PRISON HEALTH CARE IN SOUTH AFRICA:

a study of prison conditions, health care and medical accountability for the care of prisoners

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July 1996

DECLARATION

I, Judith Antoinette van Heerden, hereby declare that the work on which this thesis is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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ACKNOWLEDGEMENTS

This survey is dedicated to all those ex-detainees who were willing to share their often painful experiences with me at considerable risk to their personal safety.

I would like to express appreciation for the ongoing encouragement and support received from Govan Mbeki, Rev Mxolisi Xundu, Patha Madalana, Vuyiswa Matshaya, Manityi Blaauw, Ndeleka Qangule, Kobus Pienaar, Judy Chalmers and Bettie Grant, and further afield the Albany Council of Churches and the Black Sash, in particular Sox Leleki, Hlemi Mangcangaza, Ruth Plaatjie and Priscilla Hall from the Eastern Cape. In similar vein I received support from the Repression Monitoring Group [RMG], National Association of Democratic Lawyers [NADEL], the social workers of the Western Cape Relief Fund [WCRF] attached to the office of Essa Moosa and Associates, the South African Prisoners Education Trust [SAPET], the Association of Ex-Political Prisoners [AEPP], the Advice Office Forum as well as the local and rural offices of the ANC in the Western Cape.

I am indebted to the Executive Committee of the Teaching Hospitals Central Advisory Committee of Groote Schuur Hospital for approving sabbatical leave which enabled me to conduct interviews at a time when this kind of work was not encouraged. I would also like to thank my supervisors, Prof. S R Benatar, Prof. M Savage (until December 1993) and, in particular, Prof. Frances Ames, who unstintingly devoted time and intellectual energy to help shape this project. Prof Benatar kindly authorised bridging funds until the Equal Opportunity Foundation came to the rescue and supplied funding without which this work could not have been completed.

With patience and humour Digby Warren generously contributed his remarkable editorial skills to transform a factual document into a cohesive report. I thank him for turning an insurmountable hurdle into a stimulating challenge.

A special word of thanks is owed to those individuals who painstakingly helped with the mundane work of typing, developing the questionnaire, collating figures and

layout. Only Cynthia Woollgar, Heather and Margaret Collins know what a protracted and tedious task it has been. Without the encouragement and good cheer of the secretarial staff of the Department of Medicine this document may not have seen the light of day.

Time and energy will have been well spent if this study inspires the enhancement of the quality of life for prisoners in our new democratic society.

ABSTRACT

This quantitative and qualitative study investigates the type and quality of health care and conditions of imprisonment that prevailed in some South African prisons in the late 1980s. It was inspired by political activists who were incarcerated, yet despite, or because of, the harsh conditions in prison persisted with their struggle for human rights. Appeals for the improvement of prison conditions which they submitted to the authorities are unique primary source documents. By implication, this survey adds value to their cause, for several issues examined in it had already been raised while they were in prison.

With most information on prisons restricted until 1992, there was no body of literature on South African prison health care to review. Instead, Chapter 1 outlines the historical background of imprisonment in South Africa and key penal legislation. It also deals with events like the Biko affair which, in the recent past, affected the medical profession, the response of professional organisations to these events, and the national and international repercussions.

Chapter 2 on the methodology describes the study design, data collection process and the limitations of the survey. Numerous attempts to interview District Surgeons and visit prisons were fruitless, consequently reducing the intended scope of the primary research. Because these external limitations affected the study design, they are discussed under methodology.

A semi-structured questionnaire was developed to collect information about health care while imprisoned during the States of Emergency (1986-1990). Interviews based on this questionnaire were conducted with 123 ex-detainees from the Eastern and Western Cape. The results of the study are presented in Chapter 3, both quantitative, in the breakdowns of the data relating to each of the 14 questions, and qualitative, in the tables which reflect individual experiences and comments.

The significance of these results is examined in the discussion in Chapter 4, backed by other supportive evidence. It begins by sketching general conditions of imprisonment, using unsolicited information from the interviewees, and proceeds to discuss health care services as they pertained during the study period. Many points of discussion also draw on the seven Case Reports and the report on North End Prison, Port Elizabeth, which have been added as an appendix to that chapter.

The research indicates a disregard for the well-being of and failure to provide adequate health care for individuals at the mercy of detaining authorities. This situation was compounded by collusion among the forces of law and order and District Surgeons, and a scant response by academics and professional organisations to problems associated with imprisonment, isolation and torture.

In the conclusion, Chapter 5, strategies for improving prison health care are explored. They are based on current national and international literature, policy and practice. The main proposals for reform are then summarised in the recommendations in Chapter 6. These range from revising legislation so as to accord with the constitutional rights of prisoners to addressing the training and attitudes of personnel, establishing health care standards and auditing mechanisms, and creating a more open prison system.

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INTRODUCTION

> *"What happened to Steve Biko should never be allowed to happen in any country that regards itself as civilised. It is the duty of all of us to learn from the past, and to try to ensure that nothing of the sort can ever happen again."*
> NC Lee (Editorial, SAMJ 1/6/91)

This study investigates conditions inside South African prisons, with particular reference to health care. Since imprisonment affects the physical and mental health of prisoners, medical scrutiny is an essential though neglected aspect of prison research. In the period of transition to a new democratic South Africa it is appropriate to review prison conditions in the past and present to inform planning for the future.

AIM:

To determine the quality of health care in South African prisons, with specific reference to the role of the prison doctor.

OBJECTIVES:

1) To ascertain inmates' perceptions of health care provided during detention;
2) To establish the problems encountered by health care providers;
3) To propose strategies for improving the health care of prisoners;
4) To elucidate the medical rights of prisoners and detainees.

South Africa has one of the highest known prison populations in the world with 368 prisoners per 100,00 population (excluding the former "homelands")(1) and 400,000 per year passing through our prisons. With a prison capacity of 97,000 the average daily population has increased from 112 to 118 thousand (2). The function of prisons is to take physical care of those individuals whom the criminal justice system has removed from society. The primary concern of prison authorities has always been safe custody and security rather than rehabilitation. Few prisoners learn anything of value whilst incarcerated.

Until 1992 severe media restrictions kept the South African public ignorant of conditions in our prisons. Striking features of South African prisons up to that time were:

* racial segregation and the difference in the treatment of prisoners that it engendered;
* the legal use of corporal punishment as a disciplinary measure for infractions committed by prisoners;
* the harsh and effective regulations (1959-1992) against access to and publication of any information, which sealed prisons off from public scrutiny

(3) and had a devastating effect on all attempts at prison reform over the past three decades.

Prisoners generally come from lower socio-economic and poorly educated social strata. The prison system tends to destroy their identity and self-esteem; they become just another number. Many lack the knowledge and information, drive, belief in themselves and ability to make demands. Nobody appears to care about them; they become social outcasts. Mostly they are confined to conditions of filth and overcrowding, where the food is inadequate and health care poor, and where they are frequently subjected to humiliation, abuse and violence. Added to this are the South African prison gangs instigated by Nongoloza Mathebula shortly after the turn of the century[1] (4), which have a reputation for physical and sexual abuse. Ex-prisoners, stigmatised and ashamed, attempt to distance themselves from the experience and so fail to take up the plight of those who remain in prison (5).

This survey is, however, primarily a study of a group of South African prisoners detained for political reasons. Political prisoners differ from "criminals" in that they are usually better educated and more articulate. They use these skills to organise support inside prison, communicate with human rights organisations outside, and campaign for the betterment of prison conditions.

Political Imprisonment

Political prisoners tend to retain faith in themselves, their identity and their educative role in the community. Political leaders held on Robben Island transcended their individual suffering by sublimating it into promoting human rights. Incarceration as a group also welded them together with a common purpose. Physical hardship and psychological abuse were inevitably imposed on the intellectual black leaders by white warders steeped in the "baasskap" traditions of the apartheid system. Their survival strategy, therefore, rested partly on the education of the warders and of fellow prisoners. They decided to teach the warders basic civility and respect for human dignity, the details of prison law, and a broader understanding of South African history (6). They also provided academic and political training for their younger, and sometimes illiterate, fellow prisoners. However, the political prisoners faced many obstacles gaining access to undergraduate studies. Political education, developed and

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[1] Nongoloza Mathebula introduced his decade-old gang organising skills into prisons once he himself was incarcerated after 1900. These inevitably included the paraphernalia of rank and "boy-wives". On release many ex-convicts found jobs on the mines so that by 1912 gangs virtually controlled organised crime in prisons, the compounds and townships of the Transvaal and Orange Free State. Prison gangs flourished and to-day the remains of Mathebula's Ninevite gang exists in prisons as the feared "28" gang.

disseminated through the prison underground, was also fraught with problems (7,8). For instance, at a practical level, plastic was a godsend because it prevented water destroying documents underground (Govan Mbeki - personal communication). The skills acquired by the political activists who moved in and out of Robben Island prison, with each wave of repression, were carried back to townships across the country (9). So successful were these endeavours that, among the community, the prison became known as the "Robben Island University".

In the repressive climate of the late eighties, when political activists were detained during the State of Emergency, they used this disciplined and directed approach to improve conditions of imprisonment. Several months after the first arrests, the detainees realised that they were facing long-term incarceration. They elected representatives to present their grievances to prison officials and to their lawyers. Eventually the prison management was forced to recognise these representatives as elected negotiators (10). It was the stories and lessons of these struggles that inspired this research.

To place this study of contemporary prison conditions in context, the historical background of imprisonment in South Africa is outlined below, along with the legislation governing prison management and health care. Responses to these laws and evidence of gross maltreatment of prisoners, from local political movements and medical associations, the international community and detainees themselves, are also examined.

SOUTH AFRICAN PRISON HISTORY

Background

Since ancient times offenders against the social mores have been punished. Punishment took the form of slavery, banishment and physical assault often ending in death. During the eighteenth century the ideas of Enlightenment, which promoted reason and human progress, swept through Europe. This new perception coincided with the Industrial Revolution which brought about a move of landless peasants to towns. For many of them poverty accompanied industrialisation: homelessness, hunger, disease, lawlessness and early death were common experiences. To cope with these social problems, and in line with liberal thinking, workhouses were established. These were the forerunners of prisons(11). The emergence of "modern prisons" was based on the idea that hard labour would rehabilitate and reform outlaws into worthy citizens.

Three of the forms of punishment mentioned above - physical violence, incarceration, banishment - were all implemented at the Cape.

The Dutch East India Company [DEIC], 1652-1806

The Dutch practised a policy of physical punishment at the Cape. For the indigenous people this ranged from death by firing squad or public crucifixion, to various forms of torture, at times severe enough to result in fractured and severed limbs. Those thought to merit trial were detained in single cells at the Castle and forbidden to speak to anyone without permission. More care had to be exercised with useful company employees who, if guilty of infringements, were sometimes deported to work on Robben Island (12a). The company also banished dissident trading partners from the East (Indiaanen) to Robben Island. By 1748 an estimated 312 Indiaanen had arrived at the Cape. Local Muslims continue to make regular pilgrimages to the karamat (shrine) of Sheik Madura who was banished to Robben Island where he died and was buried in 1754(13).

The British

In 1806 the British with a different value pattern more rooted in liberal ideas annexed the Cape. In 1834, when liberal attitudes forced the abolition of slavery, a new source of easily manageable labour became necessary. Belief in prison rehabilitation through useful work helped to solve the problem. Within a decade legislation was introduced whereby road camps were established to house teams of prisoners engaged in building roads, bridges and mountain passes (12b). By 1845 the prisoners on Robben Island were returned to swell the labour force on the mainland (14). An attempt in 1848-9 to turn the Cape into a penal settlement like Australia was defeated because of widespread opposition from the colonists to the scheme to introduce British convicts. Instead they were forced to rely on indigenous supplies of labour, including prisoners (15). By 1860, 605 prisons had been erected in the Cape(11b). "Hard labour" was, in addition, intended to act as a deterrent.

Diamond and Gold Mines

The discovery of diamonds in 1867 increased the demand for cheap labour on the Kimberley mines. Extending prison labour to the diamond fields was initially not successful because of disorganised working and living conditions, poor discipline and a fluctuating market. Following the consolidation of individual diggings, the De Beers Diamond Mining Company began regular use of prison labour and thus built prison

stations to house their work force in 1885. This system of convict labour flourished. In 1873 the introduction of pass laws, regulating abode and employment for black males, resulted in a rapid rise in the prison population. When fully operational, De Beers "employed" over 10,000 prisoners daily. This system embodied a policy of criminalisation, rigid control, physical abuse, and, for the first time, racial segregation in prisons (16).

The discovery of gold on the Reef in 1884 perpetuated the use of local convict labour, which continued until 1952, on the mines (11c).

Agriculture

Throughout the nineteenth century, private farms and public works were occasionally supplied with prison labour (12c). Provision of forced farm labour was formalised with the introduction of the *Sixpence a Day Scheme* (1931). Farmers paid the prisons six pennies per day for convict labour for whom they had to supply food, clothing, shelter and a guard. Abuse of prisoners led to modification of this scheme, by what was intended to be a temporary measure, the *Ninepence a Day Scheme* (1947-1959). Henceforth the prisons fed and guarded convict labour and farmers provided transport (11d). In more remote areas farmers who needed prison labour were catered for by concessions, granted to agricultural organisations in the fifties, to build and maintain farm prisons outposts for convicts. By 1957 twenty five farm prisons were in use (11e).

Protest

The inhuman working conditions of farm prison labour became a rallying point around which black political movements organised a successful 3 month national boycott, the "Potato Boycott", in 1954. They objected, for example, to workers clothed in sacks having to dig in hard soil with their bare hands and being whipped frequently. Knowledge of these brutal farm labour practices spread abroad and led to the start of an international boycott of South African produce in 1959 (17).

The 1959 Prisons Act

The Lansdown Commission (1947), appointed to review prison labour practices, recommended reform measures which conflicted with the needs of the politically influential white farming constituency. The 1959 Prisons Act was intended to modernise prison legislation, but, in fact, it tightened control. Consequently, hard labour was "officially" abolished and the *Ninepence a Day Scheme* replaced by an

apparently more humane "parole" system. It introduced the option for short term prisoners (sentenced for less than three months) of "release on parole". "Parole" meant that a sentence could be commuted to contract "convict" farm labour. This policy of "useful and healthy outdoor work", intended to encourage respect for gainful employment rather than to punish and deter, was in line with international penal reform trends. It, however, did little to prevent the abuse of convict labour. The international community condemned these prison labour policies and threatened more boycotts of SA produce (11e). In 1986 the government agreed to phase out the parole system, as it violated international trade agreements. Nonetheless, in late 1989 it was reportedly still widely practised in Transvaal and Natal (18).

International scrutiny of South African prison conditions intensified when large numbers of political activists were detained without trial during the early sixties. At the same time the South African public, by law, were denied access to prison information.

Press Restrictions (1959-1992)

The Prisons Act No 8 of 1959 strictly controlled media reports on prison conditions. Section 44(1)(f) of the Act introduced a

> *"total prohibition on the publication or divulging of any information about prisoners or ex-prisoners or about the administration of a prison."*

Under public pressure the Minister of Justice amended the Act to make it an offence

> *"to publish (in any manner whatsoever) any false information about a prisoner or ex-prisoner or about his experiences in prison or the administration of the prison, knowing this information to be false or without taking reasonable steps to verify it."* (19)

This alteration understandably did not make much of a difference. According to Sections 44(1)(e) and (g) of the Act, it was, in addition, illegal to publish photographs of prisons or prisoners, or to publish sketches or writings by or about prisoners. It also become an offence to mention prison matters in personal correspondence or to give information related to prisons "even to one other person" (3b). The penalty for an infringement was a fine of up to R2000, or imprisonment for up to 2 years (Section 44(1)(g)).

The 1959 Act effectively put an end to the publication of "unjustified" attacks on the prison system. Articles like that of Henry Nxumalo, in which he describes prison conditions and illustrates the practice of "tausa"[2], were now illegal (20).

The State's determination to stop criticism is epitomised by its response to a letter published in the South African Medical Journal [SAMJ], of 14 August 1965, in which Dr G Dean, a Port Elizabeth physician, said that District Surgeons have "a moral duty . . . . to use their power and influence as doctors to prevent assault and cruelty in our prisons" (21). Confronted with charges of contravening prison regulations Dr Dean decided to emigrate. Tactics like this intimidated the medical press into compliance with media restrictions which shielded the prison service from public scrutiny (21).

When prison conditions were criticised in the media, the state mobilised employees who were able to testify that information was "false". Paradoxically, this meant that the accused had to verify the truth of the information published. The government's determination to impose the letter of this law was demonstrated in the case of the State versus SA Associated Newspapers Limited [SAAN].

The SAAN Case

In July 1965 the Rand Daily Mail published a series of articles on Harold Strachan's three years prison experience (see Appendix 1). At the time of publication the newspapers offices were raided and searched, and Strachan was placed under house arrest and banned (officially silenced) (22,23). At the time prisoners, cut off from all outside news, were puzzled when out of the blue they benefited from this publicity in that they were issued with mattresses, sheets, pillows and a pitcher filled with clean drinking water every morning (24).

At subsequent trials, sworn affidavits and collaborating statements, taken by experienced attorneys, were not accepted as "sufficient steps to verify the truth". The judgement went against SAAN (25) and Strachan was sentenced to two more years in jail (26).

Soon after the trial, however, the government in 1966 took the shrewd step of making public the 1964 confidential report of the International Committee of the Red Cross

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2 "Tausa" was part of the daily search routine to prevent prisoners from hiding contraband in body cavities. It is the practice of making a naked black male prisoner, of any age, jump and turn in mid-air landing with his feet astride and bending at the hip towards the warders, in order for them to inspect his anus for hidden objects (Govan Mbeki - personal communication). It was a practice which African men found particularly degrading and humiliating.

[ICRC] (presumably favourable) on South African prison conditions (12d), thereby breaking its own media rules when it suited its purpose.

The outcome of the SAAN case intimidated and silenced the media; the prisons had effectively been sealed off from society. It brought to an end any independent scientific or journalistic investigation. These drastic measures ensured that the public remained ignorant of maltreatment and abuse inside the prisons. It had an inhibiting effect on the development of liberal and ethical debate on prison reform. Hereafter, the only prison information to which the public had access was that of court evidence and parliamentary privilege.

Prison Abuses in the 1970s and 1980s

By law all unnatural deaths require an inquest (27). Prison cases heard in court were most often the result of extreme abuse resulting in death. Between 1970 and 1990 three such cases were reported:

(a) **The Leeuwkop Trial, 1974**. In attempts to extract evidence of petty theft, five warders (among them a medical orderly) assaulted prisoners so severely that one of them died without receiving medical treatment (11f).

(b) **The Zonderwater Trial, 1979**. A prisoner was brought to trial for murdering another inmate, but the victim had died following brutalisation by hostile prisoners involved in violence, sodomy and drug abuse, and from whom he had requested segregation (11g).

(c) **The Barberton Heat Exhaustion Trial, 1984**. Six of the eight warders prosecuted (one of them a medical orderly) were convicted of three murders and assaults on 34 prisoners. Court evidence exposed routine brutality such as the traditional "warming up" of new arrivals at the prison (19b).

Each of these trials was followed by editorial comment and public outcry expressing anger at the ongoing abuse which occurred behind prison walls. The damage caused by undisclosed abuse in institutions removed from public scrutiny, could, after the Heat Exhaustion Trial, no longer be ignored. In 1984 the Minister of Justice announced that

> *"the media would in future be allowed to publish allegations on prison conditions subject to the understanding that equal and simultaneous opportunity be afforded the prison service."* (19c)

Nevertheless, Section 44(1)(f) continued to serve as a formidable deterrent. Following this announcement, media reports were accompanied by more or less standard official statements which some critics regarded as meaningless. One example of the many formalised replies frequently released during the eighties, stated that:

> *"A uniform balanced diet scale is used in South Africa's prisons. This diet scale has been compiled by the SA Prisons Service in co-operation with the Department of National Health and Population Development. Regular medical inspections are carried out by inter alia medical doctors and health inspectors to ensure that the prescribed diet is prepared and served attractively and under hygienic conditions. The diet scale furthermore corresponds with international nutritional standards"* (19d).

By contrast, a Human Science Research Council [HSRC] report (1991) on the poor standard of processed food provided to prisons on tender, justified the complaints of hunger and vitamin deficiency by prisoners (28,29).

What emerges from the above survey is that media restrictions in South Africa created a screen behind which the maltreatment and abuse of prisoners could proceed with impunity. This situation vindicates the stand taken by the Human Rights Watch, an international human rights organisation based in New York which has been monitoring conditions of imprisonment since 1987. Human Rights Watch emphasise that, in their view, the free flow of information is crucial to limit abuse in total institutions; that "*prohibitions on communications are almost always conducive to abuses*" (5b).

In South Africa itself, a significant step forward occurred with the repeal of Section 44(1)(f) in 1992 (30). With prison conditions now open to media and public scrutiny, there are new constraints on abuses. A complicating factor, however, is the privilege system.

The "Privilege" System

Human Rights Watch have been critical of the South African restrictions on prison information both in terms of media coverage and at a personal level. The violation of rules on prison information in private conversations and correspondence related not only to Section 44 (1)(f) of the Prisons Act, but was also linked to the unique system of "privilege" which still operates in our prisons. All contact with the outside world depends on the "privilege" group under which a prisoner has been classified. For example, only the most privileged group (group A) are allowed contact visits.

According to the "privilege" system, prisoners have only those fundamental and enforceable rights of food, shelter, clothing and medical care related to their physical survival. Everything else a prisoner is allowed to do, or have, is a "privilege" or indulgence. Privileges are granted and withdrawn at the discretion of the Commissioner of Corrections, or his delegated Heads of Prison, as prescribed by the Commissioner in Departmental Orders. For many years these Departmental Orders were not accessible to the public or to prisoners. This situation changed when Van Zyl

Smit published his book *South African Prison Law and Practice* in 1992. Departmental Orders have dubious legal standing and cannot be challenged in court.

Four categories of privilege exist: groups A, B, C, and D. After conviction prisoners usually start serving their sentence as group C. These categories are reviewed every six months. It therefore takes at least a year for a prisoner to reach category A, the most privileged position. Privileges determine all contact with the outside world: the frequency, duration and type (physical contact or not) of visits, and the number of visitors; the number of letters, cards and photos allowed; purchases (amounts and items); access to reading materials, libraries and study; the practice of hobbies and creative writing; permission to have radios, cassettes, TV or pets; telephone calls. These privileges, reviewed in 1992, are at present far more lenient than they were in the past (3c,12e).

