‘WE’VE COME FROM THE GUTTER, WE’RE GOING BACK TO THE GUTTER’: AN EXPLORATORY STUDY OF HEALTHCARE CONDITIONS IN POLLSMOOR PRISON

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ABSTRACT

In recent years, public discourse on South African prison healthcare has highlighted a significant gap in contemporary research. While existing literature have laid a foundational understanding, there remains a lack of empirical studies addressing the changing healthcare dynamics within these institutions. Prisons, often veiled from public scrutiny, present unique challenges in understanding the actual healthcare conditions without direct investigation. This study aims to fill this gap by focusing on healthcare at Pollsmoor Medium B, a unit of the well-known Pollsmoor Correctional Centre. It focuses on identifying the specific barriers inmates face in accessing healthcare services within this facility. Through extensive thematic analysis of qualitative data collected through interviews and document reviews, the research uncovers that the healthcare provisions at Pollsmoor Medium B are markedly substandard, failing to meet both national and international human rights norms. While it is unclear whether these conditions are uniformly prevalent across all prison units, the findings indicate systemic issues with management and healthcare service delivery. The study concludes with a strong recommendation for thorough reforms to ensure the health rights of inmates are protected and upheld.

LIST OF ABBREVIATIONS

ARV	:	Antiretroviral Therapy
CSA	:	Correctional Services Act
DCS	:	Department of Correctional Services
JICS	:	Judicial Inspectorate for Correctional Services
NGO	:	Non-Governmental Organisation
RDF	:	Remand Detention Centre
TB	:	Tuberculosis

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Chapter 1: Introduction

1.1. Background to the Study

Healthcare in South African Correctional Centres[1] have been of particular concern for human rights organisations, advocates, researchers and the Department of Correctional Services (DCS). The Correctional Services Act (CSA) (Act 111 of 1998, as amended in 2011), positions these centres not only as places of detention but also as environments where healthcare and rehabilitation should be paramount. Yet, reports like the Cameron report (2015) and court rulings including *Sonke Gender Justice v. the Government of the Republic of South Africa*[2] (hereinafter referred to as *Sonke Gender Justice*), have continually highlighted the gap between policy and practice in these settings.

Pollsmoor Prison, set in the suburb of Tokai in Cape Town, emerges as a microcosm of the challenges facing healthcare in Correctional Centres. Overcrowding, inadequate medical staffing, and poor environmental conditions have been cited as persistent issues affecting prisoners' health[3]. This has led to a higher prevalence of diseases like tuberculosis (TB), HIV/AIDS, hepatitis C, and syphilis, along with mental health disorders, chronic diseases and even deaths (Dissel, 2002; Keehn and Nevin, 2018a; Mabena, 2023).

This study explores these challenges in depth, with Pollsmoor Medium B serving as a focal point. By analysing incident reports, healthcare data, and presenting the views of recently released inmates from this Correctional Centre, the study seeks to provide a better understanding of the healthcare needs and barriers faced by inmates, with the goal of improving health outcomes and upholding their fundamental rights.

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[1] In this thesis, the term 'Correctional Centre' is used as defined by the CSA (Act 111 of 1998, as amended in 2011). The CSA defines a 'Correctional Centre' to include any 'place for the reception, detention, confinement, training, or treatment of persons liable to detention in custody or under protective custody.' This encompasses not only the main facilities but also extends to 'outbuildings and premises adjacent to any such place and used in connection therewith and all land, branches, outstations, camps, buildings, premises, or places' used for related purposes such as 'incarceration, detention, protection, labour, treatment, or otherwise.' Additionally, it includes 'quarters of correctional officials' and, in specific situations, 'places used as police cells or lockups.'

[2] *Sonke v Government of Republic of South Africa* 24087/15 (unreported).

[3] Throughout this thesis, the terms 'offenders,' 'inmates,' and 'prisoners' are used interchangeably. While each term connotes a slightly different meaning, they are commonly used within the prison system to refer to incarcerated individuals. This interchangeable usage reflects the vernacular of the prison system and is not intended to imply any specific legal or sociological distinctions among these groups.

This study extends the scope of current research beyond the legal frameworks to the tangible impact of healthcare provision in correctional settings. A literature review incorporating academic studies, reports from political and oversight bodies will shed light on the day-to-day realities within Pollsmoor Medium B. Chapter four enriches this examination by offering detailed information on the living conditions prevalent in the facility. The literature review is structured thematically, with each section building upon the previous, steering the reader towards an in-depth understanding of the interplay between healthcare delivery, human rights, and the management of a Correctional Centre such as Pollsmoor. Chapter five will present the findings of the research, detailing the challenges and limitations faced by inmates in receiving healthcare services, as well as the innovative practices that have emerged as responses to these challenges. Chapter 6 will critically examine the research findings within the broader academic and practical discourse on healthcare provision in Pollsmoor Prison. Chapter seven will conclude the study by summarising the key findings and offering future research directions.

1.2. Problem Statement

Pollsmoor Prison has been internationally recognised as one of the worst prisons in South Africa (RFI, 2015; McKenzie, 2016). Reports up to 2016 indicated severe overcrowding, with some cells reaching 200% occupancy and even 300% in the Remand Detention Centre (RDF), exacerbating the spread of diseases like TB and pneumonia (Rademeyer, 2014; Cameron, 2015, p. 5). The conditions within the prison often fell short of basic living standards, with instances of inmates sleeping on floors without mattresses, and facing issues like leaking roofs and lack of access to hot water (Rademeyer, 2014; Cameron, 2015, pp. 31-32).

Access to healthcare professionals in Pollsmoor has historically been limited. Even until very recently, a doctor was available for consultations only one day a week, and there have been extended periods when dental services were completely inaccessible (Rademeyer, 2014; Petersen, 2023). This scarcity of medical staff has been a widespread problem across South Africa's prisons, contributing to inadequate healthcare provision.

The management of HIV/AIDS within Pollsmoor Prison has been a critical issue, particularly in light of the Constitutional Court's recognition of DCS responsibility for healthcare in prisons,

as established in the case *Lee v. Minister of Correctional Services*[4] (hereinafter referred to as *Lee v. Minister*). Despite efforts by DCS to implement better screening and treatment services, there have been consistent issues with access to antiretroviral therapy (ARV) (Keehn and Nevin, 2018b, p. 219). Additionally, ensuring that inmates receive the necessary dietary support and regular monitoring of their HIV status has been challenging (Rademeyer, 2014). Compounding these issues are the material conditions within the facility, such as inadequate ventilation and lack of access to hot water, which have further hampered the effectiveness of these health measures (Cameron, 2015; Skosana, 2015).

In 2016, Sonke Gender Justice, a non-profit organisation (NGO) committed to advocating human rights, presented a landmark legal challenge before the Western Cape High Court.[5] This case centred on the critical issues of extreme overcrowding and substandard living conditions within Pollsmoor RDF. One of the most pivotal aspects of the court's order was the directive for the government to reduce the detainee population at Pollsmoor RDF to no more than 150% of its officially approved capacity within a six-month timeframe. This specific mandate addressed the critical issue of overcrowding directly, aiming to alleviate the inhumane conditions caused by excessive inmate numbers.

The catalyst for the case stemmed from the findings of the Cameron report (2015), a detailed investigation led Edwin Cameron, previously a Judge of the Constitutional Court and currently serving as the Inspecting Judge of the Judicial Inspectorate for Correctional Services (JICS) — the oversight entity for prison conditions in South Africa. The report provided an in-depth analysis of conditions within Pollsmoor Prison and showed systemic failures in the prison. It also offered recommendations for reforms aimed at ensuring the humane treatment of inmates and the observance of their constitutional rights.

1.3. Research Questions

Despite all the concerns raised by legal institutions, human rights organisations and monitoring bodies regarding the healthcare conditions in Pollsmoor, there is a notable gap in thorough, up-to-date documentation and evaluations that detail the current situation within the facility. This

[4] *Lee v. Minister of Correctional Services* 2013 (2) SA 144 (CC).
[5] See note 2.

study, therefore, seeks to fill this gap by conducting an in-depth investigation into the healthcare conditions at Pollsmoor. The research will focus on the following key questions:

1. What barriers do inmates face when accessing healthcare services within Pollsmoor Prison? This question seeks to identify the specific systemic, logistical, human, and infrastructural obstacles that impede inmates' access to medical care.

2. What strategies could be effectively implemented to align the conditions in Pollsmoor Prison with national and international human rights standards for inmate care and health? This question explores potential strategies, reforms, and policy changes necessary to meet prescribed standards.

This research considers healthcare services within Pollsmoor Medium B, with a focus on understanding it from the perspectives of those who experience it first-hand — the inmates. The study assesses how the physical layout of the facility, the condition and quality of healthcare facilities, the nature of interactions between health professionals and offenders, and the overall management of space within the prison contribute to the healthcare services provided.

1.4. Purpose of the study

The purpose of this study is to conduct a critical examination of the healthcare conditions in Pollsmoor Prison and to understand their implications within the realms of health, human rights, and the criminal justice system. As one of the most famous and overcrowded facilities in the Western Cape (Ishmail, 2019), Pollsmoor Prison presents unique challenges in providing healthcare services to inmates. The substantial inmate population strains the existing healthcare infrastructure, leading to understaffing, resource limitations, and protracted waiting times for medical attention. This study documents and analyses these conditions, providing a detailed account of the healthcare system's operational challenges within the prison.

Moreover, this study considers the intricate relationship between the health rights of prisoners and the responsibilities of the State. It examines the extensive case law history concerning healthcare in South African correctional facilities, with a focus on Pollsmoor Prison. Central to this exploration are questions about the State's obligation to provide proper healthcare to

prisoners and the moral duties of healthcare workers within prisons. Through this lens, the study deepens the understanding of the State's role in protecting the health of prisoners and to suggest possible improvements to healthcare services at Pollsmoor Prison.

The research focuses on Pollsmoor Medium B as a case study to examine the healthcare conditions within the facility. The possibility for this case study to be replicated in other sections of Pollsmoor or similar Correctional Centres is significant — such replication could broaden the scope of understanding of healthcare in these settings. More data gathered from this study and any future research could lead to better health policies and interventions specifically designed for prison healthcare, with the aim of improving prisoners' health.

Chapter 2: Literature Review

2.1. Introduction

This chapter familiarises the reader with the theoretical foundations of health rights for prisoners at both national and international levels and looks at the legislative and policy frameworks that enjoin the State to ensure the health of inmates. It also examines the historical and present-day obstacles that hinder the accessibility of healthcare services, with an emphasis on Pollsmoor Prison. It further considers the complex dynamics of prison culture, such as the impact of gang activity on inmate health and welfare. The chapter concludes by identifying gaps in the literature, particularly following the *Sonke Gender Justice* judgment.

2.2. The Legal Framework Pertaining to the Right to Health for Prisoners

2.2.1. The South African Legal Framework

The South African legal framework concerning the right to health for prisoners is primarily rooted in the Constitution, supplemented by various legislative Acts, policies, and judicial interpretations. This framework serves as the bedrock for healthcare provision within the country's prison system and delineates both the rights of prisoners and the obligations of the State.

The Constitution of the Republic of South Africa (Act 108 of 1996) is the supreme law of the land and Section 35(2) addresses the rights of detained individuals, including sentenced prisoners, regarding their health. Section 35(2)(e) specifically states that 'everyone who is detained has the right to conditions of detention that are consistent with human dignity including at least the provision, at state expense, of adequate accommodation, nutrition, reading material, and medical treatment.'

Beyond the Constitution, several legislative Acts govern healthcare in South African prisons, with the CSA being particularly noteworthy. This Act explicitly outlines the responsibilities of DCS in ensuring the welfare of inmates, including their right to healthcare. Section 12(1) of the Act mandates that 'DCS must provide, within its available resources, adequate healthcare

services.’ Additionally, section 12(2)(a) sets out the obligation to provide ‘adequate medical treatment.’ Further detailing this, section 12(2)(b) specifies that ‘medical treatment must be provided by a correctional medical practitioner, medical practitioners, or by a specialist or healthcare institution identified by such a practitioner.’ Section 12(3) addresses the option for an inmate to ‘be visited and examined by a medical practitioner of his or her choice and, subject to the permission of the Head of Centre,’ thus ensuring a degree of autonomy in healthcare decisions for inmates. Finally, section 12(4) expands on provisions such as the encouragement for necessary treatment, and the requirement for informed consent for surgery. Exceptions to these provisions are noted for cases where an inmate’s health is at immediate risk, or they are unable to provide consent.

The Mental Health Care Act (Act 17 of 2002) also play a major role in the framework surrounding the health rights of prisoners in South Africa. Chapter VII of this Act specifically addresses the care and treatment of mentally ill prisoners and mandates the designation of ‘health establishments’ capable of admitting, caring for, treating, and rehabilitating mentally ill prisoners, as per section 49. Section 50 introduces a procedure for the enquiry into a prisoner’s mental health status, triggered by observations or information suggesting a prisoner may be mentally ill. For prisoners diagnosed with a mental illness that can be appropriately managed within the prison system, section 51 stipulates that ‘the necessary steps’ must be taken to provide the requisite ‘levels of care, treatment, and rehabilitation services.’ Furthermore, section 54 allows for the periodic review of the mental health status of mentally ill prisoners, requiring that their condition ‘be reviewed every six months.’

The National Health Act (Act 61 of 2003), specifically in Section 21 and Section 2, underscores the South African government’s commitment to ensuring that health services are accessible to all, including prisoners. According to Section 2, the objective of the Act is to establish ‘a national health system’ offering ‘the best possible health services’ and to uphold the rights of all South Africans to access health care services. Section 21 mandates the Director-General to ‘ensure the implementation of national health policy,’ which notably includes ‘health services for convicted persons and persons awaiting trial.’

Soft law is also part of the South African legal landscape. The White Paper on Corrections in South Africa (2005) is a significant policy document that provides a framework for the rehabilitation and management of offenders within the country’s correctional system, including

aspects related to the healthcare of inmates. Specifically, the chapter on 'Safety and Health of Offenders' recalls DCS' responsibility to provide a safe and healthy environment for inmates as part of their rehabilitation (White Paper on Corrections in South Africa, 2005, p. 78). The White Paper reinforces the principle that inmates have a right to healthcare, aligning with national and international human rights standards (White Paper on Corrections in South Africa, 2005, p. 78). It acknowledges that inmates should have access to health services equivalent to those available to the general community (White Paper on Corrections in South Africa, 2005, p. 78). Given the higher risk of disease transmission in prisons, the White Paper also emphasises the need for effective management strategies for communicable diseases such as 'programmes to reduce the impact of HIV/AIDS' (White Paper on Corrections in South Africa, 2005, p. 79).

The White Paper on Remand Detention Management in South Africa (2014) also contains good intentions regarding the improvement of the quality of health services for pretrial detainees. Notably, it states that Pollsmoor RDF must ensure that decent health conditions are maintained for the detainees. In case a detainee is in a serious physical condition, it is imperative for the centre to report the facts to the Court in order to judge a placement in a health institution (White Paper on Remand Detention Management in South Africa, 2014, p. 13).

2.2.2. The International Human Rights Framework

The international legal framework governing the right to health for prisoners is anchored in a series of conventions, treaties, and guidelines which collectively establish normative standards for healthcare in detention facilities and outline the obligations of states to ensure adequate healthcare services within these settings. Among the most prominent United Nations instruments are the Universal Declaration of Human Rights (UDHR)[6] and the International Covenant on Economic, Social and Cultural Rights (ICESCR)[7]. Article 25 of the UDHR implicitly includes prisoners in its establishment of the right to a standard of living adequate for health and well-being. The ICESCR goes further to explicitly recognise the right to the highest attainable standard of physical and mental health in Article 12. General Comment No. 14[8] elaborates on states' obligations to provide healthcare that is available, accessible,

[6] UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A (III).
[7] UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3.
[8] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4.

acceptable, and of good quality, extending these requirements to prisoners (Committee on Economic, Social and Cultural Rights, 2000, p. 34).

In addition to these global instruments, regional frameworks also play a role in safeguarding inmate's rights to healthcare services. For instance, the African Charter on Human and Peoples' Rights (ACHPR)[9] recognises the right to enjoy the best attainable state of physical and mental health in Article 16 and prohibits torture and cruel, inhuman, or degrading punishment and treatment in Article 5. This has several implications for prison healthcare. Firstly, it implies that conditions in prisons, including healthcare facilities, must not be cruel or degrading. Secondly, it means that the withholding of necessary medical care can be seen as a form of cruel or inhumane treatment, thereby obligating prison authorities to ensure timely and adequate medical attention to inmates. Finally, as a signatory to the Charter, South Africa is obligated to ensure that its prison healthcare services adhere to the standards set forth in the Charter.

The European Prison Rules (as revised in 2020), while not specific to South Africa, offers extensive guidelines on the health and well-being of prisoners. Amongst other, it mandates the integration of prison health care with national health system (Rule 40.2). This includes providing medical, surgical, and psychiatric services, ensuring access to qualified health care professionals, and offering specialised care when necessary (Rule 40.5). A significant emphasis is placed on the duties of medical practitioners to examine, treat, and maintain the confidentiality of prisoners' health conditions, with specific attention to those in solitary confinement and those with mental health issues (Rules 42.1 to 45.2). These guidelines, though European, could be influential in shaping health care practices within South African correctional services.

Finally, the United Nations Standard Minimum Rules for the Treatment of Prisoners, commonly known as the Nelson Mandela Rules[10], provide clear guidelines on various aspects of prison management, including healthcare services. It emphasises equivalence with community healthcare standards and access without discrimination based on legal status (Rule 24). These rules mandate prisons to have a dedicated healthcare service focusing on both physical and

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[9] Organization of African Unity (OAU), African Charter on Human and Peoples' Rights ("Banjul Charter"), 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).
[10] UN General Assembly, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules): resolution / adopted by the General Assembly, 8 January 2016, A/RES/70/175.

mental health, staffed by qualified interdisciplinary teams including psychologists, psychiatrists, and dentists (Rule 25). Healthcare professionals are tasked with examining new prisoners for various health needs and risks, maintaining the same ethical standards as in community healthcare, including respect for patient autonomy and confidentiality (Rules 30 and 32). Rules 33 to 35 underline the responsibility of healthcare professionals to report on health risks posed by imprisonment or prison conditions, document signs of torture or inhumane treatment, and regularly inspect and advise on prison conditions affecting health.

Although these international instruments do not automatically become law in South Africa and are not inherently binding on states, they serve as interpretive aids for courts and provide normative standards that guide policy formulation and implementation.

