison play a key role in influencing whether an inmate seeks HIV services. Sister Asavela shared witnessing at first hand a security warden using derogatory terms that stigmatize HIV positive inmates in front of other inmates, "this *Bantiti* is HIV or call that *Bantiti* that has TB or AIDS."[315] Sister Fefe also revealed that some security wardens speak openly about inmates' HIV status in prison, saying, "that one that is drinking HIV/AIDS treatment or the HIV one, it was as if it's a joke to them."[316] In addition to inmates complaining to nurses about being stigmatised by

[312] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[313] Zamela Ketye Nangamso, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza, 20 September 2024, Transcription Possession of Author.
[314] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza, 20 September 2024, Transcription Possession of Author.
[315] Bantiti is a Nguni name for inmate.
[316] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

security wardens, sister Asavela also observed security wardens at Pollsmoor use discriminatory terms towards inmates, which also contribute to HIV stigma stating that, “this Bantiti is HIV or that TB “Bantiti”[317] because they are the ones bring inmates to us and you get to hear complaints from the patients on their status being disclosed.”[318]

The provision of condoms to inmates

Condom use has been proven to be an essential component in controlling the spread of HIV infection. Since the beginning of the HIV/AIDS epidemic in South Africa, people have been encouraged to use condoms through the slogan ABC (Abstain, Be faithful, and Condomize).[319] From the late 1990s, prisons were identified in South Africa as hot spots for HIV/AIDS transmission because of the prevalence of high-risk behaviour in the prison environment. However, the Department of Correctional Services (DCS) refused to provide condoms in prison because they did not want to acknowledge that inmates were having sex. Access to condoms and lubricant in prison was achieved after the court ruled in favour of a homosexual man detained at Pollsmoor prison in a lawsuit against the DCS in 1996. This inmate tested HIV-negative when he was admitted to Pollsmoor prison and kept on testing for HIV every three months, and tested HIV-positive while in custody. As a result, the Supreme Court ordered the DCS to provide condoms in prisons in the same way as outside in 1996.

Nurses interviewed as part of this research project confirmed that condoms and lubricant are provided at Pollsmoor prison. Mr Hlophe noted, “In the past, the used to be a box against the wall and inmates could just take condoms.” However, nurses mentioned that when condoms were placed in an open space for inmates to take them freely and undisturbed, and observed that they misused them. Dr Johnson explained:

> People were taking condoms and they were polishing their shoes with the condoms, or they were blowing up and making balloons, it was just a waste. Then they were moved to where the nurses are at the clinics and the screening. There are lubricated condoms and lubricant.[320]

In line with the current policies of the Department of Correctional Services (DCS), nurses at Pollsmoor prison stated that they give inmates condoms whenever they request them. They are

[317] Bantiti is an offensive word used shame to inmates, I do not agree with but its quote in this thesis as part of words used to show discrimination and stigma of HIV in prison by prison officials.
[318] Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.
[319] Goyer, K. C. and Jeff Gow. “Alternative to current HIV/AIDS policies and practices in South African prisons.” Journal of Public Health Policy, 307-323. 309.
[320] Dr Johnson, Pollsmoor Maximum Security Prison, Interview by Nzuza 20 October 2024.

also placed in an open space inside the clinic, and their consultation rooms are for inmates to visit them without fear of discrimination. They are also distributed during HIV/AIDS education programs, counselling, and testing. Nurse Prince noted the introduction of female condoms at Pollsmoor, saying, "At some point they also introduced female condoms here in prison, I am not sure because I did not follow more on this."[321] This reflects that both female and male offenders at Pollsmoor prison receive equal medical services catering to their different needs.

Conclusion

In conclusion, this chapter has highlighted the challenges nurses face in managing HIV/AIDS within Pollsmoor Prison. The implementation of conservative policies, such as forced segregation, and the risks posed by violence, substance abuse, and overcrowding have all contributed to high transmission rates. These issues are further exacerbated by the socioeconomic backgrounds of the majority of inmates. The introduction of the Ubomi Clinic in 2008 marked a significant improvement in managing HIV, providing specialized care, and addressing privacy concerns. Despite advancements in ART administration and educational efforts, stigma and discrimination persist, driven by patriarchal gang structures.

[321] Prince Khuthele, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

Chapter 4: NGOs and the management of HIV/AIDS at Pollsmoor Prison

Introduction

The previous chapter discussed the management of HIV/AIDS at Pollsmoor Maximum Security Prison and the failures of the Department of Correctional Services (DCS) to implement comprehensive policies to reduce the risk of HIV transmission and to promote the health of inmates living with HIV in the 1990s to the early 2000s. This chapter explores the involvement and role of Non-Governmental Organisations, HIV/AIDS activists, and health professionals in advocating for inmates' access to HIV/AIDS treatment and care in prison. It shows how, from 2003 to 2011, the role of NGOs changed from that of advocacy to education and direct provision of HIV/AIDS care. Focusing on male inmates, the chapter shows how access to HIV/AIDS care at Pollsmoor has been severely hindered by aggressive forms of masculinity and gang culture. This aspect of prison life adds a critically unique aspect to the analysis in this thesis, highlighting the enduring importance of gender in efforts to control this pandemic.

The first two sections of this chapter explore how the Treatment Action Campaign (TAC) used litigation and campaigns to effectively advocate for people's access to Anti-Retroviral (ARV) treatment. In addition, this section of the chapter explores the realities and difficulties inmates faced in accessing HIV treatment and care in the early 2000s at Pollsmoor Prison and Westville Correctional Centre (WCC). The second part of this chapter discusses the lawsuit E*N and Others v The Government of the Public of South Africa* and Others (hereafter *EN and Others v the Government*). This litigation marked a significant change in the management of HIV/AIDS in DCS. Ubomi Clinic, at Pollsmoor prison, a specialized HIV/AIDS was established as an outcome of this litigation in 2008, and they streamlined care and made the medical management of HIV/AIDS more effective. The following sections of this chapter discuss HIV/AIDS education conducted by the TB/HIV Care NGO team of clinical and non-clinical practitioners, nurses. IT also describes correctional facility capacity building, as well as the creation and operation of peer education.

Finally, the chapter addresses cultural and traditional beliefs on Voluntary Medical Male Circumcision (VMMC) that was introduced at Pollsmoor prison in 2021 by TB/HIV Care. The last section highlights the introduction of Pre-Exposure Prophylaxis (Prep) at Pollsmoor prison and the challenges nurses face when educating inmates about Prep.

The early involvement of HIV/AIDS NGOs in prisons

Since the beginning of the HIV/AIDS epidemic in the early 1980s, South Africa has experienced intense social and political debates over the nature of HIV/AIDS, and over the best ways of regulating transmission and care for people infected. Paula Treichler argues that HIV has been an 'epidemic of signification' as much as it has been a biological catastrophe for millions of people.[322] This epidemic not only shapes how people perceive death and diseases, but it also catalyzed the formation of non-governmental organizations (NGOs) and community-based organizations (CBOs) across the world. It brought different communities together, including academics, health professionals, and health and human rights activists. These social groups shared the common aim of reducing HIV transmission and providing treatment to those living with the virus.

