

Not too ‘Great Expectations’: Considering the right to health care in prisons and its constitutional implementation

Joelle Barnes*

‘Many people believe that ‘prisoners either get better than they deserve or deserve as bad as they get.’¹

Introduction

Recently a doctor at Pollsmoor prison was dismissed from his employment where he had been a medical doctor for 10 years, after blowing the whistle on the ‘chronic situation in the delivery of health care in Pollsmoor.’ He claimed that there was a healthcare crisis typified by chronic understaffing and a lack of any form of disease control.² This paper seeks to take a close look at the provision of health care in South Africa’s prisons.

In South Africa there are 237 operational prisons. These house up to 160 000 prisoners at any one time. These prisoners are sentenced for a variety of reasons: to sanction them for their injury to society in the form of criminal activity; to deter other would be prisoners; to rehabilitate them and prevent recidivism; and to protect society from them until such time as they are rehabilitated.³ For this period of time these individuals are at the mercy of the state for the provision of even the most basic of necessities for a dignified existence: food, bedding, clothing and health care amongst others. It is a well established principle that prisoners maintain their *residuum* of basic rights upon incarceration, with as

* LLB (UCT) *Temporary Researcher Department of Public Law, Faculty of Law, University of Cape Town.*

¹ National Commission on Acquired Immune Deficiency Syndrome ‘HIV in Correctional Facilities’ Washington, DC; March 1991. Rep 4. quoted in A Berkman ‘Prison Health: the Breaking Point’ (1995) 85 *American Journal of Public Health* 1616 at 1617.

² ‘Pollsmoor whistle blower gets his job back’ *Mail & Guardian*, 7 December 2007. Available at <http://www.mg.co.za> (accessed 15 August 2008).

³ A Skeen ‘Effective judicial thundering from up on high or a mere brutum fulmen? Deterrent sentences in criminal cases’ (1998) 11 *SACJ* 242 at 242 243.

little disruption to their rights as can possibly be achieved within the prison setting.⁴ As Jansen JA stated in *Mandela v Minister of Prisons*:⁵

[o]n principle a basic right must survive incarceration except insofar as it is attenuated by legislation either expressly or by necessary implication, and the necessary consequences of incarceration’.

Yet, the conditions in which these prisoners live are often not adequate and very seldom what a free person would consider dignified. Our prisons face a severe crisis of overcrowding and under-resourcing that threatens the very rights that prisoners are supposed to retain despite their incarceration. One of the areas most affected by this crisis is that of the provision of health care to prisoners.

Much of South African literature regarding the right to health in prisons focuses on the ambit of the right to health care or on the lack of provision of health care within prisons. These discussions ultimately end at the same point: the right to health that is given to detainees in terms of the Constitution⁶ is not met by the practical implementation of government policy to provide these services. Many will end their discussions by commenting that the courts must take a strong interventionary approach in their remedies; often coupled with remarking that the ultimate responsibility lies in the hands of the legislature and the Minister of Correctional Services. However, few papers look at the practical remedies that a court can order to achieve better provision of health care within our Correctional Services Ministry, or at the considerations that ought to be taken into account in arriving at their remedy. Many do not even critically analyse whether and how the right to health care is infringed by the state’s action or inaction.

This paper will consider the right to adequate treatment and access to health service in prison, the actual delivery on this right and what remedies are pragmatically useful to speed up the provision thereof. It will be seen that the current state policy is consistently falling foul of the Constitutional requirements in that there are generally no reasonable legislative or other measures being undertaken, and where there are policies in place the implementation thereof falls short of the standard of reasonableness. It is submitted that if the courts were to be seized with such an action and if they would have to consider the situation, they would find that the state of health care in South African prisons is more dire than imagined. The call for reasonable state action is long overdue and has been unheeded for too long.

⁴ *Whittaker v Roos & Bateman; Morant v Roos & Bateman* 1912 AD 92; *Goldberg v Minister of Prisons* 1979 (1) SA 14 (A) at 39C F; *Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A).

⁵ *Mandela v Minister of Prisons* 1983 (1) SA 938 (A) at 957E F.

⁶ Constitution of the Republic of South Africa, 1996. Hereafter ‘the Constitution.’

Preliminary matters

In this paper I am not distinguishing between sentenced prisoners and unsentenced or awaiting trial prisoners because the state policy for providing health care to unsentenced detainees is the same as that provided for sentenced prisoners. Moreover, the constitutional rights which are central in this paper do not distinguish between the prisoners on the basis of their sentence, with s 27 applying to all persons ('everyone') and s 35(2) applying to all 'prisoners, arrested persons and detainees'. The *White Paper on Corrections in South Africa*,⁷ a document purporting to lay out the policies informing all corrections, provides that 'awaiting-trial detainees should be subjected *only* to those restrictions *necessary* for the maintenance of security and good order in correctional centres'.⁸ It envisages that where practicable, these detainees will be allowed all the amenities to which they could have access outside correctional centres. However, in practice this seldom occurs. Therefore the terms 'detainee' and 'prisoner' are used interchangeably.⁹

The right to health in prison

*'The starting and ending point of the enquiry into the reach of constitutionally protected rights is to affirm the values of human dignity, equality and freedom.'*¹⁰

Reasonable access and adequate treatment

The right to adequate health care in prisons is essential to the creation of an environment where detainees are treated with the dignity due to

⁷ Department of Correctional Services *White Paper on Corrections in South Africa* [Pretoria: Department of Correctional Services 2005].

⁸ ●p cit (n7) 92.

⁹ It is important to bear in mind that about 48 000 persons are being detained in prisons before they have even been convicted of a crime. They are deprived of their freedom for the purposes of ensuring their presence at the trial, not for purposes of punishment or rehabilitation. A shocking number of awaiting trial prisoners have been considered eligible for bail (about 11900 out of the 48 000 unsentenced prisoners) but cannot afford it and so are confined by the state. Whether these persons ought to be given differential medical treatment is beyond the scope of this paper, yet, what is the state *must* create dignified conditions for all in its care, regardless of their innocence or guilt. See *Judicial Inspectorate of Prisons Annual Report 2007/2008* [Pretoria Government Press 2008].

¹⁰ Per Sachs J in *Port Elizabeth Municipality v Various Occupiers* 2005 (1) SA 217 (CC) para 15.

every human being. This is reflected in the fact that the right to health falls within s 35(2)(e) of the Constitution: the right to conditions of detention that are consistent with human dignity. The right to health care is envisaged in the Constitution by reading two constitutional provisions together: s 35(2)(e) of the Constitution and s 27. Section 35(2)(e) guarantees detainees¹¹ adequate medical treatment¹² at state expense. Section 27(1)(a) applies to all persons in South Africa¹³ and provides that everyone has the right to access to health care services,¹⁴ which must be provided by the state through reasonable legislative and other measures, within available resources to achieve the progressive realisation of the right.¹⁵ Therefore the Constitution envisages that not only should prisoners have the same access to health services that every other person in South Africa is entitled to, but also that adequate treatment *must* be provided, at state expense.

The context

These rights do not exist *in vacuo* but must be construed in the context of the Bill of Rights and the surrounding jurisprudence on prison health. It is trite that ‘all the rights in our Bill of Rights are inter-related and mutually supporting’.¹⁶ Every person is guaranteed equality before the law and to have his or her dignity respected.¹⁷ No right contained in the Bill of Rights may be limited except by a rule of general application, where it is reasonable and justifiable within an open and democratic country and subject to an inquiry into a number of factors.¹⁸ The Courts

¹¹ I use the terms ‘detainee’ and ‘prisoner’ interchangeably throughout the paper to refer to any person detained by the state. The term ‘prison’ is used to refer to any place where a detainee is held.

¹² Hereafter the phrase ‘adequate treatment’ is used to refer to ‘adequate medical treatment.’

¹³ Including non citizens. In *Kbosa v Minister of Social Development; Mablaule v Minister of Social Development* 2004 (6) BCLR 569 the court held that ‘everyone’ was not limited to South African citizens.

¹⁴ Hereafter ‘health care services’ shall be referred to as ‘health services.’

¹⁵ Section 27(2). The Constitutional Court held that the rights in subsecs (1) and the state duties in subsecs (2) must be read together in ss 26 and 27. *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) at para 20.

¹⁶ *Government of the Republic of South Africa v Grootboom* supra (n15) para 22.

¹⁷ Sections 9 and 10 of the Constitution.