2.3. Access to Healthcare Services in South African and Pollsmoor Prisons

2.3.1. The Genesis of the Fight for Access to Healthcare in South African Prisons

Access to health services in South African prison has been a long-standing concern, with reports and court cases citing inadequate facilities, understaffing and limited access to medical care. The government and DCS have repeatedly faced legal action for failing to provide basic health services to inmates.

In 1997, the South African State was challenged in the case of *Van Biljon v. Minister of Correctional Services*[11] (hereinafter referred to as *Van Biljon*). This case emerged as a crucial touchstone in defining the extent of healthcare rights for inmates within the South African correctional system. In this case, the petitioners, a group of prisoners, confronted the State's failure to provide them with ARV, arguing that this neglect constituted a violation of their rights under the Constitution of South Africa. The core of their argument was about the interpretation of Section 35(2)(e) of the Constitution, which guarantees prisoners the right to 'conditions of detention that are consistent with human dignity,' including the provision of adequate medical treatment. The High Court's decision in this case was ground-breaking in its affirmation that the right to health care, as enshrined in the Constitution, extends to prisoners and that incarceration does not mean a forfeiture of fundamental human rights.

[11] *Van Biljon v. Minister of Correctional Services* 1997 (4) SA 441 (C).

Eight years after *Van Biljon*, the Constitutional Court addressed similar issues in *Stanfield v Minister of Correctional Services*[12] and *Du Plooy v Minister of Correctional Services*[13] (hereinafter referred to as *Du Plooy*). Both cases involved challenges to the refusal of medical parole for terminally ill inmates, emphasising the importance of humane treatment and the prisoners' rights under the South African Constitution. The first case involved Colin Stanfield, a prisoner diagnosed with terminal lung cancer, who applied for parole on medical grounds under section 69 of the CSA. His application was rejected by prison authorities, leading to a court review. The court scrutinised the decision, considering the applicant's right to dignity and the adequacy of medical facilities in prison. It concluded that the decision to deny parole was 'irrational and unreasonable,' failing to account for the applicant's terminal condition and inherent right to human dignity. The court ordered immediate parole, stressing the importance of humane treatment and dignity for terminally ill prisoners.

In *Du Plooy*, the court reviewed the decision to deny medical parole to an inmate suffering from terminal illness. The inmate, convicted of armed robbery and sentenced to 15 years, applied for medical parole due to chronic myeloid leukaemia. The refusal to grant parole was found to be 'irrational and unreasonable,' violating his constitutional rights, including the right to human dignity. The decision was set aside, and the court ordered his immediate release on medical parole, recalling the importance of treatment for terminally ill prisoners.

In 2006, *EN and Others v Government of the Republic of South Africa and Others*[14] (hereinafter referred to as *EN and Others*) highlighted ongoing challenges in accessing ARV therapy for prisoners. This case, reminiscent of *Van Biljon*, focused on HIV/AIDS positive prisoners at Westville Correctional Centre who were denied ARV treatment. The court ruled the government's failure to provide ARV treatment as a breach of its constitutional duty to ensure adequate medical care for prisoners, leading to a 'structural interdict' mandating government action to rectify this.

[12] *Stanfield v Minister of Correctional Services* 2004 (4) S.A. 43 (C).
[13] *Du Plooy v Minister of Correctional Services* 2004 (3) All S.A. 613 (T).
[14] *EN and Others v Government of RSA and Others* (2006) AHRLR 326 (SAHC 2006).

2.3.2. Legal Battles for Access to Healthcare in Pollsmoor Prison

Despite significant legal rulings, the 2007 report by the Correctional Services Portfolio Committee — a body within the legislative branch of the government, responsible for oversight and legislative matters related to correctional services — found persistent healthcare issues in Pollsmoor Prison. A committee's unannounced visit pointed out severe staff shortages, unprofessional conduct, and inadequate healthcare facilities and equipment, including expired medicines. DCS recognised these issues and proposed reforms, but the committee remained concerned about the delay in action and the 'sustainability' of these measures (Correctional Services Portfolio Committee, 2007).

Four years later, a study published in the South African Medical Journal found that while some medical services were available to prisoners, such as HIV testing and treatment, access to care was often delayed due to a lack of medical staff and inadequate facilities (Johnstone-Robertson *et al.*, 2011). Thus, it was no surprise that DCS found itself once more entangled with the Constitutional Court. In *Lee v. Minister*, the Court found that DCS had breached its obligations to provide adequate healthcare to inmates, including Mr. Lee, who had contracted tuberculosis in his third year at Pollsmoor RDF, even though he was fairly healthy when he entered the facility.

The contribution of this ruling was twofold: a resurgence of civil society activity, which until that time had been scarcely present in the landscape of the struggle for improved prisoner health conditions (Muntingh, 2007, p. 22), and action on the part of the government such as the introduction of new technologies for TB detection within the prison as well as new guidelines for maintaining the health conditions of prisoners (Keehn and Nevin, 2018, p. 219).

However, this glimmer of optimism did not last, and in 2015 Pollsmoor Prison became the subject of new scandals. In particular, the Cameron report (2015) testified to the barbaric conditions in which inmates were locked up at Pollsmoor RDF. Almost nothing that previous judgments had ordered was implemented in the facility. Edwin Cameron found it 'appalling' that the prison's medical services remained in a poor state, plagued by long-standing issues like staff shortages, inadequate equipment, delays in medical care, and lack of medicines, with no resolution despite two decades of highlighting these problems (Cameron, 2015, pp. 11-13).

The health conditions of detainees, as outlined in the Cameron report (2015), led to another legal challenge one year later. In *Sonke Gender Justice*, the Constitutional Court found the government in violation of constitutional rights to healthcare access and human dignity. The case addressed the severe issue of overcrowding and inhumane conditions in Pollsmoor RDF. The facility, designed for 1,619 inmates, was housing over 4,000, leading to extreme overcrowding and poor living conditions. The court declared that the first respondent (the Government of South Africa) failed to provide inmates with standard care as per the CSA and the Constitution. It ordered the first respondent to show cause why the number of detainees should not be reduced and to develop a plan addressing deficiencies in facility conditions and healthcare services. Additionally, the first respondent was ordered to submit a 'status report' to the court on 21st April 2017. The court's decision in this case was crucial as it considered not only the specific issue of Pollsmoor RDF but also set out a precedent for government accountability and the humane treatment of detainees across South African Correctional Centres.

2.4. Healthcare Challenges and Dynamics in Pollsmoor Prison

2.4.1. The Impact of Overcrowding and Mandatory Minimum Sentencing

Overcrowding at Pollsmoor Prison is not new. By the mid-1990s, significant legal changes had been made. These changes primarily focused on two areas: the length of sentences imposed on prisoners and the criteria for their release on bail. Firstly, there was an introduction of minimum sentencing which provides a table for serious offences, leading to longer prison terms (Dissel, 2002, p. 9). Its evolution has been a subject of considerable debate and analysis. One of the primary objectives of introducing minimum sentences was to promote consistency in sentencing, addressing the problem of widely diverging sentencing practices (Sloth-Nielsen and Ehlers, 2005, p. 17). However, some experts such as Terblanche argue that this legislation has, in some ways, exacerbated the 'disparities and inconsistencies' in relation to the offences it targets (Sloth-Nielsen and Ehlers, 2005, p. 17).

There has also been a debate on the effectiveness of mandatory sentences in reducing crime. While there was a decrease in certain types of crimes, like murder, after the introduction of minimum sentencing laws, this trend cannot be solely attributed to the legislative changes since a downward trend was already evident before these laws were enacted (Sloth-Nielsen and

Ehlers, 2005, p. 16). On the other hand, rates of certain crimes, like aggravated robbery, showed an increase, making the overall impact of these laws on crime rates difficult to assess (Sloth-Nielsen and Ehlers, 2005, p. 16; Muntingh, 2016a, p. 8).

Another significant impact of mandatory minimum sentencing has been on prison overcrowding. The introduction of these laws has led to a substantial increase in the number of prisoners serving longer and life sentences, contributing to severe overcrowding in prisons (Sloth-Nielsen and Ehlers, 2005, p. 18). Judge Cameron argues that minimum sentencing is counterproductive as it contributes to the phenomenon of overcrowding and does not promote rehabilitation at all (Cameron, 2017, pp. 19-22).

Additionally, adjusting the bail system post-apartheid significantly impacted pre-trial detainees, or people who are detained while awaiting trial, and contributed to prison overcrowding. These legislative changes have made it harder for individuals accused of serious offenses to obtain bail by shifting the burden onto the accused to prove that he or she was wrong (Dissel, 2002, p. 9). This issue was further compounded by the inability of many accused to afford even modest bail amounts (Dissel, 2002, p. 9) Additionally, the removal of the right to request after-hours bail hearings and the introduction of more stringent criteria for bail have led to extended detentions for many who cannot secure bail (Chaskalson and De Jong, 2009, p. 88). This has increased the number of people detained before trial, often in conditions not meeting human rights standards.

Pre-trial detainees often lack access to basic care, primarily because they are not viewed as falling under the purview of DCS. This is particularly problematic given that some of these individuals may spend a significant duration in confinement (Muntingh, 2009a, p. 202). According to Chapter five of the CSA, only those remand detainees who are disabled, pregnant, or mentally ill are entitled to adequate healthcare services, a responsibility that lies with DCS, irrespective of the length of their sentence. This legislation imposes a temporal constraint on the detention of awaiting trial detainees and mandates that, after a two-year period, DCS must submit the prisoner's file to the Court for review (Muntingh, 2016, p. 37). In other words, this legislation introduces a safeguard against the indefinite detention of pre-trial individuals and ensures that the detention duration is strictly monitored and subjects the State's decision to detain to judicial scrutiny, thereby upholding the principles of justice and preventing detention without accountability.

Despite the existence of these regulations, DCS faces numerous challenges that significantly hinder the maintenance of detainees' health conditions. These challenges include overcrowding, poor facility conditions, pervasive institutional prison culture, corruption and maladministration, and limited access to rehabilitation programmes for offenders (White Paper on Corrections in South Africa, 2005, p. 12; SAnews, 2013). The lack of cooperation among the courts, law enforcement agencies, and DCS further impedes the effectiveness of DCS's operations. On the one hand, the judiciary is doing its work at a very slow pace, and on the other hand, it keeps receiving a huge number of cases due to the incessant increase in arrests, and for the most part unnecessary or unjustified (Muntingh, 2016, p. 37).

In 2019, the Independent Online (IOL) headlined 'Pollsmoor most overcrowded prison in the Western Cape' (Ishmail, 2019). As it currently stands, the overcrowding rate at Pollsmoor RDF centre is 92%. This is particularly noteworthy given that the *Sonke Gender Justice* case has mandated the government to reduce this rate to below 50%. Pollsmoor RDF has a maximum capacity of 1,423 detainees. However, during the most recent inspection conducted by JICS on 18th January 2022, the facility was found to be housing 2,728 detainees. This figure largely exceeds the centre's designated capacity by 1,305 individuals (Judicial Inspectorate for Correctional Services, 2022, p. 33). Overcrowding is not only the scourge of Pollsmoor RDF but also affects other facilities of the prison. As of 29th October 2021, Pollsmoor Medium B was reported to be 'extremely overcrowded'. This has led to significant environmental and hygiene problems (Judicial Inspectorate for Correctional Services, 2022, p. 27).

2.4.2. Compromised Health and Wellbing in an Overcrwoded Prison

As early as the beginning of the 2000s, some scholars were already warning about the harmful consequences of prison overcrowding on the health of prisoners (Dissel, 2002, p. 13; Goyer, 2002, p. 25; Giffard and Muntingh, 2006, p. 14).

The Cameron report (2015) depicted disastrous conditions in Pollsmoor Prison mainly because of overcrowding, especially in Pollsmoor RDF. With an average of 65 inmates per cell, inmates had to share beds, and some were even sleeping on the floor (Cameron, 2015, p. 13). In addition, sheets and blankets were never washed (Cameron, 2015, p. 14). The toilets were almost all out of order and hygiene was deplorable, with strong urine smells (Cameron, 2015,

p. 14). The report also mentions that inmates suffered from skin irritations, and the only solution to eradicate them is to apply hot water to relieve the irritation, which is not available in the prison (Cameron, 2015, p. 18). Poor cell ventilation also contributed to the rapid spread of disease. The air is often unbreathable, and the cells contained few windows to let in natural light (Cameron, 2015, p. 19).

Because of the close physical proximity of inmates, the transmission of diseases within the prison population occurs much faster compared to well-ventilated, less crowded environments (Simpson *et al.*, 2019, p. 2). Some of the most prevalent diseases include tuberculosis, HIV, hepatitis C, and syphilis alongside skin infections like diphtheria that are potentially worsened by inadequate access to clean and hot water (Dissel, 2002, p. 13; Keehn and Nevin, 2018, p. 215; Mabena, 2023).

Notably, the HIV rate in South African prisons is lower than the general population, but still very concerning. In a study released in 2020, it was shown that women prisoners have a higher HIV risk than men, reflecting broader trends in South Africa (Stevenson *et al.*, 2020, p. 9). Staff shortages pose a significant issue, especially in the testing and screening of inmates (Stevenson *et al.*, 2020, p. 10). Equally, post-release HIV care continuity is problematic. Lack of proper systems to follow up with released inmates means many lose access to necessary HIV treatment. This issue is particularly acute for inmates moving between facilities (Stevenson *et al.*, 2020, p. 10). Larger prisons, such as Pollsmoor, may face greater challenges in providing HIV care compared to smaller facilities. The complexity of managing vast inmate populations and frequent transfers contributes to a lower rate of inmates initiating essential HIV treatments in these environments (Stevenson *et al.*, 2020, p. 11).

Prisons are tough environments for both inmates and healthcare professionals, particularly regarding mental health. The emphasis on security over mental wellbeing creates a sense of despair and alienation for inmates (Bantjes, Swartz and Niewoudt, 2017, p. 4). Many inmates arrive with pre-existing mental health issues, while others develop them during incarceration (Bantjes, Swartz and Niewoudt, 2017, p. 4).

Healthcare staff in prisons face considerable obstacles. They lack adequate tools and support for effectively addressing serious mental health issues among inmates. Collaboration is often limited, and assistance from other prison staff is minimal, hindering their ability to perform

effectively (Bantjes, Swartz and Niewoudt, 2017, p. 4). This not only impacts their job performance but also affects their own mental health. Resource shortages, such as insufficient medication and staff, add to the strain. This shortage means healthcare workers are under immense pressure and unable to dedicate adequate time to each inmate in need. Such demanding conditions lead to feelings of anxiety, sadness, and overwhelm among healthcare workers, as they struggle to provide the necessary care within the prison system (Bantjes, Swartz and Niewoudt, 2017, p. 5).

In a 2018 interview with news 24, psychologist Dr. Sandra Hoffman, with experience in Pollsmoor and other prisons, asserted that mental health services in South African prisons are outdated. Often, the established protocols for mental health care are not followed, resulting in inadequate support, particularly for prisoners lacking financial resources.

2.4.3. Gang Culture and its Influence on Healthcare Services

The pervasive gang culture within South African prisons, documented in the Human Rights Watch report as far back as 1994, poses systemic hurdles to the delivery of healthcare services within these institutions. The entrenched gang hierarchy and the violence it perpetuates create an environment where healthcare access and delivery are severely compromised (*Prison conditions in South Africa*, 1994, p. 52).

Firstly, the dominance of gangs like the 28s, 27s, and 26s, with their strict codes and internal governance, effectively creates a parallel authority within the prison system (*Prison conditions in South Africa*, 1994, p. 52; Veloen, 2022, p. 8). Gang leaders may control access to medical services, deciding who receives treatment and who does not, based on gang affiliations rather than medical need. If a gang member becomes sick, he has to go to the 'gang doctor' first, before he can see a real prison doctor (Veloen, 2022, p. 61). The gang doctor is like a make-believe doctor for the gang, with his own doctor-like uniform and a bag that makes him look like a medical officer (Veloen, 2022, p. 61). However, with no medical skills or training, this obviously denies or delays access to healthcare, and exacerbates the spread of diseases.

Secondly, inmate-on-inmate and inmate-on-staff assaults are common. This level of violence inherent in gang rivalries leads to frequent injuries and trauma among inmates, increasing the demand for medical care (*Prison conditions in South Africa*, 1994, p. 53). In 2018, a huge fight

in Pollsmoor Medium B resulted in over 50 inmates sustaining injuries (Francke, 2018). The threat of reprisals and the influence that gangs wield over inmates may discourage victims from pursuing necessary medical and psychological assistance (*Prison conditions in South Africa*, 1994, p. 54).

Research has shown the issue of sexual violence and the system of *wyfies*[15] within the 28s gang, which has significant health implications, including the spread of HIV/AIDS and other sexually transmitted infections (*Prison conditions in South Africa*, 1994, p. 54; Goyer, 2002, p. 24; Veloen, 2022, p. 20). Inmates describe distressing experiences during their time in Pollsmoor prison, witnessing sexual abuse (Mashimbwe, 2023a). Some can be sexually abused in exchange for cigarettes and food (Mashimbwe, 2023a).

Additionally, sexual abuses within prisons significantly exacerbate mental health issues among inmates. The trauma and despair resulting from such abuse can drive individuals towards self-harm, while the stigma surrounding mental health crises, especially those stemming from sexual victimisation, frequently deters inmates from pursuing the essential medical or psychological support they need (Mashimbwe, 2023a).

The collusion between some prison warders and gangs further complicates the delivery of healthcare (*Prison conditions in South Africa*, 1994, p. 56). In the allocation of medical care, certain inmates benefit from preferential access, a disparity frequently attributed to their notoriety as gang affiliates or their financial means (Mashimbwe, 2023b). If healthcare staff cannot rely on the support of the prison authorities to maintain order and ensure safe access to services for all inmates, the integrity of healthcare provision is compromised.

2.5. The Gaps in the Literature

Since the *Sonke Gender Justice* judgement, there has been a notable absence of studies or reports examining the current state of health conditions and the implementation of the ruling's measures. The primary source of valid information thus far remains the JICS annual reports.

[15] Term used to refer to females.

A close examination of the available reports reveals a contrasted picture of the healthcare situation within Pollsmoor Prison. The JICS annual report for 2017/2018 emphasises improvements in staff numbers and better access to primary care services, including psychological, dental, and general practitioners (Judicial Inspectorate for Correctional Services, 2018, p. 28). The Correctional Services Portfolio Committee (2017) confirms these positive developments, emphasising enhanced HIV and TB screening systems and the opening of a second pharmacy at Goodwood Prison, relieving the workload at Pollsmoor Pharmacy (Correctional Services Portfolio Committee, 2017).