There is also a category of group privileges. One such example is extra recreational time as a reward for good group behaviour. Group privileges can likewise be withdrawn to punish the group, a practice contrary to the United Nations Standard Minimum Rules, 63(1) and (3) (5c). The main objection to "privileges" is that any one of them can, at the whim of a warder, be suspended as an informal means of punishing a prisoner; it does not require conviction of a disciplinary infringement by an internal court (12e). It is a situation that is likely to be challenged in court following the introduction of a Bill of Rights in April 1994.

The Bill of Rights

For the first time in South Africa, the human rights of every citizen have been constitutionally enshrined in Chapter 3 of the (Interim) Constitution of 1994 (31). Constitutional rights have wide implications for the welfare of South African prisoners. Prisoners shall in future have protection from

> *"torture of any kind, whether physical, mental, or emotional, nor shall any person be subjected to cruel, inhuman or degrading treatment or punishment."*
> Section 11(2)

It reinforces the view that criminals are punished by restricting their freedom in prison, but that they retain their individual human rights (32) which may not be interfered with by the arbitrary punitive actions of prison officers.

In addition, the introduction of class action suits (31a) allows a prisoner or any other person to bring, on behalf of a group (of prisoners), a court action to uphold rights against infringements by the Correctional Services. If implemented by legal action

these protective mechanisms should, in future, provide a more humane prison environment. Furthermore, if the Government of National Unity is able to carry out the *Reconstruction and Development Plan* [RDP] for prisons over the next five years, their commitment to improving conditions of imprisonment is likely to bring about meaningful reform (33).

The establishment of constitutionally guaranteed rights for prisoners is a ground breaking move which creates a new legal and ethical framework for future prison reform. Crucial to such reform is the need to address the health care of prisoners, which is the central subject of this study. The laws which have impinged, directly or indirectly on the health and well-being of prisoners are reviewed below.

HEALTH CARE IN PRISONS

The first South African report to deal exclusively with prison health care matters was written in 1985 by a nurse in prison employ (34). It is a chronological survey of the laws and development of prison health services. Gordon points out that the "Convict Stations and Prisons Management Act" (1888) marked an early attempt to regulate care for prisoners. The more important aspects of this law, passed in the Cape, were:

1) an Inspector of Prisons and a doctor were appointed to visit prisoners;
2) the doctor was legally obliged to visit every prisoner in his district;
3) whenever a prisoner died the doctor had to issue a death certificate or order a post-mortem;
4) the (prison) governor could issue regulations with respect to clothing, food and other necessities for prisoners.

Act 23 of 1888 (34a)
(translated from Afrikaans)

For the next century the implementation of these regulations and the quality of service were not assessed.

For instance, before 1992 no study on the **delivery** of prison health care existed in South Africa. In that year the Department of Health, in consultation with the Department of Correctional Services, briefed the Human Science Research Council [HSRC] to undertake a research project on "The Evaluation of Health Services Available to and Accessible for Prisoners" (see Document 1). The HSRC study released to the public in July 1994 (35) examined health care **policy** .with reference to the Prisons Act (No 8 of 1959), accepted international declarations, and the Standard Minimum Rules for the Treatment of Prisoners adopted by the United Nations (5c). Interviews were conducted, usually in groups, with prison staff, health personnel,

prisoners and District Surgeons to ascertain their perceptions of prison health care. A wide range of topics was covered and a multitude of defects were identified and carefully documented, but not prioritised. Recommendations flowing from these findings were discussed under the headings of accessibility, effectiveness, capability, equity and affordability but this resulted in the duplication of points rather than the highlighting of important issues. Appending statistics on the "*volume of medical and nursing services to prisoners*" did little to redress the report's failure to focus on service at the point of delivery, to prioritise deficiencies or to back up suggestions for improvements with examples of workable programmes tried and tested in other countries around the globe. A crucial matter largely ignored in the report was, therefore, the interface between jailer and prisoner, which sets the tone in closed institutions and depends on the attitudes and conditions prevalent in the prison system. As so dramatically illustrated in the 1971 Attica Rebellion in the United States (36) and the Strangeways Riot in 1990 in Britain (37), prisoner vehemently objected to poor living conditions, degrading treatment and inadequate services.

Until 1992 stringent press regulations (discussed earlier) effectively blocked scrutiny and the publication of any prison material. Legally the only prison information to which the public had access were court records, namely:

* Inquests into the causes of deaths in custody. These included the death of Steve Biko (1977), Neil Aggett (1982), M Motaung (1982), Simon Mndawe (1983) (38a,39a), Nazo (1986) (39a), Simon Marule (1987) (40), Alfred Makaleng (1988) (41a), the Straitjacket Case (1989) (42,43) and the Gluckman Files (1992) (44,45).

* Supreme Court Interdicts to stop harassment and torture of inmates: the interdict by Dr Wendy Orr (1985) (38a,39a), and several cases brought by individuals (39b).

* Civil action for damages (purportedly resulting from maltreatment) against the Minister of Law and Order. These cases were mostly settled out of court without admitting liability (46). Settlements to compensate victims of violence were costly to the State: R1.86 million (1986/87 financial year) (47), R3.44 million (1987/88 financial year) (48), and R2.67 million (1988/89 financial year) (49).

It was only the Nazo, Marule, Makaleng and Straitjacket cases which dealt specifically with health care in custody; all the others related to abuse and torture during interrogation. With regard to political imprisonment in particular, the "forces" of law

and order were granted wide ranging powers during the States of Emergency. These powers were embodied in the Public Safety Act and described in Emergency Laws (1986-1990), as discussed below.

Detention Laws

The **Public Safety Act** of 1953 gave the State President the power to declare a State of Emergency. When the 1986-1990 States of Emergency [SOE] were declared all members of the police, army and ***prison services*** (my emphasis) had the right to detain, without a warrant of arrest (50a), any person who in his/her opinion endangered public security, the maintenance of public order, or the termination of the State of Emergency(50b). Such a person could be detained for an indeterminate period without providing reasons for his/her arrest. The disclosure of a detainee's identity within the first 30 days of detention was permitted only with written permission from the Minister of Law and Order. After this period had lapsed, the names of detainees had to be tabled in parliament (if sitting) within 14 days. Detainees could be subjected to interrogation. They had access to a prison doctor, but their access to lawyers and the courts was restricted (12f). When the 1987 State of Emergency was declared, emergency detainees were given awaiting-trial status (51). As a result all detainees, including children, "*were subjected to a strict code of discipline. Offences including idleness, insolence, singing, whistling and conversing with another detainee without permission were punishable by solitary confinement (for up to 30 days), deprivation of food, corporal punishment or a fine*" (52).

The **Internal Security Act** [ISA] 74 of 1982 made provision for 4 types of detention. Only 2 of these have a bearing on this survey:

***Section 29** [Sec 29] allowed for incommunicado detention for the purpose of interrogation until all questions had satisfactorily been answered, or until further detention would serve no useful purpose. After 30 days, written authority was necessary to extend the detention period to its full 180 days. Once the 180 days had lapsed, written reasons had to be given to extend the detention period by a further 90 days. Thereafter, detention had to be reviewed every 90 days (53a).

***Section 50** [Sec 50] allowed for "short term" detention of 14 days, granted by a magistrate, for persons suspected of contributing to public violence, disorder or riot (53a)

Extra-parliamentary political activities were severely repressed during the latter half of the eighties. On 21 July 1985, a partial State of Emergency was declared in 36

magisterial districts and repealed on 7 March 1986. A national State of Emergency was declared on 12 June 1986 and acted retrospectively for one week (54). Second, third and fourth States of Emergency were imposed on 11 June 1987, 1988, and 1989 respectively. The national State of Emergency finally lapsed on 11 June 1990 (55). As the four national States of Emergency continued without a break from June 1986 to June 1990, they are collectively referred to as "the State of Emergency" [SOE] throughout this study.

State of Emergency regulations and Sec 29 were the main forms of detention (without trial) applying at the time that the subjects interviewed in this study were imprisoned. Officially all detainees had a right to decent living conditions, a change of clothes, toiletries and to a "reasonable" period of exercise. In the event of prisoners complaining or showing symptoms of illness, the services of a doctor had to be called on. Significantly, state-employed doctors were supposed to enjoy clinical independence and their instructions for the health care of prisoners were ostensibly enforceable, without delay or interference from prison officials (56,57). The important difference between SOE and Sec 29 detention was that Sec 29 detainees were denied any contact with the outside world (see Table A).

Detention for the purpose of interrogation (Sec 29) was for practical purposes to procure evidence by way of torture (46). Held in isolation, these detainees were completely at the mercy of their captors. Deaths of activists in custody usually involved Sec 29 detainees. The negative press that these cases received led to the introduction of precautionary measures when Section 6 of the Terrorism Act No 83 of 1967 was superseded by Section 29 of the Internal security Act No 74 of 1982 (58):

* the District Surgeon [DS] had to visit Sec 29 detainees, routinely, at least once a fortnight (58a);
* the Magistrate had to visit Sec 29 detainees routinely every fortnight (56a);
* the Inspector of Detainees had to visit Sec 29 detainees in private and submit reports as often as possible (58b,59);
* visits by judges were permitted but optional.

Complaints laid before the doctor, magistrate or inspector of detainees were to be submitted in writing to the head of the detention facility (58c).

In an independent survey, on detention and torture (1982), Don Foster documented the practice, methods and the short and long term effects of political incarceration. This work, slated by the incumbent government, was never banned (53b). It dealt with the physical and psychological effects of torture on the victims but not with their medical care.

Organisational Responses

The seven-month partial State of Emergency of 1985 resulted in massive detentions (officially 7996) (60). In support of detainees the National Medical and Dental Association [NAMDA], launched in 1982 as a nongovernmental professional organisation concerned with human rights and opposed to apartheid (61), arranged for the routine screening of detainees after release. Records kept by NAMDA demonstrated that:

* less than half of the (ex)detainees (n=131) received medical care, and that about a quarter never saw a doctor while in detention;
* there was a correlation between patients' allegations and the physical findings in two thirds of the cases who alleged assault (n=97) (62).

In 1987 one of the members of NAMDA published his clinical findings related to torture. This provoked a court order to disclose the identities of patients or, alternatively, face a 2-5 year jail sentence. These charges were eventually dropped in February 1989 (41b). Further attempts by NAMDA to counter neglect and abuse of detainees included:

* encouraging general practitioners (and relatives) to inform District Surgeons about the condition and management of detainee patients whose health was vulnerable viz. diabetics, epileptics, asthmatics and hypertensives;

* training community health workers [CHW] in first aid to render an emergency service should professional help not be available for victims of violence resulting from confrontations with the forces in the townships (63);

* the development of an examination protocol to guide District Surgeons which was submitted to the Department of National Health and Population Development [DNHPD]. On its behalf, the Medical Association forwarded the guidelines to all doctors rendering a service in prisons (District Surgeons and MASA panelists) advising them, in view of the length of the form, rather to keep adequate records (64).

These efforts on behalf of detainees were unevenly applied and in general limited to two or three metropolitan areas. Although adverse international criticism about the shortcomings of medical services for those in custody received little domestic support, some progressive organisations like NAMDA, Detainee Parents Support Committee [DPSC], Emergency Services Group [ESG], and the Organisation for Appropriate Social Services in South Africa [OASSA] took on the task of familiarising themselves

with the meaning, conditions and effects of detention without trial. Training workshops (under constant surveillance) were started to inform those at risk of political detention about their rights (65). This way they learnt about their rights to better and healthier living while in detention, and how to keep fit and healthy. Common criminals, on the other hand, have not had the benefit of information and education of this kind.

The established medical bodies, however, reacted differently to the issues of how detainees were being treated while in detention.

The South African Medical and Dental Council [SAMDC or Council] was established in 1928 by Act of Parliament (66). It is the guardian of the "*prestige, status and dignity of the profession*" (67) and the protector of the public against unethical practice and negligence. Its work, therefore, entails the setting of standards for professional qualifications and ethical conduct and the registration of medical and dental practitioners who are adequately qualified (66, 68). In addition, it advises and informs the Minister on important health related matters (69). All doctors practising in South Africa must pay an annual registration fee to the SAMDC. Until September 1994 (70), the SAMDC consisted of 34 members (Act 56 of 1974): 20 members were official appointees and 14 elected by registered doctors and dentists (66).

Complaints, usually emanating from the public, related to breach of professional conduct are submitted to Council. All these complaints are first screened by a Committee of Preliminary Inquiry, one of several committees constituted annually by Council. It consists of 5 members: the President (or vice-President) of Council, 3 doctors and another (2 of the 4 need not be Council members). This committee assists Council in establishing whether sufficient evidence exists for further enquiry (cf the function of the Attorney General). The case is then referred to the Disciplinary Committee for investigation (71a,72). The latter has "quasi-judicial" powers to investigate allegations of improper or disgraceful conduct of registered practitioners. It may caution or reprimand the party concerned, or recommend suspension or elimination from the medical register. Before such penalties are imposed they must be approved by the full SAMDC (68,73).

The Medical Association of South Africa [MASA] is a voluntary professional organisation established in 1927. It looks after the business interests of doctors, and is affiliated to the World Medical Association [WMA] along with representative bodies of other member countries. Until the 1980s MASA did not accept medico-ethical responsibilities (74), as these were perceived as the province of the SAMDC (67). Accordingly, its official journal, the *South African Medical Journal* [SAMJ] curtailed

publication of critical comment (75) and documentation on detention, compiled by organisations such as NAMDA (38b). A case in point was the exclusion of one of four papers presented at a symposium at the Witwatersrand University on "The Health Care of Detainees - the law, professional ethics and reality" when only 3 were published in the SAMJ (76). The Lancet, however, had no such qualms when some months later it published the article raising controversial issues, related to the professional independence of doctors and their compliance with the system, by Dr G McCarthy (77).

The Biko Affair

Between 1960 and 1990 the 72 reported deaths in custody (78) repeatedly drew international attention to conditions of detention in South Africa. The death of Steve Biko, an internationally famous Black Consciousness leader, on 12 September 1977, brought the medical and ethical treatment of detainees into sharp focus at home and world-wide (see Appendix 2).

The inquest into the cause of Biko's death, held in November 1977, was presided over by the Chief Magistrate of Pretoria and 2 assessors, both forensic pathologists. They found no single person guilty of an act or omission resulting in his death, even though this was due to extensive brain damage. Relevant portions of the inquest record relating to medical conduct were forwarded, as required by law, to the SAMDC for possible disciplinary action. The Ombudsman of the SA Council of Churches, Eugene Roelofse, also raised questions about the conduct of the District Surgeons with the SAMDC. Council, however, found no cause for instituting a disciplinary investigation (71b). Next, two separate medical groups petitioned Council to pursue the matter, but both failed in April 1983. Then, in November 1984 six doctors appealed to the Supreme Court to order the SAMDC to hold a full and open disciplinary hearings, and their application succeeded. The resulting disciplinary investigation of 1985, eight years after Biko's death, found the two District Surgeons, Lang and Tucker (79), guilty of:

* failure to take a proper medical history or to ask the patient what happened;
* failure to examine the patient properly;
* failure to keep proper bedside records;
* issuing a false certificate;
* failure to monitor the patient's condition (recommended by the consultants);
* not examining the patient before transferring him;
* not insisting on transportation by ambulance with a proper medical escort (79).

Dr Lang, guilty of improper conduct, was cautioned and reprimanded. Dr Tucker, guilty of improper and disgraceful conduct, was struck off the medical register by the SAMDC (a few months later) (67).

The failure of the SAMDC to discipline the questionable conduct of the Biko doctors had international repercussions. The MASA, which was already under pressure as a result of South Africa's apartheid policies, also became involved in prison affairs (see Appendix 3). In 1975 the Japanese government had denied the MASA visas to attend the WMA meeting in Tokyo. According to MASA, a founder member, this decision was not in line with WMA rulings (80). Under mounting pressure the MASA withdrew from the WMA in 1976 (81). Five years later, at the World Medical Assembly in 1981, the MASA was readmitted (82). As a result the British and several African members resigned from the WMA. Together with the Canadian and some European Associations they formed the "Toronto Group" to protest the WMA's stand and action. By 1992 the protesters had rejoined, but the British elected to remain outside the WMA (83a). The British Medical Association hereby affirmed its stand that a prison doctor could be regarded as participating in torture if a consultation took place:

> " * *immediately before, during or after torture*
> * *without the free consent of the prisoner*
> * *with either the prisoner or the doctor not being free to identify themselves (or with the doctor refusing to be identified)*
> * *where the doctor acted in the interests of persons other that the prisoner."*
>
> Medicine Betrayed, BMA 1992 (83b)

Within months of the readmission of MASA to the WMA, Dr Neil Aggett hanged himself while in detention at John Voster Square, Johannesburg, on 5 February 1982 (84). This happened two days after the Minister of Law and Order had assured parliament that "*every possible measure was taken to ensure detainees could not injure themselves or commit suicide*" (85,86). No reasons were given for ignoring Aggett's requests to see a doctor, nor why the magistrate (38c) and inspector of detainees were denied access to him (87,88).

In May 1982, under domestic and international pressure, MASA announced the establishment of an Ad Hoc Committee under the chairmanship of S. A. Strauss (Professor of Law, University of South Africa) to inquire into the medical and ethical care of prisoners and detainees (89). Their report, submitted to the Minister of Health (90), was published in a Supplement to the SAMJ on 21 May 1983. Evidence had

been collected from concerned individuals, organisations, District Surgeons, forensic pathologists and State Departments. It was apparent that there were deficiencies in the medical care and, on occasion, serious maltreatment of detainees. They found that defects in the system were due to a lack of appropriate legislation and safeguards. They proposed that the medical care of detainees and prisoners be statutory defined under one law and that all inmates be informed of their medical rights. Legislation would also guarantee the District Surgeons full clinical independence and unrestricted access to detainees. In cases of obstruction to duty, MASA would support appeals by a District Surgeons to the Department of National Health Population Development [DNHPD]. The safeguards recommended were that:

* detainees have access to a private doctor of their own choice;
* a peer review body be established with access to detainees and to records, and be permitted to examine detainees;
* weekly physical and psychological assessments be introduced for those in isolation;
* assaults and injuries be recorded while at the same time respecting confidentiality (89).

It took one and a half years before the government responded to this report. It agreed, in October 1985, to the formation of a panel of independent doctors to which detainees would have access (91). All the other recommendations were turned down (92). In announcing this "breakthrough" the MASA stated that detainees would in future be able to obtain a second opinion "*if for any reason they were not satisfied with the care provided by District Surgeons*" (93). The state retained control by setting several preconditions for a doctor to become a member of the panel:

* (s)he had to be a member of MASA and approved by the MASA executive (91) ;
* (s)he had to obtain security clearance (94);
* treatment prescribed by a panel doctor was subject to approval by the DS (91).

The names of panellists were not made public (94). The MASA assumed that detainees would be informed of the existence of the MASA panel on arrest, but this was not implemented (95). It is not clear whether the names of panellists were supplied to detainees on request, or whether the District Surgeon provided information about the service and a name once the detainee asked to see a different doctor (94).

By February 1987, panels for consultation were in place at 20 of the MASA's 21 regional branches (38d). Two years later the MASA admitted that the panels were not functioning (96,76). Their failure to agree on a mechanism and a date of

implementation made a mockery of the MASA's efforts and intentions to provide an alternative medical service for detainees. In addition, it appeared that the Security Police [SP] were not aware of the existence of these panels for medical referral (S Kay, Convenor of the Panel, Southern Transvaal - personal correspondence 26/5/89). Finally, in June 1989, the MASA were told that the Security Police had been instructed to inform all Sec 29 detainees about the panels. The detainees were to sign a written declaration to this effect and pay for any consultation (see Document 2). However, the security forces argued that emergency detainees could, on the recommendation of the District Surgeon, obtain a second opinion and therefore had no need for such concessions (97). This view, which left the prerogative of medical referral in the hands of the District Surgeon, nullified the notion that detainees should be allowed to request independent examination by a doctor of their own choice. Referral has always been the District Surgeon's prerogative (98).

Action by Detainees

As one State of Emergency followed another, after June 1986 the repression intensified. Security measures had been tightened to such an extent that opposition politics was at a virtual standstill. By 1989 detainees, some of whom had been incarcerated since June 1986, decided that they had to take action or "*rot in jail*" (see Appendix 4). On 23 January 1989, 26 detainees started a hunger strike at Diepkloof prison, near Johannesburg, to draw attention to their plight. It soon spread to prisons throughout the country (41c). In all, 644 detainees joined the hunger strike (99a). They demanded to "*be charged or released*". Hunger strikers were warned that they would not be released unless they started eating again. By the end of April all the hunger strikers had resumed eating. By August, all leading activists had been released, although the majority of them were severely restricted. During the latter half of 1989 the crisis in schooling and the defiance campaign resulted in 3709 more detentions (99b). Despite the unbanning of opposition political organisations (African National Congress, South African Communist Party, United Democratic Front) on 2 February 1990, the State of Emergency was not repealed. But indefinite detention was curtailed to six months and detainees were granted access to lawyers and doctors of their choice. The (fourth) State of Emergency finally lapsed in June 1990 (12g).

In June 1991 the period of detention allowed under Section 29 of the Internal Security Act (incommunicado detention for the purpose of interrogation) was reduced from 180 days (with 90 day increments permitted) to 10 days (100). In this revised form, Sec 29 remained in force until 29 April 1994, when it was abolished (101).

In summary, until 1994 highly repressive detention laws in South Africa rendered political prisoners vulnerable to severe punishment, solitary confinement, interrogation and torture, with serious consequences for their physical and mental health, if not their lives. At the same time, limited legal provisions for their medical care were poorly enforced, and attempts to secure access to independent doctors were undercut by the state. It is to establish a more precise record of the health conditions of detainees under this system, as a basis for proposing measures for improving prison health care in South Africa, that this research has been undertaken, as the subsequent chapters will reveal.

Appendix 1:

Harold Strachan's Press Revelations

Strachan's revelations (about Pretoria Central and Pretoria Local prisons) reiterated previous claims of inadequate clothing, freezing cells with concrete floors, sleeping on felt mats with four thin blankets and poor hygiene and sanitation. He described living and eating surrounded by stench and filth, slopping out into the same trough from which drinking water was collected and in which eating utensils and clothing were washed; having to take cold showers on frosty mid-winter mornings while shower rooms supplied with hot and cold water remained unused and spotless awaiting inspections; confinement to cells with nothing to do for most of the day; the difficulty of several prisoners performing ablution tasks during their limited (20-30 minute) exercise time; delays in obtaining permission to study and devices to obstruct prisoners from obtaining prescribed books. The flush toilets of North End Prison, Port Elizabeth, were a comparative luxury even if prisoners were compelled to wash their faces and brush their teeth in the cistern water.