¹⁸ Section 36 of the Constitution. The factors are found in s 36(1) are:

- (a) the nature of the right;
- (b) the importance of the purpose of the limitation;
- (c) the nature and extent of the limitation;
- (d) the relationship between the limitation and its purpose; and
- (e) less restrictive means of achieving the purpose.

have a duty to consider international law in interpreting the Constitutional rights.¹⁹

Section 35(2)(e) Adequate medical treatment

Courts have generally refrained from giving exact content to socio-economic rights, preferring to confine the inquiry to the reasonableness of the measures taken in provision of the right.²⁰ Yet, when interpreting the other rights contained in the Bill of Rights, the Constitutional Court's approach gives as broad or generous an interpretation to the right as possible, so as to fulfil the purpose of the right.²¹ The court then uses the s 36 limitations clause to weigh up whether limitations to the rights were reasonable and justifiable. When dealing with the socio-economic rights, however, the court has not considered s 36. Rather, matters have turned on the failure of governmental measures to meet the reasonableness requirement in the internal limitation of the rights provisions. In both *Grootboom*²² and *Minister of Health v Treatment Action Campaign*,²³ the Constitutional Court was dealing with an omission to act, therefore there was no law of general application that was violating rights, but rather an omission on the part of the state to enact reasonable legislative and other measures.²⁴

The s 35(2) right is unqualified as it is not subject to progressive realisation or resource limitations. This means that state provision of medical treatment is a prerequisite for the right to be detained in conditions which respect human dignity.²⁵ It is therefore true that this right is intended for immediate realisation in much the same way as are civil and political rights.²⁶ This places a positive duty on the state to provide medical treatment at state expense, subject only to the s 36 limitations clause.

The content of the right therefore depends on the meaning given to the term 'adequate.' In *Van Biljon v Minister of Correctional Services*²⁷ the case turned on the meaning of 'adequate' but the court did not give

¹⁹ Section 39 of the Constitution.

²⁰ I Currie and J de Waal *Bill of Rights Handbook* 5ed (2005) at 26.5. See also C Ngwenya 'The recognition of access to health care as a human right in South Africa: is it enough?' *Health and Human Rights* 5 (2000) 27 at 30, '[t]o attempt to define the quantity or quality of health care to be received in rigid or precise terms would raise false expectations.'

²¹ *S v Makwanyane* 1995 (3) SA 391 (CC) para 9.

²² *Government of the Republic of South Africa v Grootboom* supra (n15).

²³ *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC).

²⁴ Currie and de Waal op cit (n20) 26.6.

²⁵ S Liebenberg 'The Interpretation of Socio Economic Rights' in Chaskalson, Klaaren, Roux, Stein and Woolman *Constitutional Law of South Africa* 2ed 2007 service (2006) at 33.3.

²⁶ Ngwenya op cit (n20) 34.

²⁷ *Van Biljon v Minister of Correctional Services* 1997 (6) BCLR 789 (C).

it a conclusive meaning. The court held that 'once it is established that anything less than a particular form of medical treatment would not be adequate, the prisoner has a constitutional right to that form of medical treatment'.²⁸ The court ordered that the applicants, all of whom were HIV-infected prisoners, be provided with the antiretroviral medication that had been prescribed to them by their doctors. The court read resource qualification into the scope of the right by saying that what is 'adequate medical treatment' must consider what the state can afford.²⁹

One can see the rationale behind the reasoning of the *Van Biljon* court: that the Constitution does not require the state to provide 'optimal medical treatment' but merely 'adequate' treatment.³⁰ It is important that the court stipulated this so as to avoid future cases where prisoners claim all manner of expensive treatment, which albeit prescribed, falls within the category of optimal medical treatment rather than adequate treatment. An example would be where a detainee is prescribed an expensive new drug to treat the painful gout that he suffers from. An equally effective but cheaper generic is available on the market. It does however carry the chance of some negative but not serious side effects. The dictum from *Van Biljon* will preclude the prisoner from avoiding these side effects by attempting to claim that the expensive drug ought to be provided at state expense.

This approach has faced criticism for including resource limitation in the ambit of the right.³¹ Singh and Maseko submit that the right to adequate treatment 'should not be informed by resource availability at the first stage of inquiry' but rather by what are internationally accepted and an acceptable basic standard of medical treatment for prisoners.³²

It is submitted that a more jurisprudentially sound way of approaching this right would have been for the court to take a literal approach to the term 'adequate'. The term 'adequate' sets a benchmark for provision of medical treatment. 'Adequate' means satisfactory or acceptable in quality or quantity.³³ The quality of the treatment must therefore be adequate by complying with recognised medical standards for the treatment of the illness and the quantity must be sufficient to treat the illness.³⁴ Any

²⁸ *Van Biljon v Minister of Correctional Services* supra (n27) para 49.

²⁹ Ibid.

³⁰ Currie and De Waal op cit (n20) 26.5.

³¹ Ngwena op cit (n20) 34. A Singh 'The protection of prisoners' rights to health care services in South African law: Is it adequate?' (2006) 31(1) *Journal for Juridical Science* 80 at 90.

³² Singh op cit (n31) 90.

³³ *Concise Oxford English Dictionary* 10ed (2002).

³⁴ Evans states that the policy merely needs to supply 'a minimum that provides the basis for leading a dignified life' T Evans 'A Human Right to Health' (2002) 23 *Third World Quarterly* 197 at 204. This is in contradistinction to 'access to the latest technological

resource argument could be used to justify an infringement on the s 35(2)(e) right in the normal s 36 manner. Therefore what is 'adequate' will turn on the facts presented before the court.³⁵ Similarly any action or inaction on the part of the state which provides medical treatment in such a way that undermines the dignity of the prisoner should be found inadequate.³⁶

Section 35(2) is not the only positive duty imposed on the state with regard to prisoners. The right to access to health services in s 27 places a broader duty upon the state, albeit one which is subject to its own internal limitation. We will now turn to consider this right.

Access to health care services

The s 27 right to access to health services is a qualified right, subject to the internal limitations of resources, progressive realisation and reasonableness. This imposes a duty on the state to act and, moreover, to act reasonably. In *Jaftha v Schoeman*³⁷ the court held that the rights in subssecs (1) to (3) of s 26 must be read together to inform the content of the right.³⁸ Similarly, s 27 is informed by a holistic reading. This creates a web of positive and negative obligations. The state must not impede access to health services and it must take positive steps to ensure that the right is realised as 'expeditiously and effectively' as possible.³⁹ The state will not be able to justify a complete denial of access to health care, specifically in the light of the additional duty owed to persons entirely under the state's care.

a. Reasonableness

Steps taken by the state must be reasonable, which means that the state must be able to give good reasons for its action. Thus the reasonableness inquiry will turn on the facts before the court in much the same manner that the 'adequacy' inquiry will. There is a considerable margin of discretion given to states in selecting what means they use to realise

and scientific resources for health' which are not inherently required in the provision of adequate health care. In *Strydom v Minister of Correctional Services* 1999 (3) BCLR 342 (W) the court distinguished between 'comforts' and 'necessities' at par 15. Similar logic can be used to distinguish between adequate treatment and medical treatment which exceeds the benchmark of adequate.

³⁵ *E N v Government of the Republic of South Africa* [2007] 1 All SA 74 (D) at para 18.

³⁶ Such as not treating the prisoner as an individual and 'lumping together of all prisoners suffering from terminal diseases.' *Stanfield v Minister of Correctional Services* 2003 (12) BCLR 1384 (C) at para 127.

³⁷ *Jaftha v Schoeman* 2005 (2) SA 140 (CC).

³⁸ *Jaftha v Schoeman* supra (n37) at para 31.

³⁹ *Government of the Republic of South Africa v Grootboom* supra (n15) at para 45.

socio-economic rights.⁴⁰ Courts will evaluate the reasonableness of the policy and not the actual choice of method, nor whether any other method would have better spent the taxpayers' money.⁴¹

When considering 'reasonableness' the central issue is whether the state is taking steps to ensure that the prisoners are receiving adequate treatment and access to health services.⁴² Courts will consider whether the programme (which includes the legislative schemes and departmental policies) is coherent in its allocation of responsibilities, financial and human resources.⁴³ This requires a robust approach in considering the cost of realising the right, the state's capacity, and the extent of denial of the right.⁴⁴ It must be capable of actually realising the right and must be reasonably implemented.⁴⁵ Moreover, the measures cannot overlook the 'degree and extent of the denial' of the right in the pursuance of a greater right overall.⁴⁶ This means that whilst the state may choose to ration the medication that it makes available, it may not choose to not stock cough medicine at all (amounting to a total denial of the right to access to medication for a person with pneumonia) in order to afford the most expensive ARV treatment for HIV positive prisoners who qualify for the treatment.