However, the JICS annual report for 2021/2022 revealed disconcerting findings after an unannounced inspection conducted in October 2021. The conditions within Pollsmoor Medium B prison were deemed to be 'unsatisfactory', due to inadequate medical facilities, substandard hygiene, and chronic overcrowding (Judicial Inspectorate for Correctional Services, 2022, p. 27). Inmates at Pollsmoor RDF reported restricted access to medical personnel, specifically in relation to adequate dental care. Despite the JICS annual report for 2020-2021 documenting the employment of ten nurses at the facility, disparities in medical care access persisted (Judicial Inspectorate for Correctional Services, 2021, p. 22). In line with these findings, a recent newspaper article revealed that certain Pollsmoor inmates were deprived of dental services for nearly a year (Petersen, 2023).

Thus, while the JICS annual report for 2017/2018 indicates improvements in health conditions at Pollsmoor Prison, subsequent inspections from 2018 to 2020 yield minimal data, due to the substantial impact of the COVID-19 pandemic on JICS operations. During South Africa's COVID-19 lockdown, the government's National Sate of Disaster[16] hindered prison oversight. The JICS was not classified as essential services and could not visit prisons during the lockdown.

Despite these limited sources of information, it appears that the healthcare system within Pollsmoor Prison, and Pollsmoor Medium B, falls significantly short of meeting minimum human rights standards set by national and international regulations.

[16] The National State of Disaster in South Africa was declared in response to the COVID-19 pandemic. President Cyril Ramaphosa announced this declaration on 15th March 2020, as a measure to combat the spread of the virus.

Chapter 3: Methodology

3.1. Introduction

This methodology chapter details the methods used to conduct the study. The chapter will provide an overview of the research design, data collection methods, data analysis methods, ethical considerations, and limitations of the study.

To collect data on the topic the study will use a qualitative research approach, primarily involving interviews and discussions with a group of five ex-inmates, the co-founder of a NGO focused on prisoner rehabilitation and restorative justice, as well as an ex-correctional officer from Pollsmoor Prison. These stakeholders offer invaluable perspectives and expertise of the complexities associated with delivering appropriate healthcare services to prisoners in line with their fundamental human rights and can offer avenues for improving the system.

3.2. Research Design

The research design chosen for the study was a case study. This approach was well-suited for investigating complex issues within a specific context because it involves an in-depth examination of a particular case or situation to gain a thorough understanding of its complexities (Yin, 2009, p. 29). In this study, the focus was on exploring the healthcare conditions within Pollsmoor Medium B. By employing a case study approach, I considered the nuances, unique characteristics, and environmental factors that shaped healthcare delivery and access within the facility. The case study design allowed for a thorough investigation of the healthcare conditions in the Correctional Centre. Through collecting rich qualitative data to gain a deep understanding of the prison environment and the intricacies of healthcare in prison as well as the experiences, perspectives, and challenges faced by inmates. Additionally, with a case study design, I explored the multitude of factors and barriers that affect healthcare delivery and access within Pollsmoor Medium B. These factors included resource constraints, policies and procedures, organisational structures, socio-cultural dynamics, and individual experiences. By analysing these factors, I was able to identify barriers to healthcare provision in the Correctional Centre. The case selection process involved purposive sampling, which means selecting participants based on their relevance to the research objectives.

3.3. Data Collection Methods

The data collection methods in this study included a focus group interview, a brief demographic and health survey for ex-inmates, two semi-structured interviews, and informal observations within Pollsmoor Medium B and in certain cases Pollsmoor Prison. I conducted a focus group interview with a group of five ex-inmates, some of whom had recently been released from prison. I also conducted two semi-structured interviews: one with the co-founder of the NGO, who accompanies ex-inmates in the process of rehabilitation, and another one with an ex-correctional officer from Pollsmoor Prison, with each interview lasting between 30 and 50 minutes. The interviews were carried out in person, and I made use of a tape recorder. The interview questions were developed based on the research questions and were designed to elicit detailed and nuanced responses. I also conducted informal observations during the restorative justice programme sessions facilitated by the NGO at Pollsmoor Medium B. These sessions provided me with the opportunity to observe the state of the infrastructure, though my access was restricted to certain sections of the centre, and to incidentally obtain more information on the provision of health services. Document analysis involved the review of official reports, policy documents, and court cases. The health survey facilitated the collection of supplementary information regarding the experiences of the former inmates. By incorporating questions about their age, frequency of incarceration, and number of interactions with medical officials, among other aspects, this survey complemented the primary data obtained from interviews and observations.

3.3.1. Focus Group Interview

I conducted a focus group interview with five ex-inmates (see Appendix A), each with different backgrounds, details of which are elaborated in the research findings section of this thesis. The choice of five participants was strategic — it provided a diverse range of perspectives and experiences, ensuring that the data collected was relatively representative of the incarcerated population in Pollsmoor Medium B. This number was also manageable in terms of group dynamics, allowing for meaningful interactions and discussions, ensuring that everyone had the opportunity to express their opinions and experiences. The focus group setting encouraged participants to build upon each other's responses and share insights that they might not have

considered individually. With five participants, there was a higher likelihood of generating a wide range of perspectives and experiences, leading to more in-depth and richer data.

The objective of the focus group interview was to elicit insights and perspectives from two distinct cohorts — individuals who were released from the centre several years prior and those who have been recently released to observe the evolution of the healthcare services over time. I used purposive sampling to select participants, ensuring that the focus group consisted of individuals who had direct and recent experience with the healthcare system in the facility. The participants were able to provide first-hand experiences and valuable insights into the healthcare conditions within Pollsmoor Medium B.

The interview was conducted in a meeting room where the NGO and the ex-inmates meet monthly. By choosing this familiar and neutral setting, I aimed to create a relaxed atmosphere where participants felt at ease sharing their experiences and perspectives. The ex-inmates were also familiar to one another which meant that the interview process fostered a sense of camaraderie and mutual support among them. This familiarity encouraged more open and candid discussions, as participants were likely to feel more comfortable expressing their thoughts and feelings in the presence of peers who had undergone similar experiences. Additionally, this setting minimised the power dynamics often present in researcher-participant interactions, further contributing to a more genuine and equitable exchange of information.

3.3.2. Semi-Structured Key Informants Interviews

I conducted a semi-structured interview with an ex-correctional officer from Pollsmoor Prison (see Appendix B). With forty years of experience in Pollsmoor Prison, culminating in his retirement in 2017, the inclusion of this participant was particularly valuable. His retirement was relatively recent, and he still maintained a good understanding of the contemporary issues within the prison, especially regarding healthcare conditions and services. His extensive tenure had allowed him to witness first-hand the evolution of healthcare policies, the challenges in implementing them, and the impact on the inmates' well-being. His perspective provided a unique and more complete understanding of the administrative, operational, and ethical aspects of healthcare provision in Pollsmoor Medium B. This included the interplay between prison management, healthcare professionals, and governmental oversight, as well as the potential barriers to accessing decent healthcare for prisoners.

The study also included a semi-structured interview with the co-founder of an NGO that closely works with ex-inmates (see Appendix C). This key informant not only brought specialised knowledge, expertise, and experience in supporting incarcerated and formerly incarcerated individuals but had also been conducting restorative justice programmes in Pollsmoor Prison for over fifteen years, primarily in Pollsmoor Medium A and Pollsmoor Medium B. The co-founder was directly involved with both inmates and ex-inmates throughout their rehabilitation journey, addressing issues pertinent to healthcare access and delivery in the different Correctional Centres and possessed direct knowledge of the obstacles and barriers that inmates faced in accessing healthcare services. Through this interview, I gathered valuable recommendations and best practices for improving healthcare conditions in the prison based on the co-founder's unique perspective on what has worked well, what needs improvement, and potential solutions to enhance healthcare services within the prison. The interview was conducted in a private setting and was recorded with the participant's consent.

3.3.3. Audio Recording

Using audio recordings in my research study offered several advantages. Firstly, it allowed for a more accurate and detailed record of the interviews, which could be reviewed and transcribed later, ensuring that the data collected was complete and precise. Secondly, it enabled me to focus on the conversation without the distraction of taking detailed notes — merely writing down key points of the discussion — fostering a more natural and open dialogue. Finally, it ensured that the findings of my study could be grounded in direct quotes from participants, enhancing the study's credibility and reliability.

During the informed consent process, I made sure that participants understood the purpose of the recordings and sought their consent to proceed with the recording. I clearly stated that the interview would be recorded, explained the intended use of the recordings, and the measures that would be taken to ensure confidentiality and anonymity. I gave participants the option to decline the recording if they wished. Those who agreed to the recording were asked to sign a separate consent form for this purpose, in addition to the informed consent form.

I used the recordings to transcribe the interviews and analyse the data. The transcriptions were essential in identifying themes, patterns, and trends related to the topic, and in gaining a deeper

understanding of the participants' experiences. I stored the recordings securely and confidentially, with any identifying information removed from the transcriptions to ensure the anonymity of the participants.

3.3.4. Demographic and Health Experience Survey

I conducted a brief demographic and health experience survey with the ex-inmates to gather additional information regarding the participants' health and their experiences related to healthcare in Pollsmoor Medium B (see Appendix D). The survey was distributed in the form of an anonymous paper-and-pen questionnaire. Participants were given the option to fill out the survey voluntarily. All participants agreed to fill out the survey. I securely stored the collected data and used it solely for research purposes.

3.3.5. Informal Observations

I carried out informal observations within Pollsmoor Medium B alongside the NGO to enrich the interview data and to acquire an in-depth perspective of the prison's milieu and the provision of health services. These observations were conducted regularly during the NGO's restorative justice programmes, which ran for eight sessions each from April to June 2023 and September to November 2023. My time in Pollsmoor Medium B allowed for intermittent observation of prison sanitation, the delivery of health services, and the interactions between inmates and providers, as well as an overall assessment of the centre's conditions. Whenever the opportunity arose, I would also conduct observations throughout the entire prison, including other facilities of the centre, its infrastructure, and various general areas. I took detailed notes of daily life within the facility, capturing the dynamics of inmate behaviour, staff-inmate relations, and the environmental conditions. I noted the physical condition of the living and communal spaces, paying close attention to cleanliness and overcrowding. By documenting these observations, I aimed to complement the interview data with tangible examples and first-hand insights.

3.4. Data Analysis Methods

I transcribed and analysed the interviews using a thematic analysis approach. Thematic analysis involves systematically identifying, organising, and interpreting patterns, themes, or key ideas within the data (Flick, 2014, p. 147). By carefully reading and re-reading the transcribed data,

I identified recurring topics, concepts, or perspectives that emerged from the participants' discussions. I then developed a coding framework, which involved assigning descriptive codes to different segments of the data based on the identified themes. This coding process helped in organising the data and provided a structured framework for analysis.

3.4.1. Interview Transcripts

I listened to the audio recordings and created verbatim transcripts, ensuring that the dialogue was transcribed as accurately and completely as possible. This included non-verbal cues, instances of overlapping speech, and pauses. To facilitate this process, I used a transcription software (Riverside.fm), which expedited the task and aided in accurate timestamping.

3.4.2. Data Coding

I developed a coding scheme or a set of categories that reflected the key themes analysed in the data, with these codes being grounded in my research question. I began coding by systematically going through the transcript line by line and section by section, assigning relevant codes to sections of text that corresponded to the identified themes. I maintained a coding document that described each code and its meaning to ensure consistency and transparency in the coding process. I used a qualitative data analysis software (NVivo) to facilitate the coding process and assist in organising and analysing the coded data.

3.4.3. Document Analysis

I also made use of document analysis to review policies and procedures[17] related to the delivery of health services within the prison. These documents contained qualitative information that, upon analysis, offered insights into the systemic operations surrounding healthcare services. I analysed the documents to identify any gaps or inconsistencies in the delivery of healthcare services within the prison and linked them to my observations and responses from the interviews.

[17] 'Policies and procedures' refer to the comprehensive framework of formal guidelines and operational instructions established to govern the delivery of healthcare services in the prison setting. This framework is not limited to statutory documents such as the CSA but also includes an analysis of relevant court cases, which have played a crucial role in depicting the evolution of policies and measures concerning healthcare delivery in prisons, parliamentary reports and the JICS annual reports.

3.4.4. Audit Trails

In addition to the descriptive analysis, I incorporated the use of audit trails to bolster the integrity of the research process. Following the guidance of Marian Carcary (2020), I acknowledged the significance of audit trails in qualitative research as they serve to enhance the transparency and accountability of the research process. An audit trail provides a detailed account of the decisions made and the procedures used throughout the research, facilitating a comprehensive examination of the research findings by external reviewers (Carcary, 2020, p. 167).

This meticulous documentation of the research steps, from the initial design to the thematic analysis and interpretation of findings, allows for the research process to be open to scrutiny. It ensures that every aspect of the study, including the development of the coding scheme and the analysis of documents, can be reviewed in detail. The audit trail not only adds to the credibility and reliability of the research but also ensures that the study can be replicated or re-evaluated in the future (Carcary, 2020, p. 168). By systematically recording each step of the research process and the rationale behind it, the audit trail demonstrates the rigour with which the study was conducted, thereby contributing to the trustworthiness of the research outcomes.

3.5. Ethical Considerations

My research raised several ethical considerations. These included issues related to informed consent, confidentiality, the trust between me and the participants, and potential harm to participants and myself. The study received ethical clearance from the Law Research Ethics Committee (REC) and its members (see Appendix E).

3.5.1. Informed Consent

I secured the informed consent of the participants through several steps. Initially, I provided a written consent form (see Appendix F). The form was written in clear and concise language to ensure it was easily understandable by participants.

I then explained the consent form in detail before participants signed it. This explanation covered the purpose of my study, the study design, duration, data collection and analysis processes, confidentiality, and the voluntary nature of participation. Participants were given ample time to read and consider the consent form and to ask questions or seek clarification as needed.

Once I was confident that the participants fully understood my study and their role within it, I asked them to sign the consent form. This was done voluntarily and without any coercion, and I informed participants that they were free to withdraw from the study at any time.

3.5.2. Confidentiality

I ensured that participants' information remained private and confidential through various means. I removed all names, ID numbers and other personal information from the study data. I assigned unique codes to each participant as follows: the ex-correctional officer (EX-CO), the co-founder of the NGO (NGO-CF) and the ex-inmates (EX-INM1, EX-INM2, EX-INM3, etc.). Additionally, I made use of secure storage and data management practices, such as storing data on a password-protected laptop and secure servers.

3.5.3. Trust with Participants

As an outsider to the prison environment, establishing trust between the participants and myself was of paramount importance. In addressing this concern, I strived to create a close rapport with the participants, ensuring a secure environment conducive to open dialogue. I dedicated several weeks to familiarising myself with the participants, engaging in genuine conversations to better understand them, thereby fostering a sense of ease over time. I assured participants that their contributions would have no bearing on their standing within the NGO or any external entities and emphasised the voluntary nature of their involvement in the study.

3.5.4. Trustworthiness

In my research, 'trust' went beyond just the relationships with participants — it also referred to the credibility of the study and its findings. As Bowen (2009) stated, 'trustworthiness refers to the conceptual soundness from which the value of qualitative research may be judged' (Bowen,

2009, p. 306). It is crucial for readers to trust the integrity of the research. The core of academic reporting is to present a compelling argument, supported by solid evidence, convincing the reader of the validity of the conclusions.

To meet the trustworthiness criterion, qualitative research relies on credibility, dependability, and transferability. Credibility is achieved by accurately representing what participants think and experienced, which I ensured by spending sufficient time with them, employing various data collection methods, and verifying findings with participants (Bloomberg and Volpe, 2008, p. 42). Dependability is addressed by demonstrating a clear and traceable process of how results are obtained, which I supported by keeping detailed notes and seeking consensus on data interpretation (Bloomberg and Volpe, 2008, p. 42). Finally, transferability involves assessing whether the research findings can be applicable in other situations, which required me to provide a thorough and detailed description of the research setting, and the individuals involved (Bloomberg and Volpe, 2008, p. 43).

3.5.5. Potential Risks

While the study provided valuable insights into the healthcare conditions in the facility and pinpointed areas for improvement, it was important to maintain a realistic perspective regarding the potential for immediate change or enhancements. Additionally, there was the possibility that participants might suffer physical or psychological harm from their involvement in the research. The nature of the questions and discussions during the interviews had the potential to trigger negative emotions and memories, leading to distress or discomfort for some participants.

To minimise this risk, I took steps to ensure participants were thoroughly informed about the study and what their involvement entailed. They were afforded the opportunity to ask questions and raise any concerns before agreeing to participate. In case distress or discomfort would arise during the research process, I ensured that participants were offered support and access to suitable resources, including counselling services.

3.6. Limitations

The study also faced several limitations. These included restricted access to various sections of the prison, constraints related to the sample size and its representativeness, and challenges concerning the generalisability of the findings.

3.6.1 Access to Prison

The NGO's access within Pollsmoor Medium B was confined to Unit B1, including a few cell blocks and a central room where restorative justice programmes were facilitated with inmates. Access to other sections was often unattainable due to security measures or a lack of collaborative willingness. This limitation significantly narrowed the scope of my on-site observations and data collection efforts. As a result, the full observation and evaluation of healthcare conditions across the entire facility were hindered. The study's findings, therefore, may have been influenced by the particularities of Unit B1, potentially yielding an incomplete representation of the healthcare circumstances within the broader confines of Pollsmoor Medium B and Pollsmoor Prison. Nonetheless, within these limitations, I managed to undertake significant observations in the accessible areas and engage in discussions with staff members and current inmates from other sections of Pollsmoor Medium B that provided valuable insights regarding the healthcare conditions in the accessible sections and offered perspectives on the applicability of findings across the broader prison environment.

3.6.2. Sample Size and Representativeness

The participant sample size, specifically of former inmates, may not have fully reflected the breadth of healthcare experiences within the entire prison populace. The selection might not have included the complete range of experiences across Pollsmoor Prison, potentially leading to an overrepresentation or underrepresentation of certain individual experiences. Acknowledging this limitation, I tried to curate as diverse a sample as feasible, given the restrictions on access and the availability of participants, and tried to avoid over-generalisation. I used a purposive sampling method to choose individuals with a variety of backgrounds, experiences, and perspectives.