He made revelations about medical treatment which on occasion amounted to "assaults on the patients themselves". In full view of spectators, naked prisoner patients were given enemas and made to discharge their bowels while being hit. Prisoners so ill that they had to be carried to the prison hospital were kicked and beaten. All new intake prisoners underwent routine examinations. They waited, naked and barefoot in the morning frost, from six to nine to be seen at the prison hospital.

Rand Daily Mail, 30/6/65 - 2/7/65

Appendix 2: The Biko Case

(a) The Detention and Death of Steve Biko Case (56, 67)

18 Aug 1977: Steve Biko was detained under Section 6 of the Terrorism Act, 1967 (later Sec 29 of the Internal Security Act, 1982). He was held naked in solitary confinement at Walmer police station, Port Elizabeth for 18 days.

6 Sept 1977: Biko was removed from the police station to local SP headquarters for interrogation.

7 Sept 1977: Biko "would not speak" (?stroke/shamming). The DS examined Biko on the floor. No abnormality was recorded despite an ataxic gait and slurred speech (38a).

8 Sept 1977: Physical examination by 2 DSs revealed a possible left extensor planter reflex. Biko was transferred to a local prison hospital. That night a consultant physician examined Biko on a couch at the Sydenham prison hospital and confirmed echolalia, an ataxic gait, weakness of left arm/leg, and a left extensor planter reflex.

9 Sept 1977: The consultant did a lumbar puncture: the cerebro-spinal fluid contained red blood cells. He consulted a neurosurgeon by telephone who advised regular observations.

10 Sept 1977: Biko was returned to the Walmer police cell. No medical observers were available there.

11 Sept 1977: Biko deteriorated. He was hyperventilating and frothing at the mouth. The senior DS detected weakness of his left arm. SP refused admission to general hospital and arranged his transfer to Pretoria prison hospital. Biko was transported 700 miles naked, handcuffed and alone in the back of a Landrover (71c).

12 Sept 1977: Biko arrived in Pretoria without medical records. The Pretoria prison doctor put up a drip. Biko died later that day.

17 November to 2 December 1977: An inquest was held before the Chief Magistrate of Pretoria and 2 assessors, both Professors of Forensic Medicine, to establish the likely cause of Biko's death. They found that death was due to extensive brain damage and renal failure with uraemia, and that the injury was probably sustained during a scuffle with the Security Police on the morning of 7 September. No person was found guilty of an act or omission leading to the death.

In terms of the Medical Dental and Supplementary Health Services Professions Act of 1947, the magistrate forwarded relevant portions of the inquest records to the SAMDC for their attention (38a,71b).

(b) The Aftermath of the Biko Case

20 Dec 1977 Eugene Roelofse, Ombudsman of the SA Council of Churches [SACC], wrote to the SAMDC drawing attention to the evidence of the Biko inquest (71d).

9 Jan 1978: The Chief Magistrate sent portions of the inquest records to the SAMDC for scrutiny (71d).

16 Jan 1978: Roelofse delivered a formal complaint to the SAMDC. He requested that it establish whether the conduct of the doctors concerned met professional standards (71d).

March 1978: In a civil case the Biko family claimed R90,000 damages from the Minister of Health and of Police (38a,102a).

11 May 1978: The Minister of Justice announced the appointment of two retired magistrates to visit detainees held under Sec 6 of the Terrorism Act. One Inspector of Detainees was responsible for the Cape and Natal, the other for the Transvaal and Free State (102b).

27 July 1979: In an out of court settlement the Biko family received R65,000 without the state admitting liability. The SAMDC suspended the enquiry into the conduct of the DSs for the duration of the civil case (38a).

24 April 1980: The SAMDC's Committee of Preliminary Investigation found no reason to take further action (71d).

17 June 1980: The full SAMDC considered and adopted the decision of the Preliminary Inquiry by 18 votes to 9 (71d). In response, Dr BT Naidoo resigned as member of the SAMDC (103).

July 1980: The Boards of the Medical Faculties of the Universities of the Witwatersrand [Wits] and Cape Town [UCT] dissociated themselves from the decision of the SAMDC (38a).

August 1980: The Federal Council of the MASA agreed with the SAMDC that "the case be closed." Several members of the MASA resigned in protest (38a).

17 Feb 1982: Five doctors submitted detailed documentation to the SAMDC and requested it to hold a "full and open enquiry" into the ethical conduct of the DSs who had treated Biko (71d).

18 March 1982: The Health Workers Association (black doctors, dentists, pharmacists, nurses and paramedics) lodged a list of complaints against the 2 DSs with SAMDC (71d).

4 March 1983: The Committee of Preliminary Inquiry found no new evidence to support the complaints and no reason to open the case (71d).

25 April 1983: The SAMDC adopted the recommendations of the Committee of Preliminary Inquiry (71d).

November 1983: Six doctors appealed to the Supreme Court to set aside the SAMDC's decision. They claimed that the SAMDC had neglected its statutory duty when it failed to discipline the DSs and that this had damaged the reputation of the South African medical profession (67). By requesting that the court order a disciplinary hearing, they shifted the focus from the DSs to the SAMDC. (104)

30 Jan 1985: From the evidence placed before it the court judgement found that the SAMDC had "*not applied its mind*". The court ordered the SAMDC to establish a Disciplinary Committee to investigate the conduct of the doctors (71e).

1-4 June 1985: The Disciplinary Committee, was presided over by the President of SAMDC (chair) with Judge Trollop as assessor (79).

5 July 1985: The Disciplinary Committee's findings were:

* Dr Lang, guilty on 8 counts of improper conduct, was cautioned and discharged;
* Dr Tucker, guilty on 10 counts of "disgraceful and improper conduct", was suspended from practice for 3 months, this sentence being suspended for 2 years. (105).

October 1985: The full SAMDC considered the penalty recommended and decided to strike Dr Tucker off the medical register (38a,67). Dr Lang took over as Chief DS of the region.

Oct 1991: Dr Tucker expressing remorse asked the SAMDC for pardon and re-registration. This was done (106).

June 1994: Dr Lang resigned, but returned as part-time DS (4 hours, 5 days per week) (Dr Lang - personnel correspondence, 1996).

Appendix 3: Interventions by MASA

Oct 1975: The Japanese government refused members of the MASA visas to attend the WMA Meeting, Tokyo (80).

Oct 1976: The MASA, under international pressure, withdrew from the WMA at the meeting in Sao Paulo, Brazil (81).

18/19 May 1981: An independent Ad Hoc Committee (Advocate I. A. Maisels and Professor J. N. de Villiers, Medicine) appointed to examine ethical issues related to the Biko case (107), heard evidence in Port Elizabeth (108).

23 June 1981: The Ad Hoc Committee recommend legislation to enforce the clinical independence of DSs free from interference by detaining authorities (108).

3 Oct 1981: The MASA was readmitted to the WMA. The Transkei Medical Association was admitted to the WMA despite the fact that only SA officially recognised Transkei's independence. At this meeting a declaration of patient rights was accepted by the WMA, the "protectors" of medical ethics. Medical participation in capital punishment was declared unethical (82).

5 Feb 1982: Dr Neil Aggett (26) a Sec 6 detainee (later Sec 29) hanged himself (84). He was deeply depressed after 62 hours of interrogation (85) and electric shocks (109). He was the ninth person after Steve Biko to die in detention (110).

May 1982: The Parliamentary Committee of the MASA was instructed to investigate the medical and ethical aspects of the care of detainees and prisoners. An Ad Hoc Committee [AHC] was established for this purpose (89).

23 Sept 1982: A Contact Group of the Medical Schools at Cape Town [UCT], Natal and Witwatersrand [Wits] submitted *Recommendations Relating to Health Care of Detainees* to the AHC. They condemned solitary confinement and prolonged interrogation (38c).

30 Sept 1982: Detainee Parent Support Committee [DPSC] submitted a *Memorandum on Security Police Abuses of Political Prisoners to the AHC* (38c).

Oct 1982: The Centre for Applied Legal Studies at Wits submitted a document concerning the *Health Treatment of Detainees* to the AHC (38c).

21 May 1983: The report of the MASA Ad Hoc Committee was released. Safeguards and appropriate legislation were recommended (89). A copy was submitted to a DNHPD (90).

20 Oct 1985: The Minister of Law and Order agreed to the establishment of panels of doctors from which detainees could select a doctor. The conditions for panel membership were: only MASA members, approved by the Executive and Federal Council, were accepted. Members would **advise** DSs about treatment. Names of panellists would be made available on request (91). Doctors recommended by DPSC and NAMDA were turned down (38d).

Jan 1986: *The Lancet* claimed that members of the medical panel underwent security clearance (111,94). The Minister of Law and Order and the Commissioner of Police retained power of access to all Sec 29 detainees (38d).

7 March 1986: MASA considered the *Protocol for the Examination of Detainees by District Surgeons* compiled by Wits Medical Faculty. Copies were sent to all panel members as a guideline. They advised that DSs rather keep adequate records (91).

21 April 1986: The SAMDC's Chairman reported on an investigation of the Public Safety Act (1953) & ISA (1982): the MASA panel of doctors met approval; police interference with the place or nature of doctors' orders was forbidden. It further recommended that prison and detention rules and regulations be published in a single act easily available to DSs (89,91).

June 1986: The Secretary General of the MASA confirmed that panel doctors were subjected to security clearance (94).

19 July 1986: The editor of the SAMJ stated that "*if for any reason they were not satisfied with the care provided by DSs*" detainees would have recourse to a member of the panel of doctor (93).

5 Sept 1986: A parliamentary reply stated that, between July and August, 154 doctors were appointed to the panels (94).

Feb 1987: MASA panels were formed at 20 of the 21 regional branches in the country (38d).

May 1987: No use had been made of the MASA panels(81).

20 June 1987: The SAMJ published a supplement on *Children in Places of Detention: a code for their handling*, prepared by the SA Paediatric Society (112).

1 Sept 1987: Statement by the Minister of Health: when detainees request a second opinion they are informed about the panels; the names of MASA panellists are confidential, they are made available to detainees or their parents on request (94,113).

13 Nov 87: The DNHPD rejected psychiatrists and specialists as panel members (92).

22 Feb 1988: DSs were to inform detainees about the MASA panels and supply their names if the detainee asked to see another (private) doctor (92).

Feb 1989: Detainees were not gaining access to panellists. Access depended on a referral by the DS (94). The only request for a panel doctor to the Natal Inland branch of MASA, was turned down by the authorities (95).

26 May 1989: The Southern Transvaal Branch reported only one request for a MASA panel doctor. SP in the S Tvl were not aware of the existence and function of the panels (S Kay, Convenor of S Tvl panel - personal correspondence).

June 1989: The security police were instructed to inform all Sec 29 detainees about the MASA panel and to have a written declaration to this effect signed (see Document 2) (97). This did not apply to emergency detainees who had access to second opinions via the DS (98).

5-7 June 1989: The MASA's statements on civil unrest: "*On medical grounds, the MASA deplores detention without trial. . . . MASA rejects the detention of children without trial*" (97).

1 June 1991: The editorial independence of the SAMJ was emphasised and the reluctance to publish critical opinions about the Biko case was regretted (93).

May 1994: Published for discussion: a Code of Conduct for MASA members (114) and a Charter of Patients Rights (115).

Appendix 4: Action by Detainees

23 Jan 1989: Detainees embarked on a hunger strike. This spread to prisons throughout the country (41c).

11 May 1989: The Minister of Law and Order announced that between 1 Jan and 30 April 644 detainees participated in the national hunger strike. All had resumed eating by 30 April (99a).

Aug 1989: All leading activist had been freed; many were severely restricted (99b).

2 Feb 1989: Indefinite detention (under emergency regulations) was limited to 6 months. Detainees were allowed access to lawyers and doctors of their choice (99b).

11 June 1990: The State of Emergency lapsed.

June 1991: Detention under Sec 29 of ISA was reduced from 180 to 10 days (100). Amendments included: informing relatives of name and place of detention; limited legal access; physical examination soon after arrest; inspections by the DS and magistrate every 5 days to be documented; permission to see private doctor in the presence of a DS. All these safeguards were subject to approval by the security police.

29 April 1994: Sec 29 of ISA repealed (116).

Table A: State of Emergency and Section 29 Regulations.

RIGHTS/ACCESS	SOE DETAINEE	SEC 29 DETAINEE
Period of detention	Indefinite	180 days (incr by 90 day increments)
Holding place	14 days maximum in police cell	Isolation, anywhere.
Decent living conditions	Yes	Yes
Extra clothes/toiletries	Yes	Yes
'Reasonable' exercise	Yes	Yes
Health care/DS	Yes	Yes*
Prison minister	Yes	Yes
Bible or Koran	Yes	Yes
Legal advisor	Yes (with permission)	No
Family contact	30 min fortnightly	No
Letters/cards	Yes, (number varied)	No
Books/newspapers	Yes, (with permission)	No
Study rights	Yes, (with permission)	No
Recreation (ball/board games)	Yes, (with permission)	No

* Permission to see a member of the MASA panel was granted in 1986.

Document 1: Announcing the HSRC's Research on Health Services Available to Prisoners.

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT
DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING

Private Bag/Privaatsak X828, Pretoria, 0001. Tel: 012-3255100
Fax/Faks (Media Liaison/Mediaskakeling): 012-217960

Press Release/Persverklaring

Embargo: IMMEDIATE RELEASE **Ref/Verw:** 5/92 (D)

THE EVALUATION OF HEALTH SERVICES AVAILABLE TO AND ACCESSIBLE FOR PRISONERS

The Department of National Health and Population Development has, in consultation with the Department of Correctional Services, decided to request the Human Sciences Research Council (HSRC) to do research regarding the medical and nursing services rendered to prisoners.

The need for research arose from the overall terrain of responsibility of the Department of National Health and Population Development. The health care services are evaluated on a regular basis as needs and realities change. Health care to prisoners is seen as an important element of health care services in general.

The research will be done according to the following framework :

- The Correctional Services Act, 1959 (Act No 8 of 1959)
- Other applicable legislation and international citeria
- The National Health Policy, namely the rendering of a comprehensive health service on primary, secondary and tertiary levels, measured by the criteria of accessibility, acceptability, affordability, effectiveness and equitability.

The recommendations or findings arising from the research should provide a useful basis for future development of policy in the interest of health care to prisoners in the Republic of South Africa.

ends

Pretoria DATE : 10 February 1992

Document 2: The Right of Section 29 Detainees to see a MASA Panel Doctor.

Form given to detainees advising them of available health services. (Because of the poor quality of the original, it is retyped here; the text is unchanged. Emphases are in the original.)

I, ... declare that I have been informed that the services of a district surgeon will be at my disposal should I need such services for some or other reason during the period of my detention in terms of Section 29 of the Internal Security Act 1982 (Act 74 of 1982). The services of a district surgeon would be rendered free of charge.

I am further informed that there is a panel of private surgeons at my disposal should I not be satisfied with the services of a district surgeon. I am further advised that I am entitled to make use of the services of *only one* of the surgeons on the panel of private surgeons and that I shall direct any request for the services of a panel surgeon to the district surgeon, who in turn will then contact the designated panel surgeon. I understand that should I make use of this offer, I would be held personally liable for *all the costs* which may result from using the services of such private surgeon. I understand that before acceding to my request, a guarantee for such costs can be asked of me.

PLACE .....
DATE .....
TIME .....
SIGNATURE OF DETAINEE .....

.....
SIGNATURE AND RANK OF MEMBER
INFORMING DETAINEE OF HIS RIGHTS

WITNESS .....

1059

From:

Apartheid Medicine: Health and Human Rights in South Africa. Washington DC: AAAS, 1990.

METHODOLOGY

As discussed above, the focus of this study is on health care in prisons. Torture has been covered in other reports (NAMDA and Don Foster).

METHOD

Study Design

A **cross-sectional descriptive study** was designed to record the experiences of providers and recipients of health care in South African prisons and police stations. It was a **quantitative study** based on personal interviews with each subject, using a **semi-structured questionnaire** with selected open-ended questions to elicit **qualitative** information.

A **qualitative study** records the "*meanings patients place on illness events in relationship to themselves and their environment*" (1). The qualitative study was based on data recorded in the form of:

* explanations of replies or descriptions of procedures, mentioned in preceding questions, given during interviews
* seven case studies (reconstructed from interviews) which illustrate the individual experiences of women, mothers with babies and children (under 18).
* experiences of women in the North End Prison, Port Elizabeth.

Despite several attempts, permission to explore the working conditions of health care providers serving the prison system was not granted. Details of this process are discussed later.

Target Population

The State of Emergency (1986-1990) created a unique group of political prisoners who realised the need to enlist outside help to highlight prison conditions. This group comprised those persons labelled "detainees". A detainee is a person held in detention for security reasons without being charged or sentenced. In SA the term detainee has constitutional connotations of law and order as defined in the Internal Security Act (74 of 1982) and indirectly through the Public Safety Act (3 of 1953) as promulgated in the 1986 and subsequent States of Emergency (2a). It is estimated that since 1986 more than 50,000 people were detained under emergency regulations (3a) and that among them were 9,700 children under 18 (4). They form the target population of this

study. Information was obtained from a (small) sample of them after release from detention.

Before June 1992 (4) any information on conditions in South African prisons was severely restricted by law (5a). Therefore, at the time of these interviews (1991), collecting information on prison conditions was illegal.

Study Sample

1) **Study Period**: January 1987-December 1988.
In early 1989, some 650 detainees embarked on a nation-wide hunger strike thus provoking the authorities to release them (3c). Thereafter, relatively few people were detained, particularly in the Cape Province. In order to provide an adequate sample population, the study period was limited to persons detained between 1 January 1987 and 31 December 1988 when more people were being arrested.

2) **Sampling Area**: Eastern and Western Cape; urban & rural.
Residing in Cape Town, the researcher was aware of local conditions and patterns of detention. Having links with progressive organisations in the Western Cape, it was logical to include this region in the study. At the same time, the Steve Biko and Dr Wendy Orr court procedures drew national and international attention to and criticism of the plight of detainees in the Eastern Cape. It was therefore considered essential to include interviews with this group.

Urban and rural areas of the Eastern and Western Cape were examined to contrast the quality of care in prisons and police stations of different regions (see Maps 1, 2 and 3).

The Eastern Cape [EC]:

urban area included the Port Elizabeth [PE] magisterial district and Ibhayi Council.

rural area included Grahamstown, Cradock, Uitenhage and surrounding towns.

The Western Cape [WC]:

urban area included the municipal districts of Cape Town, Bellville and Wynberg.

rural area included the Boland, the Karoo as far as Beaufort West, and the South Coast as far as Oudtshoorn.

3) **Sample Size:** 80 -100

During the study period 334 people were detained in the Western Cape. Figures for the Eastern Cape, presumably higher and not readily available, were compiled by researcher from various sources (see Table B). Under the circumstances it was thought that a list of 80 to 100 names, provided by reliable sources in each region, and from which a sample of 40 to 50 could be drawn, would be representative.

4) **Demography**

The Prisons Act (8 of 1959) separated prisoners into several categories. They included the segregation of:

* "White" and "non-white" prisoners "*in such a manner as to prevent white and non-white prisoners from being in view of each other*" (5b). In July 1990, prison apartheid was revoked by the Prisons Amendment Act (6).
* Male and female prisoners (5c)
* Juveniles (18 to 21) from adults (2b)
* Unsentenced children (under 18) (5d)
* Sentenced and unsentenced prisoners (2b).

The separation of emergency detainees from other prisoners was a Departmental Order subject to provisions under the Prisons Act (2b).

For the sample to be widely representative of all prison conditions, an effort was made to include, where possible, individuals from all categories.

Measurement

The study involved personal interviews with detainees after their release, using a semi-structured questionnaire (see Appendix 12).

The questionnaire was designed to ascertain whether official regulations governing prison health in fact applied. Certain aspects of medical care in prison are determined by law (see Table C). In addition, the Department of Health provides District Surgeons with **guidelines** regarding conditions of incarceration, management and reporting of different categories of prisoner (7). These guidelines are not binding and cannot be challenged in court.

The questions, informed by these regulations, follow a logical sequence: demography, detention details, illness before detention, illness/injury as a result of arrest, illness during detention, assault during detention and care in isolation. The purpose was to determine the quality of care during detention and the attitudes of the doctors. With

the focus on health care, medical treatment was a recurring theme. Some of the 14 questions required detailed information.

As an introduction, a summary of the sequence of the questions was attached to facilitate clarity. The need for a racial classification was explained. The survey was carried out in that section of the community which, due to its political aspirations and related experience of imprisonment, regarded the purpose of the study as of paramount importance. The goals were set out clearly and confidentiality was guaranteed. Emphasis was placed on the value of honest answers if change was to come about.

A Xhosa translation was prepared and cross-translated. Being fully bilingual and accustomed to switching from English to Afrikaans during consultations, the researcher did not consider an Afrikaans translation. The questionnaire was submitted to epidemiologists, sociologists and psychologists for comment. The language of the questionnaire had to be simplified and scrutinised for technical terms and ambiguities. This was done by the language section of the Department of Adult Education at Cape Town University (Barbara Hutton, 16/2/90).

The questionnaire was printed on one side of the paper to allow space for more detail should the need arise. The 100 questionnaires were colour coded to represent each of the four areas surveyed.

All interviews were conducted by the researcher.

Ethics

The sampling method chosen was influenced by ethical considerations.

a) Confidentiality

Before the repeal in June 1992 (4) of the media regulations (5a), it was illegal to collect information about conditions in prison. However, the sample population consisted of released "detainees" who were concerned about human rights and prison conditions and who understood the risks attached in co-operating in the study. For their safety it was crucial that the information collected be confidential. As a precaution, a system of double coding (name converted to letters and then to numbers) was used. To ensure anonymity each phase of the coding was done by a separate coder so that no individual would be able to identify any respondent.

For security reasons it was inadvisable to use voice recordings of interviews. When respondent's remarks were significant they were taken down verbatim.

Alternatively, a synopsis of their comments was made and read back to the respondents to check for accuracy.

Each participant was given the assurance that doctor-patient confidentiality would be respected. For reasons of confidentiality, the researcher conducted each interview and processed the information herself.

b) Access

To obtain access to politically sensitive material it was necessary to establish credibility with relevant organisations. Therefore this protocol was endorsed by NAMDA. Other organisations involved in the development of the programme were: Detainee Parent Support Committee [DPSC], Emergency Services Group [ESG], Legal Education and Action Programme [LEAP], Lawyers for Human Rights [LHR], Legal Resources Centre [LRC], National Association of Democratic Lawyers [NADEL], Repression Monitoring Group [RMG] and South African Council of Churches [SACC].