The Constitutional Court has stressed that a programme must be sufficiently flexible to cater for those whose 'needs are the most urgent and whose ability to enjoy all rights therefore is most in peril'.⁴⁷ The question of reasonableness must therefore be decided on a case-by-case basis, sensitive to the needs of the parties before the court and the context of the inquiry.⁴⁸ Essentially the court is interested in whether the state is taking action and in the nature of the action.⁴⁹ When considering this question of reasonableness the courts have developed a 'hard-look' approach which is much welcomed and is evident in the in-depth look taken at the reasons of the state in cases such as *TAC*, *Stanfield* and *E N v Government*.⁵⁰ In scrutinising the reality of South Africa's prison health care, it will be shown that the implementation of the right fails to meet this standard of reasonableness laid down by the Constitutional Court.

⁴⁰ Currie and de Waal *op cit* (n20) 26.2.

⁴¹ *Government of the Republic of South Africa v Grootboom* *supra* (n15) at para 41.

⁴² *E N v Government of Republic of South Africa* *supra* (n35) at par 23.

⁴³ *Grootboom* *supra* (n15) at para 39.

⁴⁴ *TAC* *supra* (n23) at para 80.

⁴⁵ *Grootboom* *supra* (n15) at paras 41, 44; *TAC* *supra* (n23) at para 68.

⁴⁶ *TAC* *supra* (n23) at para 44.

⁴⁷ *Ibid.*

⁴⁸ *TAC* *supra* (n23) at para 92.

⁴⁹ *TAC* *supra* (n23) at para 36.

⁵⁰ 'Hard look' scrutiny is mentioned with approval in Currie *op cit* (n20) 26.3.

b. Subject to resources and progressive realisation

Resource constraints are inevitable. The state does have to ration the money that it spends, both within the amount allocated to the Department of Correctional Services, as well as within the available budget for health care in the country as a whole. The dire situation in the public health care industry and in the prison context is apparent from the case law, specifically *Soobramoney*⁵¹ and *E N v The Government*.⁵² Rationing is a vital part of the provision of these sorts of health services and no stakeholders deny this. However, what is important is that, in the light of the state's special duty owed to prisoners,⁵³ the resources limitation will be criticised more strictly. In *Van Biljon* the court decided that whilst financial and budgetary constraints must be considered, lack of funds could not be the sole answer to a prisoner's constitutional claim to treatment.⁵⁴ Therefore the courts may require the department to provide them with proof of budgetary constraints as part of the litigious process. Proof of budgetary constraints may not be sufficient proof to justify a limitation of the right in question.⁵⁵ It is interesting to note that in all of the litigation regarding health care, and especially health care in prison, the state has only once successfully raised the resources justification.⁵⁶

The notion of progressive realisation recognises the inherent limitations on the state's ability to cater immediately for the needs of all persons dependant upon the public health system. Notwithstanding this, s 27(2) requires the state to commit itself to the development of the right, which is what progressive realisation is all about. Therefore, it is true that this requirement is actually focused on the future, requiring that the provision of the right does not plateau, but that it has room for developing health care for all over time. Yet the courts must not lose sight of the urgency that certain matters have for individuals, especially those who are unable to seize the health care for themselves. These interests must be found to be urgent regardless of resource constraints.⁵⁷

⁵¹ *Soobramoney v Minister of Health, Kwazulu Natal* 1998 (1) SA 765 (CC) at paras 28, 29.

⁵² *E N v Government* supra (n35).

⁵³ Namely that they are in the total care of the state.

⁵⁴ *Van Biljon* supra (n27) at para 49.

⁵⁵ Moellendorf argues that 'available resources' is ambiguous in that it may mean the amount devoted to the ministry for the protection of that right, or 'any resources that the state can marshal to protect the right'. Whilst this distinction is food for an interesting discussion, such a discussion is sadly beyond the ambit of this paper. D Moellendorf 'Reasoning About Resources: *Soobramoney* and the Future of Socio Economic Rights Claims' (1998) 14 *SAJHR* 327 at 330.

⁵⁶ This was in the case of *Soobramoney* supra (n52). In all of the other cases the state's attempts to raise the resources justification have been without merit, see especially *TAC* supra (n23); *Van Biljon* supra (n27) and *E N v Government* supra (n35).

⁵⁷ Chaskalson et al op cit (n25) 56A 33.

The interaction between s 27 and s 35(2)(e)

'Access to health care' and 'the provision of adequate medical treatment' collide when dealing with persons in the unique positions that prisoners are in. Detainees are unable to obtain any *treatment* without it being *accessible*, and in most cases by virtue of their incarceration the detainee is unable to *access* medical treatment, unless provision is made for it by the state. It may be argued that the provision of 'adequate treatment' is significantly narrower than the notion of 'health services' which includes the underlying determinants of health, such as sanitation, adequate hygiene and health education. Yet, in the context of a prison the notion of adequate treatment must not be too narrowly construed. For an immuno-compromised prisoner 'adequate treatment' will include a well-balanced and nutritious diet, blankets for warmth and to be kept separate from individuals with communicable diseases.

The Constitution requires that every detained person has the right to be detained in conditions of dignity, which requires the state to provide adequate treatment and access to health services. The state must also refrain from placing barriers to the access to medical services and must put in place both legislative and other measures to ensure that this right is progressively realised. The plan for the realisation of the right to access must be reasonable, and any limitations to the right in s 35(2) must also be reasonably justifiable in terms of s 36. But this is merely the starting point. Let us now consider what steps the state has taken in the provision of this right in the South African prison context and the extent to which the state has complied with these obligations. Through this discussion it will become clear that there is a gap between the constitutional promise of health care for prisoners and the actual delivery thereof.

The actual state of health care in SA

'How can you cure TB [tuberculosis] when they spread the virus in over crowded cells?' Mzwandile Magadla, inmate at Pollsmoor.

'Medical care is lacking and we wait three months to see the doctor.' Morne Bull, sentenced prisoner in Brandvlei maximum prison in the Western Cape.⁵⁸

The inadequacies of the health care system in prisons and the lackadaisical attitude of the departments of Health and Correctional Services to remedying these issues was made apparent in two recent high court cases. In *Stanfield v Minister of Correctional Services*⁵⁹ the court was

⁵⁸ W Roelf 'Living in crisis behind SA's prison walls' *Mail & Guardian* 03 January 2006.

⁵⁹ *Stanfield v Minister of Correctional Services* 2003 (12) BCLR 1384 (C).

reviewing the denial of an application for parole of a man who had the final stages of lung cancer. The court took notice of the fact that in the past seven years the mortality rate amongst prisoners had increased by 600%.⁶⁰ In order to ensure the detention in conditions of dignity the department suggested that the prisoner be moved to a prison which could 'adequately cater' to his illness because it was free from infections and offered twenty-four hour medical surveillance. However, the Director of the Judicial Inspectorate of Prisons testified that in most cases the prison hospital was a 'large communal cell with no specialist facilities and housing persons suffering from various diseases, such as tuberculosis, HIV/AIDS or pneumonia'.⁶¹ An independent prison visitor testified that the suggested prison would be less than adequate in that it 'did not have facilities to treat and care for terminally ill patients' and that she 'rarely saw a doctor on the premises and patients who became ill overnight would invariably have to wait until the next morning for day-nursing staff to make the necessary arrangements for the patient to see a doctor or to visit an outside hospital'.⁶² Therefore the court found that the overriding impression given by the prison in this regard was that the 'applicant must lose his dignity before it is recognised and respected'.⁶³

In the case of *E N v Government*⁶⁴ the programme for rollout of anti-retrovirals suggested by the department was one that the prisoners concerned had no knowledge of.⁶⁵ Furthermore, the court accepted that even though these were situations where 'life and death mattered', the state had delayed without good cause.⁶⁶ The plan submitted by the department was 'simply unworkable'⁶⁷ and showed that there was 'no commitment by the respondents to adhere to any workable or rational time frames' despite the immediacy of the need for treatment.⁶⁸ The court painted a grave picture of the state of prison health care acknowledging that when a prisoner is sentenced to a long term of imprisonment 'his or her prospects of emerging from prison alive [are] seriously

⁶⁰ *Stanfield v Minister of Correctional Services* supra (n59) at para 63. This statistic may not be entirely accurate due to the fact that the monitoring of prison deaths was previously not as well documented as it is now. However, the increase is also largely caused by the increased prevalence of HIV/AIDS in prisons.

⁶¹ *Stanfield v Minister of Correctional Services* supra (n59) at para 63.

⁶² *Stanfield v Minister of Correctional Services* supra (n59) at para 64.

⁶³ *Stanfield v Minister of Correctional Services* supra (n59) at para 124.