In the early days of its HIV/AIDS epidemic, South Africa had no clear national policies to prevent HIV/AIDS transmission in correctional facilities. "The Management Strategy: AIDS in Prison of 1992" was the first policy to address HIV/AIDS in the South African prison system. As discussed in detail in Chapter 3, this policy was conservative, included forced segregation of HIV-positive inmates, and was later amended. Even after 1994, when the new democratic government came into power, there was no clear policy addressing the issue of HIV/AIDS in DCS in terms of inmates' access to HIV prevention, treatment, and care. The lack of clear strategy for the management of HIV/AIDS in DCS was influenced by the then social and political debates over HIV/AIDS, including but not limited to the denial that men were having sex with men in prison, President Thabo Mbeki's AIDS denialism, lack of access to HIV treatment, under-resourced prison clinics and the conflict between issues of security and health in DCS and affected the approach to HIV/AIDS in prisons. The transition of prisons from being militarized institutions in the post-apartheid era to becoming rehabilitation-oriented correctional facilities concerned with human rights in the post-apartheid occurred alongside the issue of corruption in the early 2000s. The appointment of new DCS staff also resulted in HIV/AIDS not being prioritized from the late 1990s to the early 2000s.[323]

[322] Colvin, Christopher, J. and Robins Steven. "Social movements and HIV/AIDS in South Africa. In HIV/AIDS in South Africa 25 years on psychosocial perspectives. 155-164. New York, NY: Springer New York. 2009. 155.
[323] Muntingh, Lukas, and Chris Tapscott. "HIV/AIDS" and the Prison System. "In HIV/AIDS in South Africa 25 years on psychosocial Perspectives. 305-321. New York, NY: Springer New York, 2009. 314.

In the post-apartheid era, the Treatment Action Campaign (TAC) became actively engaged in AIDS activism, through legal battles and campaigns advocating for universal access to anti-retroviral treatment (ART).[324] The TAC was established in 1998 in Cape Town, when protestors demanded HIV treatment for people living with the disease and pressured the government to formulate a plan for treatment for people living with HIV/AIDS. In partnership with other NGOs such as the AIDS Law Project and the South African government, TAC became successful at pressuring the large global pharmaceutical industry to allow developing countries to manufacture and import generic ARVs.[325] In December 2001, the TAC legal team successfully took the South African government to court demanding that they provide access to Nevirapine (an ARV) for Prevention of Mother-to-Child Transmission (PMTCT) as part of their Constitutional obligation to promote access to healthcare services. Following further advocacy from the TAC, a national ARV program was introduced in October 2003.[326] Moreover, TAC was successful at shaping social attitudes through its grassroots HIV/AIDS campaigns and education programs hosted inside schools, churches, and clinics.[327] Sister Fefe recalled wearing a TAC T-shirt inside the correctional facility and using it as an advocacy strategy at Pollsmoor prison, saying,

> People were dying of HIV/AIDS during the early 2000s. There was no knowledge, and stigma was a big thing here at Pollsmoor, the same as outside the prison. To get people to know about HIV/AIDS and talk about it, I wore the TAC T-shirt whenever we had programs. Inmates who recognized this t-shirt started asking me questions, and I shared knowledge with them because I was trained on HIV/AIDS.[328]

In 2008, the TB/HIV Care NGO started providing support for TB/HIV healthcare services in correctional facilities in the Western Cape. Sister Fefe the former HIV coordinator at Pollsmoor prison recalled the involvement of TB/HIV Care among other NGOs during the establishment of Ubomi HIV/AIDS Clinic in 2008 in the prison at the peak of HIV-related stigma and fear saying, “When we were setting up Ubomi HIV/AIDS Clinic [from] late 2007 to 2008, I worked with several NGO’s including TB/HIV Care.”[329] In 2009, TB/HIV Care entered into an operational agreement with the DCS to provide services in its facilities in the Western Cape

[324] Colvin and Robin. “Social movements and HIV/AIDS in South Africa.” 157.
[325] Colvin and Robin. “Social movements and HIV/AIDS in South Africa.” 157.
[326] Colvin and Robin. “Social movements and HIV/AIDS in South Africa.” 158.
[327] Colvin and Robin. “Social movements and HIV/AIDS in South Africa.” 158.
[328] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.
[329] Rululu Ntombizandile, Nurse, Pollsmoor Prison, Interview by Nzuza, 20 September 2024.

province.[330] Since then, TB HIV Care has been actively involved in improving the healthcare services for offenders in DCS. In the Western Cape, TB/HIV Care programmes in DCS include the provision of health education, condoms and lubricant distribution, pre-exposure prophylaxis (PreP), VMMC, HIV testing services (including self-screening), antiretroviral therapy (ART), prevention and treatment for TB, and monitoring and evaluation support.

The involvement of activists in inmates' access to ARVs in correctional facilities

The struggle to access ARVs in correctional facilities for inmates in the early 2000s was undermined by multiple factors, including: former President Thabo Mbeki's AIDS denialism; early uninformed DCS HIV policies, HIV-related stigma and fear; the lack of resourced clinics in DCS and high treatment costs. At the peak of the HIV/AIDS deaths in inmates in the early 2000s, NGOs and AIDS activists played a significant role in advocating for offenders' access to HIV treatment. In 2005, DCS briefed the Parliamentary Portfolio Committee on Correctional Services about inmates' access to ARVs concerning the HIV/AIDS Policy for Offenders. It was revealed that DCS had no accredited sites for the distribution of ARVs to inmates, and it lacked security wardens to accompany inmates to outside health facilities to collect their ARVs.[331] That same year, the AIDS Law Project (ALP) was informed that HIV-positive inmates at Westville Correctional Centre (WCC), whose CD 4 count met the then clinical guidelines to receive ARVs, were unable to access their ARV treatment.[332] As a result, ALP discussed with those inmates and shortly thereafter wrote to the DCS and authorities at WCC informing them about those inmates' grievances and inquiring why they had not received their treatment.

In response to the letter, DCS had a meeting with ALP and assured them that they would respond to the matter and that those inmates would have access to ARV treatment. However, DCS's response to that matter was slow and ineffective in assisting those HIV-positive inmates in receiving their ARVs. As a result, ALP filed a lawsuit against the DCS on 30 May 2006, namely *EN and Others v The Government.* [333] This lawsuit was to force DSC to remove any barriers preventing all 15 HIV-positive complainants from WCC and all other HIV-positive

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[330] TB/HIV Care Annual Report. 2020. 31.
[331] Muntingh, Lukas. and Mbazira Christopher. "Prisoners' access to anti-retroviral treatment." 2006.
[332] University of the Witwatersrand. Center for Applied Legal Studies. AIDS Law Project. AIDS Law Project: Annual Review 2005-2006. AIDS Law Project, University of the Witwatersrand, 2006. 14. https://section27.org.za/wp-content/uploads/2017/03/ALP-Review-2006-2007.pdf Accessed: 10 November 2024.
[333] Hassim, Adila. And Berger, Jonathan. "Prisoners' right of access to anti-retroviral treatment: case review. "ESR Review: Economic and Social Rights in South. 2006. 18-21. 19.

offenders clinically qualifying for ARV treatment from accessing it at accredited public-sector sites.[334] Also, they argued that HIV-positive inmates should have been provided with ARVs in respect of the established government Operational Plan for Comprehensive HIV/AIDS Care, and that the DCS should have provided a strategy on how they planned to achieve that.