It proved easier to contact ex-detainees through the offices of lawyers than doctors. The majority of detainees saw only a (state) prison doctor. On the other hand, lawyers who arranged that detainees received clean clothing, funds, food parcels, visits and privileges such as leave to study, often had direct or indirect (through the security police) contact with detainees. To make these arrangements they also had regular contact with detainees' families. Some legal firms engaged social workers to assist with these arrangements. In Cape Town they were central to the setting up of detainee parent support groups.

In contrast the first, and often only, contact a non-prison doctor had with the (ex-)detainee was when he conducted a post-release physical examination. Although encouraged, several ex-detainees were, for security reasons, reluctant to attend regular counselling sessions (8). Others perceived it as a weakness when "staying strong" was part of the struggle tradition.

A protocol of the study was submitted to the Ethics and Research Committee, University of Cape Town, and approved.

Coding

A personal computer was used to enter the data using the D-Base 111 package, and Epi-Info was used for the statistical analysis.

DATA COLLECTION

Pilot Study

A pilot study was undertaken to test the veracity of this survey. Five individuals were interviewed: 3 were political ex-prisoners (sentenced) and 2 were ex-detainees (from places outside the study region).

Each interview took between 3 and 4 hours. The long periods of imprisonment and consequent range of experiences may have contributed to the length of the interviews. Some participants seized this opportunity to talk freely about their traumatic experiences so that, to some extent, they also became therapeutic sessions. These personal stories were a source of important information related to health care.

Practical difficulties, experienced by township dwellers, were encountered, these comprised: lack of private telephones, bus-strikes, taxi-wars, political harassment, and vigilante attacks.

By and large, this pilot project proved valuable in validating the questionnaire.

Research Period

The field survey was conducted during a three month sabbatical (18 February - 19 May 1991). The first 9 weeks were spent in the Port Elizabeth (urban) and Grahamstown (rural) areas of the Eastern Cape. The remaining four weeks were spent in the Western Cape rural areas.

Fieldwork

1) Eastern Cape Experience.

Preparations

During a preliminary trip to the Eastern Cape (July 1990), key individuals were familiarised with the purpose and scope of the survey. In different areas, members of the ANC Youth League, Ex-Detainee Forum, regional Council of Churches, Legal Resources Centre and Black Sash were approached. They undertook to discuss the project with their constituencies, to mobilise the help of individuals, and to elicit community support.

Arrangements were made to conduct interviews from the offices of the Interdenominational African Ministers Association of South Africa [IDAMASA] in New Brighton, Port Elizabeth and from the Albany Council of Churches [ACC] in Grahamstown.

During this period lists were compiled of individuals detained, between 1 January 1987 and 31 December 1988, from the records held in the offices of the Black Sash, the Albany Council of Churches, and Legal Resources Centre (see Table B). These records were not complete as much of the information had been destroyed when the offices were ransacked and/or damaged by fire, but they helped to give some sense of the demographic composition of Eastern Cape detainees.

Obstacles

Interviews were scheduled to start in Port Elizabeth on 17 February 1991. The first week was unproductive; in 5 days only 2 interviews were completed. The pilot project had alerted the interviewer to missed/postponed appointments, but these delays were due to different factors.

(i) Coordinator

The coordinator, previously attached to the Ex-Detainee Forum, had since been seconded to oversee the pay-out of pensions, a task that kept him fully occupied. Once the problem had been identified, others stepped in to act as contact people.

(ii) Sampling

It was not possible to select a random sample:

* In the political climate of that time the vulnerability of ex-detainees was a major concern; participants were aware that they were breaking the law and of the personal risk they were taking.
* Contact with "volunteers" depended on organisational networks and the local grapevine; participation was a personal decision.
* On day trips to rural towns community leaders had the added responsibility of protecting their vulnerable communities while taking a virtual stranger on trust. They did this by initial apparent acceptance of my credentials, but always sat in on the interviews until they felt really confident of my integrity.

* The limited time spent in selected villages (4 to 6 hours), made sample selection impossible.

(iii) Delays

There were frequent delays and missed appointments, especially on Fridays. Friday is pay-day for weekly workers and several factories and businesses close early. Manual workers used this opportunity to shop for provisions.

Geographical Area

The Eastern Cape rural areas have been divided into two regions by the South African Council of Churches [SACC]: the districts of Albany and the Midlands (see Map 1).

Albany, with Grahamstown as its centre, includes Adelaide, Alexandria, Alicedale, Bathurst, Bedford, Cookhouse, Fort Beaufort, Kenton on Sea, Port Alfred, Riebeeck East and Somerset East. Originally Cookhouse and Somerset East fell under the Midlands. In 1986 the monitoring organisations in that region collapsed as a result of the detention of key activists. They then turned to Grahamstown for support. When the structures of the Midlands were re-instated in 1988, these two towns continued their affiliation with Grahamstown. Midlands has Middelburg as its centre and a strong presence in Cradock's Lingelihle township. It includes Graaff-Reinet, Aberdeen, Hofmeyr, Jansenville, Murraysburg, Tarkastad and previously Somerset East and Cookhouse. Addo, Kirkwood, Paterson and Uitenhage fall under the Port Elizabeth Council of Churches.

In Port Elizabeth interviews were conducted from IDAMASA's offices (see Map 3). On two trips to Uitenhage, 5 interviews (classified rural) were completed.

In Grahamstown, field workers of the Albany Council of Churches [ACC] arranged appointments and acted as escorts on trips to the small towns in the region. Port Alfred (twice), Alexandria, Cookhouse, Bedford, Adelaide and Fort Beaufort were visited. In each of these towns, two, and occasionally three, individuals were interviewed. Altogether seventy interviews were completed, twenty more than planned for the Eastern Cape.

The initial exclusion of the Midlands could not be sustained. Among those interviewed in Port Elizabeth was a youth from that region who urged that the much neglected Midlands region, devastated by detentions, be included. Field workers from the ANC regional office supported his pleas. A trip to the Midlands was therefore undertaken with him as escort.

A weekend trip (13-14 April) included visits to Steytlerville, Klipplaat and Aberdeen where seven people were interviewed. Murraysburg, off the beaten track, was visited later. On a separate day trip to Cradock, 3 more interviews were completed. Early in May, while collecting data in the Karoo, Murraysburg was included and two interviews completed. That brought the total interviewed in the Midlands area to 13.

Interviewing

With experience it became possible to reduce the interview time to about two hours. The care and thoughtful consideration with which questions were answered indicated the importance that respondents attached to honest replies.

Detention was clearly an unpleasant and traumatic experience. As individuals recalled certain episodes their slower speech, long pauses and deep sighs conveyed how deeply they had been affected. To continue pacing questions while keeping a balance between emotional support and gathering facts was mutually stressful.

The merit in conducting the interviews personally was that incidents mentioned with apparent casualness could be explored and significant factual information obtained after completing the questionnaire. These included:

i) The response of medical and prison staff to hunger strikes and how they were managed;
ii) The attitudes of nurses and medical orderlies;
iii) Ways of alerting prison staff to medical emergencies.

Documentation

Questionnaire interviews were supplemented by collecting relevant documentation e.g. court evidence (some related to medical mismanagement), sworn affidavits, debriefing reports and petitions. Petitions or demands for better conditions were, from time to time, submitted by detainees to the prison authorities. Copies of these petitions were smuggled out of prison. The

They included, for example, a meticulous record of the daily diet over 2 months preceding the 1988 hunger strike at St Albans. The 1989 (nation-wide) hunger strike was an important event which resulted in the release of the emergency detainees. It was documented in detail by Port Elizabeth detainees. Because they considered the conduct of one of the doctors unethical, they submitted a complaint to the SAMDC.

The Eastern Cape field work was completed by 19 April 1991. Altogether 27 interviews were completed in the urban and 30 in the rural region of the Eastern Cape, and another 13 in the (rural) Karoo.

2) Western Cape Experience

After 20 April, the four remaining weeks of sabbatical, curtailed by public holidays (Workers Day and Ascension Day), were used to plan and implement a programme of interviews in the Western Cape rural areas.

Preparation

The Repression Monitoring Group [RMG] supplied statistical details of detention according to age, sex and race for the period January 1987 to December 1988 (see Table B).

The regional office of NADEL agreed that affiliated legal firms would provide access to ex-detainees. Two social workers who were staff of the Western Cape Relief Fund [WCRF], and attached to the office of Essa Moosa and Associates, acted as contact people.

Community leaders at the ANC Office in Worcester made recommendations and arranged introductions to each of the rural towns visited. They suggested that delegates, from as far afield as Beaufort West and Oudtshoorn, could be informed of the study at an ANC Regional Meeting due to be held at Ceres on 12 May.

The regional meeting of the Association of ex-Political Prisoners [AEPP], on Sunday 28 April, provided an opportunity to introduce the project to members from outlying areas.

Obstacles

(i) Public Holidays

During the fragmented weeks, only short day trips could be undertaken.

(ii) Poor Communication

In greater Cape Town, more than any other region, data collection was a tedious and protracted exercise. Participants were less concerned about keeping appointments because they apparently imagined that re-scheduling times would not inconvenience the researcher.

(iii) Lack of an Office

Not being based in a local township office or having an escort, with an intimate knowledge of the local geography, was a disadvantage. Arranging appointments and locating individuals was complicated.

(iv) Political Events

Political events, which required the full attention of the WCRF staff, overtook us. These included:

* The release of political prisoners from Robben Island: 36 prisoners were released on 27 April and 25 on 30 April 1991.

* The taxi war between the Western Cape Black Taxi Association [WEBTA] and the Langa, Guguletu, Nyanga Taxi Association [Lagunya] escalated during April after agreements between them had broken down.

* Mzonke `Pro' Jack, a respected mid-level ANC leader, was assassinated on 19 June and was buried on 29 June. (One of his close comrades received the news while being interviewed and could not continue.)

* Many activists attended the 48th ANC National Conference (the first in South Africa since 1960) held in Durban from 2 to 6 July.

* On 8 July 1991, Michael Mapongwana (chairman of the Western Cape Civic Association) was assassinated while in hiding, after previous attempts on his life. (His wife was killed during one of these attempts in November 1990.) He was buried on Sunday 14 July.

The township communities were deeply affected by these events. WCRF had to help with funeral arrangements. They were also responsible for seeing to the needs of newly released prisoners. All these activities took up most of their time and energy. Other means of access had to be devised.

Because of these obstacles, help was sought from:

* The Advice Office Forum who arranged introductions to the Advice Offices in Mitchells Plain and Manenberg.

* The Human Rights Commission [HRC], previously the Repression Monitoring Group [RMG], who arranged introductions to individuals in Retreat, Ravensmead and Wynberg.

* The ANC Youth League, who provided access to trade unionists.

Field Trips

Day trips were made to nearby towns; two to Paarl, one to Ceres and one to Worcester (see Map 1).

Between 6 and 9 May, a journey into the Karoo included Touwsriver, Laingsburg and Beaufort West. Murraysburg, not included in the Midlands trip of 13-14 April, was also visited.

It was disappointing to arrive in Ceres on 12 May (Mother's Day) and discover that the ANC Regional Meeting had been cancelled. A chance meeting with individuals from Robertson and McGregor, visiting Ceres to resolve a dispute, provided an introduction to the communities of the Bonnievale, Ashton and Robertson [BAR] Valley.

From Ceres, a week long trip (13-18 May) was undertaken along the South Coast route. Stops were made at Robertson, Ashton, Bonnievale, George and Oudtshoorn. During the 3 months of the field study, George was the only town where ex-detainees refused to be interviewed. This was the result of a breakdown in communication.

After 20 May, local interviews had to be scheduled between teaching commitments (see Map 2). A considerable amount of time was also taken up by attempts to arrange a District Surgeon's secondment to enable the researcher to gain insights into prison health care from within the system. It was early August before the Cape Town interviews were completed.

Altogether 24 interviews were completed in the rural and 29 in the urban region of the Western Cape.

LIMITATIONS

A number of ethical and political considerations limited the validity of the study, if judged by conventional standards. These included:

1) Inability to investigate the working conditions of prison health care providers.
2) Inability to randomly select the sample.
3) Interviews conducted by only one researcher.

Health Care Providers

An unbiased review of prison health services would include formal interviews with providers (health care staff) and recipients (prisoners) of health care. Such interviews would be enriched by perusal of medical records, procedures undertaken and on-site inspections. Ideally, this could best be achieved by personally working within the system.

All the correct channels were followed in applying for access to District Surgeons and also for a temporary appointment to a District Surgeon's post. This process failed and after 15 months deteriorated into a bureaucratic nightmare (see Appendix 5).

Random Selection

The most important factor preventing random selection was the necessity to protect respondents from possible prosecution; in practice interviewees were all self-selected.

The accessibility of offices in Port Elizabeth and Grahamstown made it possible for individuals to select and present themselves for interviews. Through self-selection respondents were predominantly articulate, leading activists who were motivated by their commitment to human rights. Their experience, of petitioning prison authorities for change, made them aware of the issues concerned and the value of accurate facts. Prison improvements were high on their agenda for change. Consequently the replies given reflected careful consideration. It should be mentioned that other documentation was collected to corroborate statements emerging from the questionnaires and interviews.

The short time available for interviews on day trips to rural towns inevitably curtailed selection.

A Single Interviewer

At the time of the study members of the public were officially not allowed access to information about prisons. For security reasons it was therefore virtually impossible to involve other interviewers. The advantages, however, of a single interviewer were:

* The tenacity of the interviewer to tolerate delays
* The commitment to record responses meticulously
* More easily established trust.

Appendix 5

Attempts to Obtain Access to the Working Conditions of District Surgeons

(for detail see Record of Applications below)

The collection of politically sensitive information was carefully planned to avoid excessive state displeasure. For this reason interviews with ex-detainees preceded requests for access to District Surgeons' views.

The hospital directorate of the Cape Provincial Administration, however, were informed about this study at an early stage because they sanctioned my sabbatical leave (10-12-90). A later request to gain first-hand experience of the working conditions of District Surgeons was approved by the Medical Superintendent [MS] and the head of the unit.

After completing rural interviews, the possibility of a District Surgeon's secondment was pursued (see details below). Discussions were held with the Executive Director of Hospital and Health Services [HHS] (25/4/91), the Commissioner of Prisons (19/6/91) and the Chief District Surgeon of Cape Town (10/6/91). This was the beginning of numerous efforts made, over many months at all levels of Health and of Correctional Services, to obtain a District Surgeon's secondment. Whatever agreement seemed to be reached was always subject to approval by the other party.

On 8/7/91, secondment, starting in August, was approved by the Executive Director of HHS, the Chief Director of HHS, the Chief Superintendent of Groote Schuur Hospital and both supervisors. The following week at a planning meeting with regional and provincial health authorities, the matter of security clearance was raised, security clearance being mandatory before a District Surgeon could commence official duties in prison. To obtain security clearance within weeks necessitated signing the Official Secrets Act. The University of Cape Town (Vice Chancellor's Office) would not accept restraints which could prejudice the results of objective research. It argued that a thesis is not a publication; that this research was not top secret; that doctors on the teaching staff were public servants subject to the Public Service Act (54 of 1957) and not permitted to make public statements. The dispute was resolved when Security Clearance, valid for 5 years (September 1991 to 1996), was granted late in August (21/8/91) (see Document 3).

A further requirement was approval in writing from the Commissioner of Prisons. Two days before commencing duty, the Commissioner expressed reservations about the appointment (29/7/19). It took 4 months to establish that the Department of

Corrections "would render assistance" provided the Director General of the Department of National Health and Population Development [DNHPD] sanctioned the secondment (25/11/91). Finally, at a meeting on 17/5/92 the Commissioner of Corrections, the Director General of the DNHPD, the Executive Director of HHS and a supervisor proposed an alternative. Their recommendation was that the research proceed in conjunction with that of the Human Science Research Council [HSRC] on *The Evaluation of Health Services Available to and Accessible for Prisoners.* The head of the HSRC's prison project turned this request down. The Director of HHS stated that the DNHPD had initiated a national survey on 10/2/92, and that I was free to survey prison conditions in the Cape on my own (subject to approval).

Furthermore, a self-administered questionnaire for District Surgeons was developed as part of the research project. District Surgeons are appointed and paid by the Department of Health. Their working conditions are medical matters which have nothing to do with the Department of Correctional Services [DCS]. Approval from the health authorities was, however, not forthcoming for this venture either.

The first and only limited access the researcher had to police station holding cells was as a Special Monitor of the Independent Electoral Commission [IEC] during the national elections, held from 26 to 28 April 1994. In that capacity 13 different stations in Cape Town and the Boland were visited. A report of visits made by 19 monitors to 69 police stations on the three voting days was submitted to the Regional Peace Commission and the South African Police Services (9).

Record of Applications

(see list of officials and abbreviations below)

15/11/90 Applied for sabbatical.

10/12/90 Executive Committee of the Teaching Hospitals Central Advisory Committee sat & approved sabbatical.

5/02/91 Meeting with Chief MS, GSH: Directorate enquired whether prison authorities had been informed about the study. Concern and desire to upgrade DS image was expressed.

12/02/91 Letter to Chief MS suggesting secondment to gain first hand experience of DS's working conditions.

14/02/91 Chief MS requested approval by head of unit, before approaching Chief Dir HHS re secondment.

18/02/91 Sabbatical started with work in Eastern Cape.

3/03/91 Appeal to the head of FP/PC Unit for extension of sabbatical

8/03/91 Permission to extend sabbatical if locum provided.

19/04/91 Returned from Eastern Cape.

30/04/91 Meeting Chief MS: concern expressed about publishing research findings.

10/05/91 Locum available for the next 6 months.

24/05/91 Meeting with Exec Dir HHS: no objections, but required approval from Commissioner.

6/06/91 Exec Dir asked to discuss project with supervisors (Benatar & Savage).

19/06/91 Meeting with Commissioner, DCS: DS secondment is a medical matter; a DNHPD decision. (They in turn wanted to know that he did not object in principle.)

19/06/91 Meeting with Chief DS, CT.

8/07/91 Meeting between Exec Dir [DNHPD], Chief Dir [HHS], Chief MS and both supervisors: **DS secondment approved**, starting 1/8/91

9/07/91 Letter to Chief Dir: planning meeting with Regional DS requested.

16/07/91 Meeting with Chief Director, Regional DS, Chief DS, Dis Com Health Services: **security clearance [SC] required**.

17/07/91 Applied for SC. Signing Official Secrets Act would accelerate SC.

22/07/91 Meeting with Regional DS & Dr Hassim: regional DS requested written confirmation of secondment and approval by Commissioner.

29/07/91 Deliver copy of Official Secrets Act to Deputy Vice Chancellor [VC].

30/07/91 Message from Exec Dir (via Regional DS): Commissioner had reservation about appointment. Starting date postponed.

6/08/91 Meet Deputy VC: UCT cannot accept restraints that bias research results; a thesis is not a publication; this research is not subject to the Official Secrets

Act; all medical officers are subject to the Public Service Act and cannot make public statements.

21/08/91 **Security clearance approved** for 5 years (Sept 1991-96). Costs to state R5,000.

26/08/91 Supervisor wrote to Chief Dir: Enquired about DS secondment.

9/09/91 Exec Dir received copy of SC, awaiting consent from prisons.

23/09/91 Letter to Commissioner: requested approval of DS secondment.

31/10/91 Copy of above letter with a request for a reply posted to Commissioner.

13/11/91 Reply from Commissioner: Prison medical care falls under DNHPD. If they approve the DS post, Dept Corrections "will render assistance."

15/11/91 Letter to Commissioner: Ask for clarification of statement. Details of 8/7/91 meeting provided.

21/11/91 Phoned DCS, Pretoria. Spoke to Col Kalfman: no answers given.

25/11/91 Phone message from Col Kalfman: Director General, DNHPD, must first approve DS secondment. Letter confirming conversation posted to Commissioner.

13/12/91 Chief Dir, HHS, informed supervisor that the DNHPD (Dir Gen) plans a national investigation on Prison Health Care. There was no objection to a "pilot study" in the Cape.

28/01/92 Submitted on request to Exec Dir, HHS, an outline of research proposal into the working conditions of prison health care providers (see Appendix 6).

10/02/92 Press release: DNHPD and Correctional Services have requested HSRC to do research regarding the nursing and medical services rendered to prisoners (see Document 1)

17/05/92 Commissioner, Dir Gen, Exec Dir and supervisor meet to discuss DS secondment. Advised to approach the head of HSRC team re participation in their prison research project. The request is turned down.

1/06/92 Supervisor wrote to Exec Dir: Requested that the DS secondment be reconsidered.

4/08/92 Supervisors, researcher and Chief Dir of Advanced Health Care [AHC] in DNHPD met to discuss purpose and possibility of DS secondment.

10/08/92 On request outline of DS research project faxed to Chief Dir, AHC.

13/01/93 Letter to Chief Dir, AHC: Enquired about decision following meeting of 4/8/92 and requested outline of HSRC study to avoid duplication.

Feb 1994 Provisional report of HSRC (for internal use) appeared.

July 1994 HSRC published the report on *Prison Health Care Services: Legislation, Perceptions and Statistics.*

Attempts to trace reports of previous prison research, not necessarily related to health care.

5/10/93 Letter to Commissioner: asked where reports of previous prison projects are kept.

29/11/93 Request for location of research material repeated.

13/12/93 Phoned Commissioner in Pretoria: He was on leave. No information available. Receipt of letter 5/10/93 would first be confirmed within 14 days. (Nil received.)

Queries arising at SA Medico-Legal Conference (Johannesburg) 6 & 7 August 1994

7/8/94 When was security clearance for DS first introduced? Was it still a requirement?

17/8/94 Letter to Deputy Director, HHS (Dr Kahlberg) requesting information about:

* number of DSs employed in Cape (pre-election)
* details of refresher courses for DS
* information about security clearance of DSs.

31/8/94 Reply: all full-time and those part-time DSs who work in prisons need security clearance.
(Dr Kahlberg retired on 31/8/94.)

6/9/94 Letter to Director of Community Health Services (Dr Truck): Repeat request for statistics about DSs employed in the Cape before May 1994.

14/12/94 Reply Dir CHS: Can only furnish information of Western Cape region (after May 1994). Details of security clearance is a prison matter.

List of officials

* Director General, Department of National Health and Population Development [DNHPD]: Dr Coen Slabbert.

* Chief Director, Advanced Health Care, DNHPD:
Dr H Pretorius.

* Executive Director, Hospital and Health Services[HHS], Cape Provincial Administration [CPA]:
Dr George Watermeyer.

* Chief Director, HHS, CPA:
Dr Hannah-Reeve Sanders.

* Director of Community Health Services, HHS, CPA:
Dr N E Kahlberg.

* Chief Medical Superintendent, Groote Schuur Hospital:
Dr J Kane-Berman.

* Regional District Surgeon, Western Cape:
Dr J Moodie.