⁶⁴ *E N v Government* supra (n35).

⁶⁵ *E N v Government* supra (n35) at para 22.

⁶⁶ *E N v Government* supra (n35) at para 23.

⁶⁷ *E N v Government* supra (n35) at para 25.

⁶⁸ All of the applicants had already been prescribed with the treatment as their CD4 counts had dropped below 200, which indicates the onset of full blown AIDS.

compromised because of the HIV/AIDS pandemic'.⁶⁹ The court found that it was unfortunate that the vulnerability of prisoners was overlooked in the drafting of the Operational Plan and Guidelines for the provision of antiretrovirals. These guidelines were drawn up with the public in mind and only make passing reference to prisoners.⁷⁰ The court took judicial notice of the dictum from *Stanfield*⁷¹ that the state of affairs in South African prisons is 'shocking' and that 'untold numbers of prisoners die in prisons in the most inhuman and undignified way'.⁷²

Constitutional infringement?

These cases paint a bleak picture of the actual state of prison health care that is a far cry from the ambitious right to health care identified in the Constitution. There are various impediments to the department's ability to provide the level of health that is envisaged by the Constitution. These impediments affect both the access to, and the adequacy of, the health care provided in prisons. The first of these is the lack of a reasonable legislative oversight and adequate devolution of responsibility. The second has to do with available facilities and resources, and finally, there are systemic impediments to the provision of health services. Combined, these impediments often place the achievement of a healthy and dignified life out of a prisoner's reach.

Lack of legislative or regulative oversight

The Correctional Services Act⁷³ takes a very general approach to the right to health, briefly outlining the state's duty to provide medical treatment in s 12. This states that within the department's resources it must provide adequate health services to prisoners, based on the principles of primary health care, in order to allow every prisoner to lead a healthy life.⁷⁴ Additionally, every prisoner has a right to 'adequate medical treatment' and should be encouraged to undergo any medical treatment necessary for the maintenance or recovery of his or her health.⁷⁵ The Correctional Services Act also insists that prisoners ought to be properly housed and fed in conditions that respect the prisoners' life and dignity.⁷⁶ These provisions also play a role in guaranteeing the right to

⁶⁹ *EN v Government* supra (n35) at para 29.

⁷⁰ Ibid.

⁷¹ *Stanfield v Minister of Correctional Services* supra (n59) at para 128.

⁷² Ibid.

⁷³ Correctional Services Act 111 of 1998 .

⁷⁴ Subsection (1) of the Correctional Services Act 111 of 1998.

⁷⁵ Subsections 2(a) and 4(a) of the Correctional Services Act 111 of 1998.

⁷⁶ Sections 4, 7 and 8 of the Correctional Services Act 111 of 1998.

health (in a broad sense) to prisoners. The minister is empowered in terms of the Act to make any such regulations as he or she sees fit in order to comply with the provisions of the Act and the Act is informed by the Department of Health's policies and programmes regarding the provision of public health care.⁷⁷

The *White Paper on Corrections in South Africa*⁷⁸ is essential in supplementing the Correctional Services Act and explaining the department's strategy in dealing with health. This document recognises the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'⁷⁹ and that 'prison health must be a priority'.⁸⁰ According to this policy paper, corrections are based on the principles of restoration within secure, safe and humane custody, in line with international human rights standards.⁸¹ This paper commits the department to policies of 'care and development' of the prisoners. Where 'care' means the 'maintenance of the well-being of persons under departmental care; providing for their physical well-being in the form of nutrition and health care'.⁸² Development focuses rather on the skills of the person and aims at realising the prisoner's full potential, in aspects including health awareness.⁸³ It pledges the department to addressing communicable diseases such as HIV, TB and sexually transmitted infections as an integral part of the provision of comprehensive health services. Furthermore, it commits the department to providing health care education programmes which deal with communicable diseases in such a way as to reduce the impact of HIV/ Aids and other communicable diseases so that people may leave the system as 'healthy as possible'.⁸⁴

In terms of the Correctional Services Regulations⁸⁵ primary health care *must* be available in a prison '*at least* on the same level as that rendered

⁷⁷ The main forms of which are the Health Act 63 of 2003 and the Primary Health Care Policy (2001).

⁷⁸ Department of Correctional Services *White Paper on Corrections* op cit (n7).

⁷⁹ Department of Correctional Services *White Paper on Corrections* op cit (n7) 157 quoting Art 12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR).

⁸⁰ Department of Correctional Services *White Paper* (n7) 159 quoting the Heads of Government at the 4th Baltic Sea States Summit on the Threat of Communicable Diseases, at St Petersburg, 10 June 2002.

⁸¹ ●p cit (n7) 79.

⁸² ●p cit (n7) 131.

⁸³ ●p cit (n7) 136.

⁸⁴ ●p cit (n7) 158.

⁸⁵ Correctional Services Regulations 26626 *Government Gazette* (30 July 2004).

by the State to members of the community'.⁸⁶ The services of a medical officer and dental practitioner *must* be present,⁸⁷ and a medical officer must treat any sick prisoner as often as is necessary, including after hours.⁸⁸

Very little other information is available which deals with the provision of health care in prisons. It would appear that protocols are adopted within the individual prisons themselves, under the authority of the Head of Prison for each site. This also means that the standard of provision of amenities varies considerably across the country.⁸⁹

● One of the key failure areas of this legislative scheme is its inability to take cognisance of the extreme vulnerability of prisoners. The current legislative nexus (the Correctional Services Act, regulations and other legislation) fails to provide for health care needs that are truly specific to prisoners. Moreover, it fails to provide relief or schemes to ensure that prisons comply with their constitutional mandate, even for the duration that it takes to alleviate the current problems of overcrowding, understaffing and inadequate facilities in our prisons. These existing legislative measures do not assign responsibility to any person other than, presumably, the Minister of the Department. This cannot be called a legislative scheme dealing *comprehensively* with the provision of health care. It does not commit itself to any time periods for the provision of a specific plan, nor does it account for the failure presently to provide the same medical treatment that is provided at public hospitals.

Furthermore, the current framework does not allocate responsibility at a national or provincial level to members who may be held accountable for the provision of health care in the prisons. The scheme does not deal with the problems that resource-related issues create for the access to medical treatment. There is no standardisation of policy with regard to how the officials decide whether or not a prisoner requires medical attention and very little provision for self-medication by means of access to pharmacies. The state has failed in its obligation in terms of s 27(2) to take reasonable legislative and other steps to ensure the fulfilment of the rights contained in s 27(1), and this failure results in a failure to provide adequate treatment, because in the prison context access is essential for treatment.

⁸⁶ Correctional Services op cit (n85) sub regulation 7(1)(a) (own emphasis). However, in *Van Biljon v Minister of Correctional Services* supra (n27) at para 54, the court held that due to the heightened vulnerability of prisoners at the hands of the state the government could not rely on the defence that the applicants would not have qualified for the treatment prescribed if they were attending at a community hospital.

⁸⁷ Correctional Services op cit (n85) sub regulation 7(2) (own emphasis).

⁸⁸ Correctional Services op cit (n85) sub regulation 7(4).

⁸⁹ Judicial Inspectorate of Prisons 2007/2008 op cit (n9) 19.

The case of *E N v Government*⁹⁰ highlighted another problem within the health provision system in prisons — the problem of obscurity of policy. The prisoners in that case denied having any knowledge of the HIV programme that was allegedly implemented and active in that prison.⁹¹ The state is required to make its policy known. This may seem an unusual requirement, however it is one that lies in the very foundations of a state committed to the accountability, responsiveness and openness of the government.⁹² In *TAC* the court stressed the fact that an effective public health programme must be made known to all stakeholders in the programme, from the government to the district nurse and the patients.⁹³ This is a factor that is considered in evaluating the reasonableness of a policy. In the present health care system the policies are not made clearly known to all the stakeholders, including the prisoners themselves.⁹⁴ This further mitigates against the reasonableness of the current policy.

The implementation of policy facilities and resources

Even where a policy exists, such as the HIV guidelines or the prison regulations, the crisis in South African prisons is such that there is 'very little coordination and implementation of the policy to effectively access treatment, care and support'.⁹⁵ The Department of Correctional Services Annual Report 2006/2007 stated that 'comprehensive health services were provided to all offenders who required the services,' and some reports claim that services providing curative treatment are 'well established and running despite the presence of certain challenges'.⁹⁶ Yet, the annual report of the Judicial Inspectorate of Prisons reports that the provision of medical treatment remains a problem generally across South Africa's prisons, although it does vary according to which prison is in question.⁹⁷ The Inspectorate also found that health care continues to

⁹⁰ *EN v Government* supra (n35).