While the litigation was ongoing, significant improvements to inmates' access to ARVs at WCC were reported, including the fact that all inmates clinically qualifying for ARVs received their treatment, and the prison's hospital was accredited by the Department of Health to provide ARVs onsite. By the end of the court case, Judge Nicholson ordered DCS to implement measures to ensure inmates' access to ARVs and produce an affidavit detailing how they would ensure inmates' access to treatment. Although the judgment in that court case had no direct impact on HIV-positive inmates accessing treatment at Pollsmoor prison, it drew the attention of: HIV/AIDS activists and NGOs, healthcare professionals and friends and family members of offenders about the state of HIV/AIDS management inside correctional services and they forced DCS to take more active steps. Those actions included DCS forming relations with the Department of Health, which accredited WCC's onsite hospital as an HIV treatment site. After much campaigning by HIV/AIDS activists, including the ALP, the DCS started setting up more accredited ARV centers inside correctional facilities. By 2008, there were 12 of them, and one of those sites was the Ubomi HIV/AIDS Clinic established at Pollsmoor prison in 2008 (discussed in Chapter 3).[335] Before the establishment of the Ubomi HIV/AIDS clinic at Pollsmoor prison, inmates in this facility faced similar struggles to those at WCC in accessing their ARVs from outside hospitals. Therefore, without this litigation by human rights activists and NGOs, inmates would have continued struggling to access ARVs, and HIV/AIDS deaths in prisons would have continued to increase in the early 2000s. Sister Fefe attested to this saying,

> In the early 2000s, people were dying from HIV/ because at that time HIV people had no access to ARVs, and they were very sick. Here at Pollsmoor, the staff members were affected by HIV a lot, and others, like inmates, struggled to get treatment. The start of the Ubomi Clinic made HIV/AIDS easy to manage here because nurses also started being trained on HIV, and the health of inmates improved. After all, we were given our resources to assist inmates.[336]

[334] Hassim and Berger. "Prisoners' right of access to anti-retroviral treatment." 19.
[335] Muntingh, Lukas, and Chris Tapscott. "HIV/AIDS and the Prison System. "In HIV/AIDS in South Africa 25 years on: Psychosocial Perspectives, 305-321. New York, NY: Springer New York, 2009. 306.
[336] Rululu Ntombizandile, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

Similarly, Sister Anele noted significant improvement in the management of HIV/AIDS at Pollsmoor prison after the ALP litigation and the establishment of the Ubomi Clinic in 2008, saying,

> There were some great improvements in how we were managing HIV/AIDS here. Things were no longer worse than before since the establishment of the Ubomi clinic and the introduction of primary healthcare. Back then, HIV-positive inmates were taken to Victoria Hospital, and we were not trained on how to start them on ARVs. But with the Ubomi clinic, we received more training, and since then, we have done things on our own, from counselling inmates to testing and starting them on treatment here in prison.[337]

TB/HIV Care capacity-building at Pollsmoor prison

Dr Theodore Hammett recognized the issue of HIV/AIDS in correctional facilities and acknowledged that "prison health is public health, and inmates come from communities that have limited access to public health services, and these are the same communities to which they will return."[338] He reiterated that there is a strong need for effective strategies and HIV education programs in correctional facilities to reduce transmission and manage the virus, saying;

> The disproportionately high burden of disease in correctional institutions identifies an extremely important opportunity to intervene aggressively with prevention and treatment programs. Such interventions promise to benefit not only inmates themselves and their partners and families, but also the broader public health.[339]

Clinical and non-clinical practitioners from TB/HIV Care interviewed for this thesis revealed that offenders at Pollsmoor prison fear testing for HIV because of the stigma, fear of death, and lack of knowledge about HIV/AIDS and support. So, TB/HIV Care runs several programs in this facility intended to educate inmates and correctional officials about HIV/AIDS. DCS nurses and security wardens are also provided with sensitivity training by TB/HIV Care to address any potential negative moral attitudes towards inmates seeking healthcare services, including, counselling and testing for HIV/AIDS; ARV therapy for inmates living with HIV

[337] Anele Dlamini, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza 20 September 2024, Transcription Possession of Author.

[338] Goyer, K, C., Saloojee, Yusuf. Richter, Marlise and Hardy, Chloe. "HIV/AIDS in Prison: Treatment, Intervention, and Reform, A Submission to the Jail Commission." On behalf of the AIDS Law Project and the Treatment Action Campaign. www.tac.org.za/Docuemnts/Other/jali_submission.doc (2004) 50.

[339] Goyer. Saloojee. Richter and Hardy. "HIV/AIDS in Prison". 50.

and Post-Exposure prophylaxis (PEP) for inmates and officials exposed to infection. Masizole from TB/HIV Care explained the significance of building capacity at Pollsmoor prison, saying,

> We provided HIV prevention programs for inmates and officials. We also educated officials on HIV prevention programs because they can be viewed as gatekeepers when they do not understand the healthcare needs of inmates and do not understand how to care for people living with HIV. The officials are also part of what we call the key population in terms of HIV infection and TB, because they are at risk of contracting HIV and TB in prison. So, it's important to capacitate them and make them understand that they are also at risk by working in prison, a risky environment.[340]

Echoing him, Bandile said, "From my years of experience and personal opinion, the is a big change and improvement with regards to the management of HIV/AIDS inside correctional centers at Pollsmoor prison."[341]

Peer educators

Inmates at Pollsmoor prison experience significantly worse health than the general population of South Africa, and the conditions inside this correctional facility further increase offenders' risks of contracting HIV/AIDS, sexually transmitted infections (STIs), and other communicable diseases such as Tuberculosis (TB). In addition, offenders at Pollsmoor prison are a highly mobile population moving in and out of Pollsmoor prison as well as within different centres. As a result, these offenders are at a greater risk of being infected with HIV, STIs, and other communicable diseases from both within and outside correctional facilities. As a strategy to reduce HIV/AIDS transmission and promote the healthcare of offenders, TB/HIV Care runs peer education programs at Pollsmoor prison. Peer education is defined as "sharing HIV/AIDS information in small groups or one-to-one by a peer-matched either demographically, or through risk behavior, to the target population."[342] Masizole from TB/HIV Care revealed that they make use of peer educators to provide and educate other inmates with information about HIV/AIDS because of time constraints and for security reasons at Pollsmoor prison, saying,

[340] Masizola Gonyela, TB/HIV Care, Cape Town, Interview by Lesego Mpumelelo Nzuza 25 November 2024, Transcription Possession of Author.

[341] Bandile Mpehle, TB/HIV Care, Cape Town, Interview by Lesego Mpumelelo Nzuza 25 November 2024, Transcription Possession of Author.

[342] Medley, Amy. Kennedy, Caitlin. O'Reilly, Kevin, and Sweat, Michael. "Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis." AIDS education and prevention. 2009. 181-206. 182.

> We identified inmates to be trained as peer educators so that they can be able to share the information with other inmates. Because at DCS, we did not have the luxury of time because the primary goal is to look at issues of safety and security. So, we come second, hence we needed peer educators' inmates who became our eyes and ears as TB/HIV Care and DCS, because some of the sessions took place in the afternoon when inmates would already be locked up.[343]

Therefore, peer educators at Pollsmoor prison play a significant role in the management of HIV/AIDS by providing other offenders with essential information and support. The recruitment process for peer educators is a collaborative effort between TB/HIV Care, nurses at Pollsmoor prison, and the HIV/AIDS coordinator. Peer educators are a diverse group of inmates consisting of inmates living with HIV and open to discussing their HIV status and living positively with the disease, and inmates who were previously sexually abused and are open to talking about their struggles with another offender.