3.6.3. Generalisability

The outcomes of the case study may not be universally applicable to other penal institutions or healthcare frameworks. Pollsmoor Prison is distinguished by its particular infrastructure, policy environment, healthcare delivery systems, and other systemic issues, which may not align with those of other facilities. Consequently, the direct extrapolation of these findings to disparate situations may be unwarranted. Nonetheless, the case study's primary objective was to conduct a thorough examination and understanding of a singular situation. The intent was not to achieve widespread generalisability but to obtain insights into the intricate nature of healthcare conditions within Pollsmoor Medium B. To foster the potential applicability of the findings, I tried to provide detailed descriptions of the processes and elements that shape healthcare conditions within the facility.

Chapter 4: Pollsmoor Prison, Pollsmoor Medium B, and Pollsmoor Medium B Hospital

4.1. History and Infrastructure of Pollsmoor Prison

The history of Pollsmoor Prison can be traced back the 17th century. The land changed ownership multiple times, initially purchased by a German woman. In 1834, it was acquired by Hendrick van der Poll, who established the ‘Poll's Moor’ farm, giving the place its name, ‘Pollsmoor Prison’. The land continued to be sold until World War II, after which, it became a military camp. The camp required maintenance for which prisoners from Roeland Street Prison were brought in. It was later decided to keep the prisoners at Pollsmoor to cut down on transport costs. Thus, in 1956, it was officially designated as a prison and has undergone continuous expansion over since (Jackman, 2014). The area, extending across 2.5 square kilometres, is positioned between four distinct districts: affluent Tokai, the prosperous Steenberg estate, the historically less privileged Westlake district — once home to coloured staff during apartheid — and Kirstenhof, a relatively more affordable middle-class area.

Pollsmoor Prison gained prominence when Nelson Mandela, the ex-President of South Africa, was moved from Robben Island to Pollsmoor in 1982. Here is how he described the facility for common-law prisoners: ‘Pollsmoor had a modern face but a primitive heart. The buildings, particularly the ones for the prison staff, were clean and contemporary; but the housing for the prisoners were archaic and dirty’. (Mandela, 1994, p. 513)

Pollsmoor Prison includes five distinct correctional facilities: Pollsmoor RDF, Pollsmoor Medium A, Pollsmoor Medium B, Pollsmoor Medium C, and Pollsmoor Female Centre (see *Figure 1*). Pollsmoor RDF serves as the initial reception point for individuals from various court jurisdictions within the Cape Peninsula, exclusively housing detainees awaiting trial. With the RDF’s increasing congestion, a part of this population was transferred to Pollsmoor Medium A, which was initially reserved for juvenile inmates. Consequently, Pollsmoor Medium A now houses both juveniles and detainees awaiting trial. This redistribution to Pollsmoor Medium A has not effectively resolved overcrowding. Hence, some juveniles have been moved to Pollsmoor Medium B, traditionally intended for sentenced adult males, and the facility now accommodates both juveniles and sentenced adult males. Pollsmoor Medium C is designated

for sentenced adult males with incarceration terms not exceeding one year and includes individuals on day parole or those who are soon-to-be released. The Female Centre provides for both juvenile and adult women, irrespective of their trial status or sentencing. Additionally, each unit houses a hospital, with the main hospital located in Pollsmoor Medium A.

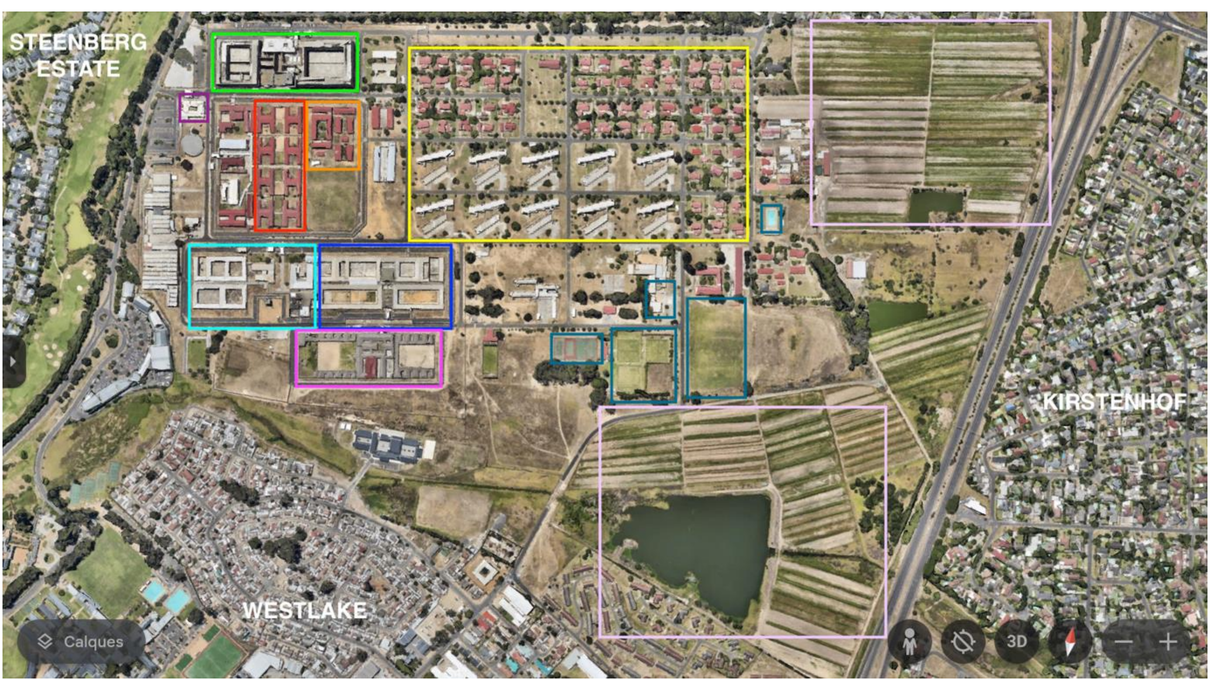

Figure 1: Aerial view of Pollsmoor Prison and its surrounding areas, showcasing the expansive layout, adjacent residential communities, and cultivated lands (Google Earth).

Pollsmoor RDF	Public Visitation Area
Pollsmoor Medium A	Staff Training Facilities
Pollsmoor Medium B	Staff Residential Area
Pollsmoor Medium C	Staff Sporting Facilities
Pollsmoor Female Centre	Agricultural Lands

4.2. Site Observations in Pollsmoor Medium B[18]

Pollsmoor Medium B includes five units: B1, B2, B3, B4, B5 and a hospital (see Figure 2). These facilities are in close proximity to the Female Centre, with the exception of Unit B5, which is located slightly beyond the Female Centre. Each unit typically houses an average of 200 inmates, although in some cases, this number can rise to as high as 250, resulting in an approximate total inmate population of 1000 within the entire facility. As previously mentioned, Pollsmoor Medium B now accommodates both sentenced juveniles and adult males. However, it is evident that the structural design of the facility is ill-suited to accommodate such a large number of inmates.

Pollsmoor Medium B employs approximately 200 staff members. It is important to note that this figure represents the total workforce within the unit, and not all employees are on duty simultaneously. Staff members work on a shift basis, with alternating schedules. In each unit, an average of six wardens are on duty during the day, working from 07:00 to 16:00. Some wardens have shifts on weekdays, while others work on weekends. During night-time hours, there is only one warden responsible for each unit. This staffing arrangement can pose significant challenges when conflicts between inmates arise. As per the information I have gathered, in the event of such conflicts, the night-time warden may request backup and medical support from other facility centres to ensure that injured inmates are promptly taken to the hospital. A similar procedure is followed if inmates report feeling unwell.

Upon entering the facility, we find various staff offices and two visitor search rooms. Moving towards the rear, the visitor waiting room is followed by a network of corridors leading to the cells. From the outset, it becomes apparent that the conditions within this section are substandard. The walls exhibit signs of decay, and most notably, an unpleasant smell, consisting of hay, animal feed, and urine in certain parts, saturate the environment, likely due to inadequate cleaning and maintenance.

As we traverse the corridors leading to Unit B1, with ceilings no higher than two meters, we can observe dark alleys, suspended electricity cables, and unsanitary flooring. Natural light is

[18] From now on, the following sections will focus only on Pollsmoor Medium B and its different units, with references to Pollsmoor Prison for contextual purposes.

scarce, and the lighting fixtures are non-functional. Upon entering the unit, the smell becomes even more pronounced. While it remains barely tolerable, most inmates seem to have developed a degree of insensitivity to the smell. During visits on rainy days, floors were flooded, due to water leaks within the facility.

During a brief access to Unit B1's corridor, I observed the inside of the cells. This unexpected glimpse revealed inadequate lighting and overcrowding, with approximately 40 inmates housed in a space designed for 16 to 20 individuals. The cells were cluttered, poorly lit, and the sanitation facilities were in a state of disrepair, highlighting severe neglect and unsanitary conditions. My observations and interactions with inmates from Units B2, B3, and B4 revealed a consistent pattern of neglect and dire living conditions across all units, mirroring those witnessed in Unit B1. The cells exhibited signs of significant wear, with outdated and malfunctioning facilities, including inoperative intercom systems and inadequate shower and toilet amenities. Overcrowding was notably more severe in these units compared to B1, with reports of up to 69 individuals in a cell, again, intended for 16, leading to inadequate sleeping arrangements and poor ventilation. Clothing provided to inmates was insufficient for weather conditions, and the lack of proper footwear raised health concerns due to the unhygienic conditions of the floors. These accounts underscore the urgent need for systemic improvements to ensure the health and dignity of inmates across the facility.

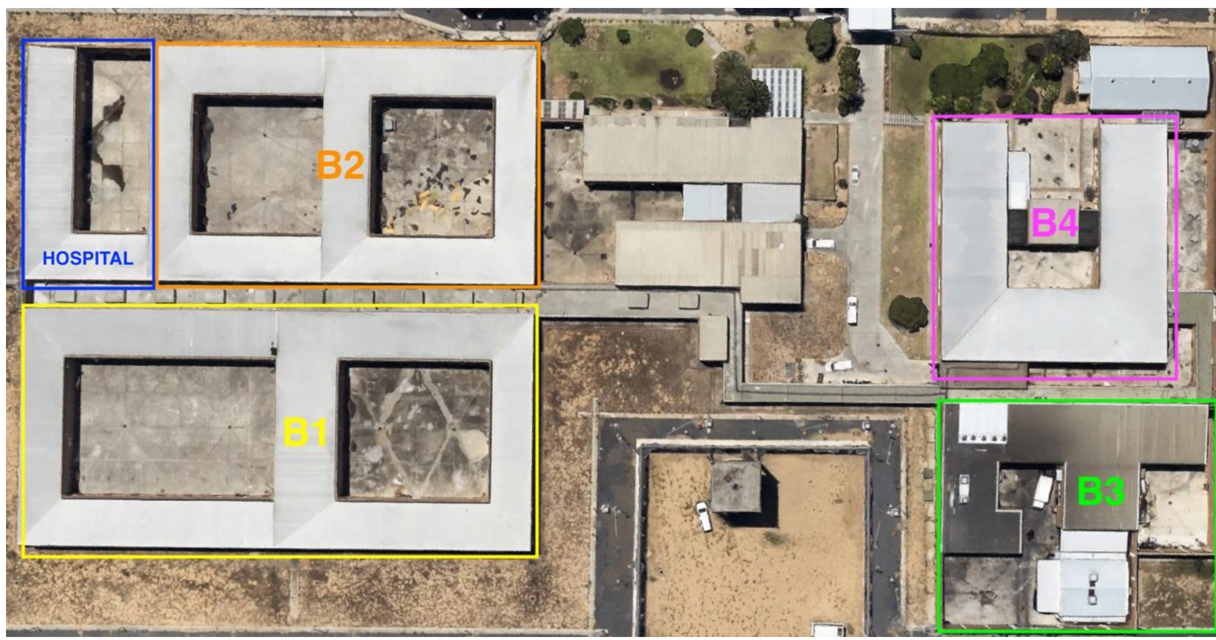

Figure 2: Aerial view of Pollsmoor Medium B, showcasing its different units and hospital (Google Earth).

4.3. Pollsmoor Medium B Hospital

Through various discussions with staff members, including nurses, I learned that Pollsmoor Medium B Hospital is not only equipped with the essential medical apparatus but also benefits from the services of a dedicated medical team and external doctors who visit regularly, complementing the expertise of an in-house doctor available during standard working hours. The hospital staff comprises four nurses: a unit manager who is the sister nurse in charge, two general sister nurses, and one HIV-coordinator, also a sister nurse. Additionally, there is a senior enrolled nurse, and one administration clerk to support operations. All staff are scheduled to work from 07:00 to 16:00 which means limited access to in-house medical staff for after-hours care.

The hospital's layout is multifunctional: at the entrance lies a space serving as the staff office, followed by a staff toilet and a medicine store. The facility also houses a dentist's room and a treatment room, which is used for general medical cases, including wound care, stitching, and dressings. Due to space constraints, this room also doubles as the doctor's consultation room. The doctor's consultation days are scheduled for Wednesdays and Fridays, while dental services are provided on Tuesdays. The State psychiatrist's sessions were usually held on Mondays, although recent changes may have altered this schedule.

Adjacent to the staff office is the kitchen, which plays a vital role in the preparation and serving of food to the inmates. The largest area within the hospital is the courtyard, multipurposed for exercise, weekend church services, and as a waiting area for inmates from various units who require daily treatments, such as anti-TB injections, wound care, and the changing or removal of plaster casts.

The holding area of the hospital is designed to accommodate patient-inmates and includes two communal cells, each estimated to house 20 prisoners, though typically only 10 inmate-patients are housed in each to avoid overcrowding. These cells are adjacent to the ablution facilities, which include a shower, a bath, toilet, urinal, and four washbasins. Additionally, there is a storage room for clothing, linen, and cleaning materials. Four single cells are reserved for isolation purposes, particularly for new TB cases or other contagious diseases like leptospirosis,

and notably for Multidrug-Resistant (MDR) and Extensively Drug-Resistant (XDR) TB cases before their transfer to Brooklyn Chest hospital.

Despite the wide array of services and technological equipment, staff members are frequently required to visit Pollsmoor Medium A Hospital, situated at the far end of the prison. This means staff must walk in adverse weather conditions, be it rain or hot weather, to obtain medication or medical assistance for inmates, which is not readily available within Pollsmoor Medium B Hospital. The medical staff at Pollsmoor Medium A Hospital also operates from 07:00 to 16:00, and one medical nurse is available on duty beyond office hours — which is not the case in Pollsmoor Medium B hospital. Should an emergency arise during the night, inmate patients are left with no alternative but to await the arrival of morning staff for potential assistance.

4.4. Conclusion

In conclusion, Pollsmoor Prison, as described by Nelson Mandela, retains its 'archaic and dirty' characteristics, particularly Pollsmoor Medium B. Despite broader changes within the prison, this particular section continues to endure substandard conditions, characterised by poor maintenance and an unsuitable structural design. The facility's design is ill-equipped to accommodate the current inmate population, with evident issues like dilapidated walls, scarce natural light, and malfunctioning lighting fixtures.

The stark contrast between the maintained areas of the prison and the neglected sections like Pollsmoor Medium B and its hospital highlights systemic issues in resource allocation. Despite the equipped and staffed hospital within the facility, the overall living and healthcare conditions for inmates remain dire. Overcrowding exacerbates these problems, leading to health risks and an environment that is far from conducive to rehabilitation or basic human dignity.

The condition of inmates' clothing, a seemingly minor yet telling detail, reflects the broader neglect within the prison. The lack of appropriate attire, especially in the harsh winter months, not only speaks to the disregard for inmates' basic needs but also symbolises the overall state of neglect in Pollsmoor Medium B.

Chapter 5: Research Findings

5.1. Introduction

My research journey has been guided by two fundamental research questions: Firstly, I sought to understand the barriers that inmates face when accessing healthcare services within Pollsmoor Medium B. Secondly, I tried to identify strategies that could potentially enhance the quality and availability of healthcare services for inmates. To address these questions, I interviewed a former correctional officer (EX-CO), five ex-inmates (EX-INM), and an NGO representative (NGO-CF). I also conducted a survey among these five ex-inmates to gather valuable demographic information and more insights into their health experiences within Pollsmoor Medium B. The findings from the interviews were systematically organised under thematic headings that correspond to the core issues and strategies identified during the discussions, arranged in descending order of prominence from the most significant to the less critical themes. The purpose of delineating these categories was to discern the unique and shared challenges each group perceived or encountered within the prison and to formulate the most effective strategies in addressing these issues.

5.2. Participant Profiles and Their Experiences in Pollsmoor Prison

The study engaged three distinct groups of participants: a former correctional officer (EX-CO), the co-founder of an NGO (NGO-CF), and five ex-inmates (EX-INM).

EX-CO, with a 40-year experience at Pollsmoor Prison beginning in 1977, initially faced challenges due to his residence in the underprivileged Westlake neighbourhood, adjacent to the prison, until 1998. His entry into Pollsmoor Prison was atypical, stemming from a military background with a focus on discipline and firearms, rather than conventional prison staff training. This lack of preparatory training in handling prisoners was reinforced by the prevalent racism, discrimination, and violence against prisoners during his early years at Pollsmoor. Despite these adversities, EX-CO adopted innovative, inclusive, and humane approaches, driven by the belief that personal change is pivotal for transforming the environment.

NGO-CF, with 18 years of experience in working with offenders at Pollsmoor Prison, leads a restorative justice NGO established in 2012. The NGO's work involves conducting a range of restorative justice programmes aimed at rehabilitating offenders by addressing the root causes of their criminal behaviour and fostering self-awareness. These programmes incorporate diverse methods, including recreational activities, educational resources, creative outlets like clay modelling, and pedagogical approaches informed by trauma awareness. Beyond the prison, the NGO actively engages in participatory action research projects and a journalism initiative, encouraging ex-inmates to write and disseminate their narratives in a South African journal.

The ex-inmates, all clients of the NGO, have been actively engaged in its various programmes, with some participating for nearly a decade. Coming from disadvantaged backgrounds like Mitchells Plain or Khayelitsha, their life experiences were diverse. Aged between 28 and 43, the majority were Black African, with the exception of EX-INM5, who was Coloured. Although the sample size was limited, this demographic composition may mirror the skewed trends in South African prison populations, where individuals who are incarcerated are predominantly Coloured or Black African (Gopolang, Skosana and Hopkins, 2017). Each had multiple incarcerations at Pollsmoor Medium B, ranging from two to five times, indicative of a pattern of re-entry. Chronologically, their periods of incarceration were as follows: EX-INM4 from 2006 to 2008, EX-INM5 from 2013 to 2016, EX-INM3 from 2016 to 2017, EX-INM1 from 2014 to 2019, and EX-INM2, the most recently released, with three separate terms — first from 2010 to 2012, then from 2016 to 2019, and finally from 2020 to 2021.