⁹¹ *EN v Government* supra (n35) at para 22.

⁹² Section 1(d) of the Constitution.

⁹³ *Minister of Health v TAC* supra (n23) at para 123.

⁹⁴ *E N v the Government* supra (n35) at para 22.

⁹⁵ Singh and Maseko op cit (n31) 85.

⁹⁶ S Sifunda, P S Reddy, R Braithwaite, T Stephens, RAC Ruiters, B van den Borne 'Access point analysis on the state of health care services in South African prisons: A qualitative exploration of correctional health care workers' and inmates' perspectives in Kwazulu Natal and Mpumalanga' (2006) 63 *Social Science & Medicine* 2301–2309 at 2301.

⁹⁷ Judicial Inspectorate of Prisons 2007/2008 op cit (n9) 5, 16.

feature amongst the most common complaint received from prisoners.⁹⁸ The state needs to commit itself to provide services, and encourage inmates to undergo medical treatment. Neither adequate treatment nor reasonable access is currently achieved.

Non-infectious facilities

● One of the key areas inhibiting the actual provision of health care is a lack of appropriate facilities to render health services.⁹⁹ Rather than promoting health, conditions in the prisons often threaten it. Data produced by the Inspecting Judge reveals that 39 per cent¹⁰⁰ of prisons are equipped with hospital facilities and that only 53% are able to provide access to clinics.¹⁰¹ Yet, in *Stanfield*¹⁰² the court's attention was drawn to the fact that these 'hospitals' are hardly highly specialised facilities but rather offer the bare minimum, with little supervision after hours and no facilities to prevent the spread of communicable diseases.¹⁰³ Eight per cent of South Africa's prisons have no facilities at all for on-site provision of health care and 94 of the 237 prisons (39.7%) have no facilities to separate prisoners with contagious or communicable diseases from the general prison population.¹⁰⁴ For the 8% with no facilities at all, prisoners have to be transported to outside facilities to be treated for even the slightest ailment. All but three prisons do not have any cells to accommodate contagious prisoners whilst they await transportation to outside facilities. Thus, these prisons have no ability to curb outbreaks of contagious diseases and so jeopardise the health of the inmates from the moment they are imprisoned. This inhibits the adequacy of treatment provided.

⁹⁸ ● Office of the Inspecting Judge, *Judicial Inspectorate of Prisons Annual Report 2006/2007* Available at <http://judicialinsp.puv.gov.za/Projects/projects1.asp> accessed on 8 May 2008; Singh and Maseko op cit (n31) 83 state that 'malnutrition, unhygienic conditions and lack of medical care remain some of the most common causes of death in prison'.

⁹⁹ Department of Correctional Services *Annual Report 2006/2007* accessed at http://www.info.gov.za/corrections/annual_rpt_06_07.pdf at 59.

¹⁰⁰ Hereafter '%.'

¹⁰¹ Judicial Inspectorate of Prisons 2007/2008 op cit (n9) 12.

¹⁰² *Stanfield v Minister of Correctional Services* supra (n59).

¹⁰³ *Stanfield v Minister of Correctional Services* supra (n59) at para 120.

¹⁰⁴ Judicial Inspectorate of Prisons 2007/2008 op cit (n9) 12.

Maintenance of the health of prisoners

Section 35(2)(e) is currently infringed by the failure to provide prisoners with vital amenities to promote the underlying determinants of health care such as non-infectious environments, adequate bedding, ablution facilities, hygienic and nutritious meals. Such non-pharmaceutical services are prerequisites for the adequate treatment of illness and would be 'prescribed' by a doctor in order to maintain or restore health. Less than 35% of all prisons are able to provide prisoners with all of the amenities that most persons would consider essential. Additionally, 12% of prisons do not have enough beds and 71 prisons do not have appropriate facilities to make use of the dining halls for eating meals. Moreover, combined with overcrowding and staff shortages, the dining halls often become too unsafe to use and so prisoners eat their meals in their cells where there is often no separation between the sleeping areas and the ablution areas. A further 9% of prisons do not have enough eating utensils, which forces many prisoners to eat out of plastic containers and to eat with their hands.¹⁰⁵ The plastic containers are kept by the prisoners in their cells and are not cleaned properly.¹⁰⁶ ●f the 93 on-sight prison inspections by the inspecting judge, 56% of these didn't comply with the required intervals between meals, choosing to provide only two meals a day, at 7h30 am and at 1h30 pm.¹⁰⁷ Five per cent of all prisons do not have adequate ablution facilities. Moreover, the department faces severe problems with regard to the provision of services and amenities, which has direct impact on health care. Allegedly, many prisons fail to comply with water and sewerage maintenance standards and the contamination of surrounding rivers poses a severe risk to the lives of the prisoners and the surrounding populations.¹⁰⁸

The state has a negative duty to not inhibit a prisoner's right to health but prisoners can only look after their health if they are enabled to. This infringement of their ability to maintain health cannot be easily justified either in terms of s 27(2) or in terms of s 36 of the Constitution, because it mitigates against conditions being consistent with the prisoner's inherent, and non-derogable, human dignity.

Prevention programmes

Studies show that whilst curative services are a priority in the prisons there is little budget, time or incentive to run preventative and health

¹⁰⁵ Judicial Inspectorate of Prisons 2007/2008 op cit (n9) 9.

¹⁰⁶ ●p cit (n9) 10.

¹⁰⁷ ●p cit (n9) 18.

¹⁰⁸ M Hamlyn 'Scathing report on lack of SA prison maintenance' *Mail & Guardian* 13 August 2008.

promotion programmes.¹⁰⁹ Foreign commentators on prison health recommend the development of and adherence to aggressive infection control programmes which utilise ‘respiratory isolation, restrictions on transfer of ill inmates, rigorous surveillance and contact tracing’ mechanisms.¹¹⁰ The benefits of preventative programmes to prevent the spread of disease within the prison and to educate prisoners to be able to make wise decisions about their health are well documented.¹¹¹ The immediate and long term impact of such programmes should safeguard not only the health of the prisoner and other prisoners within the detention centre, but also the health of the community upon release. However, preventative programmes are almost entirely overlooked in the South African situation where resource constraints and other challenges dictate the provision of services rather than a commitment to access to health services.¹¹² This is exacerbated by the poverty stricken community situations from which the vast majority of prisoners come, and most often to which they return. In many situations prison health services are the first or even only public health services with which the inmate will come into contact. Approximately 300 000 former prisoners return to their communities each year taking ‘their illnesses, infections and diseases with them.’¹¹³ Despite the tremendous presence of communicable diseases in South African prisons, the South African prison policy is silent on such methods, requiring only that upon entrance to prison a prisoner be screened for ‘communicable, contagious or obscure diseases’ and the presence of any such disease is noted.¹¹⁴ This is the only strategy to deal with the spread of communicable diseases, other than HIV/AIDS,¹¹⁵ and falls short of what would be required to ensure that prisoners are housed in conditions which respect their inherent dignity, as they are helpless to ensure their own safety against infection, especially of airborne diseases, such as tuberculosis.

¹⁰⁹ Sifunda et al op cit (n96) 2306.

¹¹⁰ JB Glaser and RB Greifinger ‘Correctional Health Care: a Public Health Opportunity’ (1993) 118 *Annals of Internal Medicine* 139 at 142.

¹¹¹ See generally Glaser and Greifinger op cit (n110) for an in depth discussion of the benefits of preventative programmes, including educational schemes.

¹¹² Sifunda et al op cit (n96) at 2308. R Watson, A Stimpson, T Hostick ‘Prison health care: a review of the literature’ (2004) 41 *International Journal of Nursing Studies* 119 at 125, available at <http://www.sciencedirect.com>, accessed 10 June 2008. This study illustrates the international commitment to the education of prisoners. This is motivated by the fact that the health care problems in prisons, worldwide, ‘largely reflect, but magnify, the problems present in the communities which the prisons serve’.

¹¹³ KC Goyer ‘Prison Health is Public Health: HIV and the case for prison reform’ (2002) 2 *SA Crime Quarterly* 23 at 24.

¹¹⁴ Correctional Services Regulation 14 op cit (n85) subregulation 2(3)(c).

¹¹⁵ HIV/AIDS is dealt with by the state in terms of a public health care policy.

Systemic impediments to health care

Many further impediments to the provision of health care in prisons stem from systemic issues of overcrowding, under-staffing and few resources or pragmatic security measures.