According to Masizole, peer educators have a unique understanding of the needs of inmates and can better share essential HIV/AIDS information with other offenders in comparison with healthcare professionals.

> It's easier for inmates to talk to other inmates about certain issues. Therefore, peer educators became the first people to know about other inmates who were sexually violated, the inmates who were defaulting from their treatment, and those who struggled to attend their treatment. So, by the time we got to those inmate's peer educators already have this information. They bridged the gap between us and the other inmates.[344]

He continued to state that;

> Peer educators assisted other inmates in understanding why it is important for them to take their treatment, and if they have been sexually abused or have been tattooing themselves, and who are the relevant people to talk to about Pep and Prep? They used the language that is best understood by other inmates and not us outsiders, because that is how we are viewed.[345]

Inmates inside correctional facilities engage in multiple high-risk activities that increase their chances of infection, such as injecting drug use, consensual and non-consensual sex, stabbing,

[343] Masizola Gonyela, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.
[344] Masizola Gonyela, TB/ HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.
[345] Masizola Gonyela, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

and tattooing. Some of these activities are stigmatized (such as men having sex with other men), and others are illegal, such as the use of drugs. Masizole described how some of the peer educators were either drug addicts, or engaging in high-risk activities such as having unprotected anal sex, but had changed their behaviour to using condoms when having sex, adhering to their HIV-treatment and they stopped tattooing their bodies and injecting drugs since they had been participating in TB/HIV Care educations sessions saying,

> Some of the peer educators were inmates who had taken a 360 [degree] turn (which means changed behavior). I'm talking about inmates who have had tattoos and were doing drugs, and they now understand the risk associated with having a tattoo. So, they would share valuable information about Prep with other inmates who were getting tattoos to protect themselves by testing and knowing their HIV status, and starting to take Prep. They understand prison culture more than us and they also serve as a support group to other inmates because they understand their realities.[346]

Voluntary Medical Male Circumcision at Pollsmoor prison

In 2007, the World Health Organization (WHO) and the United Nations Programme on HIV/AIDS (UNAIDS) recommended voluntary male medical circumcision (VMMC) as an HIV prevention strategy specifically for all countries with generalized heterosexual HIV epidemics, higher HIV prevalence, and low rates of medical male circumcision. HIV acquisition in the uncircumcised penis occurs preferentially across the inner foreskin tissues due to increased susceptibility linked to elevated inflammatory cytokine levels in the sub-preputial space and a higher density of HIV-susceptible CD4+ T cells in the tissue. Circumcision protects by directly removing the susceptible tissues of the inner foreskin and by reducing inflammation and residual penile microbiome. Therefore, VMMC decreases HIV susceptibility by removing vulnerable penile tissues and affecting the penile immune and microbial environment. The benefits of VMMC in reducing HIV transmission are further enhanced when combined with other preventive measures such as condom use, pre-exposure prophylaxis, and antiretroviral treatment (ART) for individuals living with HIV.

In 2010, the South African government introduced Voluntary Medical Male Circumcision (VMMC) as an HIV prevention intervention in response to the country's shocking HIV-prevalence statistics. Four years later, TB/HIV Care introduced VMMC at Pollsmoor prison as one of the HIV prevention measures in the facility. Since 2014, TB/HIV Care has been

[346] Masizola Gonyela, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

providing VMMC services to offenders at Pollsmoor prison, educating medical professionals, offenders, and correctional officials about it through different awareness sessions hosted within the facility. A clinical practitioner (Danielle Esau) from TB/HIV Care working at Pollsmoor prison explained the significance of VMMC to offenders, saying,

> Inmates are people, some of them move in and out of the prison to their communities. So, they need to know their HIV status and get circumcised because they also engage in sex, and VMMC is an important one of important preventative measure for HIV.[347]

Danielle spoke about the importance of capability building of inmates, resulting in positive feedback and change of attitudes about VMMC, saying,

> The lack of knowledge by officials and traditional beliefs in the past served as a barrier to the services that we provided in DCS. However, with the training that we provided, the has been a change in the officials' attitudes, and more inmates began being open to VMMC because of the changing officials.[348]

Before the VMMC procedure, offenders are educated about HIV/AIDS and the health risks and benefits of the intervention by the TB/HIV Care team at Pollsmoor prison in a group discussion. Furthermore, on the day of the procedure, inmates are provided with pre-procedure counselling about VMMC, and nurses ensure that inmates give full consent to the procedure. At the end of the procedure, offenders are also provided with post-procedure counselling by the medical personnel conducting the procedure, and are responded to any questions inmates may have about the procedure. Danielle stated that,

> after group sessions about VMMC, we ensured that inmates fully understood the risks and benefits of VMMC, as we provided them with counselling. We also explained to them what to expect as the wound heals, how to take care of the wound, and see a nurse if they notice anything wrong with the wound, such as bleeding.[349]

Despite being sensitized on VMMC, Danielle reported inmates' feelings of anxiety, stress, and fear of pain, saying,

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[347] Danielle Esau, TB/HIV Care, Cape Town, Interview by Lesego Mpumelelo Nzuza 25 November 2024, Transcription Possession of Author.
[348] Danielle Esau, TB/HIV Care, Cape Town, Interview by Lesego Mpumelelo Nzuza 25 November 2024, Transcription Possession of Author.
[349] Danielle Esau, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

> it's not a walk in the park getting inmates to circumcise at Pollsmoor prison. Many of them are anxious and stressed about the procedure and the care of their wounds in the sections where they sleep. They get stressed out to the point of not listening and forgetting most of the things we say.[350]

To reduce their pain, inmates are provided with a pack of twenty tablets of Panado. When they run out of their pain medication, they are allowed to request more pain medication by consulting with a nurse from the inside clinic.

The harsh reality and conditions at Pollsmoor prison pose a significant barrier to the effectiveness of VMMC as a measure to reduce HIV transmission in the facility. Daniel explained that in 2023, some inmates were found with infections because of unhygienic conditions inside their cells, saying,

> After the procedure, inmates would be sent back to their cells. In 2023, we identified several infections. These infections were caused by overcrowding, and inmates sharing beds and not properly washing their wounds as instructed. The activities they engage in during the sections as fighting, also affect their process of healing. After identifying those inmates, we arranged with the operational manager to ensure that they do not share beds with other offenders and that they have access to water to clean themselves and their wounds.[351]

Similarly, Bandile said,

> The rate of infections depends on the center, in juvenile centers there would be more infectious rates due to violence, inmates' behavior, and lack of supervision when it comes to healing, and inside adult inmates' centers, there would be no big complications when it comes to infections because they would take care of themselves better than younger inmates.[352]

In addition, the strong traditional, cultural, and religious beliefs held by both officials and inmates at Pollsmoor prison serve as barriers to inmates' accessing VMMC services at Pollsmoor prison. Male circumcision has been part of many African communities, such as the Xhosa community in the Eastern Cape, South Africa, known as *Ulwaluko,* carried out as part of a secretive cultural practice. Within these communities, the practice of male circumcision is largely celebrated as it symbolizes the transition from youth to manhood. The procedure is