During their incarceration, these ex-inmates encountered varied experiences with the prison's healthcare system. Notably, EX-INM1 and EX-INM3 never visited the prison hospital, while EX-INM4 did so briefly, and EX-INM5 did not provide an answer. Their interaction with healthcare facilities was minimal, with EX-INM1 and EX-INM4 having 1-5 interactions, and EX-INM2, EX-INM3, and EX-INM5 having none. Prior to their imprisonment, their health was generally good, but the inconsistency in medical screening upon entry, particularly for EX-INM2, EX-INM3, and EX-INM4, raises concerns about the prison's health monitoring practices.

While in Pollsmoor, EX-INM1, EX-INM2, EX-INM4, and EX-INM5 faced health issues such as abscesses and dental problems. However, only EX-INM1 and EX-INM2 felt they received adequate medical management and were satisfied with it. Access to healthcare officials varied,

with EX-INM1 having regular contact with a range of healthcare professionals, and EX-INM3 receiving mental health assessments. The waiting time for healthcare also varied, with some waiting a few hours and others more than a day. All participants had used the services of the NGO more than six times, showing the significant role this organisation plays in inmate care and rehabilitation.

Upon release, their health ranged from 'Excellent' to 'Fair,' with diverse opinions on the quality of healthcare in Pollsmoor Prison. Additional comments from the participants revealed a complex picture of the healthcare system in Pollsmoor Prison, with acknowledgements of the staff's efforts under challenging conditions, notes on the fair quality of care but also the gang violence associated with healthcare access, and perceptions of healthcare providers as very 'laid back' [EX-INM 5].

5.3. Barriers to Inmate Healthcare Services

This section gathers the numerous obstacles impeding effective healthcare delivery within Pollsmoor Medium B. The section draws on the insights and experiences of NGO-CF, EX-CO, and EX-INM each of whom have had extensive involvement with the prison, providing them with a deep understanding of its operational dynamics. Their perspectives reveal a range of challenges, from poor infrastructure and resource limitations to systemic and bureaucratic hurdles, that collectively hinder the provision of adequate healthcare services. The section considers various facets of these barriers, including issues related to staffing, the impact of gang dynamics, policy constraints, and the problem of overcrowding, each of which significantly affects the health and well-being of the inmate population.

5.3.1. Poor Infrastructure and Resources

Within Pollsmoor Medium B, the quest for adequate infrastructure and resources is a daily challenge. EX-CO revealed the lack of private and confidential areas, stating, 'We don't have enough space, confidential space, where a doctor can consult privately.' This lack of privacy is a fundamental breach of the conditions necessary for effective healthcare provision as outlined by the National Health Act[19]. EX-CO further detailed the logistical hurdles in medication

[19] National Health Act No. 61 of 2003, Section 14.

distribution, 'The availability of medication, it's always a struggle... the immediate availability of medication is always a problem'. This statement not only points out the immediate challenges but also hints at the broader systemic inefficiencies affecting Pollsmoor Medium B more remote from the main medical facilities.

Ex-inmates provided a narrative that complemented and expanded upon these issues. One of them described the decrepit state of the prison's infrastructure: 'The plumbing is extremely old... there are few only a few geysers that are running right and they're old. Some sections will have more water running than other sections' [EX-INM1]. This account serves as evidence of the neglected maintenance of essential utilities, corroborating the findings of the unannounced inspection conducted by JICS in October 2021, which notably identified the need for plumbing repairs as one of its primary concerns.

The same participant also touched upon the alleged misappropriation of funds, suggesting a deeper malaise within the system: 'The money that gets pumped into the prison system, basically all of it doesn't get allocated to the places which actually needs to be sorted out' [EX-INM1]. This testimony paints a grim picture of the prison environment, where basic amenities are in disrepair and financial resources do not reach areas most in need.

NGO-CF provided a detailed depiction of the environment, which is far from rehabilitative. They[20] described the recreational area as 'just a big square space that they can walk up and down', adding, 'that environment is quite raw'. The lack of greenery and natural elements translates the dehumanising aspects of the prison landscape. NGO-CF also noted the pointlessness in providing resources when they are not managed or respected:

> I have seen resources either being donated or like the best intention with certain projects. And then eventually it just sits there or gets paused or maybe someone gets moved to another department and things then just stagnate.

This observation speaks a lot about the mismanagement and lack of continuity in efforts to improve conditions.

[20] The pronoun 'they' is used as a gender-neutral singular pronoun to maintain confidentiality.

NGO-CF further detailed the destructive impact of security measures on resources meant for rehabilitation following a fight between inmates, 'The task team comes in and absolutely trashes the entire room. And so, all the resources that we have donated or spent time and money on, nobody cares.' This disrespect for the value of educational and recreational materials reflects an indifference to the welfare and development of the inmates.

Moreover, NGO-CF vividly described the dilapidated conditions of Pollsmoor Medium B, 'The paint is peeling off the roofs and the walls, and some of the lights aren't working in the hallways', which not only suggests neglect but also a dark living environment. NGO-CF also commented on the sensory impact of the prison, 'I probably have got a bit used to the prison smell, but yeah, it does smell', showing a level of normalisation of poor conditions that should otherwise be unacceptable. Corroborating these observations, the unannounced inspection by JICS, in October 2021, identified the facility's overall dirtiness and lack of hygiene. However, NGO-CF did concede that efforts are made to maintain cleanliness, with cleaners striving to 'keep the room clean as best as they can,' suggesting that despite the overarching issues, there are attempts to preserve some level of hygiene and order.

The nutritional aspect of inmate health is often overlooked, but as NGO-CF described, it is a significant concern: 'The prison food is often just these massive containers of I would say like white sump... it doesn't look that nutritious.' Proper nutrition is a cornerstone of health, and the lack thereof within Pollsmoor Medium B is a glaring oversight in the care of the inmate population. This neglect contravenes Section 35(2) of the South African Constitution, which stipulates the provision of adequate nutrition, amongst other.

Lastly, NGO-CF highlighted the scarcity of necessities such as clothing, which becomes particularly evident during the colder months: 'During wintertime... some of the guys were sitting with short sleeve tops and were quite cold... it's limited. And then once it's handed out within the cell, there may be limitations there as well.' They added, 'I think that is a challenge where you could physically see that it's cold and we as volunteers had our jackets on and these young guys were sitting in short sleeve t-shirts.' It is self-evident that inadequate clothing in cold weather increases susceptibility to cold-related illnesses, thereby exacerbating existing health challenges within the prison.

5.3.2. The Staffing Crisis

The second critical theme emerging from the interviews was the pervasive staffing issues which ranged from insufficient numbers to allegations of corruption and misconduct.

EX-CO painted a picture of a chronically understaffed facility, where the term 'skeleton staff' is not just a metaphor but a daily reality. 'The whole prison staff is skeleton,' EX-CO stated, showing that both the wardens and the hospital unit often operates with the bare minimum, only able to address critical emergencies. This scarcity of staff leads to dilemmas for those without medical training, 'How could I? Ascertain what is an emergency or what is critical and what is not?' [EX-CO]. The implications of such shortages are profound, not only limiting access to healthcare but also placing unqualified individuals in positions where they must make medical judgments.

Corruption within the ranks is another dimension of the staffing crisis. EX-INM4 described a corrupt system within the prison where both male and female staff members are involved in criminal activities, such as smuggling drugs and knives for inmates. He explained the payment process: inmates pay the staff double the value of the item they want. For example, if an inmate wants a packet of cigarettes, they must give the staff member the equivalent of two packets in money. The staff member then buys one packet for the inmate and keeps the money for the other. This system also applies to other contraband like weed. If an inmate wants cannabis worth 500 rand, he will have to pay 1000 rand, with the staff member keeping the extra 500 rand. Additionally, the inmate will have to pay someone else to store the cannabis in his room, revealing the complexity and extent of corruption within the prison. This view was shared by EX-INM3, who noted the power of money in influencing staff behaviour, indicating a system where financial incentives can dictate the quality of treatment an inmate receives.

EX-INM1 conversely highlighted training inadequacies: 'I think that that, I think that's due with the training now. I know that there's a certain, like… degree of professionalism when it comes to basically being what you call this, what are they called, "baas"[21], they go for training, but they're not actually really following the procedure to the T.' This comment underlines a

[21] Term used to refer to wardens.

disconnection between formal training and its practical application, implying that despite undergoing procedural education, staff may fail to adhere strictly to the prescribed protocols.

NGO-CF added another point to the discussion, noting the root cause of the problem: ‘Pollsmoor and other prisons run on a two-shift policy staff, policy systems, so they are very understaffed in the afternoons going into the evenings.’ This operational model results in long periods where inmates are left unattended, exacerbating the potential for neglect and abuse.

Lastly, NGO-CF raised concerns about the adequacy of mental health support within the prison:

> I don’t think mental health is addressed very well within the present environment and many programmes may not have that element to it either. Even on a level of depression and like suicidal thoughts or, you know, things like that, I’m not sure what interventions are really happening there.

This statement underscores a significant gap in the provision of mental health care, which is often overlooked in the face of physical health issues and may be further neglected due to the lack of specialised staff. NGO-CF also observed the psychological toll on the wardens themselves, ‘I think the wardens come with their own trauma and their own stress,’ suggesting that the toxic environment of the prison affects not only the inmates but also the staff, potentially impacting their ability to perform their duties effectively.

Ex-inmates also touched upon this neglect of inmates with mental health conditions. EX-INM1 recounted a brutal incident involving an inmate with mental health issues. This individual was awaiting trial and exhibited signs that something was wrong. One morning, it became clear that the situation had escalated when it was discovered that the inmate had grabbed another person’s hand and was trying to bite off their finger. This incident highlights the lack of adequate mental health care and supervision within the prison, as the behaviour was extreme and should have been addressed before it reached such a critical point. EX-INM5 elaborated on another story:

> There was a guy in my room he used to get strokes. Epilepsy. He was diagnosed with epilepsy. So, he used to sleep on the top bed. Now every third or fourth day in a week he would get it and he would fall down the bed. But every time he’d get it, he’d start bleeding. You see, so every time in the morning when the wardens, they come, they ask what happened to this guy, then he can’t remember what happened. But we would say “no, he falls.” Every time it happened continuously, so they thought that he actually got beaten the whole time, you understand.

Based on this story, there seems to be significant gaps in staff training and healthcare services. The repeated misinterpretation of an inmate's epileptic seizures as physical assault indicates a lack of awareness and understanding of medical conditions among the staff. It also points to a possible deficiency in training regarding how to handle such medical emergencies. The fact that an inmate with epilepsy was assigned to a top bunk, with no apparent measures in place to prevent injury from falls, further implies a lack of appropriate healthcare protocols and accommodations for inmates with known medical conditions.

In light of these findings, it is essential to remember the broader implications of these staffing and training issues on the overall health and well-being of both inmates and staff. Reports and studies from 2007 to 2015 have consistently highlighted persistent issues within the prison system, particularly at Pollsmoor RDF. These include inadequate medical staffing, delayed access to healthcare, and a general non-compliance with healthcare standards. *Lee v. Minister* was a stark reminder of DCS' failure to provide adequate healthcare in Pollsmoor Prison. Despite initial government efforts to address these issues, the 2015 Cameron report laid bare the ongoing challenges: significant staff shortages, inadequate medical equipment, and persistent delays in care.

Mental health care is not a peripheral concern but a fundamental right. As established in General Comment No. 14 of the CESCR[22], this right extends to all individuals within the prison system, including both staff and offenders.

5.3.3. Attitudinal Barriers

The third significant theme that emerged from the interviews was the attitudinal barriers that impede the delivery of appropriate medical care to inmates at Pollsmoor Medium B.

EX-CO pointed out a lack of empathy and basic human respect in the treatment of the sick, 'some of the nurses say that Mr. EX-CO, you must see that your friend is washed before they come visit.' To put it differently, certain nurses would refrain from treating inmates on the grounds that they are not clean enough. This statement reflects a disturbing disregard for the

[22] See note 8.

dignity of ill inmates, where the focus is shifted from care to superficial concerns. EX-CO also raised the issue of 'object rape'[23] which is a severe violation of human rights and indicative of a broader culture of dehumanisation within the prison. Such practices not only endanger the physical health of the inmates involved but also reflect a neglect of basic healthcare standards and human dignity.

EX-CO also identified logistical challenges reinforced by staff attitudes:

> A barrier could be, because the [main] hospital is many times, is always on the other side of the prison. You need to walk now. We have a winter in Cape Town. So, I am very, very concerned about it because staff must go out in the open to take the offender to the hospital. And when it rains like this, they become like sugar. They will say, it rains. Can I take you tomorrow? So, it's the willingness of the staff.

This shows how environmental factors, such as weather, can exacerbate existing attitudinal barriers, with staff using these as excuses to delay necessary medical treatment.

Ex-inmates provided harsh accounts that corroborate these attitudinal barriers. EX-INM1's statement about an inmate beaten to death without intervention is chilling:

> And the one person that they beat, they didn't realise that they beat him so badly that it was the end of his life. When, later on in the evening, when everybody was knocking at the gate calling for the warden, there was no warden that came. The following morning, when they actually opened up, the guy was basically dead.

In October 2023, during a restorative justice session, NGO-CF shared a troubling account from their team, set against the backdrop of the challenging conditions faced by prison wardens. While acknowledging that many wardens strive to do their best despite limited resources and the stress of their environment, NGO-CF recounted a disturbing incident of violence. During a break in their program, some team members looked out the windows to see the inmates during their recreation time. To their shock, they witnessed a warden severely beating an inmate. This incident deeply upset several team members who observed it. Although the context and reasons behind the beating were unknown, the fact that such an act of violence occurred in plain view was alarming and indicative of the tense and often volatile atmosphere within the prison.

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[23] Term used to describe the forced internal concealment of drugs by inmates.

Finally, NGO-CF added another layer to the discussion of attitudinal barriers and spoke to the psychological impact of verbal abuse and the power dynamics at play. During a discussion about experiences inside the prison, the team asked inmates about interactions with the wardens. The response they received was disheartening. Inmates recounted that the wardens often told them, 'We've come from the gutter, we're going back to the gutter.' The way some wardens spoke to and treated the inmates was concerning. It is difficult to foster positive change in an environment where inmates are constantly belittled and told they are worthless or likened to street criminals. Such negative reinforcement undermines any potential for rehabilitation or transformation.

5.3.4. Systemic and Bureaucratic Challenges

A fourth challenge within Pollsmoor Medium B was the systemic and bureaucratic hurdle that affects the timeliness and quality of healthcare and support provided to inmates. EX-INM1 highlighted a stark difference in healthcare quality based on sentence length. He noted, 'the quality of service is totally different to someone that's going to be in awaiting trial […] Lower your sentence, the greater the possibilities of you actually getting sick.' As outlined in Chapter 1, Section 2.4.1., pretrial detainees at Pollsmoor RDF confront challenges stemming from entrenched systemic and bureaucratic hurdles. These individuals frequently experience a lack of basic care, largely due to their status as pretrial detainees, which often places them outside the usual purview of DCS. Consequently, those in pre-trial detention often endure inferior healthcare services compared to sentenced prisoners.

Paradoxically, EX-INM1 also criticised the system for wasting resources on short-term prisoners who 'are going to come through'. This contradiction underscores a complex and potentially inconsistent healthcare and resource distribution system within the prison, affecting inmates differently based on their sentencing status. He also implied that the system does not effectively manage or rehabilitate these individuals.

From NGO-CF's perspective, there are significant bureaucratic hurdles and systemic opacity. They indicate a problematic lack of follow-up and collaboration, as well as challenges in tracking the progress or needs of inmates. This is exemplified by their efforts to address issues such as inmates' health complaints, which often lead to referrals to external bodies like JICS, but with little success in terms of effective follow-up or meaningful collaboration.

Furthermore, the opacity within the system is evidenced by the challenges external service providers face in obtaining information. Information is not freely available, and connections must be actively pursued by service providers themselves. This is indicative of a possible intentional policy by the DCS to limit interaction among wardens, external entities, and inmates as suggested by NGO-CF: 'I get the impression that they [DCS] don't necessarily want the wardens to be too familiar with whether it's people from the outside or obviously the inmates themselves'. This policy-driven barrier not only hinders the establishment of a rehabilitative environment based on trust and understanding among the different actors within the system but also contributes to the fragmentation and inefficiency of the correctional system. Each entity operates in isolation, resulting in slow and ineffective processes, which exacerbate the challenges faced in the correctional environment. The lack of cooperation within DCS, as well as between DCS and external organisations, judicial system actors, and law enforcement, manifests in a disjointed approach that ultimately undermines the effectiveness of correctional services.

NGO-CF also stated the difficulty in establishing contact with the right people within the prison system, suggesting that there is a lack of clear and accessible lines of communication for external organisations to coordinate with prison staff: 'it was going through some networking meetings that we got the correct numbers of the people to be in touch with'.

NGO-CF also acknowledged that while they can identify challenges within the programme, 'we can't address those needs one-on-one.' This limitation speaks to the systemic barriers that prevent care and support for inmates, which is further illustrated by the NGO's experience with cases where inmates have raised concerns that were not promptly addressed. As NGO-CF recounted:

> I could think of... at least five or six cases where the inmates specifically spoke to us and there may be more because of you know, whether they spoke to myself or some of the volunteers but where they spoke up and it took, it did take some time for the issues to be addressed.

This testimony recalls the findings from various reports and cases outlined in Chapter 1, highlighting systemic delays and inefficiencies that result in prolonged suffering and unaddressed healthcare needs within the prison population.

Compounding these challenges, EX-CO identified a critical shortfall in the correctional healthcare system – the absence of a multidisciplinary approach to inmate care. He said:

> One of the biggest challenges is that we don't operate in a multidisciplinary approach, that collaboration of the doctor, the psychologist, the social worker, they meet and discuss the patient because each one worked in their own silos.

This approach likely results in a lack of care for inmates, as the absence of collaboration and communication among different healthcare specialists can lead to disjointed and potentially ineffective treatment. Moreover, the absence of a multidisciplinary approach suggests a limited understanding of the complex health needs of the prison population. Inmates may require not just medical care but also psychological and social support, addressing issues that could range from chronic physical conditions to mental health challenges and the social implications of incarceration. EX-CO's statement also implicitly critiques the current correctional healthcare system's inability to see the inmate as a whole person with diverse needs.