Staffing problems challenge to access and to adequacy

The Department of Correctional Services Annual report mentions a challenge, being the inability to recruit and retain health care workers.¹¹⁶ Yet, 18% of the prisons inspected by the inspecting judge had no nursing staff at all¹¹⁷ and whilst most prisons complained of a staffing shortage some record an average ratio of 1 correctional services official to more than 200 prisoners.¹¹⁸ These officials are the persons responsible for making the subjective decision as to whether to conduct a medical examination of a prisoner complaining of illness.¹¹⁹ This poses an impediment to the access to medical treatment.¹²⁰ Many officials and health workers share the belief that prisoners somehow get better health care than they deserve, or than they would usually receive, if they were not in prison.¹²¹ This negative attitude affects both the access to, and the adequacy of, medical treatment in prisons.¹²² It is often difficult to distinguish between situations where a prisoner has refused to undergo treatment and one where he or she has been denied treatment. The former often occurs where there is inadequate communication between the official and the patient, or an inherent distrust of the medication prescribed.¹²³ South Africa's levels of illiteracy and the ethos of distrust of Western health care emanating from the prominent members in the Department of Health exacerbate this.¹²⁴ Clearly such staffing issues are not conducive to the provision of health care that is adequate or sympathetic.

¹¹⁶ Department of Correctional Services *Annual Report 2006/2007* op cit (n99) 59.

¹¹⁷ Judicial Inspectorate of Prisons 2007/2008 op cit (n9) 19.

¹¹⁸ ●p cit (n9) 13.

¹¹⁹ Section 56(1) of the Correctional Services Act 111 of 1998.

¹²⁰ Singh and Maseko op cit (n31) at 82.

¹²¹ Sifunda et al op cit (n96) at 2304.

¹²² J van Niekerk 'Lock up and Stay South Africa's sick prisons' (2005) 95 *South African Medical Journal* 281 at 281.

¹²³ Glaser and Greifinger op cit (n110) 141.

¹²⁴ N Bolognesi 'AIDS in Africa: a question of trust' (2006) 443 *Nature*, 626 at 627, available at <http://www.nature.com/nature/journal/v443/n7112/full/443626a.html>, accessed on 27 June 2008.

Overcrowding

It is obvious that South Africa's prisons do not have the capacity to deal with the number of prisoners incarcerated and this forms the main challenge facing the delivery of health care in prisons.¹²⁵ This is reported by the minister, and is corroborated by most other reports that are generated from outside of the Department of Correctional Services.¹²⁶ At one point as many as 53 435 unsentenced prisoners were held in South African prisons.¹²⁷ South Africa's total capacity stands at 114 559 prisoners. However, as at 1 January 2007 there were 165 987 inmates incarcerated. The impact of such overcrowding cannot be stressed enough.

Resource constraints

The lack of resources also affects the provision of health services. However, this argument only really justifies inadequate service provision if it is reasonable and if the policy shows a clear reason for the rationing of resources. As was stated earlier, it is difficult for the government to argue that lack of resources justifies the total (or near total) denial of access to medical treatment, yet this excuse has been used to justify the inadequacy of preventative health services in prisons.¹²⁸

Movement of prisoners

Challenges are also created by necessary precautions that must be taken when providing health care to prisoners. For example, there are movement restrictions imposed to keep different categories of prisoners separate (for example, juvenile and adult offenders are kept separately), and when transportation of inmates is required to outside facilities appropriate measures are taken both in the transportation to and at the actual facility.¹²⁹ Whether or not to treat an inmate is often informed by these safety concerns, and by protocols that are balanced against the urgency or need of the inmate.¹³⁰

¹²⁵ Department of Correctional Services *Annual Report 2006/2007* op cit (n99) 55.

¹²⁶ Singh op cit (n31) 82.

¹²⁷ Judicial Inspectorate of Prisons 2007/2008 op cit (n9) 21.

¹²⁸ Singh op cit (n31) 83.

¹²⁹ Sifunda op cit (n96) 2307. See also criticisms of the logistics of transporting prisoners in *Stanfield v Minister of Correctional Services* supra (n59) and *E N v Government of the Republic of South Africa* supra (n35) .

¹³⁰ Sifunda op cit (n96) 2302.

No commitment

The state is mandated to provide immediate, adequate treatment and to take legislative and other steps to provide the best access to health services. There is an apparent omission on the part of the State to seriously commit itself to an undertaking of either of these duties. It is undeniable that the state faces tremendous demands on its resources. In the light of South Africa's disparate past, the state is obliged to act positively in the promotion of education, land, housing, health care, food, water and social security. As the Constitutional Court recognised in *TAC* 'in the light of our history this is an extraordinarily difficult task. Nonetheless it is an obligation imposed on the state by the Constitution'.¹³¹ Furthermore, Yacoob J in *Grootboom* stressed that 'despite all these qualifications, these are rights, and the Constitution obliges the state to give effect to them'.¹³²

In the light of the especially vulnerable position that prisoners are in the above paragraphs clearly show that the State is falling short of its obligations to provide adequate treatment and reasonable access to prisoners. Particularly worrying is the failure to provide a committed, coherent and comprehensive plan for the provision of health care, and the alleviation of the suffering, to those who are the most vulnerable until such plan has been implemented. The Constitution requires the state to give effect to these rights and has appointed the courts to ensure that this happens. This brings us to the final part of this paper, which is to consider the role of the courts in promoting and protecting the right to health care in prisons.

Role of the Courts

'Corrections may be the context in which care is given, but it should not dictate the content.'¹³³

An active approach

The frequent shortcomings of the health care in prisons are not reflected in the litigious challenges to s 35(2)(e).¹³⁴ Nonetheless, there is an

¹³¹ *TAC* supra (n23) at para 94.

¹³² *Grootboom* supra (n15) at para 94.

¹³³ Berkman op cit (n1) 1619.

¹³⁴ Currie and De Waal op cit (n20) 32.4.

increase in the success rates of such litigation, both internationally¹³⁵ and locally.¹³⁶ This shows that there is still a pressing need to constantly challenge the 'institutional culture of the organisations of government' in the delivery of health care.¹³⁷ The courts, as watchdogs of the Constitution, must take an active approach in interpreting the right to health in prisons, as well as in the drafting of their orders. Ngwena urges the courts to 'inquire robustly into alleged breaches of state socio-economic obligations' and says that it is incumbent upon the courts to go 'beyond the traditional approach'.¹³⁸ Hogerzeil calls for 'careful litigation' into the right to health services in prison.¹³⁹ The question, therefore, is: to what extent are the courts allowed, or even constitutionally obliged, to go to ensure that the rights of prisoners in the Bill of Rights are respected, protected and promoted?

Forging new tools . . .

If a court has decided that any conduct or law is inconsistent with the Constitution then it *must* declare that it is such to the extent of its invalidity¹⁴⁰ and it may make any order that is 'just and equitable' to grant 'appropriate relief' in the situation.¹⁴¹ In *Fose v Minister of Safety and Security*¹⁴² the Constitutional Court held that 'appropriate relief' is any 'relief that is required to protect and enforce the Constitution', and that the courts may 'even have to fashion new remedies to secure the protection and enforcement of these all-important rights'.¹⁴³ In *TAC*¹⁴⁴ the court referred to this approach favourably, saying that

¹³⁵ See generally HV Hogerzeil, M Samson, JV Casanovas, L Rahmani ●cora 'Is access to essential medicines as part of the fulfillment of the right to health enforceable through the courts?' (2006) 368 *The Lancet* 305 11, available at <http://www.thelancet.com>, accessed 14 June 2008.

¹³⁶ Such as can be seen in *EN v the Government* supra (n35), *Stanfield v Minister of Correctional Services* supra (n59), *Van Biljon v Minister of Correctional Services* supra (n27) and even *Ehrlich v Minister of Correctional Services and Another* (6113/2007) [2008] ZAECHC 33 (5 May 2008), available at <http://www.saflii.org/cgi-bin/disp.pl/za/cases/ZAECHC/2008/33.html>, accessed 8 August 2008.

¹³⁷ L London 'Health and Human Rights: What Can Ten Years of Democracy in South Africa Tell Us?' (2004) 8 *Health and Human Rights* 1 at 15, available at <http://www.jstor.org/stable/4065374>, accessed 14 June 2008.

¹³⁸ Ngwena op cit (n20) 31.

¹³⁹ Hogerzeil et al op cit (n135) 309.

¹⁴⁰ Section 172(1) of the Constitution of the Republic of South Africa 1996.

¹⁴¹ Section 38 of the Constitution the Republic of South Africa 1996.

¹⁴² *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC).

¹⁴³ *Fose* supra (n142) at para 49.

¹⁴⁴ *TAC* supra (n23).