* Chief District Surgeon, Cape Town:
Dr Coetzee.

* Commissioner, Department Correctional Services [DCS]:
Gen W H Willemse.

* Supervisors: Prof S R Benatar, Dept Medicine
Prof M Savage, Dept Sociology (to Dec '93)
Assoc Prof Frances Ames (retired), Dept Neurology (from Jan '94).

* Assoc Prof, Family Practice\Primary Care Unit (FP\PC):
Assoc Prof D E Whittaker

* Deputy Vice-Chancellor, UCT:
Prof D R Woods

Appendix 6

PRISON HEALTH CARE, A RESEARCH PROJECT
THE ROLE OF THE DISTRICT SURGEON

Background

International medical and ethical standards exist for prison health care. This research project (divided in 2 parts), examines how these standards are met in South Africa.

1. How inmates perceive their health care. The fieldwork for this half of the study has been completed. This will not be discussed here.
2. The working conditions of health care providers.

Health Care Providers

In South Africa [SA] the medical care of prisoners is provided by District Surgeons, who are appointed by the Department of Hospital and Health Services. They are therefore the only prison health workers that do not officially fall under the Department of Correctional Services, previously the Department of Prisons.

The medical care of prisoners is a complex matter in that a balance between human frailty and security risks must be maintained. It is a world-wide dilemma; SA is not unique in this respect. Nevertheless, the difficulties encountered by District Surgeons need to be identified if we wish to improve their working conditions and efficiency.

At the moment District Surgeons work under extremely difficult conditions. To determine how they perceive their work situation a self-administered questionnaire was designed (3/2/92). In addition, a secondment to a District Surgeon's post was envisaged to obtain first hand experience of medical care in prisons.

Questionnaire

The proposed questionnaire was intended to deal with general information, education and specifics about the District Surgeon's appointment. Details of preparatory and in-service training as well as working conditions (salary, workload, work environment, administrative duties, patient population and leave privileges) were requested. A specific section dealt with the management of prisoners. There was also a section on job satisfaction, recommendations and space for further comments.

Three General Practitioners with experience in epidemiological research were requested to work through the questionnaire. That was to be followed by GPs, who

had previously done District Surgeons' duties, working through the questionnaire to test its validity.

District Surgeon Secondment

In SA prison conditions and care have been taboo. The Regional Director's advice was sought on the type of prison experience from which maximum exposure could be gained. In preliminary discussions we agreed on a 14-21 day attachment to a full-time District Surgeon in order to experience the full spectrum of his general work day commitments. To familiarise myself with general prison routine and practice, 2 weeks at a major prison such as Pollsmoor was envisaged. This would then be followed by short spells at other major prisons (Victor Verster, Caledon, Eben Donges) and day visits to smaller country prisons, police stations and holding cells in the nearby towns.

Proposed Discussion

Once this factual information had been obtained it would be compared with international standards. For this purpose, the booklet *Ethical Codes and Declarations Relevant to the Health Professions* (June 1985), produced by Amnesty International, would be useful. It includes:

* The Hippocratic Oath (5th century BC)

Statements adopted by the World Medical Association

* Declaration of Geneva (1983)
* The International Code of Medical Ethics (1983)
* The Tokyo Declaration (1975) related to the question of torture and cruel, inhuman or degrading treatment.

Statement by the World Psychiatric Association

* The Declaration of Hawaii (1983)

United Nations Declarations and Codes

* Principles of Medical Ethics (1982)
* Declaration on the Protection of All Persons from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1975)
* Standard Minimum Rules for the Treatment of Prisoners and Related Recommendations (1977)

The independent British Prison Reform Trust aims to maintain prison health standards and has produced several publications, among them *Prison Medicine: Ideas on Health*

Care in Penal Establishments, 1985. Similarly the National Committee for Correctional Health Care [NCCHC], an independent American organisation, takes responsibility for the constant review and maintenance of health care standards in their jails and prisons. In 1989 Robert Ross and Curtis Prout, M.D (formerly Director of the Prison Health Project in Massachusetts and at present Chairman of NCCHC) published *Care and Punishment: The Dilemmas of Prison Medicine.* The most important recent research related to prison doctors, however, is *A Report of a Working Party of the Royal College of Physicians to the Chief Medical Officer of Prisons, Recruitment and Training of Doctors*, commissioned by the British parliament and published in 1990.

Table B: Western and Eastern Cape Detention Figures 1987-1988.

AGE DISTRIBUTION OF DETENTION FIGURES (1987 - 1988) EASTERN CAPE AND WESTERN CAPE				
Ages	**East, Cape**		**West, Cape**	
12 - 15	31	(5.6%)	7	(2.6%)
16 - 17	56	(10.3%)	29	(10.9%)
18 - 19	78	(14.3%)	49	(18.4%)
20 - 29	264	(48.5%)	103	(38.9%)
30 - 39	78	(14.3%)	39	(14.7%)
40 - 59	36	(6.6%)	33	(12.2%)
60+	1	(0.2%)	5	(1.8%)
Total	544		265	

Figures compiled and cross referenced from records available at the offices of Black Sash (PE), Albany Council of Churches and Legal Resources Centre.

MEDICAL RIGHTS OF DETAINEES

PRISONS ACT (1959)

- Inform on admission of rights of treatment and conduct.

EMERGENCY REGULATIONS (1987)

- Examine as soon as possible after arrest
- Examine as close as possible to release
- All treatment to be carried out promptly
- Outside treatment depends on referral by DS.

SECTION 29 15A (1982)

- Illness/Injury requires immediate examination.
- Medical examination after (alleged) assaults.

SAFEGUARDS:

- Visit by DS every 14 days.
- Visit by magistrate every 14 days.
- Inspector of detainees allowed free access.
- Visits by judges optional.

Document 3: Security Clearance for District Surgeons to work in Prisons.

VERTROULIK

KAAPSE PROVINSIALE ADMINISTRASIE
CAPE PROVINCIAL ADMINISTRATION

SEKERHEIDSKLARING
SECURITY CLEARANCE

Hiermee word 'n sekerheidsklaring van:
Hereby a security clearance of

GEHEIM

uitgereik aan / is issued to:

DR J A VAN HEERDEN

Die klaring is geldig vir 'n tydperk van 5 jaar vanaf:
The clearance is valid for period of 5 years from:

1 SEPTEMBER 1991

en is onderhewig aan die volgende/subjected to the following:

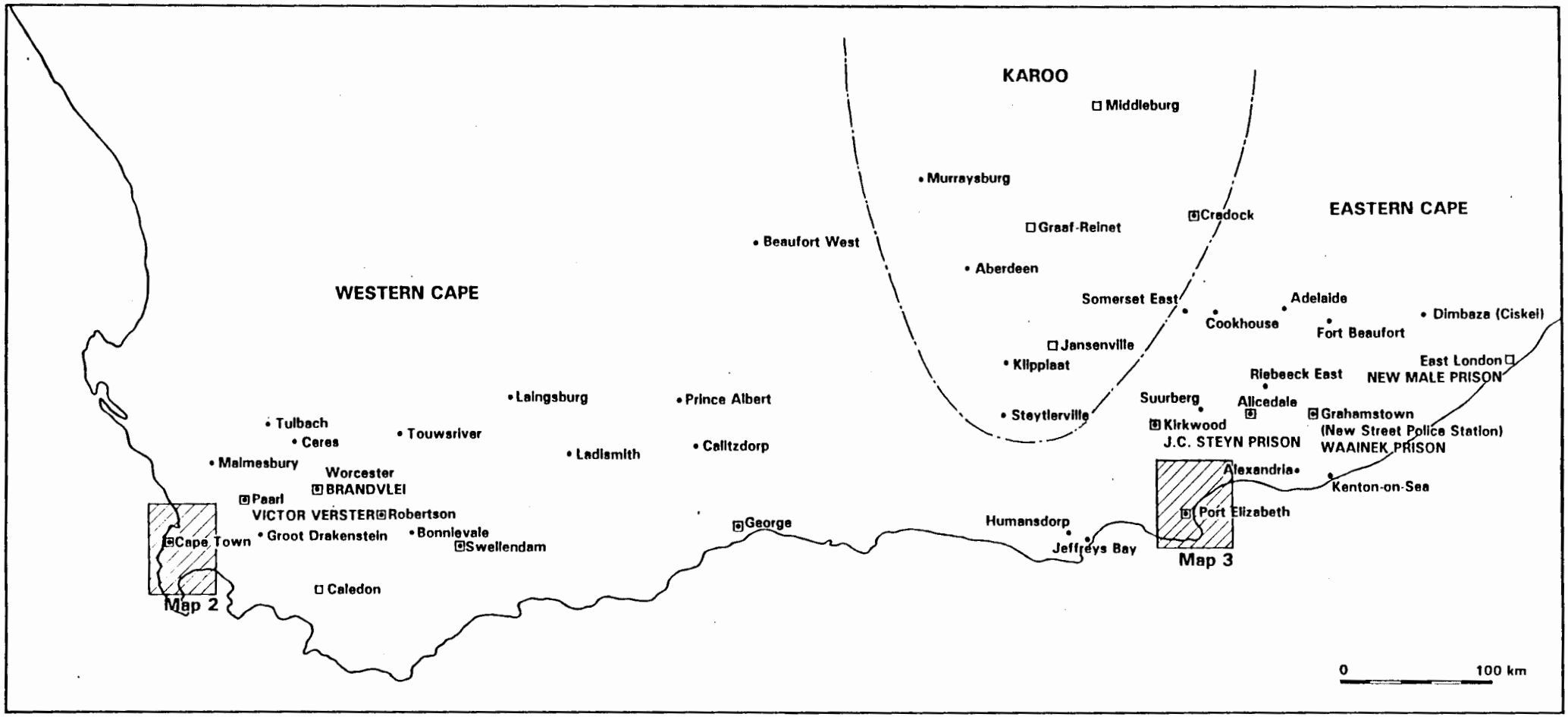
* kan teruggetrek word indien u sekerheidsbevoegdheid nadelig beïnvloed word.
* Is nie noodwendig oordraagbaar na 'n ander departement nie.
* Gee u nie noodwendig toegang tot alle inligting van dieselfde klassifikasie nie.
* Die verantwoordelikheid berus by u om maatreëls/wetgewing rakende inligtingsekerheid te verkry en na te kom.

* Could be withdrawn if your security competence is discredited.
* Is not necessary transferable to other departments.
* Does not necessary give you access to all information of the same classification.
* It is your responsibility to obtain comply with measures/laws regarding information security

PROVINSIALE ADMINISTRASIE
VAN DIE KAAP DIE GOEIE HOOP
SEKURITEITDIENSTE
SECURITY SERVICES

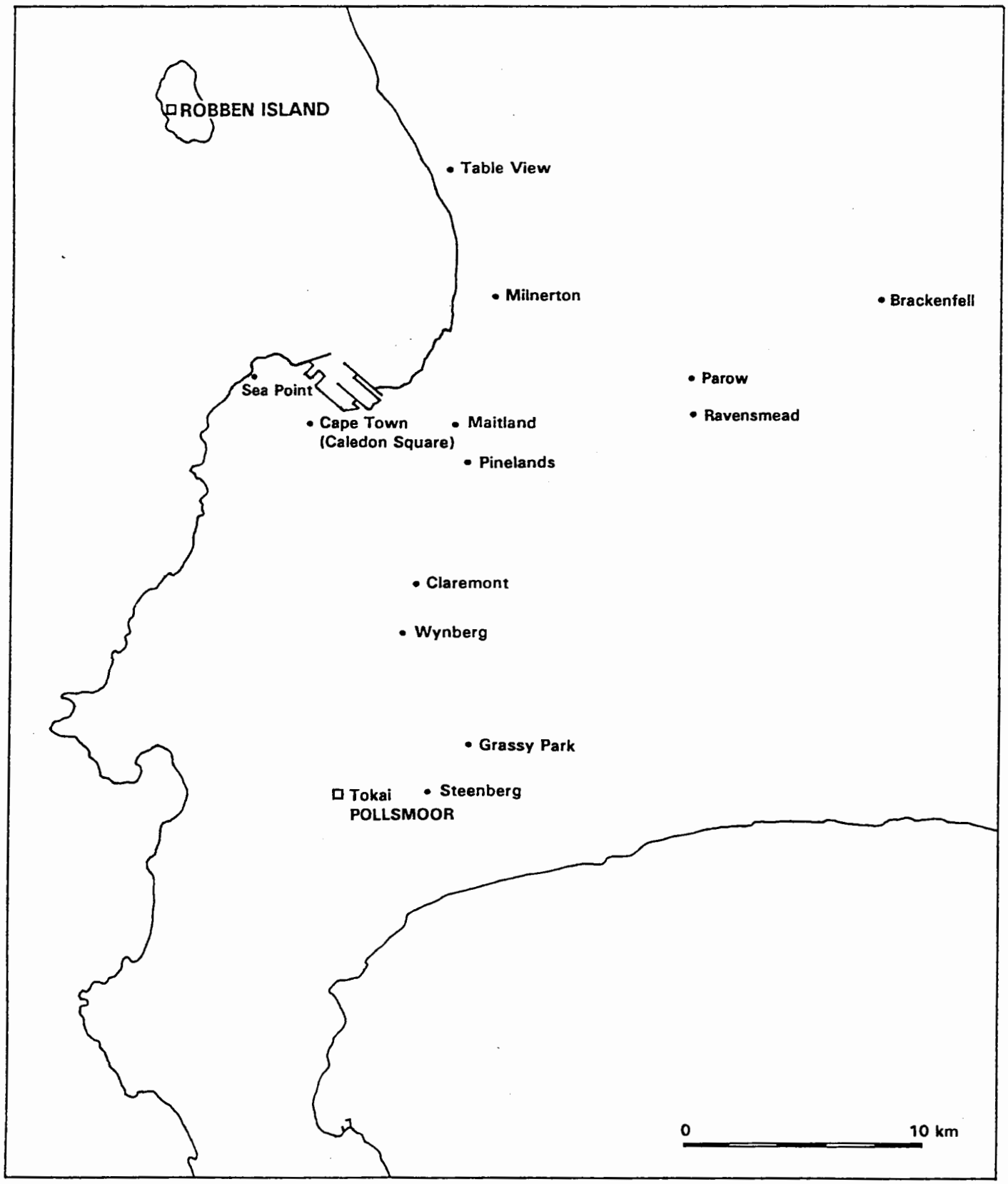
Signed
DIREKTEUR-GENERAAL

VERTROULIK



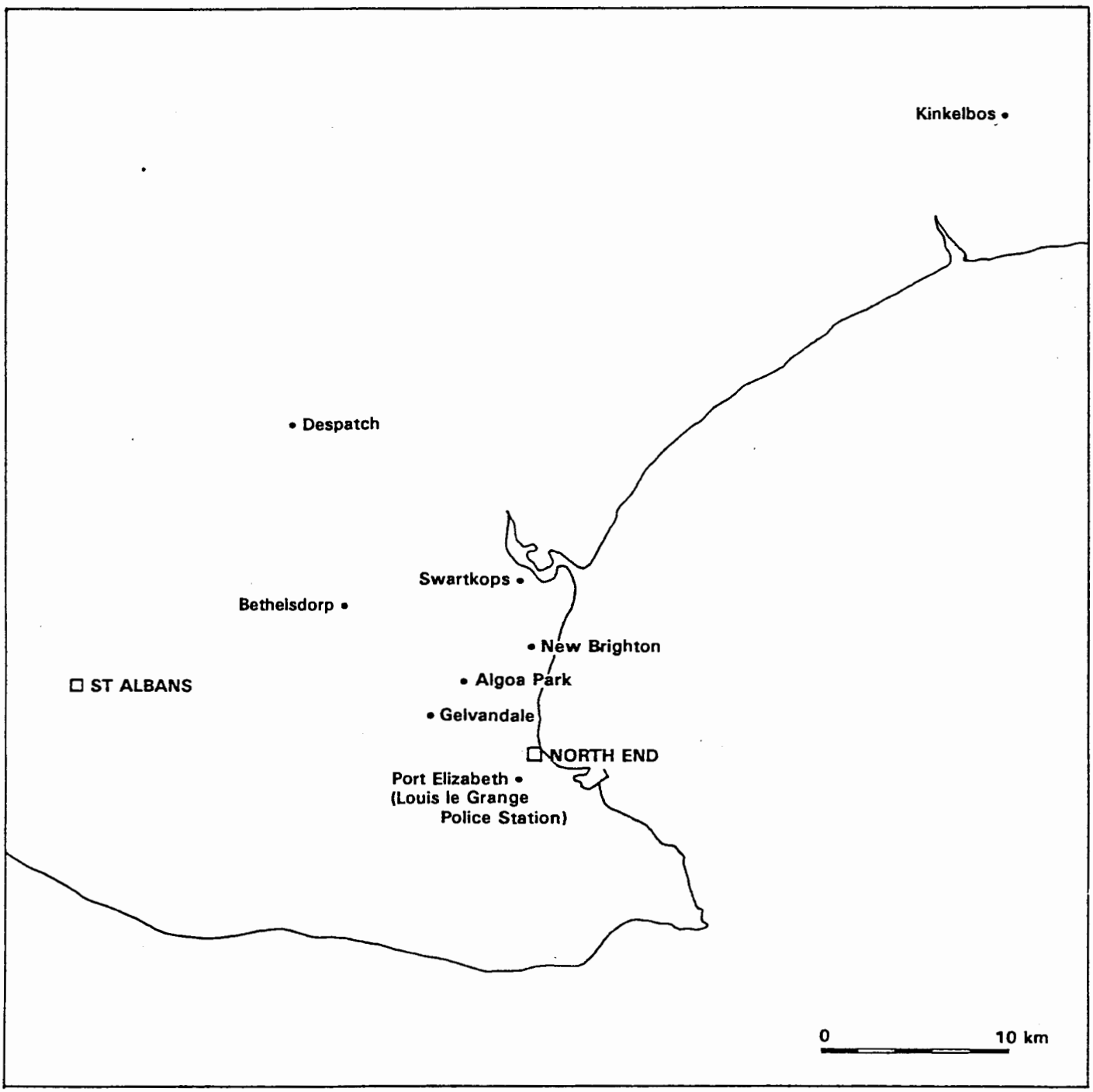
Map 1: PLACES OF DETENTION
Western Cape, Eastern Cape and Karoo

Key: • Police Station
□ Prison



Map 2: PLACES OF DETENTION
Cape Town and Environs

Key: • Police Station
□ Prison



Map 3: PLACES OF DETENTION
Port Elizabeth and Environs

Key: • Police Station
□ Prison

RESULTS

The following data analyses are based on information obtained via the interviews and questionnaires.

1. DEMOGRAPHICS

This section outlines the demographic profile of the 123 individuals interviewed in the Eastern and Western Cape.

1.1 Region

70 interviews conducted in the Eastern Cape (ECape) including the Karoo
53 interviews conducted in the Western Cape. Urban and rural breakdowns are shown in **Table 1.1** and pie chart.

1.2 Race

118 Blacks (African, Coloured and Indian) and
5 Whites (3 male, 2 female) were interviewed.

The Prisons' Act (1959 no. 8, Section 23) enforced segregation; "white" and "non-white" prisoners had to be housed separately. The Act was amended in 1990. (Prisons Amendment Act 92 of 1990, Section 10).

1.3 Gender

103 males (100 black and 3 white) and
20 females (18 black and 2 white) were interviewed.
See **Table 1.3** for the geographical breakdown.

1.4 Age

Interviews covered the age spectrum of detention cohorts from under 15 to over 60. The largest number, 54, fell into the 20-29 age group, followed by 24 in 30-39 age group, tailing off on either side to the younger and older age groups. This age distribution of the sample as a whole was reflected in the age distributions of the Western Cape urban and the Eastern Cape urban and rural figures as shown in **Table 1.3** and accompanying graph.

1.5 Occupation

Respondents were asked what their work/education status was before detention, whether it was affected by their detention and what their post-detention work/education status was. Four categories were identified:

Employed (full or part-time)
Students (full or part-time)
Scholars (full or part-time)
Unemployed.

The occupational status of respondents before detention and the decline in both employment and study after detention are reflected in **Table 1.5**.

1.5.1 Students

Before detention 9 respondents were full-time students.
After spending time in detention

- 2 continued their studies
- 4 were employed full-time
- 1 was employed part-time
- 2 were unemployed.

1.5.2. Scholars

31 respondents were full-time scholars prior to detention.
After spending time in detention

- 10 continued with full-time schooling
- 6 *said* that detention did not affect their schooling although one missed 6 and another 12 months at school
- 2 were detained from September to March, missing year end exams
- 4 said their schooling had been interrupted by detention
  (For detailed comment see **Table 1.5.2(a)** and **Table 1.2.5(b)**
- 1 continued part-time schooling
- 4 started tertiary education (1 part-time)
- 5 were employed (1 part-time)
- 11 were unemployed

Table 1.1: Regional Distribution.