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[350] Danielle Esau, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

[351] Danielle Esau, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

[352] Bandile Mpehle, TB/HIV Care, Cape Town, Interview by Lesego Mpumelelo Nzuza 25 November 2024, Transcription Possession of Author.

performed in a secret non-clinical setting, such as the top of a mountain or by the fields far from the communities, by an adult male who himself is traditionally circumcised or by a traditional healer.[353] In addition, male circumcision is accompanied by certain beliefs about manhood among Xhosa-speaking people practicing male initiation. According to Andile Mhlahlo, to be recognized as a man within a Xhosa-speaking community, a boy must go to the initiation, and all men circumcised in hospitals and clinics are socially discriminated against and not recognized as men by both men and women.[354]

At Pollsmoor prison, many black correctional officials, nurses, and inmates are isiXhosa-speaking people who hold strong cultural traditions. Danielle described how the introduction of VMMC at Pollsmoor was met with resistance because of the cultural, religious, and traditional beliefs of officials and inmates, saying,

> Here in the Western Cape and Pollsmoor prison, people have strong traditional beliefs about circumcision. To isiXhosa-speaking people, it's a big thing. Because of this, we face…resistance to VMMC, and as a solution, we tried and explain to the officials and inmates that VMMC is a medical intervention to prevent the spread of HIV, and we are not aiming at stopping people's culture, we respect them and their traditions. As part of sensitization sessions with the officials, we talked more about this so that they can understand our purpose of male circumcision, that we are not forcing it on anyone, that it is completely voluntary, and that we won't overstep cultural boundaries.[355]

Inmates' harmful body modification practices increase their chances of contracting HIV.

Nurses and non-clinical practitioners interviewed as part of this thesis from DSC and TB/HIV Care reported the prevalence of penile implants among offenders at Pollsmoor prison, increasing the risk of contracting HIV and Sexually Transmitted Infections (STIs). Penile implants are objects that are placed beneath the skin of the penis by cutting the skin and inserting them. Some of the known objects used by inmates at Pollsmoor prison include, but are not limited to, plastic beads made from broken toothbrushes and shaped on the floor into beads, marbles, and silicone. Inmates refer to a penile implant as a 'lunch bar', comparing it to

[353] Wilcken, Andrea. Keil, Thomas, and Dick, Bruce. "Traditional male circumcision in eastern and southern Africa: a systematic review of prevalence and complications. "Bulletin of the World Health Organization, 2010, 907-914. 907.
[354] Mhlahlo, Andile, P. "What is manhood? The significance of traditional circumcision in the Xhosa initiation rural." MPhil, University of Stellenbosch. 2009. 18.
[355] Danielle Esau, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

a brand of chocolate bar made up of crunchy peanuts and a nougat center covered in a layer of milk chocolate.

Danielle said,

> 'Lunch bar' penile implant is one of the things that inmates do without medical supervision, and this also places them at the risk of contracting other infectious diseases because they use the same equipment to perform those procedures, increasing their risk of STIs and HIV.[356]

A study conducted at French Guiana's correctional facility care unit in 2014, revealed that penile implants interfere with condom use, because offenders with implants have difficulties fitting in condoms over their penile nodules, and reported common condom breakages during anal intercourse.[357] In addition, this body modification can result in several medical complications, such as throbbing pain and inflammation after insertion and infections.

Despite health risks associated with penile implants, Bandile from TB/HIV Care mentioned that they perform VMMC on offenders at Pollsmoor prison who want to get circumcised even though they have penile implants, saying,

> The penile implant does not necessarily affect VMMC, if the beads that are inserted are far from where the circumcision is performed, and we have examined them so that there are no complications, we proceed with the procedure. So, VMMC depends on the clinical assessment of the inmate. If there's any reason not to continue with the procedure, we stop and refer the client to a higher institution for further assessment.[358]

Pre-Exposure Prophylaxis (PREP)

South Africa has the highest number of people living with HIV in the world. In 2019, it was recorded that it has 7.64 million people who were living with HIV, and 4.7 million of those people were on antiretroviral treatment (ART).[359] Despite the significant progress that has been made by the government, Non-Governmental Organizations (NGOs), health and HIV/AIDS activists in recent years, and the introduction of the "Test and Treat All" strategy,

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[356] Danielle Esau, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

[357] Parriault, Marie-Claire. Chaponnay, Amandine. Cropet, Claire. About, Vincent. Perusseau-Lambert, Rock. Nacher, Mathieu and Huber, Florence. "Penile implants and other high risk practices in french Guiana's correctional facility: a cause for concern." *Plos one*, 2019, 1-19. 2.

[358] Bandile Mpehle, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

[359] Republic of South Africa, Department of Health, 2021 Updated Guidelines for the provision of Oral Pre-Exposure Prophylaxis (Prep) to persons at substantial risk of HIV infection. 7.

South Africa still records high rates of new infections. In the meantime, inmates have been at increased risk of contracting HIV/AIDS in prison and upon release. In addition, in the period after release, former inmates ' engagement in behaviours such as multiple overlapping relationships and sex without condoms increases their risk of contracting HIV/AIDS. Sister Asavela revealed that inmates at Pollsmoor prison engage in high-risk behaviors for HIV transmission while incarcerated and after release, and that they frequently return to prison, moving between their communities and Pollsmoor prison, saying,

> In terms of rehabilitation, I don't know if inmates are rehabilitated because we get the same people repeatedly. After their parole, they still came back here. We already know that when someone leaves that they will be back here at Pollsmoor. Especially the ones that are sick and HIV-positive, we know they will come back in about two months, and when they come back, they are severely ill and defaulting on their medication. Those who use drugs and inject themselves also move between their communities and prison.[360]

Echoing her, Dr Johnson said;

> Here we always find the same people over and over again. Some of the inmate patients I speak to before they leave prison do not last more than six months outside; they always come back. When they came back they came back sick and demanded fast service from the nurses who were already understaffed saying they have rights but outside prison, they do not go to the clinics for their medication because we make sure that when they leave here, they have referral letters and the nurses call to check with their outside clinics to ensure they continue with their treatment but they do not show up for appointments and collect their treatment.[361]

In response to high HIV prevalence in inmates, TB/HIV Care introduced Pre-Exposure Prophylaxis (PrEP) in 2021 to offenders at Pollsmoor prison. Prep as defined by the World Health Organisation (WHO) is "the use of antiretroviral drugs by HIV-negative individuals who are at substantial risk of acquiring HIV before potential exposure to HIV to prevent HIV acquisition."[362] Daily oral PreP, including emtricitabine and either tenofovir alafenamide or tenofovir disoproxil fumarate, has demonstrated up to 99% protective efficacy against sexually acquired HIV infection.

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[360] Asavela Sodinga, Nurse, Pollsmoor Maximum Security Prison, Interview by Lesego Mpumelelo Nzuza, 20 September 2024, Transcription Possession of Author.