[p]articularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. The Courts have a particular responsibility in this regard and are obliged to 'forge new tools and shape innovative remedies, if needs be to achieve this goal'.¹⁴⁵

Limitations on the mandate of the courts

By virtue of the fact that the judiciary are an elite and undemocratically elected group, there has been concern about the judiciary overstepping their mandate and treading upon the domain of the legislature by developing policy and deciding on the distribution of resources.¹⁴⁶ Nevertheless, the Constitution mandates courts to 'apply [the law] impartially and without fear, favour or prejudice'.¹⁴⁷ It is clear that the courts are well aware that whilst they are the watchdogs of the implementation of the Bill of Rights, they are not in a position to be 'rearranging budgets'.¹⁴⁸ Furthermore, courts recognise, as an inherent limitation of the adjudication of socio-economic rights, that any decision made will have the affect of rearranging 'mutually interacting variables'.¹⁴⁹ To require a government to make more medicines available to prisoners means that the money to do so must be taken from some other source, and in all probability provision of other amenities or services will suffer. Notwithstanding these considerations, the Constitutional Court has already held that such rights are justiciable and do not *per se* infringe the doctrine of the separation of powers. After all, the courts would be shirking *their* constitutional obligations if they were to avoid inquiring into state policy and budgetary decisions. There is a call for a judiciary who are 'appropriately deferent and appropriately transformative' in performing their mandate.¹⁵⁰ The Government in turn must comply with the order given by the court even if it affects the state's policy and it is required to find the resources to do so.¹⁵¹ The courts have not hesitated to do this so long as the remedy imposed is sufficiently flexible as to allow the state to

¹⁴⁵ *TAC supra* (n23) at para 102, quoting *Fose v Minister of Safety and Security supra* (n142) at para 69.

¹⁴⁶ Currie and de Waal op cit (n20) 26.2.

¹⁴⁷ Section 165(2) Constitution of the Republic of South Africa, 1996.

¹⁴⁸ *TAC supra* (n23) at para 38.

¹⁴⁹ Currie and de Waal op cit (n20) 26.2 call this the problem of polycentricity and recognise that it is a matter of judicial capacity in that judges can only decide the matter before them and the intricacies of these interacting interests may be beyond the expertise or ability of the court to decide.

¹⁵⁰ Marius Pieterse 'Coming to terms with judicial enforcement of socio economic rights' (2004) 20 *SAJHR* 383.

¹⁵¹ *TAC supra* (n23) at para 99.

maintain ownership over the matters of policy.¹⁵² The courts have been instrumental in protecting the constitutionally enshrined rights both with regard to their approach to standing as with their remedies. I shall consider these in turn, and suggest their usefulness in improving health care in prison.

Standing

In s 38 the Constitution gives a broad standing to parties litigating about rights enshrined in the Bill of Rights.¹⁵³ Furthermore, the courts have taken a generous approach to standing especially in the light of the exorbitant cost of litigation in South Africa.¹⁵⁴ The approach expressed is that there is no need for undue complication and obstruction to anyone bringing a case before the court.

Whilst individual litigation is the most common form of litigation, one of the biggest problems with this form of 'piecemeal litigation' is that it takes a long time to develop a cohesive rights jurisprudence. The jurisprudence that will result is largely driven by the persistence and financial resources of the individual litigants and depends on which cases are brought to the courts and the way in which they are argued. This process can develop the law in a haphazard way. Through this form of litigation it may take many years to give meaning to the right to health care in prisons. This is not a suggestion that such litigation should play a more minor role in the development of the right, on the contrary, it is this very form of litigation which is the primary law-developing role of the court. However, where the government has been very slow in enacting legislation it would be imprudent to sit back and wait for the legisla-

¹⁵² In *Premier, Mpumalanga and another v Executive Committee, Association of State Aided Schools, Eastern Transvaal* 1999 (2) BCLR 151 (CC) the court set aside a government policy and required the state to continue paying subsidies to schools for several months. In *August and Another v Electoral Commission and Others* 1999 (3) SA 1 (CC) the court ordered that the IEC alter its policy and implement it in a way that allowed prisoners to vote, which no doubt had severe cost implications. See also *Minister of Health v TAC* supra (n23), *Van Biljon v Minister of Correctional Services* supra (n27), *Ebrlich v Minister of Correctional Services and Another* supra (n136) and *E N v Government* supra (n35.)

¹⁵³ Section 38: The persons who may approach a court are

- (a) anyone acting in their own interest;
- (b) anyone acting on behalf of another person who cannot act in their own name;
- (c) anyone acting as a member of, or in the interest of, a group or class of persons;
- (d) anyone acting in the public interest; and
- (e) an association acting in the interest of its members.

¹⁵⁴ *Ferreira v Levin NO and others* 1996 (1) SA 984 (CC) at 1083G H; *Beukes v Krugersdorp Transitional Local Council* 1996 (3) SA 467 (W) at 474C H; *Permanent Secretary Department of Welfare, Eastern Cape Provincial Government and another v Ngxuzza and others* (493/2000) [2001] ZASCA 85; *E N v Government* supra (n35) at para 9.

ture to give meaning to the right or to let the courts stand alone in developing what is meant by this right in the test cases brought.¹⁵⁵

This need not be the only way that cases may come to court — there is a much more dramatic role which the courts may play — namely through class actions and public interest cases. Class actions and public interest cases allow for a broader litigation that focuses more on requiring delivery of constitutional obligations than on individual remedies. These have been used in *TAC*, *Ngxuza* and most recently in *EN v Government*, where Pillay J held that since incarcerated persons are the wards of the state who suffer physical and financial constraints it would be 'unreasonable' to expect that each prisoner bring an individual case.¹⁵⁶

In keeping with this logic Froneman J in the court a quo in *Ngxuza*¹⁵⁷ emphasized the benefit of making it easier for disadvantaged and poor people to approach the court on public issues as a mechanism of holding the public administration to account for its exercise of public power in a manner that adheres to the fundamental constitutional principle of legality.

Both class actions and public interest cases often attract more public and political attention. The class action was particularly helpful in improving the health care in prisons in America during the 1960's and 1970's.¹⁵⁸ In the current South African context there is an urgent need for such a case, where a group of prisoners acting on behalf of the whole (or part) of the prisoner population or a public interest group approaches the court calling for a reasonable legislative scheme to be put in place — not one which merely states the rights — but one which gives meaning to the rights in the Correctional Services Act and the Constitution and commits the state to a plan to effect the rights. After all, the extra-ordinary duty owed to the prisoners deserves an extra-ordinary solution.

Nevertheless, once *at* court the effectivity of the courts is proved mainly through the remedies that they order to protect and enforce rights.

¹⁵⁵ A prime example is the Sexual Offences Bill which was first tabled in Parliament nearly 8 years before it was finally enacted in 2007, following a disapproving dictum of the Constitutional Court judgment in *Masiya v Director of Public Prosecutions (Pretoria)* 2007 (8) BCLR 827 (CC). The Child Justice Bill of 2003 has seemingly suffered a similar fate and is yet to be enacted.

¹⁵⁶ *EN v the Government* supra (n35) at para 9.

¹⁵⁷ *Permanent Secretary Department of Welfare, Eastern Cape Provincial Government and another v Ngxuza* supra (n154) at para 629E.

¹⁵⁸ Berkman op cit (n1) 1617.

Remedies

The courts have a broad discretion in the drafting of their remedies and what they choose will be largely determined by the facts of the particular case and the prayers for relief argued by the parties.¹⁵⁹ This may include a declaratory order, a structural or mandatory interdict that may involve submission to the supervision of the court to ensure the fulfilment of the specific rights into the future. It may also require the government to submit a policy with timelines to the court.¹⁶⁰

Whilst a full discussion of constitutional remedies is beyond the ambit of this paper, there are various remedies that the court may order which have proved to be particularly effective in holding the state to account for its treatment of prisoners.

The declarator giving meaning to the right

The courts are called upon to develop the law in accordance with the spirit, purport and objects of the Bill of Rights and in doing so to consider international law and foreign law.¹⁶¹ This enables the court to perform an important function in the adjudication of cases as it may give substantive meaning to the right to health and this will be reflected in the declaratory part of the court order. As was mentioned above, the Correctional Services Act and the Constitution lay the foundation for a very powerful and protective right to adequate treatment and access to health care. The courts should build upon this foundation in interpreting the right.

● One key method in doing this is with the use of international sources.¹⁶² For example, as part of the ‘minimum core’ of the right to health, the United Nations Committee on Economic, Social and Cultural Rights suggests that there is a duty on a state to enact and implement a cohesive public health strategy, which addresses health concerns of the whole population. This must include methods to show the progress in the provision of the right, and the content of the right, giving

¹⁵⁹ *Minister of Health v TAC* supra (n23) at para 106.