Region	Freq	Percent
E Cape urban	27	22.0%
E Cape rural	30	24.4%
Karoo	13	10.6%
W Cape urban	29	23.6%
W Cape rural	24	19.5%
Total	**123**	**100.0%**

Figure 1.1: Detentions by Regions
Breakdown of sample, n=123

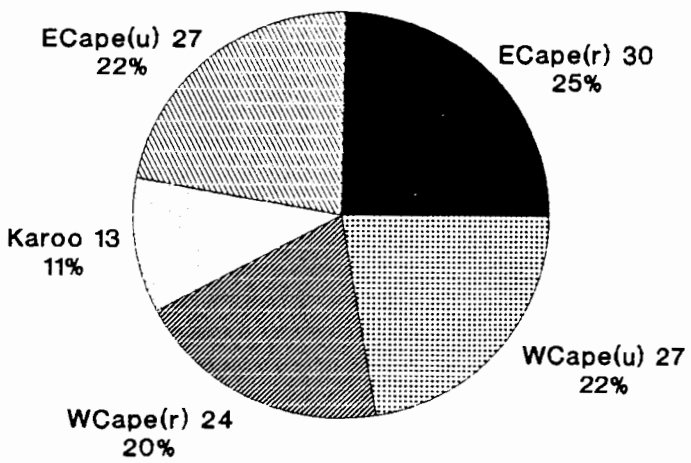


Table 1.3: Age and Gender Distribution

Eastern Cape Figures							
	Urban		Rural				
	Port Elizabeth		Albany & Uitenhage		Karoo (Midlands)		
Age	Male	Female	Male	Female	Male	Female	Total
12-15							
16-17	1		1		1		3
18-19	2		3				5
20-29	10	1*	14	1	5	1	32
30-39	9		4*	2*	1		16
40-59	2	1	2	3	3	2	13
>60	1						1
Total	**25**	**2**	**24**	**6**	**10**	**3**	**70**

Western Cape Figures					
	Urban		Rural		
	Cape Town		Boland & S Coast		
Age	Male	Female	Male	Female	Total
12-15			1		1
16-17	1	2*	3		6
18-19	4		5		9
20-29	10	1	10	1	22
30-39	4	4*	1		9
40-59	1	1	2		4
>60	1		1		2
Total	**21**	**8**	**23**	**1**	**53**

* Indicates a white detainee, total = 5

Figure 1.4: Age Distribution of Detainees

E.Cape & W.Cape Detainees (1987-1988)
Sample Interviewed

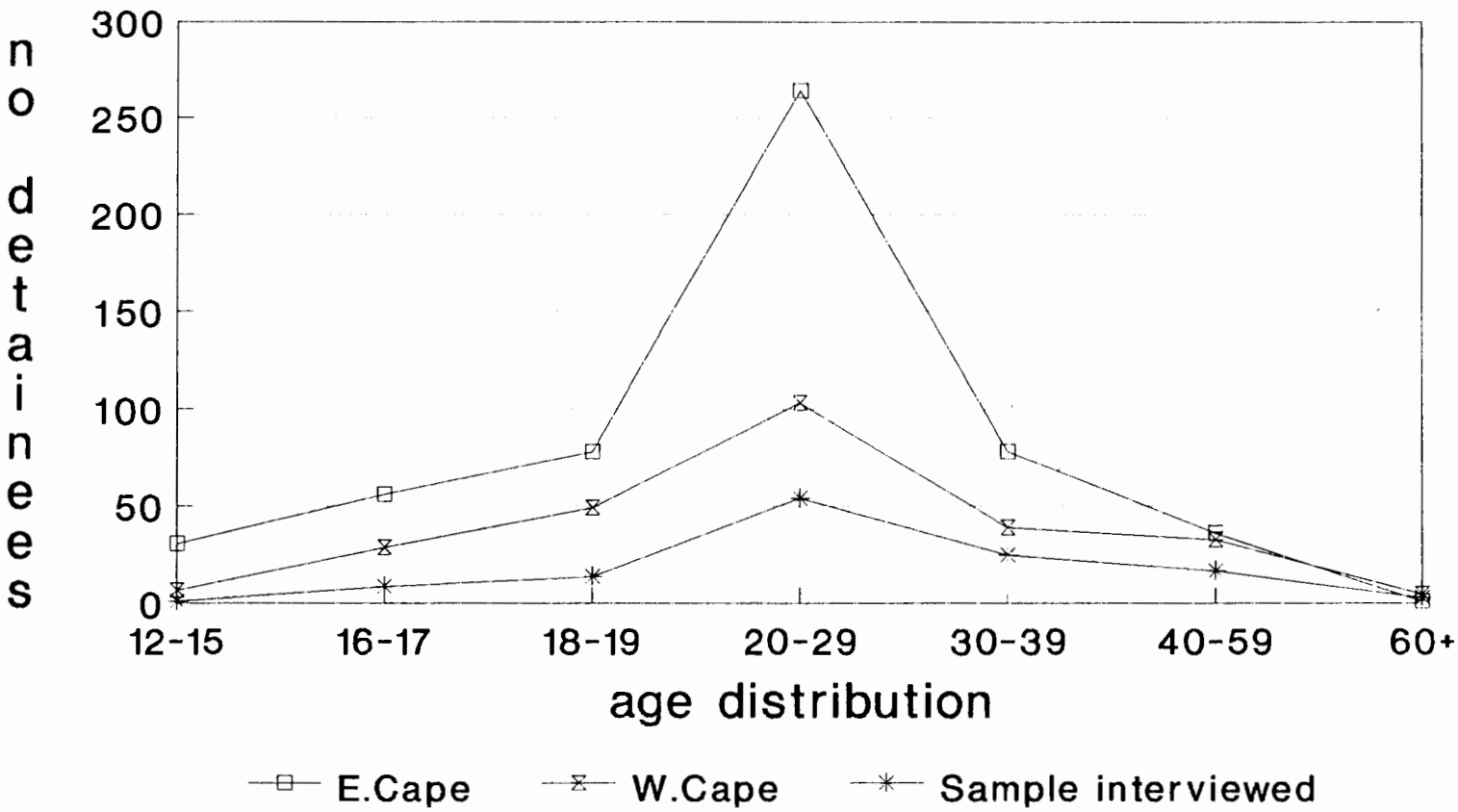


Table 1.5: Occupation Before and After Detention.

Occupation		Before	After
Employed:	Full-time	53	46
	Part-time	5	5
Student:	Full-time	9	9
	Part-time		2
Scholar:	Full-time	31	10
	Part-time		1
Unemployed		25	50
Total		**123**	**123**

Table 1.5.2(a): Schooling continued.

No change in schooling reported			
Scholar	**Area**	**Period**	**Scholars' Comments**
19 yr M	WCr	6/52	Arrest before Sept exam, release just before final. Timing bad.
17 yr M	WCr	4/52	Limited detention.
23 yr M	K	134/52	Missed school 1984-1990 (6 yrs).
21 yr M	ECr	26/52	Held Sept-March, missed finals.
20 yr M	ECr	35/52	Missed Std X exams (Sept-March).
20 yr M	ECr	52/52	Returned to Std X (March 88 - March 89).

Table 1.5.2(b): Schooling Interrupted.

Delays in schooling reported.			
Scholar	**Area**	**Period**	**Scholars' Comments**
18 yr M	WCu	9/52	Passed Std IX after release, missed 1 year at school.
17 yr M	ECu	126/52	Day School --> correspondence course in jail --> day school (Held for 29 months.)
18 yr M	ECu	135/52	Std VII --> correspondence course in jail --> bureaucratic delays for permission to attend school after release. (Held for 31 months, transferred 12 times.)
21 yr M	ECr	76/52	Delays in schooling (Oct 1987 - April 1989).

2. DETENTION

2.1 Detention Laws Applicable

107 respondents were State of Emergency [SOE] detainees (under the Public Safety Act, no 3 of 1953).

2 respondents were detained under Section 50 of the Internal Security Act, no 74 of 1982 [ISA] ("short term" detention).

9 respondents were detained under Sec 29 of the ISA.

5 respondents did not know under which section of the law they were held. They were detained after the SOE had lapsed on 11/6/90.

2.2 Date of arrest

5 between 21/7/85 and 7/3/86 during the partial SOE:
- 4 in the Western Cape
- 1 in the Eastern Cape (held until Sept 1987).

2 between 8/3/85 and 11/6/86, under Sec 50 in the Eastern Cape. After the national emergency was declared (12/7/86), their status was changed to SOE detainees. They were held for 11 and 34 months respectively.

110 between 12/6/86 and 11/6/90, during the successive national emergencies.

6 after 11/6/90 when the national SOE lapsed:
- 1 under Sec 29 of ISA (enforced until 28/4/94)
- 5 were not informed under what act:
  - 1 was released after 10 days
  - 4 were charged. These charges were dropped after 2, 16, 17 & 36 weeks.

2.3 Change in detention (legal) status.

In 101 cases there was no change in legal status.

In 22 cases the legal status of the respondent changed (initially unknown unless otherwise indicated):

5 became SOE detainees (2 initially Sec 50)
5 became Section 29 detainees.
12 were charged:
11 were found not guilty/had charges dropped.
1 Sec 29 detainee found guilty; sentenced to three months on Robben Island.

2.4 Period of detention.

There was a marked difference in the duration of detention in the Western Cape and Eastern Cape regions (see **Table 2.4** and accompanying bar graph).

From this data it appears that repression in the Eastern Cape, particularly in the urban region, was more severe than in the Western Cape. A greater proportion of respondents in the urban areas of the Eastern Cape were detained for far longer periods of time than elsewhere.

2.5 Number of places held.

There appears to have been some correlation between the length of detention and the number of places where respondents were detained. Three quarters of the respondents from the urban Eastern Cape were held in more than 3 different places (see **Table 2.5**).

2.6 Previous Detentions

50 (41%) had no previous detentions.
73 (59%) had previously been detained:
- 41 had 1 previous detention
- 17 had 2 previous detentions
- 8 had 3 previous detentions and
- 7 had 4 or more previous detentions.

Table 2.4: Period of Detention.

	Region				
Period	**WCu**	**WCr**	**ECu**	**ECr**	**Karoo**
0-6 months	24 (83%)	21 (88%)	3 (11%)	11 (37%)	10 (74%)
7-12 months	3 (10%)	3 (12%)	0	7 (23%)	1 (8%)
13-24 months	2 (7%)	0	3 (11%)	10 (33%)	1 (8%)
25-36 months	0	0	21 (78%)	2 (7%)	1 (8%)
Total	**29 (100%)**	**24 (100%)**	**27 (100%)**	**30 (100%)**	**13 (100%)**

Figure 2.4: Detention Periods by Region

Number detained 1-52, 53-104, 105-156wks

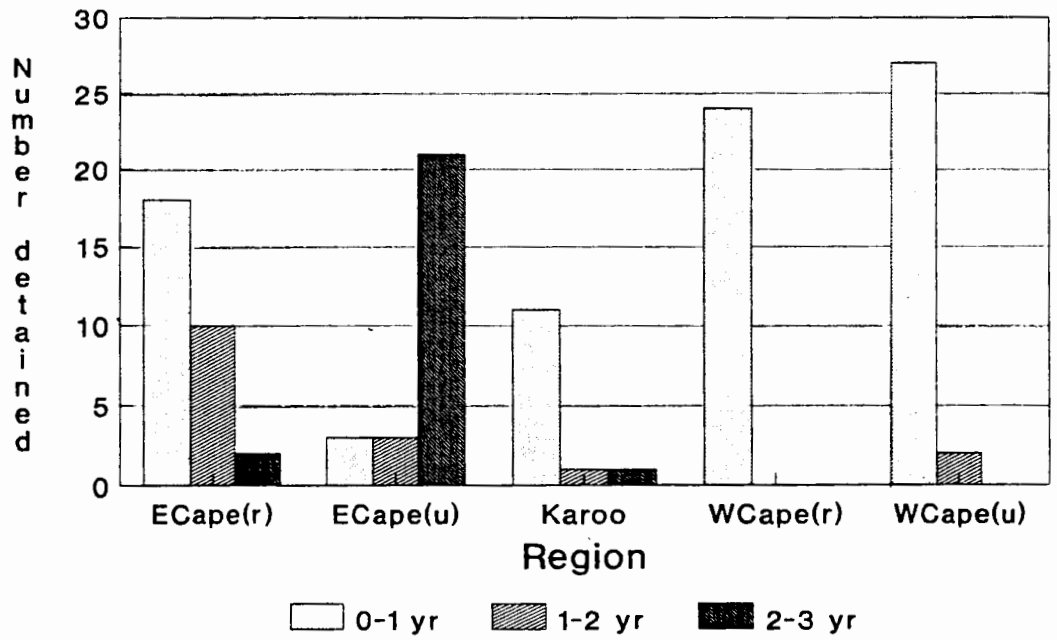


Table 2.5: Number of Holding Places.

	Region					
Number of places	**WCu**	**WCr**	**ECu**	**ECr**	**Karoo**	**Total**
1-3	26 (90%)	22 (92%)	7 (26%)	24 (80%)	12 (92%)	**91**
4-6	3 (10%)	1 (4%)	8 (30%)	5 (17%)	1 (8%)	**18**
7-12		1 (4%)	12 (44%)	1 (3%)		**14**
Total	**29 (100%)**	**24 (100%)**	**27 (100%)**	**30 (100%)**	**13 (100%)**	**123**

3. ILL AT TIME OF ARREST

3.1 Illness

26 (21%) reported ill health at the time of arrest

97 (79%) were not ill at the time of arrest.

3.2 On treatment

Of the 26 who were ill at the time of arrest:

16 (62%) were already on medication for their illness

10 (38%) were not on treatment.

3.3 Continuation of treatment

3 reported treatment continued within 48 hours of arrest, some with interruptions of one day.

13 asked for treatment to be continued. The time between asking for and receiving treatment varied:

- 1 waited 2 - 7 days
- 4 waited 1 - 4 weeks
- 2 waited 1 - 3 months
- 2 waited for more than 3 months
- 4 did not receive treatment.

(For details see **Table 3.3**)

3.4 Ill without requiring medication

10 respondents said that they were not on treatment.

Their conditions included the following:

- 2 were having regular counselling (? for PTSD) which they did not regard as `treatment'
- 1 was having physiotherapy for a back injury which he did not regard as `treatment'
- 1 was prone to severe headaches (? PTSD)
- 1 suffered from episodes of pain related to an old mastoid problem
- 1 polio victim was on crutches
- 1 amputee (post Buerger's Disease)
- 1 woman was recuperating from a Caesarean Section and breastfeeding her infant.

Table 3.3: Delays in treatment for illness at time of arrest.

Patient/Area	Illness	Treatment	Respondents' comments on health management.
> 48 hours			
64 yr M WCe	Diabetic	Pills tds	Continued Rx. Taken to Somerset Hospital for monthly follow-up appointments. Given a prison bed at VV. Well known activist.
76 yr M ECu	'flu	Medicine	After arrest taken straight to DS. DS sent him back home with police to collect the medicine.
49 yr F ECu	Old leg injury.	Meds and injections	Informed captain. Taken to DS and tablets (not injections) continued.
2 - 7 days delay			
21 yr M Eu	Peptic ulcer	Mucaine	Request made to male nurse. Delayed response from prison authorities. Med given irregularly.
1 - 4 week delay			
41 yr M K	Epileptic (fit-free)	Pills tds.	Request to police ignored. Saw Magistrate (his wife's employee) and requested pills. Pills brought and kept in cell. Not re-issued when they ran out.
54 yr F WCu	High BP --> Arthritis -->	tabs tds tabs bd	Ignored at 1st police station (Caledon Square). Transferred. Taken to DS after several requests.
21 yr M ECr	Genital sores	Pills	Request at rural police station ignored for 14 days. Routine examination at prison (cursory). After legal application for hospital treatment sent to STD Clinic.
44 yr F (nurse) ECr	GIT symptoms	Medicine (After Ba meal)	No treatment at police station (14 days). Treatment restarted after transfer to prison.

Table 3.3: (Contd.)

Patient/Area	Illness	Treatment	Respondents' comments on health management.
1 - 3 months			
41 yr F WCu	High BP	Tabs daily.	Confused and didn't request tablets. Transferred after two months. New DS diagnosed and treated high BP.
27 yr F ECu	Sinusitis	Nasal spray.	No medical care for one month at police station. After transfer to prison, treatment continued (by Dr Good).
> 3 months			
37 yr M ECu	PTSD (after 1985 detention and torture)	Pills	GP sent information to prison by telex, no response. Complained to family at first visit (after three months). They informed GP who applied more pressure. Treatment restarted.
19 yr M ECu	Asthma	Pump	Requests ignored at police station and prison. Saw Dr Good 9 months later. Station Commander instructed to concede to requests for medical care.
Treatment not continued after arrest.			
24 yr M ECr	Nerves (PTSD)	Medicine	When asked for meds, the DS said I was undermining him. I explained and he promised to look into it. Nothing happened.
50 yr M ECr	TB (ambulatory)	Medicine	The medicine he took with him was removed by the police and never issued. DS said "The State doesn't allow detainees their own pills. Sort it out with your lawyer." The DS was the same doctor who treated him at SANTA.
24 yr M WCr	Valve replacement	Digoxin	Asked police. Told script required for medicines. Never taken to DS because they didn't want others to know where he was held.
17 yr F WCu	Recovering from nervous breakdown.	Pills	"I never mentioned it because I was too frightened and nervous. I felt too vulnerable."

4. INJURY OR ILLNESS RESULTING FROM ARREST

4.1 Injury or Illness

34 (28%) said the arrest resulted in injury or illness (n=123).
- 27 were injured at the time of arrest
- 6 became ill as a result of their arrest
- 1 was both injured and became ill.

4.2 Need for treatment

22 (65%) needed treatment for the injury/illness (n=34)
12 (35%) did not need treatment.

4.3 Request for treatment

Of the 22 in need of treatment:
- 18 asked for treatment
- 4 did not ask for treatment.

4.4 Treatment given for injury/illness as result of arrest

8 (24%) were treated for their illness/injury (n=34).
- 3 were seen routinely:
  - 1 after 2 hours
  - 1 after 4 hours
  - 1 after 14 hours.
- 5 waited for treatment:
  - 1 for 2 days
  - 2 for 3 days
  - 1 for 5 days
  - 1 for 7 days.

(For details of consultations see **Table 4.4**)

Table 4.4: Consultation following injury at arrest.

Patient/Area	Delay	Respondents' comments on consultation.
24 yr M ECr	2 hours	Beaten about face. Nosebleeds. R ear deaf. Routine examination. Pulse, mouth, ears, chest examined. Made notes before and after examination. Treatment not indicated.
44 yr F ECr	4 hour	First questioned by SP, then to DS. He asked about illness and treatment, (hypertensive on Rx). Examined heart and chest. "My BP short up". Dr ordered SP to have my BP checked on alternate days. This was never done.
28 yr M ECu	14 hours	Interrogated, forced exercise, beaten for 12 hours. Then to GP. Whole body ached, nothing visible. DS felt body, examined heart and chest lying on couch. No notes made. No treatment given.
21 yr M ECr	2 days	Interrogated and beaten for 2 days. Face swollen, ears sore. Taken to DS. SP first went to speak to DS. Patient stood while DS listened with the stethoscope. Dismissed. Not interested, just "looked" to check that I was fit for detention.
24 yr M ECu	3 days	Face kicked during arrest. Teeth broken. R ear sore. 3 days later DS looked at ears, gave me drops, cotton wool and pain pills which didn't help. Referred to dentist (9 teeth extracted).
25 yr M WCr	3 days	Beaten with baton and shambok. Face swollen, chest wall lacerated. DS came to cells. A group of detainees stood with shirts pulled up. He looked at us, and inside our mouths. He did not touch us. No notes made. He gave me ointment (12 cm scar visible).
27 yr M ECu	5 days	Hit around face, severely bruised, hearing affected. Asked to see DS. Seen after 5 days - details recorded. Shirt off, listened to my chest, did not look for other injuries (in mouth or ears).
29 yr M ECu	7 days	Handcuffed to door, hit with butt of gun. Asked SP to see DS. Beating, choking, suffocating, hooding, for 3 days. Saw DS on day 7. He recorded details (not shown to me). He felt all over my body, nil else. Gave pain pills; they didn't help. Unsure of his role, but the assaults stopped.

5. MEDICAL RIGHTS

5.1 Informed about rights

10 (8%) were **informed** that they had medical rights (n=123)
51 (41%) **knew** that a doctor should see them soon after arrest
62 **did not know** that they had medical rights.

5.2 Type of information provided

Of the 10 **informed** that they could see a doctor if ill, only 4 were given further details (see **Table 5.2**).

5.3 Informed about MASA panel

1 respondent was **informed** about the MASA panel of doctors. She was arrested late in June 1990 (after the emergency lapsed) under Sec 29.
4 respondents **knew** about the MASA panel at the time of their arrest.
10 respondents **learnt** about the MASA panel while in jail from lawyers, comrades or newspapers.

5.4 Requests to see MASA panel members

6 of the 15 respondents, who knew about the MASA panel of doctors, asked to see a panel doctor. None of them saw one. The responses to these requests were:

(i) They promised to look into it. He waited in vain.
(ii) He asked the SP for a MASA doctor, they refused.
(iii) The lawyer tried on his behalf. Nothing happened.
(iv) There was no response to his request. He wrote to the prison authorities twice, but never received a reply.
(v) He asked the 2 white nursing sisters on duty at St Albans prison, they refused.
(vi) They (? the prison authorities) refused. When he applied through a lawyer the request was again turned down.

Table 5.2: Details about Rights to Medical Care

Patient/Area	Length of stay	Type of information provided
36 yr F WCu	9 weeks Sec 29 (June 1990)	Can ask to see a DS, or pay to see a doctor from a list of names (MASA panel). No document signed. No names provided.
16 yr M WCu	24 weeks Sec 29 --> SOE	The Gov. Gazette (with the SOE regulations) was pasted on the door of the cell.
44 yr M ECu	34 months	Demanded to know my rights. The Gov. Gazette was provided on request.
56 yr F ECr	19 months	Advised by police woman to press the bell and call for help if anything went wrong, even at night.

6. MEDICAL SCREENING AFTER ARREST

6.1 Incidence of medical screening

70 (57%) were routinely examined after arrest

53 (43%) were not examined routinely.

6.2 Time of medical screening

Delays in 70 routine examinations `soon after arrest' (see **Table 6.2**):

49 waited 0 - 2 days (during first 24 hours)

16 waited 3 - 7 days

3 waited 8 - 14 days

2 waited > 14 days.

Of the 49 seen within 48 hours, 25 indicated the time seen in terms of hours, while 24 gave it in terms of days.

During the first 24 hours:

9 were seen immediately , within 0 - 2 hours

11 were seen fairly soon, within 3 - 6 hours

5 waited some time to be seen, 7 - 14 hours. These figures include those arrested during the very early hours of the morning and seen during the course of the working day.

During the first 2 days:

9 were seen on day 1

15 were seen on day 2.

6.3 Requests for examination after arrest

51 (41%) knew that they should be examined soon after arrest (see 5.1).

24 **asked** for a routine examination

27 did not ask for routine examinations.

6.4 Details of history

The 70 respondents seen routinely were asked details of the story taken by the District Surgeon [DS].

8 (11%) had a full history was taken
7 (10%) were asked about past or chronic illness
1 (1%) was asked about medication
17 (24%) were asked "What's wrong?"
12 (17%) said that the DS never spoke to them
25 (36%) gave no details of a history taken.

"What's wrong?" or phrased differently, "Are you sick?", "Are you OK?" or "Any problems?" was the commonest form of history taking.

In cases where respondents had obvious injuries the DS's asked similar types of questions: "What happened?", "Were you assaulted?" or "Were you injured?"

One young female reported that the DS asked if she was pregnant. According to her a prison doctor concerned enough to ask about a possible pregnancy, must be a `nice person'.

(Comments:

* The sergeant asked the DS if we were "OK to be transported."
* The DS was annoyed that I requested a vegetarian diet.)

6.5 Details of examination done

The 70 examined routinely, were asked for details regarding their physical examination:

11 (16%) were examined thoroughly; the doctor took special care
18 (26%) had satisfactory general examinations
19 (27%) had their chests listened to while they stood in a row with their shirts pulled up
2 (3%) had only the `part' they complained about examined, e.g. ears
3 (4%) said the part complained about and their chests were examined
4 (6%) said the examination was rushed; that the DS had too many patients to see in a short time (see **Table 6.5**)
5 (7%) said the DS only looked at them, they were not examined.
8 (11%) did not comment.