[361] Dr. Johnson, Doctor, Pollsmoor Maximum Security Prison, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

[362] Republic of South Africa, Department of Health, 2021 Updated Guidelines for the provision of Oral Pre-Exposure Prophylaxis (Prep) to persons at substantial risk of HIV infection.8

Bandile from TB/HIV Care explained that Prep was introduced at Pollsmoor prison as a collaborative initiative by TB/HIV Care, and the Department of Health as a measure to prevent the spread of HIV in prison and improve access to Prep services to the population, saying, "we started with Prep here at Pollsmoor prison about three years ago. It was a partnership between the Department of Health and TB/HIV Care to prevent the spread of HIV in prison."[363]

He continued to explain the process of initiating inmates on Prep at Pollsmoor prison, saying;

> Before we started providing the offender with Prep, we held sessions with peer educators, nurses at Pollsmoor, the HIV/AIDS coordinator, and our team of clinical and non-clinical practitioners to educate inmates about Prep, its side effects, and benefits. After all, for those who are interested in prep, we performed an HIV test. When the test comes back negative and we inform them that there are no complications, then we provide them with Prep.[364]

Inmates on Prep are provided with their medication every month either by nurses from Pollsmoor prison or nurses from TB/HIV Care Non-profit Organisation. Those who are due to be released are counselled, tested, and encouraged to take Prep.

Dr Johnson revealed that at first, the initiation of Prep to inmates was hindered by the pervasive stigma surrounding HIV and gang culture, saying,

> The issue of HIV stigma in prison, although it has gotten better, affects treatment adherence, especially if an inmate is a number (meaning a gang member) because, in a number (gang), inmates have to be strong, and they cannot be sick and take medication. So, those who do take Prep, ART, or TB treatment hide it, and sometimes they end up not taking treatment and default because they were scared of other inmates' remarks and discrimination. We saw that when we got the lab blood results and those who are HIV positive, their viral load is high, and when we asked, the stories started to come up saying 'my bros cannot see me taking medication, they will see me as weak'.[365]

Similarly, Bandile noted that although inmates' attitudes towards Prep have become more positive over the years, other inmates are still scared of taking Prep because Prep is associated with gay men, saying,

[363] Bandile Mpehle, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.
[364] Bandile Mpehle, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.
[365] Dr. Johnson, Doctor, Pollsmoor Maximum Security Prison, Interview by Nzuza 25 November 2024, Transcription Possession of Author.

> Inmates in prison do have consensual sexual intercourse, and this is not something that anyone can manage. Not all the inmates were open to us as healthcare professionals about their sexual orientation. Others were scared to come out, and when they requested prep, they would say it's because they are leaving prison soon. After all, the stigma of being gay prevented some of the inmates from taking prep in prison.[366]

Echoing him, Danielle recalled being taken aback by offenders having an open discussion about sex in prison in one of the sessions they were running at Pollsmoor prison, saying,

> During one of the sessions, I was surprised that some of the inmates were talking about sexual intercourse. One of them even asked me if I knew that some of the offenders were married to one another, not legally, but in prison terms.[367]

She added to say,

> To get inmates to talk about their sex life here in prison and encourage them to take Prep and those who are HIV-positive to take their treatment we called sex between men 'transactional sex' because some of the male inmates who are having sex with other male inmates said they are not gay and they do not want to be referred to as gay. They are engaging in the same sex because they want protection, food, cigarettes, and whatever substance they are into. And when having sessions, I can see the relief from some of the offenders when we say the word transactional sex instead of gay.[368]

Conclusion

In conclusion, this chapter has shown how a focus on gender and sexuality helps tell a more detailed story of the HIV/AIDS pandemic in prisons, and particularly in Pollsmoor prison. The chapter shows that NGO's role changed over time, from a purely advocacy role of the Treatment Action Campaign and the AIDS Law Project, to a more service-oriented role of TB/HIV Care. Over time, these NGOs have had to contend with complex DCS policies, beliefs, and practices among both inmates and prison staff. As Susan Sontang showed in Illness as Metaphor many years ago, diseases are not merely biological, but are implicated in social life.[369] The chapter showed how the landmark 2006 case *EN and Others vs. the Government*

[366] Bandile Mpehle, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.
[367] Danielle Esau, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.
[368] Danielle Esau, TB/HIV Care, Cape Town, Interview by Nzuza 25 November 2024, Transcription Possession of Author.
[369] Sontag, Susan. "Illness as a metaphor." *Farrar, Straus and Giroux*, 3, 1978. 9.

led to the provision of life-saving ARVs in Pollsmoor prison. Ubomi Clinic was a direct result of this case.

The involvement of TB/HIV Care at Pollsmoor prison since 2008 has yielded positive outcomes, notably alleviating the workload of nurses and giving nurses more time to provide primary healthcare to offenders. In 2009 TB/HIV Care team introduced HIV/AIDS educational sessions and peer education. I argue that TB/HIV Care circumvented the challenges of aggressive, masculinity-infused gang culture by giving inmates some autonomy in sharing their experiences and strategies of dealing with HIV/AIDS. The same NGO, following global best practices, introduced VMMC to reduce the transmission of the virus. Facing detrimental cultural beliefs and practices, they have nevertheless largely succeeded in offering VMMC. Another recent intervention by TB/HIV care is PrEP, introduced in 2021, and it is very effective in reducing the spread of HIV/AIDS. Faced with inmates' objections stemming from PrEP's association with gay men, the NGO has nevertheless been effective in communicating the benefits to incarcerated men. In sum, this chapter has shown how NGOs have been crucial in providing HIV/AIDS care and education at Pollsmoor prison. These efforts complemented the work of the Ubomi clinic, where nurses played a key role in the provision of HIV prevention and treatment services.

Chapter 5: Conclusion

This thesis has explored the history of prison nursing regarding HIV/AIDS prevention and treatment. It has drawn on twenty key informant interviews (16 with prison nurses, two with clinical practitioners, and two with non-clinical practitioners from the NGO TB/HIV Care). It has also examined prison laws and policies. It reaches several conclusions, including that nurses have had to operate in dual systems (DCS and DOH) in ways that have affected their provision of health care services. It has discussed how factors such as prison gangs and violence, transactional sex, substance abuse, and overcrowding have affected inmates' vulnerability to HIV infection and their uptake of HIV prevention services offered by the nurses. Finally, it has discussed AIDS activism starting with the TAC's litigation and ending with TB/HIV Care's work providing HIV prevention and treatment services, and this advocacy improved prison nurses' ability to care for inmates vulnerable to, and living with, the virus.

Chapter Two, entitled: 'Dual System of the Department of Correctional Services and Department of Health', explored the complexities of nursing in a dual system of the Department of Correctional Services (DCS) and Department of Health (DOH) examining how the Prison Act No. 8 of 1959 influenced and shaped everyday realities of nurses working at Pollsmoor prison during and post-apartheid. This served as a dialectical purpose, through a close review of this piece of legislation, consulting with nurses' memories from transcribed interviews and documentary sources. This was done to provide apartheid experiences of nurses working inside Pollsmoor prison clinics, responsible for maintaining the health of inmates inside a militarized, unhealthy, overcrowded, and racially divided prison facility. Chapter Two also unveiled how the issues of violence and human rights violations were compounded by the fact that the Prison Act No. 8 of 1959 administered prisons as a military institution and restricted any writing about prison conditions until 1992, when it was amended. Moreover, this chapter explored the complexities and issues brought by prison reforms and demilitarization of correctional facilities in the late 1990s to early 2000s for healthcare professionals at Pollsmoor prison. This offered an insight into everyday barriers nurses faced when providing healthcare to HIV-positive inmates and discussed that despite the efforts taken to reform correctional facilities, Pollsmoor prison infrastructure and healthcare resources remained inadequate, hindering nurses' ability to cater to inmates' health needs. With specific reference to the Remand Detention Facility (RDF), where gross human rights violations and torture of inmates occurred during apartheid, and was repurposed as a clinic. Furthermore, Chapter Two delved into nurses' ethical dilemma that arose from working in a prison clinic that is not conducive for healthcare to providing healthcare

services, and where security concerns and healthcare priorities often clash. Finally, by examining the histories of prison nurses and exploring the contemporary realities of nursing in a dual system of DCS and DOH, this chapter concluded by unveiling persistent challenges of nurses at Pollsmoor and that the relationship between nurses, inmates and wardens is influenced by multiple factors including the legacy of apartheid laws, prison gangs and fear of unpredictable inmates behaviors.