EX-CO's comments also revealed a profound disconnect within the prison administration itself, exacerbating these systemic and bureaucratic barriers stating:

> There's always animosity between office staff and people working in practical... in contact with offenders then there's disparity between professional staff and so each one and we need to work integrated.

The lack of communication and collaboration he described not only hinders the sharing of essential information but also creates a fragmented environment where the left hand does not know what the right hand is doing, metaphorically speaking.

EX-CO further illustrated the consequences of this siloed working culture by sharing the challenges faced when information about an offender's health and behaviour is not shared:

> The offender goes to the hospital. He comes back. Nobody tells me that this guy complained about the salt. There's no salt or too salty or it's less food or… Because I need to go to kitchen. I need to go with the diet of him.

This lack of 'cross pollination' between staff working with offenders and professionals leads to missed opportunities for providing holistic care and support.

EX-CO further highlighted the issue that critical information regarding the reasons for an offender's incarceration often remains inaccessible to the staff who interact with him on a daily basis, saying, 'I work with an individual whose I don't know what his pathology is in order for me to establish a relationship and interaction with him.' This secrecy not only hinders the staff's capacity to create effective working relationships with the inmates, essential for delivering suitable care, but also obstructs the preparation necessary for their rehabilitation.

5.3.5. Gang Dynamics and Control

Gang dynamics and control also emerged as a profound and complex barrier to healthcare access in Pollsmoor Medium B, and more broadly in Pollsmoor Prison. The influence of gangs extends deeply into the daily operations and social structures of the prison, affecting not just the social order but also the health and well-being of the inmates.

EX-CO explained that the power gangs wield over individual health decisions, stating:

> The barriers, firstly, is that Pollsmoor is known, and prison is known for gangs. So, if an offender wants to come to the morning hospital parade, he needs to get firstly the bind in of the gang. He needs to inform them that when staff arrive on duty I want to go to the hospital. So, one of the gang officers in post is a doctor. I don't know where he studied away qualified a doctor, but the offender must go to the gangs' doctor first to get the bind in to visit medical staff. This is one of the barriers.

In other words, gang members assume roles that parallel official positions, such as that of a doctor, thereby gatekeeping access to legitimate medical care (Veloen, 2022, p. 61).

EX-INM3 provides further insighted into how gang-related activities can overshadow genuine healthcare needs, 'Like what I said, it's because of gang-related violence, you see.' He recounted an incident that illustrates the intersection of healthcare and gang dynamics:

> There's a story which happened, like another inmate... The fact is that he was sick, and he wanted outside health services. But they arranged his escape. I think there's a prison officer who was shot dead. And the guy ran away. And that's the other thing which makes the prison management not to give attention.

The gang culture within the prison system leads to frequent violence, including inmate-on-staff assaults. This violence exacerbates the demand for medical care, yet the fear of reprisals and gang influence often deters victims from seeking necessary assistance (*Prison conditions in South Africa*, 1994, pp. 53-54).

NGO-CF shed light on the implications of gang control within the prison:

> I think between the prison environment itself and the prison gangs that are inside the prison environment it's very difficult to... It's not impossible but I think it's very difficult to bring healing and reconciliation in the current space of Pollsmoor.

They added the challenges faced by inmates with learning difficulties or mental health issues:

> Many of them have learning challenges, they've dropped out of school early, they may have other mental health challenges like disassociation, split personality, foetal alcohol syndrome where there's delays in growth and you know again that leads often needs to maybe like school dropout or maybe joining the gangs because of the challenges of growing up.

This shows that this specific part of the inmate population may be more vulnerable to gang influence.

5.3.6. Policy and Procedure Constraints

The sixth salient theme identified pertains to the constraints imposed by existing policies and procedures, which significantly hinder the provision of healthcare within Pollsmoor Medium B and potentially the whole prison.

EX-CO highlighted a notable procedural shift in handling the admission of injured inmates, though its implications can be debated. Previously, police would bring inmates to the prison who had sustained injuries during their arrest or court proceedings. This often led to complications, as DCS was not adequately addressing the medical needs of these inmates. The prison has since revised its policy, no longer accepting these injured individuals directly. Instead, they require that the police take these inmates to an external doctor for medical treatment before their admission to the prison. While this policy shift appears to ensure that injured inmates receive appropriate medical care before incarceration, it also raises questions

about the shifting of responsibility. By mandating law enforcement to handle the initial medical needs of inmates, a role traditionally not within their purview, the change potentially absolves DCS of its immediate healthcare responsibilities. This shift could be seen as a way to manage the prison's healthcare challenges, but it also suggests a transfer of duty from correctional services to law enforcement, which may not align with their core responsibilities.

In a similar vein, EX-INM5 provided a perspective on the healthcare prioritisation system within the facility:

> If I can put it like in colours, red being serious and so they take you to the hospital. Maybe they see you have a severe pain, they can see you busy dying here, so they have to take you. And in the sense of maybe orange, if I put it in a colour, it's like maybe I have a boil or something and they know that you can still survive, so they're not going to attend to you immediately. You're still going to wait a period of time before they attend to you.

This account suggests a triage procedure that may delay treatment for conditions not deemed immediately life-threatening, reflecting a pragmatic, yet potentially problematic, approach to medical care under resource constraints.

NGO-CF also emphasised the impracticality of reporting mechanisms for inmates:

> The warden will ask the prisoners when they're all kind of lined up two by two... and that's also not conducive to people being able to put up their hands and go, "I was beaten up last night", "I was raped last night."'

This procedure does not afford inmates the privacy or security to report abuses safely and thus benefit the necessary care.

Lastly, NGO-CF, with a strong orientation towards restorative justice, pointed out a significant policy-driven barrier that hinders the implementation of restorative practices. They recounted an incident where, following a gang fight, their access to the prison was restricted:

> After the gang fight happened... we were asked to not come in for that week... it would have been critical to sit down and have perhaps a circle process and a debrief with the young people.

This instance reveals a policy that prioritises security over therapeutic intervention, potentially missing opportunities for improving the well-being and rehabilitation of inmates, as well as resolving conflicts effectively.

5.3.7. Overcrowding

A seventh theme identified was the issue of overcrowding within the prison system. Participants provided first-hand accounts of the conditions of the Correctional Centre. EX-INM1 stated, 'the prison is overcrowded as we all know', translating a widely acknowledged problem. EX-INM2 offered a more detailed description of the overcrowding issue in Pollsmoor Medium B, 'So those were designed rooms for 16. Now there's 88 in a room.' This dramatic increase in the number of inmates per cell far exceeds the intended capacity, leading to severe overcrowding.

NGO-CF corroborated these accounts, noting the direct impact of overcrowding on service delivery: 'More currently I know that there has been a struggle and a delay in the inmates being seen too because I think of the overcrowding'. They further commented on the broader implications, suggesting that the prison system has resorted to 'warehousing of prisoners because of the overcrowding'. NGO CF also highlighted the strain on resources was also in the delivery of food provision: 'I think when you bulk cooking for you know, seven or eight thousand prisoners a day, then as far as I know, they still have two meals a day.' This observation points to the challenges of providing meals in a system burdened by high numbers. The necessity to prepare food on such a large scale impacts the quality and nutritional value of the meals served. Furthermore, the limitation to two meals per day raises concerns about the adequacy of nutrition for the inmates, which is a fundamental aspect of their health and well-being as guaranteed by the Constitution.

The first-hand accounts of overcrowding in Pollsmoor Medium B, as described by EX-INM1, EX-INM2, and NGO-CF, are substantiated by historical and contemporary data outlined in Chapter 1, Section 2.4.1. This overcrowding is a direct consequence of the legal changes made in the mid-1990s, particularly the introduction of mandatory minimum sentencing and the difficulties in obtaining bail. These legal changes have led to longer sentences and fewer bail releases, contributing significantly to the overcrowding problem.

5.3.8. Misuse of Healthcare Access for Other Purposes

A final theme that emerged was the misuse of healthcare access for other purposes. Participants spoke of instances where inmates would feign illness for ulterior motives. EX-INM2 recounted personal experiences and observations, noting the difficulty for prison staff to discern genuine medical needs from false claims: 'it's almost impossible for them to get around especially because so many of the guys lie.'

EX-INM3 expanded on this, indicating that some inmates exploit healthcare visits for purposes such as smuggling contraband: 'I think there are some inmates which take advantage of seeing the health facilities in order to promote their violin stuff.' These comments shed light on the complexities faced by prison staff in identifying authentic health complaints amidst a culture of mistrust and deception.

This prevalence of dishonesty among inmates leads to scepticism and potential neglect of serious health issues, as staff become desensitised or overly cautious in their response to inmates' medical claims. EX-INM4 added another point to this view, mentioning, 'they want to smuggle drugs around the rooms. They just claim they're sick because they want to smuggle stuff around.' This situation presents a complex challenge for prison staff who must balance the dual responsibilities of providing care and maintaining security and order. The difficulty is further exacerbated by the earlier mentioned example of wardens in facilitating drug smuggling, adding another layer of complexity to their role.

5.4. Strategies to Inmate Healthcare Services

This section presents an array of approaches developed from the extensive experience of NGO-CF and EX-CO within Pollsmoor Prison. Their deep understanding of the prison environment and its challenges informs these strategies, which aim to enhance healthcare services for inmates. These strategies include a broad spectrum of initiatives, from multidisciplinary collaboration among healthcare professionals to empowering inmates with essential healthcare skills. They also include the integration of holistic and restorative justice approaches, the implementation of educational and recreational programs, a focus on mental and therapeutic interventions, and improvements in communication and information sharing.

5.4.1. Multidisciplinary Collaboration

The narrative of improving healthcare services within Pollsmoor Prison essentially calls for a multidisciplinary collaboration, fostering synergies across various expertise. Indeed, as noted earlier, a significant barrier is the lack of an integrated multidisciplinary framework, where healthcare professionals, including doctors, psychologists, and social workers, operate in isolation rather than in concert. EX-CO's aspiration is to see these professionals come together, discussing, and strategizing around the healthcare needs of inmates as a unified body, thus eliminating the silo effect that currently hampers the efficiency of healthcare delivery.

This pursuit of a collaborative approach extends beyond healthcare professionals alone. As DCS often emphasises, prison is a 'societal responsibility', necessitating the involvement of all stakeholders, including NGOs, in the rehabilitation process for offenders. 'I am for the NGOs support,' EX-CO began, suggesting a model where NGOs not only offer aid but also play a crucial role in coaching inmates. Specifically, he visualised a scenario where inmates are taught by NGOs to assume responsibility for their own health, including medication adherence and basic first aid, fostering a sense of communal responsibility within the prison community.

EX-CO also highlighted the critical aspect of offender management within the prison advocating for the segregation of different categories of offenders to prevent violence and abuse, which is integral to maintaining inmates' physical and mental well-being. He stressed, 'So, first time offenders must be kept away from habitual offenders,' indicating that a tailored approach to inmate classification could significantly reduce harmful incidents and contribute to a safer environment conducive to rehabilitation.

Finally, NGO-CF underlined the critical role of engaging directly with inmates. 'So, having more access and more time to engage with offenders or those inside, either one-on-one or in group work,' they argued, is essential. In other words, there is a need for personal interaction and the establishment of trust-based relationships as foundational elements for a healing prison environment.

5.4.2. Inmates Empowerment

In the face of the challenges posed by the lack of medical expertise among prison staff, EX-CO offered a forward-thinking approach: the education of inmates in emergency healthcare. He recounted, 'We can only take on critical or emergencies as lay warders. Meaning I'm not qualified in any medical experience'. He further elaborated on this by sharing one of his initiatives from his time at Pollsmoor Prison, where he collaborated with a paramedic to instruct gang leaders in first aid, thus empowering them to act in emergencies. His rationale is to embed basic healthcare skills within the inmate population: 'It's to have offenders inside their rooms and cells that has a basic understanding of emergency care, to become first aiders. Teach them, teach them, you know, while you're waiting for a professional to arrive.' [EX-CO].

He further suggested that room leaders should ensure their fellow inmates take their medication as prescribed, thus fostering a sense of community responsibility and self-care. He advocated for conflict resolution techniques to be known amongst inmates, enabling them to contribute positively to the prison environment:

> The conflict resolution is the need for inmates to be active in the resolution of disputes or how offenders, inside the rooms, can diffuse and support, how they can oversee the administration of medication within their cells, see that no harm is happening… because I think each cell needs to have a kit with a responsible and accountable offender inside.

This initiative underscores a broader vision that views inmates not as liabilities, but as potential contributors to their own well-being and that of their peers. By equipping them with the knowledge and tools for basic healthcare and conflict resolution, the prison can cultivate an environment in which empowerment and responsibility lead to improved healthcare outcomes.

5.4.3. Holistic and Restorative Justice Approaches

The interviews also emphasised holistic and restorative justice strategies, a finding that aligns with the core mission of the NGO, which specialises in restorative justice programmes. NGO-CF pointed out the need for a holistic approach to inmate welfare, stating, 'We bring a very holistic approach, so, which I think is quite unique in the sense of being aware of their physical needs, their emotional needs, their spiritual needs.' This viewpoint recognises the necessity for

a health strategy that transcends conventional medical treatment, focusing on inmates' overall well-being.

NGO-CF also recognised the power of the environment in the healing process, advocating for a transformative space within the prison: 'And on that note, I would highlight that restorative justice can also be about space and creating space that is more healing,' further implying such spaces might include areas where plants and flowers grow, introducing natural elements that have been shown to contribute to emotional and psychological healing.

Echoing the value of structured activities, NGO-CF accented the potential of evening classes to curb gang activities:

> I remember one warden many years ago saying to me, we need to have night classes... And the reason behind night classes was that's often when the gang activities happen and if one were to kind of intervene and break in the evenings, one could perhaps see some shifts in things as well.

This quote stresses the importance of engaging inmates in productive and structured activities during times that are typically prone to disorder and violence. By filling the evening hours with educational opportunities, the prison environment can foster personal growth and development while simultaneously deterring the negative influences and interactions that can flourish during periods of inactivity.

5.4.4. Educational and Recreational Programmes

The introduction of educational and recreational programmes emerged as the fourth strategic approach to meeting the healthcare needs of inmates. 'We've tried to bring in magazines and puzzles and games just because there's a lot of time spent inside locked up with not much to do,' NGO-CF recounted, recognising these activities as not merely pastimes, but as vital components in promoting mental health and well-being among the incarcerated.

NGO-CF's prior experience at Pollsmoor Medium C, underlined the effectiveness of having structured recreational activities: 'There seemed to be more engagement with a sports and recreation department within the centre... there was a particular warden assigned to that.' The engagement not only provided physical activity but also fostered a sense of community and

support, factors that are known to contribute to overall health and decrease the incidence of psychological distress among inmates.

NGO-CF also mentioned an innovative project at Pollsmoor Medium A, where they worked with juveniles to repurpose old tyres as planters, adding a touch of horticulture to the prison setting: 'We tried to grow plants,' they stated, suggesting a form of nature therapy that contributes to the inmates' psychological and emotional well-being, which is a critical aspect of healthcare. NGO-CF's vision for a prison environment also included sensory enrichment: 'At its very basic level, there needs to be bright colours, there needs to be gardens, there needs to be... access to some kind of classical music or some kind of therapeutic intervention.' This holistic approach recognises that healthcare extends beyond the physical treatment — the environment in which healing takes place should also be prioritised.

5.4.5. Mental and Therapeutic Interventions

A fifth theme identified within the strategies was the emphasis on mental health and therapeutic interventions. NGO-CF's insights on mental and therapeutic interventions are pivotal for enhancing healthcare services in the prison, as they articulate an approach that acknowledges the profound impact of trauma on individuals. NGO-CF emphasised the importance of addressing the psychological scars of inmates as part of their rehabilitation. They incorporate a trauma-informed lens into their programme, which includes techniques such as breath work, exercise, and movement.

The integration of trauma-informed practices into the programme recognises that many inmates arrive with complex trauma histories, which are exacerbated by the prison environment. The therapeutic art and journaling components serve as avenues for self-expression and processing of experiences, which are critical for healing. These activities are part of a thoughtful strategy to prepare inmates for learning and personal development. NGO-CF explained that there is a therapeutic element in the artwork, which helps bring inmates into a state conducive to learning. This is particularly important considering their background of trauma and violence.

5.4.6. Communication and Information Sharing

Lastly, a pivotal aspect in enhancing healthcare services for inmates lies in the optimisation of communication and information sharing protocols within the prison. EX-CO highlighted the necessity for a paradigm shift, stating, 'The prison administration must stop working in silence.' There is a need to dismantle the silos of communication that traditionally exist between the departments, which constitute barriers to the delivery of effective healthcare.

The compartmentalisation of inmate information leads to critical oversights in inmate care. For instance, the lack of shared knowledge in the earlier mentioned instance on dietary requirements or health complaints following hospital visits results in the failure to provide appropriate care to the inmates, impacting their health outcomes.

Emphasising the need for strong communication, EX-CO suggested that interchange of knowledge between the staff working with offenders and professionals is important. This approach fosters a deeper understanding of each inmate's background, enabling a more nuanced approach to their healthcare and management. Such an integrated perspective is not about judging the inmates but is aimed at equipping the staff with the right tools and knowledge to 'manage behaviours and conflicts more effectively' [EX-CO].

EX-CO further discussed the importance of sharing insights into an inmate's temperament and triggers: 'Knowing what sets someone off can help in preventing situations from escalating.' It is the nuance in this shared information that can empower the staff to adopt a more proactive and preventive stance in managing the inmates, which can significantly contribute to a reduction in conflicts and the promotion of a safer correctional environment.

Chapter 6: Discussion

6.1. Introduction

The preceding chapters of this research have navigated through the intricate landscape of healthcare services in Pollsmoor Prison. More specifically, the primary objective of this research was to uncover the challenges faced by inmates in accessing healthcare services, understanding how these issues are influenced by a range of factors including prison infrastructure, staffing, attitudinal barriers, and gang dynamics within the prison, set against the legal and human rights framework governing prisoner health in South Africa. This chapter aims to provide a nuanced analysis of the healthcare situation in Pollsmoor Prison by contrasting the research findings with the established body of literature. The structure of the chapter is methodical: it begins by aligning the research findings with existing literature to pinpoint areas of both convergence and divergence. This is followed by an in-depth interpretation of the key findings. It concludes with recommendations for future research, setting a path for ongoing investigation in this area.