Table 6.2: Delays in Medical Screening.

Time		No of patients
Day 1	0 - 2 hours	9
	3 - 6 hours	11
	7 - 24 hours	5
	unspecified	9
Day 2		15
Day 3 - 7		16
Day 8 - 14		3
> 14 days		2
Total		**70**

Table 6.5: Details of screening described as rushed.

Patient/Area	Detention	Respondents' comments on screening.
21 yr M, WCu	5 weeks	After 8 hours of torture he told the DS that there were no marks on his body because he was "cleverly assaulted". The DS "wasn't interested", he was "endorsing that I was fit" (for detention).
62 yr M, ECu	27 months	The doctor behaved like a policeman: he did not speak, only walked past and looked at our eyes and into our mouths.
37 yr M, ECu	6 months	We waited from 2 a.m. until noon at the prison to be examined. We stood in a queue (shirts pulled up) while he listened to our chest. He was too rushed, I didn't get a chance to tell him about my chest.
18 yr M, ECr	3 months	We were lined up with our shirts pulled up. The DS put his hands around our chests and made us breathe. He did nothing else. He never spoke to us.

7. PHYSICAL SYMPTOMS

7.1 Incidence of physical symptoms

96 (78%) respondents reported experiencing physical symptoms while in detention as shown in the pie chart below. The accompanying **Bar Graph** 7 illustrates the incidence and severity of various physical symptoms (monthly, 2-3 times weekly, daily or continuous/intense).

7.2 Changes in body weight

From the pie-chart below it can be seen that weight loss, and particularly severe weight loss (2 Kilograms or more), occurred fairly commonly, whereas weight gain was unusual.

51 (41%) complained of weight loss:
- 14 (27%) moderate
- 37 (73%) severe.

2 (1.6%) gained weight.

Figure 7.1(a):
Incidence of Physical Symptoms

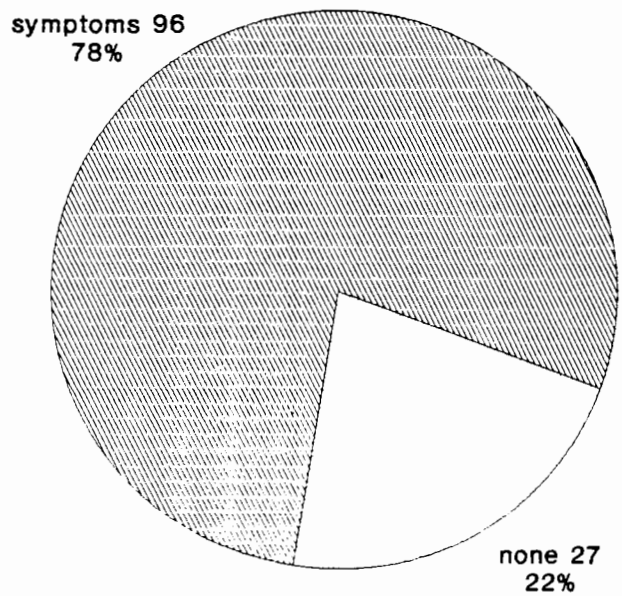
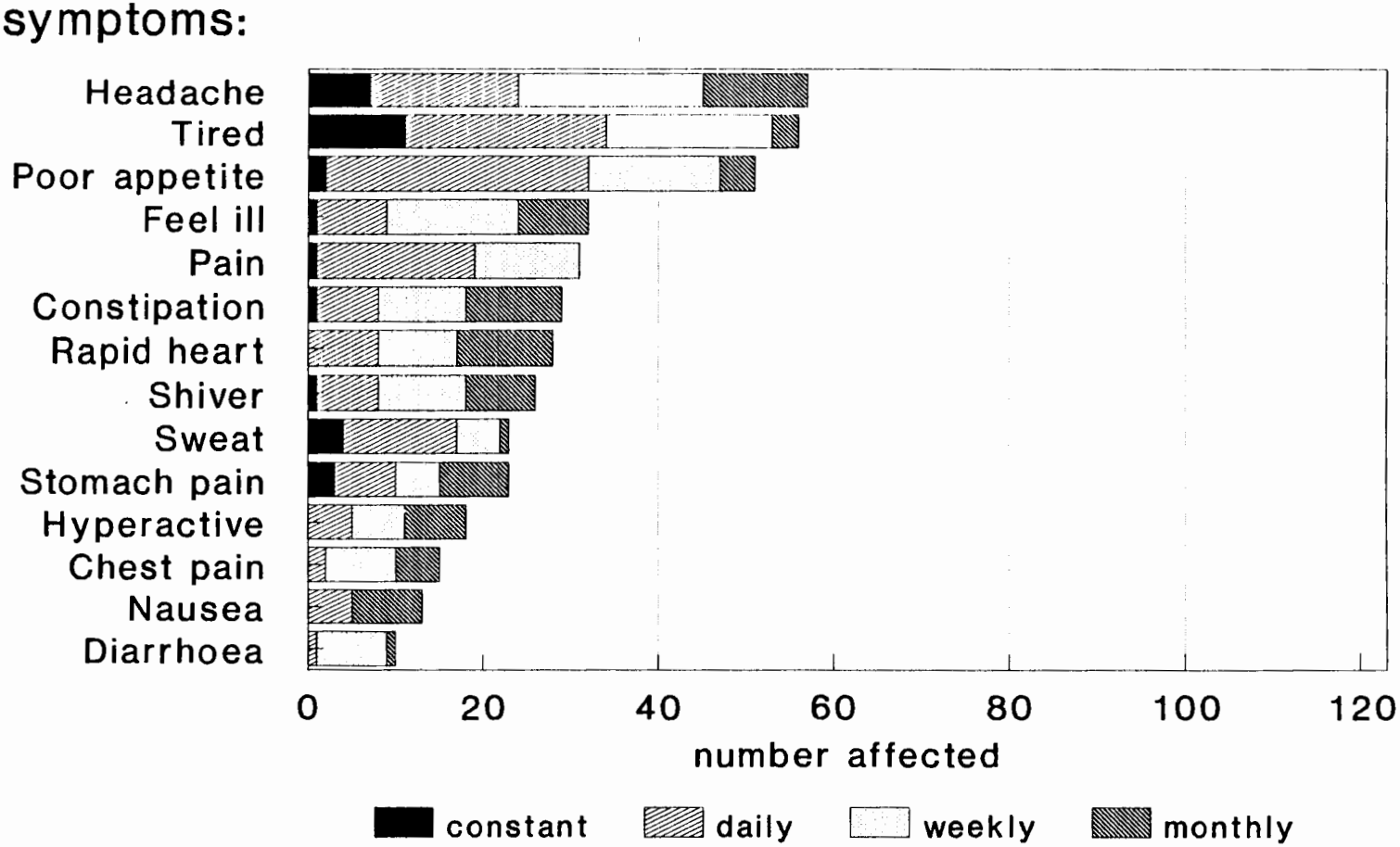


Figure 7.1(b):
Type of Physical Symptoms



8. PSYCHOLOGICAL SYMPTOMS

8.1 Incidence of psychological symptoms

87 (71%) interviewees (n=123) indicated that they experienced psychological distress, as shown in the pie chart below. The table and accompanying **Bar Graph 8** illustrates the frequency and the severity with which these symptoms occurred (monthly, 2-3 times weekly, daily or continuously/intensely).

8.2 Changes in sleep patterns

81 (66%) complained of sleeplessness (n=123):

- 25 (31%) were moderately affected
- 56 (69%) were severely affected.

9 (7%) slept a lot.

Figure 8.1(a):
Incidence of Psychological Symptoms

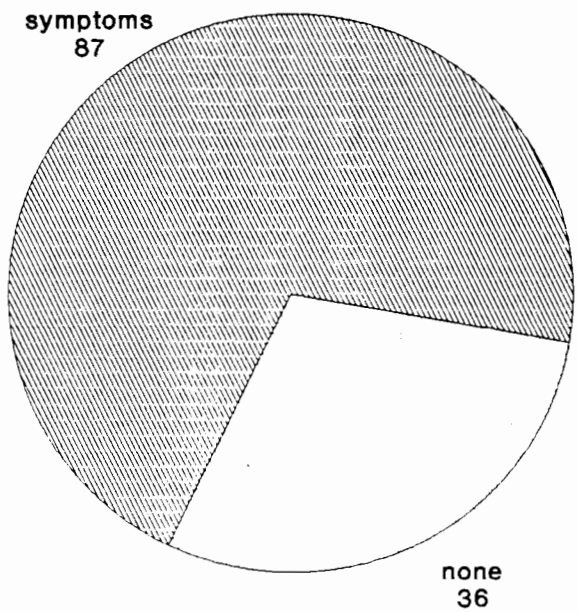
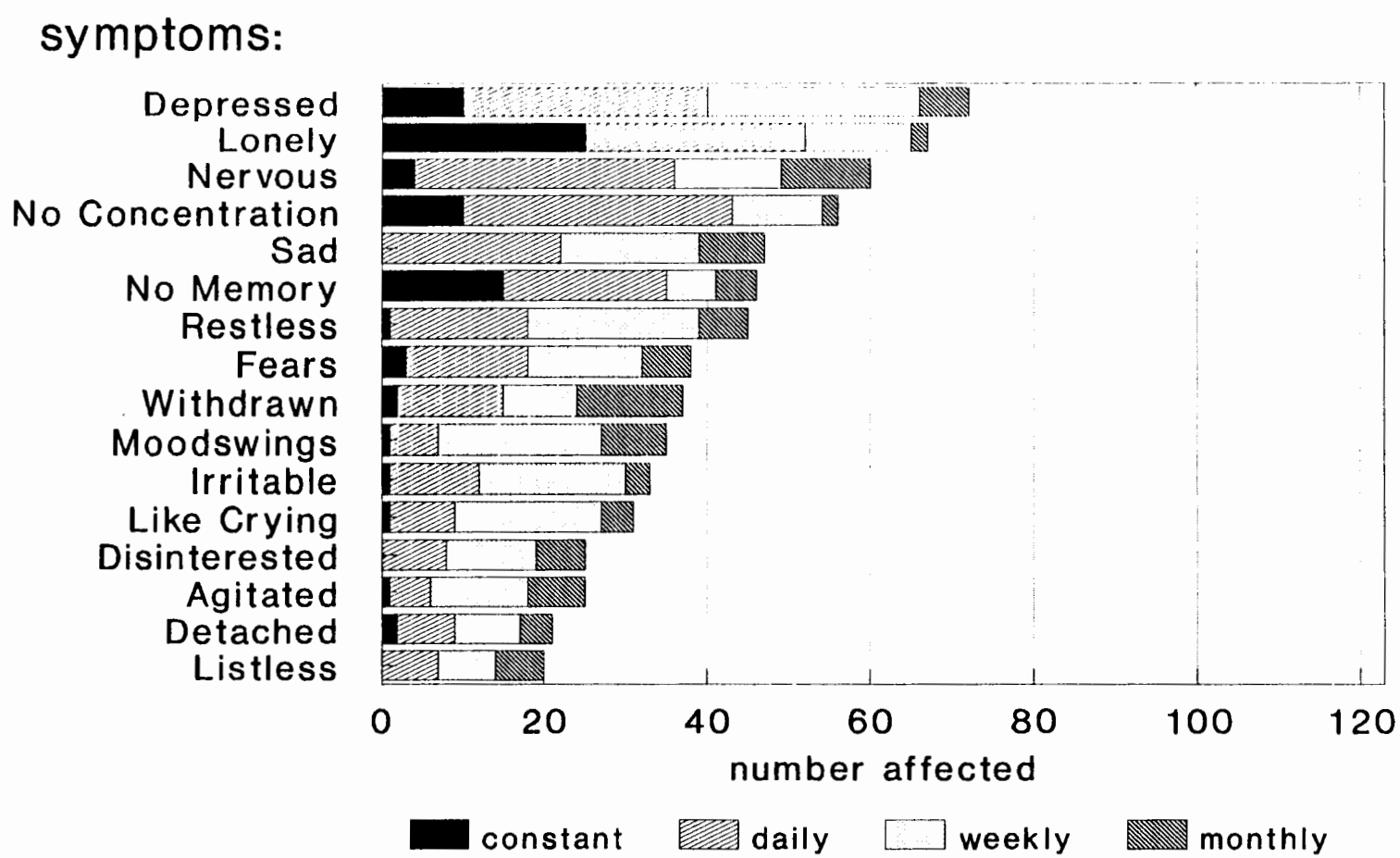


Figure 8.1(b):
Type of Psychological Symptoms



9. MEDICAL MANAGEMENT

It was possible to establish the different types of health care providers (DS, dentist, medical officer, specialist or paramedical) with whom respondents consulted.

9.1 District Surgeons [DS]

Each DS who dealt with a respondent was recorded as a separate "consultant". When asked how many different DSs they saw, some mentioned only those whom they requested to see. Others included those encountered at routine examinations (without necessarily being sick): after arrest, on admission to a prison, or as Sec 29 detainees.

111 (90%) were seen by DSs with 239 encounters between specific doctors and patients recorded:

- 27 (24%) were seen by 1 DS
- 50 (45%) were seen by 2 DSs
- 27 (24%) were seen by 3 DSs
- 8 (7%) were seen by 4 DSs
- 1 (1%) was seen by 5 DSs.

9.2 Dentists

42 respondents were seen by 44 dentists:

- 40 were seen by 1 dentist
- 2 were seen by 2 dentists.

9.3 Hospitals and Hospital doctors/specialists

10 respondents spent time in a general hospital (cf prison "hospital" or sick-bay).

32 respondents were seen as in- or out-patients by a 35 different medical officers or specialists:

- 29 were seen by 1 doctor
- 3 were seen by 2 doctors.

9.4 Psychiatrists/Psychologists

9 were referred for psychological treatment involving 10 consultants:
- 8 were seen by psychiatrists
- 1 was seen by both a psychiatrist and a clinical psychologist (private practice).

9.5 Other health care providers

6 respondents were seen by 7 paramedics or others:
- 2 were seen by physiotherapists
- 1 was seen by an optician
- 1 was seen by a (private practice) ophthalmologist
- 1 was taken to a local chemist who extracted a tooth (he asked to see a dentist)
- 1 respondent attended:
  - * a polyclinic for a Barium-meal
  - * an ENT surgeon in private practice for sinus irrigation after many months and several legal applications.

SICK WHILE IN DETENTION

10.1 Requests for medical care.

83 (67%) **asked** to see a DS

38 did not ask. They were either not ill or spent fairly short periods (<30 days) in detention.

2 did not ask because they felt intimidated:

* 1 was scared to ask
* 1 was warned that if she "made trouble" she would be transferred away from her home town.

10.2 Received medical care.

94 (76%) **were seen** by DSs while in detention:

73 (88%) of those who asked, were seen (10 were not).

18 were seen routinely without asking.

3 were referred to the DS by prison or police staff (they made no requests).

The reasons for the 3 referrals were:

* Fits at night: after a seizure a 41 year old man was removed from the cell to the prison hospital at St Albans where the DS saw him the next morning(ECu).
* Chronic chest complaint: a man of 37, with a chest complaint not responding to the medication of a nurse, was referred by her to the DS (ECr.)
* Depression: the prison Station Commander (WCr) brought the DS to see a 41 year old man who had complained of loneliness and depression.

10.3 Delays in medical care.

94 respondents were seen by a DS (see **Table 10.3**):

57 waited 0-3 days

3 waited 4-6 days

23 waited < 7 days (some DSs did weekly rounds)

5 waited < 14 days (Sec 29 seen fortnightly)

4 waited 3 - 4 weeks

2 waited > 6 months.

The 57 seen within 3 days included:

3 referred by staff members without asking

3 taken with groups for routine checks
(not requested, therefore no delays reported).

In 2 cases delays of more than 6 months were reported:

* 21 year old male made repeated requests to the police station commander (ECr) to see the DS for an ear complaint. Seven months later he was taken to see the DS at Eben Donges Building, PE. The DS ordered that he should have 2 monthly check-ups.

* Repeated requests of a 19 year old asthmatic, at police station (ECr), to see a doctor were ignored for 9 months. After seeing him, the DS wrote instructing the Station Commander to arrange consultations whenever they were requested.

10.4 Medical history taken.

10.4.1 Past History

83 (88%) were not asked about medication, previous or chronic illness

11 were asked some past history (detailed in **Table 10.4.1**):

- 8 were asked about incidents related to their presenting complaint
- 1 was asked about chronic illness
- 2 gave no details.

10.4.2 Present History

15 said that the DS did not speak to them, that their complaints were read off the "prison card" or presented by the nurse or medical orderly on duty.

63 were asked what was wrong, if they were sick, when "it" started, or how they felt (Hoe voel jy)?

6 were asked in some detail (**Table 10.4.2(a)**)

8 were asked details about complaints (**Table 10.4.2.(b)**)

2 reported discussions with the DS.

The 2 cases, who reported that the only interaction with the DS was confined to discussion, were:

* 21 year old male (WCr) held alone in a police cell for 4 months. He complained about the limited space, poor food and hygiene. He was told to accept the situation because there was no other place for him.

* 17 year old white female, with difficulty sleeping, asked the DS at Pollsmoor for Calmex because she was depressed. She was told that as he was not a qualified psychiatrist he was unable to diagnose, record or treat depression. He could record sleeplessness and offered her sleeping pills which she declined - by that stage "in a state of hysteria and tears".

7 of the detainees who were asked detailed past histories were also asked present histories in some detail.

10.5 Medical Examination

10.5.1 General comments on examination.

83 (88%) were examined by a DS

11 were not examined.

Respondents reported that physical examinations ranged from thorough and satisfactory (23%) to rushed or cursory (61%), to no examination being done at all (16%) (n=94).

11 had thorough examinations.

11 were satisfied with the general examination.

11 said only the part complained about was examined: sore ears were looked at with an aurescope; the eyes of those with visual problems were looked at (opthalmoscopes and Snellen's chart were not mentioned); if they had stomach-aches their tummies were felt (prodded), often while standing.

18 said that the examination consisted of listening to the chest with a stethoscope, usually while standing. Several described standing in a queue with their tops pulled up waiting to be "examined". One mentioned that he was examined over his clothing, another that during his examination the stethoscope was around the DS's neck.

22 said that the part complained about and their chests were examined.

6 said that the examination was rushed. Mention was made of large numbers waiting to be seen in a limited time. Three, from different regions, described the examination as `tut-tut-tut' (with the stethoscope) on the chest wall. (see **Table 10.5.1**)

4 said the DS only looked at them.

10.5.2 Examination Details

Routines and systems were listed to establish in more detail what the above examination entailed. Respondents ticked off which examinations were done. They include:

Routines (Weight, temp, BP, and urine tests)
Chest auscultation (heart and lungs)
Abdominal palpation
CNS examination (reflexes, sensation, power)
Eyes (vision)
Ears (hearing).

83 respondents had physical examinations (see **Table 10.5.2**).

66 were weighed
58 temperatures were taken
69 blood pressures were taken
47 urines were tested
75 chests were auscultated
46 abdomens were palpated
9 had their CNS examined
34 had their ears examined
38 had their eyes examined.

General comments on examinations:

* 2 respondents had their reflexes tested.
* Figures for ear examinations could be inflated if they were done following assaults which caused painful ears.
* The number of weights, temperatures, and urines done may be above average if detainees were on hunger strike at the time of examination.

Routines were often performed by assistants. It was not clear whether these were registered nurses or warders functioning as medical orderlies.

DSs took the blood pressures of 18 respondents.

DSs did routines in **10 cases** (BP on its own excluded):

1 Sec 29 detainee seen at the prison had **all 4 routines** done by a DS. (Several respondents identified this DS as thorough.)

6 at police stations had **3 routines** done by DSs:

- 2 at the DS's consulting rooms
- 4 at police stations without nursing help

3 had **one routine** each done by a DS (**Table 10.5.2**).

10.6 Quality of medical care

94 were seen by a DS on request or routinely:

- 25 (27%) were satisfied with their treatment
- 67 (71%) were dissatisfied with their treatment
- 2 said it depended on who the DS was.

10.7 Diagnosis

20 (21%) respondents were given a diagnosis

68 (72%) were not given a diagnosis

3 seen routinely had no physical complaint therefore a diagnosis did not apply

3 felt their complaints were not taken seriously because they were told there was nothing wrong with them; that they were malingering (see **Table 10.7**).

10.8 Attitudes of doctors

Consultations between detainee-patients and 251 different doctors (number of doctors, not times examined) were rated for attitude. They include DSs, dentists and specialists. Using a Likert scale the following results were obtained:

57 (22.7%) were rude and abusive

107 (42.6%) were disinterested and uncaring

63 (25.1%) were caring

24 (9.6%) were very caring and understanding

Altogether 164 of the doctors encountered were regarded as uncaring (n=251); in 65.3% of cases the doctors' main concern was not the well-being of the patient.

A few gave reasons for their rating of the doctors:

Caring

* A young woman (WCr), transferred to Pollsmoor, called the DS caring because he enquired about the possibility of pregnancy (without examining her).

Uncaring

* The DS was the same person who treated the respondent at SANTA (ECr) for TB. They knew each other. The DS listened to his chest, but did not continue the TB treatment. When in a hurry, this DS walked past the detainees and said they were "OK".

* The respondent presented for the 3rd time with a stomach ache which had not responded to treatment, to ask for other medicine. The DS acted "like a policeman", he would "not be told what to do".

District Surgeons, identified as Dr Good (sympathetic) and Dr Bad (rude and abusive), were identified and compared in both the Eastern and Western Cape regions.

One DS in the EC was rejected by all but one, of the 13, respondents who identified him by name. She was very depressed. She said that when he came to inspect the rural prison, where she was held, he always came to chat to her although he was not responsible for her care. He advised her "to sit in the sun" and "not to think about her children". She thought he was a "nice old man".

On at least 2 occasions his attitudes were sharply contrasted with those of Dr Good in the same region. For more detail see **Table 10.8.(a)** and **Table 10.8(b)**.

10.9 Privacy during consultation

31 (33%) respondents were alone with DS and able to speak to him privately (n=94).

61 (65%) had no privacy. There was either a nurse, medical orderly, warden, policeman or security policeman present during the consultation.

2 (2%) reported that it depended on the DS examining them; some DSs insisted on being alone with patients.

10.10 Treatment

10.10.1 Prescriptions

80 (85%) received medication for their complaints

14 (15%) did not receive treatment.

10.10.2 Medication delays

Delays reported by the 80 put on treatment:

76 waited < 48 hours

2 waited 3 days

1 waited 7 days

1 waited 10 days (see **Table 10.10.2**).