Chapter Three, 'The management of HIV/AIDS at Pollsmoor Maximum Security prison', explored the complex issue of HIV/AIDS at Pollsmoor, beginning by analyzing the first policy that was formulated and passed by the Department of Correctional Services (DCS) in 1992 in response to HIV/AIDS epidemic the "Management Strategy: AIDS in Prisons". This policy was found to be conservative, including forced segregation of HIV-positive inmates and those suspected to have contracted HIV, which was later rescinded when DCS came under scrutiny for not adhering to the international guidelines on HIV/AIDS set by the World Health Organization (WHO) in 1993. This was done to provide a background history of the apartheid policies and laws that influenced and regulated healthcare and the management of HIV/AIDS in prison towards the end of apartheid and the early 2000s at the height of HIV/AIDS. After the historical analysis of the policies passed by DCS in response to HIV/AIDS epidemic in prisons during the late 1990s to the early 2000s, Chapter Three, examined sexual risk factors contributing to the transmission of HIV/AIDS at Pollsmoor prison consensual and coerced sex including other risk factors namely violence, tattooing and substance abuse. In addition, this chapter explored the challenges nurses were faced with when providing care to HIV-positive inmates at Pollsmoor prison before the advent of antiretroviral therapy (ART) and further discussed how the introduction of Ubomi Clinic a specialized HIV/AIDS clinic that was established at Pollsmoor prison in 2008 streamlined care and made management of HIV/AIDS in prions easier. The oral histories analyzed in this chapter explored nurses' memories, alongside documentary evidence to construct nurses' everyday realities and histories, politics, and challenges they encountered in managing HIV/AIDS at Pollsmoor in the late 1990s to the early 2000s. Finally, the chapter addressed the issue of Condom distribution to inmates and the persistent issue of HIV/AIDS stigma and discrimination that was largely perpetuated by inmates' and correctional officers' fear of the unknown and patriarchal structures within gangs.

Finally, Chapter Four, 'NGOs and the management of HIV/AIDS at Pollsmoor Prison', examined the involvement of NGOs. This chapter examined the involvement of Non-Government Organizations, HIV/AIDS activists, and health professionals in advocating for

inmates' access to HIV/AIDS treatment and care in prison. It began by presenting a historical analysis of how the Treatment Action Campaign (TAC) used litigation and campaigns to effectively advocate for people access to antiretroviral treatment (ARV) for HIV/AIDS since the late 1990s. In addition, through close examination of the lawsuit by the Aids Law Project (ALP) against the Department of Correctional Services (DCS) *EN and Other v The Government of the Public South Africa and Others,* this chapter unveiled the barriers in DCS that prevented awaiting trial and sentenced inmates living with HIV from accessing treatment and medical care in the early 2000s. Furthermore, this chapter highlighted some significant historical events and turning points to the management of HIV/AIDS at Pollsmoor prison and Westville Correctional Centre made possible by pressures imposed to because of the ALP lawsuit that drew media attention to DCS and pressures coming from HIV/AIDS activists and medical professionals. Chapter Four also examined HIV/AIDS education facilitated by the TB/HIV Care Non-Governmental Organization team of clinical and non-clinical practitioners, to nurses, inmates, and correctional officials, including capacity building and inmate peer education. Lastly, this chapter highlighted the introduction of Pre-Exposure Prophylaxis (Prep) introduced by TB/HIV Care at Pollsmoor Prison in 2020 as a measure to reduce HIV transmission and addressed cultural and traditional beliefs on Voluntarily Medical Male Circumcision (VMMC) another measure introduced by TB/HIV Cape in 2015 at Pollsmoor prison to reduce HIV transmission and concluded that the strong sense of traditional, cultural and religious beliefs held by both prison officials and inmates.

Concluding remarks: Possible areas of further research

This thesis has explored the history of prison nursing regarding HIV/AIDS prevention and treatment. It has drawn on twenty key informant interviews (16 with prison nurses, two with clinical practitioners, and two with non-clinical practitioners from the NGO TB/HIV Care). However, it is significant to note that there were a few limitations on the research data, and some areas could have been further explored to provide a more comprehensive analysis. Engaging with prison nurses' trade unions through oral history interviews could provide more insights into nurses' working conditions, grievances, and the challenges they have experienced. Additionally, interviews with inmates who are identified as low risk could have offered valuable insights into the effectiveness of Ubomi Clinic services and changes and continuities in their access to HIV/AIDS counseling, testing, and treatment in prison. Interviews with prison wardens responsible for collecting HIV treatment for inmates living with HIV and escorting

them to hospitals on the outside for their doctors' appointments could provide further valuable insights. While this thesis focused on the management of HIV/AIDS in the male section of Pollsmoor Maximum Security Prison, future research could explore the experiences of nurses involved in the management of HIV/AIDS in the women's prison and the mother-and-baby unit (BMU). Although these sections of the prison were briefly described to present a fuller picture of the history of, and present day realities at, Pollsmoor prison complex, women prisoners' HIV/AIDS-related challenges and the specific dynamics of the HIV treatment services they receive are particularly deserving of further study, especially in relation to perinatal HIV services and maternal health, and the paediatric health services provided for infants born within the correctional centre. The timeframe of this study, combined with ethical clearance delays from the Department of Correctional Services (DCS), limited access to these sections, and shaped the final scope of the research.

Future research could also address the challenges that health professionals and other patients using public health facilities face in sharing healthcare facilities with inmates. It could also shed light on the relationship between outside health professionals and prison health professionals, and wardens. Furthermore, more oral history interviews with retired prison nurses could contribute to a richer historical dimension about the management of HIV/AIDS at Pollsmoor prison in both the apartheid and post-apartheid eras. Additionally, the section of Pollsmoor prison that houses LGBTQIA+ inmates, mentioned in this thesis but not examined in detail, presents another critical site for future inquiry, particularly regarding how sexuality, stigma, and institutional policy intersect in the provision of healthcare and HIV prevention services.

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Appendix 1

correctional services

Department:
Correctional Services
REPUBLIC OF SOUTH AFRICA

Private Bag X136, PRETORIA, 0001 Poyntons Building, C/O WF Nkomo and Sophie De Bruyn Street, PRETORIA Tel (012) 307 2770, Fax 086 539 2693

Dear Mr L M Nzuza

RE: The Politics of Prison Nursing and HIV/AIDS at Pollsmoor Maximum Security Prison 1990-2008.