6.2. Overall Analysis of Literature and Research: Alignments and Disparities

6.2.1. Legal Theories vs. Practical Realities

The literature review meticulously outlined the robust legal framework in South Africa, designed to safeguard prisoners' healthcare rights. As grounded in the Constitution of South Africa, especially Section 35(2)(e), this framework establishes 'the right of detained individuals, including sentenced prisoners, to conditions of detention consistent with human dignity,' including the provision of 'adequate accommodation, nutrition, and medical treatment, at state expense.' Additionally, Section 12 of the CSA mandates DCS to provide 'adequate healthcare services, including the right to medical treatment and the choice of medical practitioner.' These legislative acts and constitutional provisions collectively form a legal framework that guarantees the healthcare rights of inmates.

Internationally, instruments such as the ICESCR provide a solid framework for the rights to physical and mental health, which also extend to prisoners. Similarly, the Nelson Mandela Rules

offer explicit guidelines for the treatment of prisoners, including healthcare. Although these do not inherently possess binding force on states, they function as normative standards and aids for interpretation.

Contrasting with these well-established legal structures, the research findings present a markedly different reality. Interviews with EX-CO and NGO-CF revealed a systematic failure in implementing these legal mandates. EX-CO shared insights into the day-to-day operations within the prison, showing the lack of private and confidential spaces for medical consultations, a fundamental breach of the conditions necessary for effective healthcare provision. According to The National Health Act No. 61 of 2003, 'all patients have a right to confidentiality, and this is consistent with the right to privacy in the South African Constitution.'[24] This lack of privacy not only contravenes the legal rights of prisoners but also undermines the dignity and confidentiality integral to medical care. Yet, in situations requiring immediate care, such as post-assault or rape, the practice of summoning inmates in a public manner by wardens does not foster a safe or confidential space for disclosure. Consequently, the current procedures fall significantly short of facilitating the necessary confidential environment, and the provision of medical care.

The contrast is clear between the legislative provisions of the Mental Health Care Act and the realities reported by NGO-CF and ex-inmates. The Act establishes a framework for mental health care in prisons, including regular assessments and treatments for inmates. However, NGO-CF reports suggest mental health concerns are not sufficiently addressed, with a lack of interventions for serious conditions such as depression and suicidal tendencies. Furthermore, EX-INM1's account of a violent incident indicates a failure to provide the care mandated by law, which should prevent such extreme situations. This discrepancy points to a significant gap in the effective implementation of mental health care in Pollsmoor Prison.

NGO-CF's descriptions further illustrated the discrepancies between legal expectations and on-ground realities. They depicted a prison environment that is far from rehabilitative, with inadequate resources and facilities that starkly contrast the legal obligations outlined in Section 35(2)(e) of the Constitution, i.e., 'conditions of detention that are consistent with human dignity.' For instance, the inadequacy of recreational areas, the neglect of the prison

[24] See note 19.

infrastructure, including peeling paint and malfunctioning lights and the non-nutritious food served to inmates all reflect a disregard for the legal standards of prisoner care.

While *Van Biljon* and subsequent legal battles established the State's responsibility to provide healthcare services in prisons, the research findings indicate a deviation from this obligation. The procedural shift in admitting injured inmates, instead of ensuring immediate healthcare within the prison as mandated by legal precedents, suggests an evasion of responsibility by DCS, contradicting the intentions of these legal mandates.

Additionally, the legal literature advocates for equitable healthcare access in prisons, as seen in *EN and Others* mandating care for HIV-positive inmates. In contrast, the research findings reveal a triage system in Pollsmoor Prison that prioritises severity over equity, reflecting a resource-driven approach that diverges from the ideals of healthcare equality.

The disconnect between legislations and legal victories in court and their materialisation in daily prison operations raises questions about the efficacy of legal mechanisms in driving policy and practice changes within Pollsmoor Prison. The continuous issues with healthcare access and quality in the Correctional Centre, despite clear legal mandates, points out a broader problem of accountability and enforcement in the prison system.

6.2.2. Disparities in Infrastructure and Hygiene

The literature review significantly highlighted the persistent issues of infrastructure and poor hygiene conditions in Pollsmoor Prison. These problems have been documented over the years, with various studies, reports and inspections from JICS emphasising the negative impact of these infrastructural inadequacies on the prison conditions and thus the health and welfare of inmates (Judicial Inspectorate for Correctional Services, 2022). The challenges range from dilapidated buildings to inadequate medical facilities, all contributing to a substandard living and healthcare environment. These issues are not only a violation of the legal rights of prisoners but also pose significant health risks.

The observations from Pollsmoor Medium B lend credence to existing research, showing two primary impacts of the inadequate infrastructure. Firstly, the environment significantly hampers staff members' ability to work effectively. Facilities such as sports, residential, and training

areas are in a state that fails to inspire or facilitate efficient job performance. These substandard conditions create a challenging workspace for staff. It raises a pertinent question: how can wardens be expected to function optimally in such uninviting surroundings? Prisons are inherently complex environments, and without any measures to enhance staff well-being, it becomes unreasonable to anticipate that they will maintain a respectful and stable approach towards inmates.

Secondly, the environment severely undermines the potential for rehabilitation and the maintenance of health for the inmates. The lack of basic infrastructure and hygiene significantly affects inmates' perception of being treated justly. Let us consider the impact of enduring conditions where sinks overflow, necessitating buckets to catch the water, or where shared bathrooms and showers are overcrowded, servicing more than 20 inmates per room. The dusty blankets and the heightened risk of disease further exacerbates the deplorable living conditions. These circumstances naturally lead to a deterioration in self-respect and respect for others. The answer to how long one would tolerate such conditions seems self-evident.

The research findings resonate strongly with the long-established infrastructural inadequacies underlined in both academic literature and on-site observations. These issues are further illuminated through contemporary narratives provided by NGO-CF and EX-INM1, offering a current view to these enduring challenges.

NGO-CF painted a bleak picture of the prison environment, one that starkly contrasts with the concept of rehabilitation. Her description of the recreational area as a mere 'big square space,' devoid of greenery or natural elements, not only aligns with the literature and previous observations but also emphasises the dehumanising nature of the prison landscape. This stark depiction underscores the failure of the prison environment to provide an atmosphere conducive to rehabilitation and mental well-being.

EX-INM1's account further corroborates the findings detailed in the literature, specifically regarding the deteriorated state of the prison's infrastructure. His reference to outdated and malfunctioning plumbing, along with the uneven distribution of essential amenities like water, depicts a scenario of severe neglect and disrepair. This situation is particularly distressing given the crucial role of water in maintaining basic hygiene and health. The prevalence of health issues such as sores, boils, and skin infections among inmates, and the lack of adequate

remedies like hot water, illustrates the prison's failure to meet even the most fundamental human needs.

Such conditions are not only inhumane but also counterproductive to the aim of rehabilitation. The notion of treating inmates, who are still human beings, in such deplorable conditions raises serious ethical concerns. Subjecting individuals to an environment akin to treating them 'like dogs' is not only morally reprehensible but also ineffective in fostering any meaningful reform.

The convergence between the literature, the on-site observations and the research findings shows a consistent failure to address and improve the physical conditions in Pollsmoor Prison over time. Despite the awareness and documentation of these issues, little progress seems to have been made in rectifying the infrastructural and hygiene deficits. This ongoing neglect not only affects the health and well-being of inmates but also raises serious questions about the commitment to upholding the standards set by legal frameworks and human rights conventions.

6.2.3. Human Resource Dilemmas

The literature review extensively discussed the chronic issue of staffing challenges in South African prisons, including Pollsmoor Prison, a problem persisting for decades. It highlighted not only the shortages of personnel but also allegations of corruption within the prison. These challenges have historically hampered the effective delivery of healthcare services to inmates. Sources have consistently stressed the detrimental impact of these staffing issues on the quality of healthcare and the overall management of prison facilities.

The research findings build upon and amplify these historical concerns. Accounts from EX-INM 3, EX-INM4, and EX-CO illustrate an ongoing battle against understaffing and corruption, contributing to a bleak portrayal of the prison's current conditions. Notably, EX-INM4 detailed a deeply rooted corruption network within the prison, involving staff in activities like contraband smuggling for inmates, with EX-INM3 corroborating these illicit practices. Significantly, EX-INM4's incarceration period of 2006 to 2008 coincides with a time when corruption was already known to be widespread (Muntingh, 2006). EX-INM3, incarcerated from 2016 to 2017, has affirmed the enduring nature of corruption challenges within Pollsmoor Prison. His testimony, indicative of the deep-rooted difficulty in eradicating such practices, aligns with the findings of a recent newspaper article that, while not specifically referencing

Pollsmoor Prison, confirms the widespread issue (Matlhabe, 2022). Corruption lead to the diversion of resources meant for healthcare, prioritise certain inmates over others based on illicit agreements, and create an environment where healthcare provision is not based on medical need but on corrupt practices (Mashimbwe, 2023b).

EX-CO's experiences further illuminate the impact of understaffing on healthcare delivery. He mentioned the frequent operation of the prison on 'skeleton staff,' a term that vividly captures the severity of the staffing shortage. This situation often leads to critical emergencies being the only health issues that can be addressed, leaving many inmates' medical needs unmet. The reality described by EX-CO aligns with the documented historical issues and indicates that despite awareness and documentation of these problems, little progress has been made in resolving them.

The alignment between the literature and contemporary accounts from Pollsmoor Prison suggests that staffing challenges remain a chronic and unresolved issue in the prison's administrative and healthcare systems. The persistence of these problems indicates systemic failures in addressing the root causes of understaffing and corruption. These issues not only compromise the quality of healthcare provided to inmates but also reflect broader problems in prison management and governance.

6.2.4. Staff Attitudes and Healthcare Delivery

The literature review identified systemic and bureaucratic hurdles in the provision of healthcare in South African prisons, emphasising issues such as red tape, inefficiency, and policy misalignment. These obstacles, as discussed in academic studies and governmental reports, create a framework in which the delivery of healthcare services is often delayed or compromised. The review, however, primarily focused on the structural and procedural aspects of these barriers, providing a more macro-level perspective on the challenges within the prison healthcare system.

In contrast, the research findings shed light on the human element of these barriers, specifically focusing on staff attitudes. EX-CO and NGO-CF's narratives revealed a concerning level of disdain and lack of empathy among healthcare staff towards inmates. For instance, EX-CO's accounts of nurses refusing to treat inmates based on their cleanliness illustrate a disturbing

disregard for the inmates' dignity and healthcare needs. This attitude starkly contrasts with the principles of human dignity and right to healthcare enshrined in South Africa's legal frameworks.

NGO-CF's experiences further underscore the impact of negative staff attitudes on healthcare delivery. They noted instances where the lack of respect and understanding from healthcare providers towards inmates' conditions significantly hindered the provision of care. Such attitudes not only exacerbate the existing structural challenges but also contribute to an environment where inmates' healthcare needs are not adequately addressed.

This divergence between the literature's focus on systemic issues and the research findings' emphasis on human factors highlights a critical gap in understanding the full spectrum of barriers to effective healthcare in prisons. While structural and bureaucratic challenges are undoubtedly significant, the attitudinal barriers presented by healthcare staff play an equally, if not more, crucial role in hindering healthcare service delivery. These attitudes contribute to an environment of mistrust and neglect, further alienating inmates from accessing the care they are legally entitled to.

6.2.5. Dominance of Gang Culture

The literature review establishes a historical background for the influence of gang culture in South African prisons, particularly in Pollsmoor Prison. It considers how gang dominance has been a persistent issue, significantly affecting various aspects of prison life, including healthcare access. This historical precedent underlines how entrenched gang hierarchies and their control over the social and operational dynamics within prisons have been a longstanding challenge. The literature documents how gangs, through their power structures, have often dictated not just the social order but also crucial aspects of prison administration, including access to healthcare services.

The research findings resonate with this historical narrative and further illustrate the current state of gang influence within the facility. The accounts from EX-CO and EX-INM3 provide first-hand insights into how gang dynamics continue to control healthcare decisions and access. For instance, EX-CO describes a scenario where inmates must first seek approval from their gang's 'doctor' before accessing actual medical care, demonstrating the extent to which gang

authority supersedes official prison protocols. Similarly, EX-INM3's accounts reveal how gang-related activities and violence can overshadow and complicate healthcare provision, indicating a deeply ingrained system of gang control that permeates even into healthcare administration.

The alignment between the literature and the research findings suggests a continuity in the challenge posed by gang dynamics within Pollsmoor Prison. Despite various legal and policy interventions aimed at improving prison conditions and administration, the influence of gangs remains a deeply rooted issue. It is complex to address gang dominance in the prison environment and there is a need for more targeted strategies that specifically address these unique challenges.

6.2.6. Exploiting Healthcare for Unintended Uses

A notable omission in the literature is the exploration of healthcare service misuse in prisons for non-medical purposes. This includes instances where inmates simulate illnesses to obtain certain medications, seek relocation to medical wards for reasons unrelated to health (such as interacting with specific inmates or avoiding certain prison areas), or to find a temporary escape from the prison environment. The existing literature's limited attention to the misuse of healthcare services for purposes beyond intended medical care shows a significant gap in our understanding of the intricate operational dynamics of Pollsmoor Prison. This gap may be attributed to various factors, such as the difficulties inherent in collecting reliable data within prison settings, where reluctance from both inmates and staff to share information is common. Additionally, the more pressing concerns of infrastructure, staff shortages, and limited resources in Pollsmoor Prison could eclipse the specific issue of healthcare misuse.

6.3. Unpacking the Hidden Complexities in Pollsmoor Prison

In Section 6.2., we considered the convergence and divergence between the literature and the research findings, uncovering critical issues such as legal frameworks, infrastructure challenges, staffing dilemmas, attitudinal barriers, and the pervasiveness of gang culture within Pollsmoor Prison. However, this analysis pushes for a deeper exploration of certain core issues, including infrastructure inadequacies, accountability and enforcement challenges, the nuances of attitudinal barriers, and the persistent problem of overcrowding. These issues are not merely

surface-level challenges — they conceal a myriad of sub-problems often overlooked in the literature. This section aims to evaluate these complex layers, offering a more profound understanding of the systemic issues that hinder the effective operation and reform of Pollsmoor Prison.

6.3.1. Infrastructure: Beyond Physical Barriers

The extensive review of literature and interviews data highlight a disproportionate emphasis on infrastructure as the primary impediment to effective healthcare delivery. Although the prison's physical conditions are undeniably substandard, this singular focus masks more ingrained, systemic problems. The frequent blaming of service delivery shortcomings on infrastructural limitations serves as a convenient diversion, shifting attention away from the lack of political determination and collaboration among various stakeholders to confront the fundamental causes of these issues that contribute to inadequate healthcare conditions.

This diversion is particularly troubling because it perpetuates the neglect of more urgent matters, such as staff training, resource allocation, and policy implementation. By persistently identifying infrastructure as the chief barrier, there is a danger of ignoring the essential need for reforms that transcend simple physical improvements.

Issues like plumbing, updating water heaters, replacing electrical cables, repainting walls, or refurbishing floors represent tasks that could be swiftly addressed. The question arises: why do these issues remain unresolved?

It appears that the government is reluctant to resolve these issues, preferring to hide behind the facade of infrastructure challenges rather than admitting their own shortcomings in improving prison conditions. This observation is particularly relevant considering the potential workforce available within Pollsmoor's approximately 8000 inmates. Using this labour force could significantly improve prison conditions for both inmates and staff, creating an environment conducive to well-being and rehabilitation. However, despite this potential, the infrastructure continues to deteriorate, as evidenced by my repeated observations during visits where no maintenance work was apparent, not even in the sporting facilities or the outdoor areas, which suffer from neglected landscaping and poor maintenance during inclement weather.

Thus, the fixation on infrastructure as the predominant hurdle in Pollsmoor Prison is a misrepresentation, obscuring deeper systemic issues that require urgent attention and action.

6.3.2. Attitudinal Barriers: The Core of Systemic Dysfunction

A key finding from the research at Pollsmoor Prison is the prevalence of attitudinal barriers, which, despite their significance, are often overlooked in local literature regarding systemic failures. The core issue stems from the attitudes of prison staff, especially those involved in healthcare delivery. Negative attitudes, such as disrespect and lack of empathy towards inmates, are major obstacles to effective healthcare in the prison. Instances of staff making dismissive comments about inmates' hygiene or wardens mistreating inmates are indicative of this pervasive problem. These attitudes not only degrade the quality of medical services but also violate inmates' rights to adequate healthcare.

These negative attitudes are often driven by a 'paycheck-first' mentality, leading to a culture of neglect and apathy where inmates' health needs are routinely side-lined. This situation creates a dysfunctional healthcare environment, contradicting the basic human expectation of fair and respectful treatment.

Furthermore, such disrespect is detrimental to both staff and inmates. Many inmates, who often have limited educational backgrounds and may have ceased formal education early, arrive in prison with undeveloped societal values like respect and self-esteem. Witnessing or experiencing mistreatment by wardens, such as physical abuse or constant negative labelling, does nothing to improve their mental well-being or rehabilitative prospects.

Despite the goal of correctional facilities to reform prisoners and reduce recidivism through rehabilitation programs, the prevalent negative attitudes among Pollsmoor Prison staff suggest a stark disconnect from these rehabilitation ideals. This lack of a humane approach in the correctional system hampers any potential improvements, creating a paradox where the very individuals responsible for facilitating change are instead perpetuating negative cycles.

6.3.3. Accountability and Enforcement: Essential Elements for Systemic Change

The research findings have identified a significant gap in the form of inadequate accountability and enforcement mechanisms, particularly within the prison's healthcare services. The absence of a strong framework to hold staff accountable and enforce policies and procedures has led to a marked decline in discipline, order, and the effectiveness of healthcare services. This situation is akin to a military operation without discipline or structure, resulting in a collapse of the chain of command and overall operational efficacy.

The literature review acknowledges the importance of accountability in numerical terms, such as statistics and reports, which help in understanding the delivery of healthcare services in prisons. However, true accountability goes beyond just numbers and statistics. It encompasses moral and ethical responsibility, especially in adverse situations within the prison. While existing reports and studies have focused on the poor infrastructure of the prison, they have not adequately addressed the underlying moral and ethical issues. This lack of in-depth exploration in the literature, as pointed out by the research findings, means that moral attitudes and ethical considerations are often overlooked. In a performance-driven society, this oversight is concerning, as DCS tends to view inmate treatment more as a performance metric rather than a matter of moral duty. This perspective raises critical questions about the delivery of optimal medical care to inmates in the absence of moral and ethical accountability.