¹⁶⁰ *City Council of Pretoria v Walker* 1998 (2) SA 363 (CC), *E N v Government* supra (n35). For a good discussion of remedies see *Minister of Health v TAC* supra (n23) at paras 102–114.

¹⁶¹ Section 39 of the Constitution.

¹⁶² See *S v Makwanyane* supra (n21) at para 35. In both *Government of the Republic of South Africa v Grootboom* supra (n15) at para 26 and *Minister of Health v TAC* supra (n23) the Constitutional Court referred to the General Comments of the UN Committee on Economic, Social and Cultural Rights in looking at the notion of progressive realisation of the right to access to housing and health respectively.

particular attention to all vulnerable or marginalised groups.¹⁶³ The way that this duty is put forward by the committee is similar to the order of the court in *TAC*¹⁶⁴ which required the state to implement a policy with certain prerequisites, but without binding the hands of the legislature or executive. An order will bind the hands of the state when the court prescribes exactly what policy needs to be undertaken to realise a right. This is distinct from the court ordering which substantive issues are encompassed by a right and ought to be delivered by the policy. Albeit nuanced, this distinction is necessary to avoid complications with the separation of powers doctrine. The General Comment also suggests that states prioritise measures to prevent, treat and control epidemic and endemic diseases, provide education about health, and provide adequately trained health personnel.¹⁶⁵

The courts have begun to flesh out the meaning of the right to health care and this is shown in the declarators in the order granted by the courts. In *Ehrlich*¹⁶⁶ the right to conditions consistent with human dignity was held to include the plaintiff's right to take part in a karate development scheme. In *Van Biljon*¹⁶⁷ the state was required to provide antiretrovirals, and in *E N v Government*¹⁶⁸ the Department of Health was required to develop a plan to provide the prisoners in question with access to health services where such access had been obstructed. The declarator in the order should be structured in such a way as to clearly state what the court has found the right to health to include, thus expanding through judicial order the meaning of the right rather than merely stating what the right says.¹⁶⁹

The structural order a call for a legislative scheme, plan or policy

In structuring their orders courts should 'attempt to synchronise the real world with the ideal construct of a constitutional world' and they do this by moulding an order that will provide effective relief to those

¹⁶³ United Nations Committee on Economic, Social and Cultural Rights General Comment 14 at para 43.

¹⁶⁴ *TAC* supra (n23).

¹⁶⁵ United Nations Committee on Economic, Social and Cultural Rights General Comment 14 op cit (n163) at para 44.

¹⁶⁶ *Ehrlich* supra (n136).

¹⁶⁷ *Van Biljon* supra (n27).

¹⁶⁸ *E N v Government* supra (n35).

¹⁶⁹ *Modder East Squatters and Another v Modderklip Boerdery (Pty) Ltd, President of the RSA and Others v Modderklip Boerdery (Pty) Ltd* 2004 (8) BCLR 821 (SCA) at para 39 the court stated that 'simply to declare what the Constitution states serves no purpose. Declaring that a breach of a constitutional duty occurred is however on another level.'

affected by the constitutional breach.¹⁷⁰ Courts may ensure the implementation of their orders through the use of mandatory orders and structural interdicts.

Court orders before *TAC*¹⁷¹ seldom used structural interdicts. In *Van Biljon*¹⁷² the court merely ordered the provision of the drugs without requiring any proof of compliance. A year later in *Pretoria City Council v Walker*¹⁷³ the Constitutional Court recognised that there may be cases where a mandamus and an order to report back would be appropriate. However, in *TAC*¹⁷⁴ the court was hesitant to use a structural interdict, relying on the goodwill of the state shown by it taking steps during the course of the proceedings to comply with its obligations. The court expressed the sentiment that structural interdicts ought to be sparingly used, only when there is

‘a failure to heed declaratory orders or other relief granted by a court in a particular case. We do not consider, however, that orders should be made in those terms unless this is necessary’.¹⁷⁵

Yet, nearly 6 years later a survey of the law reports indicates that structural interdicts are frequently ordered, and in *S v Z*¹⁷⁶ the court noted that ‘a structural interdict is particularly suited to a society committed to the values of accountability, responsiveness and openness in a system of democratic governance’. This shift in favour of the structural interdict is seen in many of the cases that require the state to revise its existing policy or legislation and submit a revised one to the court.¹⁷⁷ The change in attitude may be attributable to what the Constitutional Court has termed the ‘flimsy excuses’ that have been used by state functionaries to excuse their failure to abide by court orders ‘which in the end only point to their dilatoriness’.¹⁷⁸ This gives rise to a greater need for courts to

¹⁷⁰ *Modder East Squatters* supra (n169) at para 42, see also footnote 41 thereof.

¹⁷¹ *TAC* supra (n23).

¹⁷² *Van Biljon* supra (n27).

¹⁷³ *Walker* supra (n160).

¹⁷⁴ *TAC* supra (n23).

¹⁷⁵ *TAC* supra (n23) at para 129.

¹⁷⁶ *S v Z* 2004 (4) BCLR 410 (E).

¹⁷⁷ *Permanent Secretary Department of Welfare, Eastern Cape Provincial Government and another v Ngxuzza* supra (n154); *Rail Commuter Action Group v Transnet t/a Metrorail* 2003 (3) BCLR 288 (C) at 351; *City of Cape Town v Rudolph* 2003 (11) BCLR 1236 (C); *Magidimisi v Premier of the Eastern Cape* [2006] J●L 17274 (Ck); *Kiliko v Minister of Home Affairs* 2007 (4) BCLR 416 (C); *City of Johannesburg v Rand Properties (Pty) Ltd* 2007 (6) BCLR 643 (SCA); *E N v Government* supra (n35); *Ehrlich v Minister of Correctional Services and Another* supra (n136); *Nyathi v MEC for Department of Health, Gauteng; Centre for Constitutional Rights (amicus curiae)* [2008] J●L 21824 (CC).

ensure the implementation of their orders through the use of structural orders.

Damages

Another form of remedy that the courts may award is that of damages, which is more punitive in the sense that it requires the state to make reparation for not complying with its constitutional duties. Courts may award delictual damages where rights violations have occurred and there is 'damage' that can be quantified in a delictual sense, such as where an individual suffers pain, suffering, or disability because of the lack of service provision of health care in the prisons.¹⁷⁹ The litigant will have to prove causation and a duty attributable to the state, which can be especially difficult where the original harm requiring treatment was caused by other prisoners. This remedy is reparative, not fixing the underlying problem, but hopefully provides an incentive to the department to abide by the obligations that it owes to those in its care.

Review fair process and implementation

It is also important to remember that the courts role is also to ensure that administrative process is fair, and that the implementation of policy is just.¹⁸⁰ The process of being taken on review for the exercise of public power is an additional method of holding the administration accountable in the implementation of the right to health. When dealing with decisions made by prison officials or prison medical staff, the question is whether the reasonable authority would make such a decision and the courts may inquire closely into this.¹⁸¹

Conclusion

The title of this paper refers to Charles Dickens' famous novel, *Great Expectations*, which is a story of a young boy who has to endure many hardships in order to become the great man that he is later. His innate perseverance and a fair amount of luck help him along the way. The Constitution sets a high expectation for what the right to health means in the prison context, *viz* immediate provision of adequate treatment that promotes and respects the inherent dignity of the prisoners, and

¹⁷⁸ *Nyathi* supra (n177) at para 60.

¹⁷⁹ *Hofmeyr* supra (n4).

¹⁸⁰ Section 33 of the Constitution of the Republic of South Africa, 1996.

¹⁸¹ *Stanfield* supra (n59) at para 97 referring to the dictum of Chaskalson in *Bel Porto School Governing Body and Others v Premier, Western Cape, and Another* 2002 (3) SA 265 (CC).

progressive improvement of access to health services. Yet, the current legislative scheme, albeit reiterating the right, falls short of providing for the realisation of this right. This failure on the part of the State to commit to providing health care to prisoners, who are arguably the persons most dependant on the state, has tragic implications for the prison population. This paper suggests that the courts should play an active role in vindicating and protecting the right to health care in prisons. This role is reflected in the seriousness with which the courts approach the cases that come before them. The court is required to craft remedies that are sufficiently deferent and yet practically effective. This is a hard task to take on and one which requires commitment and the development of a coherent prisoners' rights jurisprudence. Provided the state commits itself to the task and the courts hold the state to account, it is submitted that these expectations are not too great for the health care in the South African prison system.