I wish to inform you that your request to conduct research in the Department of Correctional Services has been approved Your attention is drawn to the following:

- This ethical approval is valid from **31 July 2024 to 31 July 2025**
- The relevant Regional and Area Commissioner where the research will be conducted will be informed of your proposed research project.
- You are requested to contact the Area Commissioner before the commencement of your research.
- It is your responsibility to make arrangements for your interviewing times.
- Your identity document/passport and this approval letter should be in your possession when visiting regional offices/Correctional Centers.
- You are required to use the terminology used in the White Paper on Corrections in South Africa (February 2005) and Correctional Services Act (No. 111 of 1998) e.g. "Offenders" not "Prisoners" and "Correctional Centers" not "Prisons".
- You are not allowed to use photographic or video equipment during your visits, however the audio recorder is allowed.
- Comply with COVID - 19 safety and hygiene procedures during data collection processes
- Ensure that all participants have been duly screened for Covid19 according to DCS screening protocols
- You are required to submit your final report to the Department for approval by the Commissioner of Correctional Services before publication (including presentation at workshops, conferences, seminars, etc.) of the report.

Should you have any enquiries regarding this process, please contact the REC Administration for assistance at telephone number (012) 307 2059

Thank you for your application and interest to conduct research in the Department of Correctional Services.

Yours faithfully
YRE: GEkES
Ses
ND MBULI Chair:
DCS REC DATE:
31/07/2024

Appendix 2

Department of Historical Studies

Research Ethics Committee

Private Bag X3, Rondebosch, 7700
235 Beattie Building, 5 University Avenue, Rondebosch, 7701

E-mail: adam.mendelsohn@uct.ac.za
Internet: www.historicalstudies.uct.ac.za

7 June 2024

Dear Lesego Mpumelelo Nzuza,

HSTREC04/2024: "The Politics of Prison Nursing and HIV/AIDS at Pollsmoor Maximum Security Prison 1990-2008."'

The HSTREC has reviewed the above research proposal and found it to be compliant with ethical research best practice in the Faculty of Humanities at the University of Cape Town.

Yours sincerely

Professor Adam Mendelsohn
Chair HSTREC

"Our Mission is to be an outstanding teaching and research university, educating for life and addressing the challenges facing our society."

Appendix 3

Participant Information Sheet (PIS)

Dear Sir / Madam

My name is Lesego Mpumelelo Nzuza and I am a master's student in the Department of Historical Studies, Faculty of Humanities, at the University of Cape Town. My supervisor is Associate Professor Mandisa Mbali. I am conducting a research study to learn more about the experiences of prison nurses and HIV/AIDS at Pollsmoor Maximum Security Prison, how nursing operates within the prison context, and how nursing practices and cultures in prison have changed between 1990 and 2008. The study title is: **The Politics of Prison Nursing and HIV/AIDS at Pollsmoor Maximum security Prison 1990-2008**.
I am inviting you to take part in an interview. If you decide to take part in an interview, your participation in this research study will last about 45 minutes to an hour. The interview will take place at the comfort of your home, or another venue of your choosing – either face to face or online.

With your permission, I would like to audio record the interview. This data will be stored in google drive protected by a password for 1 year and be deleted after a year. Only the researcher will have access to the data. Any hard copies of research materials will be kept under lock and key.

During the interview, I will need to ask for some personal information about you, including your upbringing, educational background and working conditions. Data collection during the interview of this research will be confidential. When I share the results of this research, I will not include your name or anything else that could identify you, if you do not wish me to do so. In this instance I will use a pseudonym to protect your identity. With your permission, other researchers may use the data collected from this research study, but your name and any personal information will not be used or passed on.

If you decide to take part in the research study, it should be because you want to volunteer. You do not have to take part. You can stop being in the study at any time. You do not have to answer any questions if you do not want to. You will not get any direct benefits if you choose to join the research study. You will not lose any services, benefits or rights you would normally have if you

decided not to join. Taking part in the research study will not cost you anything. You will not be paid for being in this research study.

The risks for this research study are no more than what happens in everyday life. If some of the questions asked may make you feel sad or upset, I will stop the interview and continue another time.

This research study will be written up as a master's dissertation. The dissertation will be available on the university library website. If you want to receive a summary of this report, I will be happy to send it to you.

If you have any questions during or afterwards about this research study, feel free to contact me or my supervisor on the details listed below. If you have any concerns or complaints about the ethical procedures of this research study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), email: Deputy Dean: Research and Internalization - Associate Professor Ryan Nefdt (Acting) ryan.nefdt@uct.ac.za ; Head of Department Historical Studies; Professor Adam Mendelsohn; email: adam.mendelsohn@uct.ac.za

Yours sincerely,
Lesego Mpumelelo Nzuza

Researcher:
Lesego Mpumelelo Nzuza
NZZLES001@myuct.ac.za
068 019 4873

Supervisor:
Associate Professor. Mandisa Mbali
Mandisa.mbali@uct.ac.za

Appendix 4

University of Cape Town
Faculty of Humanities

Consent Form

TITLE OF PROJECT

The Politics of Prison Nursing and HIV/AIDS at Pollsmoore Maximum Security Prison 1990-2008.

NAME OF RESEARCHER

Lesego Mpumelelo Nzuza

I, ……………………………………….., agree to participate in this research project.

I agree to the following:

(Please circle the relevant options below)

The research study was explained to me. I understand what this study is about.	YES	NO
I understand that I can volunteer to take part in the study	YES	NO
I agree that the interview may be audio recorded	YES	NO

I agree that direct quotations from my interview may be used by the researcher in their research report	YES	NO
I agree that my participation will remain anonymous (my name will not be used by the researcher in their research report/manuscript/book chapter)	YES	NO
I agree that other researchers may use the information I provide in my interview/questionnaire (depending on their own ethics clearance being obtained) but my name and any personal information will not be used or passed on	YES	NO

…………………………………… (signature)
…………………………………… (Name of participant)
…………………………………… (date)

…………………………………… (signature)
…………………………………… (name of researcher/person seeking consent)
…………………………………… (date)

Researchers Contact details:

Contact Number:	0680194874
Email address:	NZZLES001@myuct.ac.za

Appendix 5

Interview Schedule for Prison Nurses

1) Demographic information

Race:

Gender:

Age:

2) Tell me about your upbringing?
   - Where and when were you born?
   - Tell me about your education background?
3) How did you come to work in prison as a prison nurse?
   - How long have you worked as a prison nurse?
   - When you get employed as a prison nurse- do you undergo any specific training? If yes, can you tell me more about it?
4) Have you worked as a nurse in other clinical settings (public, private, overseas, community rural nursing)?
   - If so which ones and for how long?
5) Have you seen any changes in terms of how nursing operates in prison during this period?
6) What kind of tasks and activities do you do as a prison nurse?

- What are your working hours and conditions?

7) How do you feel about your working conditions?
8) What is your relationship with your patients like?
9) How would you describe the relationship between prison nurses and prison wardens?
10) What are some of the highlights of your job? (And some of the challenges?)
11) Would you advise current nursing students to choose this career?
12) If you have worked outside prison as a nurse, how does it compare?
13) Do you have contact with other nurses who work outside of prison in other settings?
    - What is your relationship with them?
14) How did HIV/AIDS impact nursing conditions in the late 1990s to the early 2000s in prison?
15) When you first started off nursing – how did you see yourself and your profession?
    - How do you see yourself now and your profession?