Drawing an analogy with the military, where accountability is enforced at all levels, a similar approach should be adopted in prison settings. In the military, everyone, from the highest to the lowest ranks, is required to report issues to their superiors, with failure to do so resulting in serious consequences. In Pollsmoor Prison, moral accountability should include effective communication among staff members about problems that arise and also ensuring transparency with the wider public. Despite DCS's official stance on promoting transparency and accountability, the reality often contradicts these policies.

Instances have been reported where critical incidents, such as an inmate falling ill, are not handled with the urgency or care they require. It is alarming to hear from interview participants that certain illnesses are prioritised over others, or that some sick inmates are neglected until the following day. Reports of nurses refusing to tend to inmates due to cleanliness issues further underscore the lack of moral accountability. This lack of ethical consideration in healthcare raises serious questions about the effectiveness and humanity of the services provided. Without

a foundation of moral accountability in Pollsmoor Prison, the proper delivery of healthcare services remains a significant challenge.

6.3.4. Re-evaluating Overcrowding

The final aspect I wish to address concerns the disparity between the prominence of overcrowding in existing literature and its relatively subdued presence in the interviews conducted for my research. The literature extensively covers the topic of overcrowding, tracing its historical development and its evolution over time. This issue has been a significant focus, debated in legal literature, culminating in recent judicial rulings specifically addressing overcrowding.

However, this emphasis contrasts starkly with the findings from my research interviews. Among participants, overcrowding was not a primary concern — it was mentioned infrequently and emerged as a subordinate theme in the thematic analysis. This notable divergence between the literature and interview responses suggests that overcrowding, while acknowledged as a contributing factor, may not be the central issue in addressing the challenges of healthcare service delivery at Pollsmoor Prison.

Recalling the primary themes of the research findings — infrastructure and resources, staffing challenges, and attitudinal barriers — it becomes evident that these areas garnered more focus and concern. Their prevalence is not merely coincidental but indicative of more pressing issues within the prison system. Overcrowding, though undeniably a significant problem, may have a less direct impact on healthcare service delivery than these other factors.

Overcrowding remains a pressing concern. However, maintaining hygienic conditions, providing adequate medical treatment, and upholding a focus on rehabilitation and humane treatment are crucial. Addressing these foundational issues could mitigate the adverse effects of overcrowding. This perspective is not to diminish the seriousness of overcrowding but to accent that its resolution alone might not suffice to resolve the broader healthcare delivery challenges at Pollsmoor Prison. It is in the improvement of conditions, resources, and attitudes where more immediate and impactful changes can be made.

6.4. Recommendations

To envision a transformed healthcare landscape within Pollsmoor Prison, this section embarks on a bunch of strategic recommendations, each building upon the other to create a cohesive and impactful change.

6.4.1. Beginning with Legal and Ethical Foundations

Pollsmoor prison must be a system where the existing legal frameworks are not just words on paper but living standards that are meticulously enforced. Independent bodies must keep frequently inspecting the facilities, ensuring that the rights to privacy, dignity, and adequate healthcare enshrined in the South African Constitution are not just upheld but celebrated. Concurrently, there must be an emphasis on legal education, where both staff and inmates become advocates for healthcare rights, fostering an environment of mutual respect and understanding.

6.4.2. Tackling the Human Element – Staffing and Attitudes

Pollsmoor Prison must be a place where every staff member, from the wardens to the healthcare providers, undergoes thorough training. This training is not just about procedures and policies but is imbued with lessons on empathy, respect, and the ethical treatment of inmates. In this perspective, corruption must also be tackled, rooted out by stringent policies and a robust system that protects and encourages whistle-blowers.

6.4.3. Revamping the Physical and Communal Space

What would a new Pollsmoor Prison look like? The walls would be freshly painted, the medical facilities would be state-of-the-art, and there would be a sense of cleanliness and order. Inmates would be actively involved in maintaining these spaces, learning valuable skills and contributing to their environment. This physical transformation would go hand in hand with a shift in how inmates view their surroundings — not as a place of confinement, but as a space of growth and self-improvement.

6.4.4. Fostering Collaboration and Communal Responsibility

Now, the barriers between different professionals as doctors, psychologists, and social workers must fall and come together in a unified front. They must be joined by NGOs and other stakeholders, collectively crafting a holistic healthcare approach. This collaboration must be not limited to professionals — inmates themselves are learning and teaching each other basic healthcare practices, embodying a new ethos of communal responsibility and care.

6.4.5. Empowerment Through Education

Inmates should stop being seen just as recipients of care but rather as active participants. Health education programs must be widespread, turning each inmate into an ambassador of health, both for themselves and their peers. From learning first aid to understanding the importance of mental health, these educational initiatives must empower inmates, equipping them with knowledge and skills that transcend the prison walls.

6.4.6. Confronting and Dismantling Gang Dynamics

To transform Pollsmoor Prison, it is imperative to robustly address the pervasive control of gangs over healthcare access. Establishing secure and confidential avenues for inmates to voice their concerns without fear is crucial. Introducing night sessions coordinated with external organisations could be essential in disrupting the cycle of negative behaviour and fostering positive change. This will guarantee that healthcare is recognised as a fundamental right, not a privilege monopolised by a select few.

6.4.7. A New Era of Mental Health and Healing

Most profoundly, Pollsmoor Prison must be a place where mental health is not an afterthought but a cornerstone of inmate care. Through trauma-informed practices like breath work and artistic expression, inmates find new ways to process their experiences, fostering healing and preparing them for a life beyond the prison gates.

6.4.8. Closing the Loop with Effective Policies and Communication

Finally, the system must be a system where policies are not static but dynamic, evolving to meet the actual needs of inmates. Communication must flow freely and effectively among staff, ensuring that everyone is on the same page, working towards a common goal — the health and well-being of every inmate.

Chapter 7: Conclusion

As this thesis draws to a close, it is essential to reflect on the journey through the many-sided and intricate landscape of healthcare in Pollsmoor Prison. This exploration has been a deep dive into a complex system, marked by challenges and shaped by the interplay of legal frameworks, staffing dynamics, infrastructure, attitudinal barriers, and gang influence. The research findings have illuminated the stark realities of prison healthcare, often contrasting sharply with the established legal and theoretical frameworks.

The narrative of this thesis has sought to not only identify and analyse the challenges but also to propose strategic and transformative recommendations. These recommendations aim to address the systemic issues in a holistic manner, envisioning a future where Pollsmoor Prison emerges not merely as a correctional facility, but as a beacon of rehabilitation, health, and hope.

This journey towards transformation requires a commitment to legal integrity, human dignity, and a shared vision for a better future. It calls for a paradigm shift in the approach to prison healthcare, transcending traditional methods to embrace a more integrated, empathetic, and collaborative model. By empowering inmates through education, addressing mental health with trauma-informed care, and fostering a culture of accountability and enforcement, the prison can significantly enhance the quality of healthcare and, by extension, the overall well-being of its inmates.

Building on the insights from this research, there is a clear avenue for further study. Future investigations should incorporate the perspectives of wardens and healthcare professionals, as their first-hand experiences are invaluable for crafting more interventions. Additionally, comparative analysis across multiple prisons could yield a better understanding of the variability and commonalities in healthcare provision. Such research could inform broader policy and practice, potentially influencing correctional healthcare on a global scale. It is hoped that this thesis will serve as a catalyst for ongoing discussion, research, and action, setting a path for meaningful change in the realm of prison healthcare.

Appendices

APPENDIX A

FOCUS GROUP INTERVIEW (EX-INM)

I. INTRODUCTION

1. Research project overview.
2. Interview format.
3. Consent.
4. Confidentiality.
5. Audio recording.
6. Right to withdraw/refuse to answer questions.
7. Any questions before we start?

II. HEALTHCARE EXPERIENCE

1. Overall, what is your perception of the quality of healthcare services in Pollsmoor prison?
2. What are the main barriers you faced in accessing good healthcare in prison?
3. Can you share any specific experiences of different healthcare issues you encountered during your time in prison? (e.g., physical health, mental health, chronic conditions)
4. Were there any concerns regarding basic social care facilities such as beds, meals, showers, and toilets in the prison?
5. What is your perspective on the availability of mental health care services in Pollsmoor prison?
6. How would you describe your relationship with the healthcare staff in the prison?
7. Based on your experience, what aspects of healthcare in prison have been helpful in managing your well-being?

III. CLOSING

1. Is there anything else you would like to add about your experiences related to healthcare in Pollsmoor prison?
2. Overall, how would you summarize the healthcare conditions in the prison?
3. Are there any recommendations or suggestions you would like to provide for improving healthcare services in Pollsmoor prison?

Thank you for your participation, and an explanation of what happens next with the study.

APPENDIX B

SEMI-STRUCTURED INTERVIEW (EX-CO)

I. INTRODUCTION

1. Research project overview.
2. Interview format.
3. Consent.
4. Confidentiality.
5. Audio recording.
6. Right to withdraw/refuse to answer questions.
7. Any questions before we start?

II. PRISON OVERVIEW

1. Could you provide an overview of Pollsmoor prison's structure, including healthcare facilities and services offered?
2. How does the prison system support the overall well-being and rehabilitation of inmates, particularly in relation to healthcare?

III. CHALLENGES IN ACCESSING HEALTHCARE

1. From your experience as an ex-warden, what are the main challenges faced by inmates in accessing healthcare services within Pollsmoor prison?
2. Can you share specific examples of situations where inmates have encountered difficulties in obtaining healthcare?

IV. EFFECTIVE APPROACHES AND SUCCESSES

1. In your opinion, what strategies or approaches have been successful in addressing healthcare needs within the prison?
2. Can you provide examples of instances where the prison's efforts have led to improved healthcare outcomes?

V. COLLABORATION WITH NGOs AND OTHER AUTHORITIES

1. Could you describe the nature of Pollsmoor Prison's collaboration with NGOs or other authorities to enhance healthcare conditions?
2. Are there any specific initiatives or collaborative efforts aimed at improving healthcare provision within the prison system?

VI. CHALLENGES IN MANAGING PRISON HEALTHCARE

1. What are some of the specific challenges in managing healthcare services within the prison setting?
2. How do these challenges impact the provision of healthcare and support for inmates?
3. Are there any areas where you believe collaboration between prison authorities and other stakeholders could be strengthened to improve healthcare conditions?

VII. IMPROVING SUPPORT FOR INDIVIDUALS ENTERING PRISON

1. In your experience, what are the key areas where support can be improved for individuals entering Pollsmoor prison, particularly in relation to healthcare?
2. Are there specific recommendations or strategies you would suggest to enhance the support available during the transition into the prison system?
3. How can the prison administration contribute to improving the overall support for individuals entering prison, specifically regarding healthcare?

VIII. ADDITIONAL INSIGHTS

1. Is there anything else you would like to add regarding your experiences, observations, or suggestions for improving healthcare conditions in Pollsmoor prison?

Thank you for your participation, and an explanation of what happens next with the study.

APPENDIX C

SEMI-STRUCTURED INTERVIEW (NGO-CF)

I. INTRODUCTION

1. Research project overview.
2. Interview format.
3. Consent.
4. Confidentiality.
5. Audio recording.
6. Right to withdraw/refuse to answer questions.
7. Any questions before we start?

II. PROGRAM INFORMATION

1. Could you provide an overview of your NGO’s programs and services offered within Pollsmoor prison?

2. How does your organization support the overall well-being and rehabilitation of inmates?

III. CHALLENGES IN ACCESSING HEALTHCARE

1. From your experience, what are the main challenges faced by inmates in accessing healthcare services within Pollsmoor prison?

2. Can you share specific examples of situations where inmates have encountered difficulties in obtaining healthcare?

IV. EFFECTIVE APPROACHES AND SUCCESSES

1. In your opinion, what strategies or approaches have been successful in addressing healthcare needs within the prison?

2. Can you provide examples of instances where your organization's efforts have led to improved healthcare outcomes?

V. COLLABORATION WITH THE DEPARTMENT OF CORRECTIONAL SERVICES (DCS)

1. Could you describe the nature of your organization's collaboration with the DCS to enhance healthcare conditions in Pollsmoor prison?

2. Are there any specific initiatives or collaborative efforts aimed at improving healthcare provision within the prison system?

VI. CHALLENGES IN WORKING IN PRISON/WITH DCS

1. What are some of your organization's specific challenges in delivering restorative justice programs and services within the prison setting?

2. How do these challenges impact the provision of healthcare and support for inmates?

3. Are there any areas where you believe the collaboration between your NGO and the prison authorities could be strengthened to improve healthcare conditions?

VII. IMPROVING SUPPORT FOR INDIVIDUALS ENTERING PRISON

1. In your experience, what are the key areas where support can be improved for individuals entering Pollsmoor prison, particularly in relation to healthcare?

2. Are there specific recommendations or strategies you would suggest to enhance the support available during the transition into the prison system?

3. How can your organization contribute to improving the overall support for individuals entering prison, specifically regarding healthcare?

VIII. ADDITIONAL INSIGHTS

1. Is there anything else you would like to add regarding your experiences, observations, or suggestions for improving healthcare conditions in Pollsmoor prison?

Thank you for your participation, and an explanation of what happens next with the study.

APPENDIX D

PARTICIPANT DEMOGRAPHIC AND HEALTH SURVEY

Thank you for participating in my focus group interview on healthcare conditions in Pollsmoor prison. Before we begin, I would appreciate it if you could provide me with some basic demographic and health information. Please answer the following questions:

1. Age:

2. What is your ethnic group?

   Black African ☐

   Colored ☐

   Indian ☐

   White ☐

3. Length of time spent in prison:

   Less than 1 month ☐

   1 – 6 months ☐

   7 – 12 months ☐

   13 – 24 months ☐

   More than 2 years ☐

4. Time spent in the prison hospital:

   Never ☐

   Less than one week ☐

   1 – 4 weeks ☐

   More than one month ☐

5. Number of times incarcerated:

   Once before ☐

   2 – 5 times before ☐

   6 – 9 times before ☐

   More than 10 times before ☐

6. Number of times interacted with prison healthcare facilities:

Never ☐

1 – 5 times ☐

6 – 10 times ☐

More than 10 times ☐

7. How would you estimate your level of health before entering prison?

Excellent ☐

Good ☐

Fair ☐

Poor ☐

8. Did you receive any medical screening or assessment upon entering Pollsmoor Prison?

Yes ☐

No ☐

9. If yes, please specify:

Physical examination ☐

Mental health evaluation ☐

Other ☐

10. Have you experienced any illnesses or health issues while in detention at Pollsmoor Prison?

Yes ☐

No ☐

11. If yes, please specify the nature of the illness or emergency healthcare:

12. Did you need medical management or treatment during your time in Pollsmoor Prison?

Yes ☐

No ☐

13. Did you receive the necessary medical management or treatment during your time in Pollsmoor Prison?

Yes ☐

No ☐

14. If yes, were you satisfied with the provided services?

Yes ☐

No ☐

15. Did you have access to healthcare officials while in Pollsmoor?

Yes ☐

No ☐

16. If yes, please specify the designations of healthcare officials available to you (e.g., nurse, doctor, therapist, etc.):

17. What internal processes did you have to go through to see a healthcare official in Pollsmoor Prison? Please describe:

18. Was permission required from other prisoners or gang members to see a healthcare official?

Yes ☐

No ☐

19. If yes, please explain:

20. What resources were available to you at the time of treatment (e.g., medication, medical equipment, therapy sessions, etc.)? Please specify:

21. How long did you typically have to wait for healthcare provision services?

Less than an hour	☐
1 – 4 hours	☐
1 day	☐
More than one day	☐

22. How many times have you used the services of the NGO that will be used in this study?

Never	☐
1 – 5 times	☐
6 – 10 times	☐
More than 10 times	☐

23. How would you estimate your level of health after leaving prison?

Excellent	☐
Good	☐
Fair	☐
Poor	☐

24. Overall, how would you rate the quality of healthcare services provided in Pollsmoor Prison?

Excellent ☐

Good ☐

Fair ☐

Poor ☐

25. Is there any additional information or comments you would like to provide regarding your healthcare experiences in Pollsmoor Prison?

Thank you for taking the time to complete this survey. Your responses will remain confidential and will be used solely for the purpose of this research study.

APPENDIX E

2023/09/18

LAW/00319/2023

RE: Research Ethics Committee Project Approval Letter

Dear Victor Busco,

Your application for ethics review of your project titled

Unveiling the Forgotten: Illuminating the Challenges and Opportunities of Healthcare Conditions in Pollsmoor Prison

has been reviewed and evaluated by the

Law Research Ethics Committee.

You may proceed with your research project titled:

Unveiling the Forgotten: Illuminating the Challenges and Opportunities of Healthcare Conditions in Pollsmoor Prison

Please note that should:

(i) any serious or adverse effects to participants occur and/or,

(ii) aspect(s) of your current project change and/or

(iii) any unforeseen events that might affect continued ethical acceptability of the project occur then you should immediately report this to the approving REC. You may be required to submit an amendment to this application, in order to determine whether the changed aspects increase the ethical risks of your project.

Based on the information supplied your application has been successful and is approved.

Please note the following additional conditions associated with this approval:

(i)

Regards,

Law Research Ethics Committee.

APPENDIX F

CONSENT FORM

Please read and answer the following questions to indicate your consent to participate in the research project about healthcare conditions in Pollsmoor Prison. Your participation is voluntary, and you can choose not to participate without any negative consequences. You can also stop at any time during the study. Your answers will be kept private and confidential. Please answer “Yes” or “No” to the following questions:

1. Do you consent to participate in the research about healthcare conditions in Pollsmoor Prison?

   Yes ☐

   No ☐

2. Do you understand that you can stop participating at any time, and it will not have any negative effects on you?

   Yes ☐

   No ☐

3. Do you understand the purpose of the study and that it may not directly benefit you?

   Yes ☐

   No ☐

4. Have you received a contact number in case you need support?

   Yes ☐

   No ☐

5. Do you understand that your answers will be kept confidential?

   Yes ☐

   No ☐

6. Are you comfortable using the NGO for access during this research?

   Yes ☐

   No ☐

Additional consent for audio or video recording:

7. Do you agree to have this interview audio and/or video recorded for data capture?

Yes ☐

No ☐

8. Do you understand that no personally identifiable information will be shared, and the recordings will be securely stored and later erased?

Yes ☐

No ☐

Participant's Signature: Date:

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