10.10.3 Effect of medication

36 found the medicine helpful

36 found it unhelpful

4 said it depended (what and by whom) - **Table 10.10.3(a)**

1 was unsure

3 discarded/did not use the medicine - **Table 10.10.3(b)**.

Table 10.3: Delays in awaiting Medical Care.

Time	No. of Patients	Comment
0 - 3 days	57	
4 - 6 days	3	
< 7 days	23	DS did weekly rounds.
< 14 days	5	Sec 29 seen fortnightly.
3 - 4 weeks	4	
> 6 months	2	
Total	94	

Table 10.4.1: Details of Past Medical History.

Circumstances	Complaint	Reported details of questions asked.
24 yr M Pott's spine	Breathing difficulties (cell damp/cold).	About past TB and treatment. Whether pills and medicine helped.
17 yr F	Sinus problems (damp).	About previous illness, allergies and treatment.
19 yr M	Headaches. Asked for psychological help.	Questioned about blood pressure and asthma.
24 yr M	Abdominal pain.	About previous episodes, their duration and what caused them.
33 yr F	Sleeplessness.	Mention of heart nerves led to questions about Rheumatic Fever.
50 yr M injured 1979	Ongoing leg problem.	Details about injury.
36 yr F & baby, Sec 29	Infant ill.	Feeding and inoculation details.
41 yr M	Fit in cell.	About previous episodes. How he felt (the next morning).
21 yr M	Diarrhoea, sleeplessness.	About serious previous or chronic illness.
49 yr M, Sec 29	Routine check-up	Past history (no details given).
20 yr M	Eyes, ears, diarrhoea.	Past history at first visit (no details given).

Table 10.4.2(a): Present Medical History in Some Detail.

Circumstances	Complaint	Reported details of questions asked.
17 yr M on HS	Beaten/dizzy, fainted.	Details about the incident. Seriousness of injuries.
22 yr F	Sick/distressed.	How she felt. About night sweats.
32 yr F on HS	Pimples on face.	How it started. How often it occurred.
21 yr M	Diarrhoea.	When it started. How bad it was.
33 yr F	Sleeplessness.	Was this the first time? How bad was it?
37 yr M	Persistent cough.	About prison medication, X Rays, and pain between shoulders.

Table 10.4.2(b): Present Medical History in Detail.

Circumstances	Complaint.	Reported details of questions asked.
34 yr F & Baby Sec 29	Infant ill.	Details about infant's illness, cell conditions, effects of detention.
19 yr M	Headache Psychological help.	About assaults, injuries, fears. Effects of isolation on the person/appetite.
44 yr M	"I am a most insistent man" (his words)	Some DSs took detailed histories and others took no history.
33 yr M	Painful to sit.	Detail about duration, constipation and defecation.
49 yr F Alone	Air conditioning (L le G).	About temperature variations (hot during day, cold at night). About blankets. Arranged for more blankets. Followed it up.
24 yr M	Chest, sore ear, headache.	Seriousness of attacks (asthma). Types and effectiveness of medication.
49 yr M, Sec 29	Routine exam.	DS asked details about assaults. He made notes.
24 yr M	Stomach pain.	Outset, duration, type of pain. Effect of medication.

7 of the detainees who were asked about past illnesses were also asked details about present illness.

Table 10.5.1: Details of examination described as rushed.

Patient/Area	Detention	Comments about examination.
18 yr M WCu	9 weeks	Quick, once over my chest (with a stethoscope).
41 yr M ECu	34 months	Referring to Dr Bad – he just prods you (in the stomach) and dishes out medicine.
38 yr M ECu	34 months	He asks about illness, he prescribes and you go. Occasionally he uses the stethoscope if you are seriously ill.
31 yr M ECu	32 months	Usually in a hurry with the stethoscope over your clothes; never thorough.
26 yr F ECu (White)	8 weeks	Cursory – only listened to the chest.
21 yr M ECr	18 months	Many waiting to be seen – 20 to 30 in one hour. Not always examined, sometimes uses a stethoscope (on chest).

Table 10.5.2: Examination routines.

Routine	DS	Nurse	Total
Weight	8 (12%)	58 (88%)	66
Temperature	8 (14%)	50 (86%)	58
B.P.	18 (26%)	41 (74%)	69
Urine	8 (17%)	39 (83%)	47

Table 10.7: Detail of "Malingering".

Patient/Area	Complaint.	Distric Surgeons' comments about condition.
24 yr M, WCu	Stomach pain.	The DS thought I was bluffing. He said there was nothing wrong with me.
27 yr M, WCr	Alone. Headache. Backache.	The DS said I was healthy. The Police "accused me of play-acting".
17 yr F, WCu	Sinus problems. Backache.	The DS looked at me. He hit down my spine with a (patella) hammer. He did not examine me (properly). He said there was nothing the matter with me.

Table 10.8(a): Comments on Dr Bad's Attitude.

Patient/Area	Reported comments on District Surgeons.
34 yr M, ECu	There were many complaints and petitions about the quality of food; sand in the vegetables; stinking fish full of bones; many flies. We were provided with "standard rations" but poor quality. In September 1986 we went on a hunger strike. The DS claimed that he ate the food (never in front of us) and that baby fish have many bones. I know fish, I worked at a fishery. We had a major confrontation. We never saw him again.
29 yr M, ECu	He always defended "The State". No matter what we asked for "The State could not afford it."
27 yr M, ECu	I had marks and bruises from assaults. He never spoke or asked questions, just looked at me. Gave me Panado. He was just there to "do his duty". He "didn't do anything that I know of to prevent further assaults".
32 yr M, ECu	He did routine examinations. When he saw me he said "You again" and moved on.
49 yr M, ECr, Sec 29	Routine Sec 29 visit after assaults. Dr Good took a history, examined me and recorded everything. Dr Bad (more senior) had to prescribe treatment. "He wanted to know who assaulted me. He held me to ransom. He refused to treat me for 3 months because I would not identify the culprits".
31 yr M, ECu	The detainees knew him by reputation. When he was on duty for sick parade we refused to attend.
44 yr M, ECu	I refused to be seen by him.
18 yr M, ECu	He visited JC Steyn prison carrying a gun. We had a meeting and submitted a complaint to the Commanding Officer. We were told it was an empty gun holster. He did sick parade on alternate weeks. When it was his turn, we stayed away.
41 yr M, ECu	The attitudes of DSs were tainted by the Biko experience. One DS carried a pistol holder - sometimes he left the pistol at reception, sometimes he carried it with him (more than 3 times). We knew it was not procedural but at St Albans we ignored it. At JC Steyn we threatened to boycott sick parade if he carried a gun. The major tried to defend him. After that the gun was removed.
24 yr M, ECu	When Dr Bad came to JC Steyn we refused to see him because of his reputation. We informed the staff that we would riot if he returned. We never saw him again.
26 yr F, ECu	I was the only white woman. I was isolated. Solitary confinement was psychologically damaging. He did not seem able to address that. He offered me tranquilisers. I refused because I am against that type of medication. Because I had no physical problems he felt I was fine. When I complained about solitary he "didn't see it as a problem". He accused me of "premenstrual aggression", something I have never suffered from. He put me on sleeping pills but I stopped taking them.
32 yr M, ECr	Rated by a white academic as rude and abrasive without further comment.
56 yr F, ECr	He came to Waainek prison every 2 weeks (? to inspect the books). I was very depressed (he may have been told). He came to the cell to check on me. "Hoe is jy? Hoe gaan dit met jou pyne? Jy moet nie so baie aan jou kinders dink nie. Sit in die son dan sal jy 'n bietjie beter voel".

Table 10.8(b): Comments on Dr Good's Attitude.

Patient/Area	Reported comments on District Surgeons
29 yr M, ECu	He was the only DS we could talk to like a doctor. He listened and did thorough examinations. Unlike Dr X who shouted at us and was rude if we asked questions, and who told us to f.. off. We refused to see Dr X - we boycotted him.
33 yr M, ECu	The medical orderlies blocked access to the DS. When I saw Dr Good he asked about my complaints - constipation, pain when sitting and passing a stool. I undressed and lay on an examining couch. He examined my ears, chest, tummy and did a rectal examination. He referred me to hospital.
37 yr M, ECr	The staff took me to the DS because I was not responding to treatment. He asked about the pain between my shoulders, about X-Rays. He saw I was sick and examined me properly. Said he didn't like what he was hearing and sent me for a chest X-Ray.
24 yr M, ECr	I had stomach pains. He asked about previous attacks, illness, childhood and operations. How long I had been sick. Did a fairly thorough examination; said I was suffering from ulcers and sent me to hospital for X-Rays. He put me on treatment which gave me relief. When it was finished, I relapsed. Dr X was racist and rude. He just looked. He asked "What do you want? You were here the other day, there is nothing wrong with you. Take him back to the cells."
49 yr M, ECr	Dr Good asked about assaults. I refused to give details (fear of retribution), but asked him to record his findings. Dr Good examined and diagnosed me. Dr Bad had to treat me. I had no treatment for 3 months because Dr Bad insisted that I first divulge who had assaulted me; he was holding me to ransom.

Table 10.10.2: Delays Receiving Medication.

Patient/Area	Complaint	Comments on medication delays.
36 yr F and baby, WCu Sec 29	Baby ill.	Script given to SP who bought medicines from chemist. Available after 3 days. Not given regularly.
24 yr M, ECu	Painful, discharging ear.	Pain pills issued after 3 days. Waited 3 weeks for eardrops.
38 yr M, ECr	Sore finger.	Taken from Kinkelbos Police Station to see DS at Eben Donges Building, P.E. Brufen prescribed. Nurse brought the pills from town at her next weekly visit to the Police Station.
26 yr M, ECr	Headaches, vision.	Waited 10 days for medicines and pills. Not given regularly.

Table 10.10.3(a): Prescription Sometimes Helped.

Patient/Area	Complaint.	Script.	Helpfulness.
41 yr M, ECr	Eyes, stomach pain, backache.	Panado for backache. Rubbing stuff for legs.	Sometimes.
24 yr M, ECr	Asthma	**Dr A** – No questions, shackled.	Gives same treatment for asthma and sore ankle. Not helpful.
		Dr B – Past history. Proper examination.	Continued with previous medication (ordered from chemist).
24 yr M, ECu	Chest	Medicine.	Effective
	Headache, deafness (R)	Pills.	Didn't help.
24 yr M, ECu	Constant abdominal pain	**Dr C** – "You were here the other day. You complained of nothing. Take him away".	No treatment given.
		Dr D – Past history and examination → "ulcers", sent for investigation.	Medicine gave temporary relief. When finished, relapsed.

Table 10.10.3(b): Prescription Discarded.

Patient/Area	Complaint	Script/comment	Reason for Discarding.
40 yr F, Karoo (on HS)	Pain L hip, numbness	Pills (HS* decision: only those with serious conditions would take medicine – BP/diabetes).	Didn't take them because didn't know what they were for.
18 yr M, WCu Alone 2 weeks	Loss of weight. Headaches.	Pills to "put on weight". Was allowed to take them to the cell with me.	Never used them.
26 yr F, ECu Alone	"Solitary" Headaches and sleeplessness.	Sleeping pills. Told I was fine because no physical abnormalities found.	Stopped taking them. "I am against that type of thing".

* HS - Hunger strike.

11. MEDICAL CARE FOR EMERGENCIES AFTER HOURS

11.1 Availability of help after hours

After hours (approximately from 4pm to 6am or 7am) help was generally more accessible at prisons than at police stations (see **Table 11.1(a)**).

97 (79%) said **help was available** at night:
- 62 could call for help at night
- 4 had cell guards who were always available
- 16 referred to routine rounds, at prisons and police stations
- 15 said that it was very difficult to get help at night

26 (21%) said **help was not available** at night:
- 19 said that there was no help available at night
- 7 had no day or night access to medical help.

(For details see **Table 11.1(b)**)

Description of help available after hours (see Table E under Discussion):

Warder on duty contactable:

62 respondents said that they were able to summons help in the event of an emergency during lock-up time. In many instances they were referring to intercom or bell systems available in prisons at Pollsmoor (CT), Victor Verster (Paarl), St Albans (PE), Graaff Reinet, Middelburg, and the female sections of Caledon, George and Waaineck (Grahamstown) prisons. Males held at George prison reported easy access to warders who were visibly present.

Cell guards:

4 respondents said that cell guards were always available. Some Section 29 detainees were guarded around the clock. At Worcester and Brandvlei prisons warders did nightly guard duty at the cell doors.

Routine rounds:

16 respondents spoke of routine rounds at prisons or police stations. Warders did regular rounds at JC Steyn (Kirkwood), North End (PE) and Robertson prisons. Routine checks done at the time of shift changes (10 pm, 6 am) were mentioned in relation to Brackenfell, Kensington, Milnerton, Ravensmead (all in CT), Stellenbosch, Beaufort East and Somerset East police stations.

The Louis le Grange police station in PE had a well regulated night patrol system. Cells had angled glass window ceilings and police guards patrolled along a wall at window level. In passing they knocked on every "window" and inmates were expected to respond physically (wake up and wave) in order to demonstrate that they "were not dead" (had not committed suicide).

Difficulties in obtaining help at night:

15 respondents said that it was difficult or impossible to get help at night. Their only option was to call for help; to shout and scream and bang on the bars. At Bonnievale and Swartkops, respondents were able to summons help in this manner, while at Parow and Maitland, Fort Beaufort, Murraysburg and Simondium it was sometimes very difficult and at Steenberg, Claremont and Ceres the cells were too far away from the charge office for detainees to be heard. At Hankey the station commander seldom did a round and the policemen were forbidden to talk to detainees. Several respondents commented that the help available at small places depended on the work demands at that moment.

11.2 Requests for help after hours

18 (15%) did not need help after hours.

105 (85%) asked for help after hours:

- 52 calls were heeded
- 45 elicited no response
- 8 said it was impossible for them to get help (see **Table 11.2**).

11.3 Delays in help after hours

52 (42%) calls for help at night were answered:

- 12 did not wait (0-30 minutes)
- 16 waited 1-3 hours
- 7 said that the time varied
- 1 waited until the next morning
- 2 said the intercom was answered, but nobody came
- 14 did not specify the length of time waited.

In 28 (54%) cases somebody came to determine the reason for calling within 3 hours (n=52). At St Albans prison (PE) it took 3 hours to arrange to have a patient removed from the cell.

7 (13%) said that the waiting time varied:
at **police stations** it depended on
* the number of people on duty
* how busy they were

at **prisons** it depended on
* how far the warder was with his rounds.

A white woman held at Caledon prison said that there were no female warders on night duty. Male warders answered intercom calls but were not allowed to enter the female section. All emergencies had to wait until the next morning.

2 men at the New Male Prison at East London, at different times, both said that their calls over the intercom were answered but their requests were ignored; nobody ever came to see what was happening in the cells.

Different night-time routines were practised. Respondents held at St Albans (PE) and Waainek (Grahamstown) prisons described a similar night emergency routine. The warder on duty would go to the cell to determine what was needed. If medicines were necessary, the medical orderly on duty would be summoned to provide medication. If injections were necessary, as in the case of fits, the patient had to be taken to the window for the injection to be given through "the flap".

At Waainek, Grahamstown, the cells were not unlocked at night. At St Albans, PE, the major had to be called and woken to come and unlock the cell for seriously ill patients to be removed to the prison hospital. The DS saw patients at the prison hospital the next day.

The ability to alert personnel was not necessarily synonymous with obtaining help:

* At the Graaff Reinet Police Station the warder on duty responded to the bell. In the case of a seriously ill person the adjutant had to be woken at home to come and unlock the cell for the patients to be "removed".

* At Worcester prison the cell guard would come to see what was wrong but the cells were never opened, "not even in cases of assault".

* At Middelburg the warder would inspect the situation, but medication and care were only available the following morning.

* The women at North End Prison, PE, reported similar circumstances: that warders would respond "maar kon niks doen nie, want ons was toegesluit".

* At Robertson anyone who complained "after things had settled down" (for the night) was "looking for trouble" (? vulnerable to gang attacks).

Table 11.1(a): Availability of help after hours.

Response	Number	Percent
Access, could call	62	50.5%
Guards	4	3.3%
Rounds	16	13.0%
Difficult	15	12.2%
Never tried	19	15.4%
No access	7	5.7%
Total	**123**	**100.0%**

Table 11.1(b): No Medical Help Available, Day or Night.

Patient/Area/Period	Problems specified	Comments on availability of help.
22 yr M, WCr 14 weeks	Valve replacement. On Digoxin.	Never saw a Dr (day or night). Asked several times. Ignored, refused. They didn't want anybody to know where I was/to see me.
22 yr M, WCr 3 weeks	Held alone.	I never saw a Dr (after arrest or on transfer). All I got to eat was "katkop"* and jam three times a day. When I asked for more food they cursed and swore at me. Help at night was out.
22 yr M, Karoo 14 weeks		Never saw a Dr all the time. Asked (during day). Refused. Told to find "Mandela's Dr".
25 yr F, Karoo 12 weeks		I only saw a DS once soon after arrest. He didn't speak to the group, just looked and said we were OK. They threatened to send us away (to another town) if we made "trouble".
26 yr M, WCu 2 weeks		I never saw a Dr. I was never really ill. It was unwise to ask for a doctor, even during the day.
20 yr M, ECr 33 weeks		Never saw a Dr, except on hunger strike. Then we were taken as a group and he spoke to us. The nurses checked us daily. They were abusive - called us stupid, terrorist, communists.
27 yr M, ECr 24 weeks		All I had was a routine examination, otherwise I asked nurses for medicine. Unless you were very sick it was better not to ask to see a DS.

* Katkop: A $^1/_4$ to $^1/_2$ end of bread (dry).

Table 11.2: "Impossible" to Obtain Help at Night.

Patient	Place	Comments on availability of help.
17 yr M (on HS*)	Tulbach	Nobody could hear me except 2 other detainees in an adjacent cell. Once during the day I called the gardener to summons the Station Commander for me.
40 yr M	Murraysburg	We tried without success. At times nobody manned the station. (Returning from a braai, drunken off-duty officers kicked up such a shindy that "the youngster on duty" ran away.)
20 yr M (on HS)	Keevespos, Suurberg	This remote farm police station was manned by 2 officers. They locked up to go home in the evening and returned the next morning.
39 yr M	Simondium	Over the weekend I got no food; from Friday to Sunday I never saw a soul.
23 yr M	Brackenfell	I called for food. They either did not hear or ignored me.
19 yr F	Sea Point	I called and called but nobody came.
33 yr F	Parow	I shouted and shouted. They did not hear me or if they did, they didn't come.
26 yr M	Maitland	The cells were in the yard (far away). You could shout, but they didn't hear or care about you.

* HS - hunger strike.

12. REFERRALS AND INVESTIGATIONS

12.1 Hospital Referrals

49 (40%) **requested** hospital care:
- 20 attended general outpatients (for details see **Table 12.1(a)**)
- 2 attended dental outpatients
- 9 were hospitalised
- 18 requests were ignored.

74 (60%) **did not ask** for hospital care.
- 1 respondent on hunger strike (HS), who suffered from dizzy and fainting spells, after an assault, was transferred to hospital for admission without asking.

Altogether 10 were hospitalised (see **Table 12.1(b)**).

12.2 Specialist Care

31 (25%) **requested** specialist care (n=123).

18 (58%) of these **received** specialist care (n=31):
- 5 had psychiatric care (all in WCape)
- 4 were seen by ophthalmologists
- 4 were seen by ENT specialists (2 with injuries) (See **Table 12.2**)
- 3 were seen by physicians/medical officers
- 1 was seen by a urologist
- 1 was seen by a "nerve doctor" (? neurologist).

12.3 Special Investigations

23 (19%) special investigations were done (n=123).
13 (57%) were given results of these tests (n=23).

Comments on special investigations:

* A doctor in OPD ordered a Chest X-Ray. The patient was upset because the DS (not the doctor concerned) gave him the results.

* The respondent "got away" (escaped) before the results were available.

Table 12.1(a): Reasons for 20 OPD referrals.

Number of patients.	Reasons for referrals.
4	Injuries
4	Chest complaints/pains
3	Gastro-intestinal tract complaints
2	Backaches
2	Headaches
1	Rash
1	Diabetic
1	Sexually transmitted disease
1	For investigation (poor response to treatment).
1	Ill infant (mother breastfeeding).

Table 12.1(b): Details of Hospital Admissions.

Patient/Area	Complaint & Mx	Type of care reported.
23 yr M, Karoo	Operation for piles.	No guards. Shackled. Staff decent and efficient.
32 yr M, WCu	Arthroscopy R Knee.	24 hr guard (2 SP). Not shackled. Gowned SP escorted patient into theatre. Staff aggressive.
39 yr M, WCr	Bladder scope.	24 hr guards. Staff nice but nervous. Doctor rude.
26 yr M, WCu	Breast lump biopsy.	3 guards. Legs shackled, he objected. Shackles removed. Staff helpful.
44 yr M, ECr *	Ear trouble after severe assault. (Stopped by St. Com.). Refused surgery.	2 guards. Refused shackles. Isolated.
21 yr M, ECu	Ch. abdominal pain, 4 day HS: vomiting ++ on eating. Refused op.	1 guard. 1 arm shackled.
33 yr M, ECu	Rectal abscess incised. Improved.	2 guards. Not shackled. Staff friendly.
34 yr M, ECu	Dogbite in custody.	Guarded (? number). Refused to be shackled. Snr Sister arrogant. Nurses sympathetic.
29 yr M, ECr	Persistent ear trouble. No response to Rx. Investigated. "Got away" before results given.	1 guard per shift. Not shackled. Staff ordered not to speak to him. Order ignored.
32 yr M, Karoo	Weak from HS. Sent to Uitenhage hospital.	2 guards. Leg shackled during day, arm at night. Nurses friendly, spoke to him.

* This case was first referred to ENT, and later hospitalised.

Table 12.2: ENT Referral Details.

Patient/Area	Situation and comments on referrals.
44 yr, M/ECr *	Severe assault (stopped by Station Commander). Caused painful, leaking ear. Hospitalised and operated.
24 yr, M/ECu	Face kicked (teeth broken/ear injured) and head dunked into stinking water. Developed micropurulent discharge and deafness. Attended ENT Clinic. Refused operation.
32 yr, M/ECr	Sinusitis drained at ENT, Uitenhage Hospital (very painful), no improvement. After legal intervention over 4 months sent to private ENT consultant, and improved.
29 yr, M/ECr	Old mastoid problem caused severe earache, attended ENT OPD.

* This case was referred to OPD and hospitalised.

13. ASSAULTS WHILE IN DETENTION.

Assaults in detention exclude the physical manhandling associated with arrest. It includes those who, after arrest, were taken from detention to isolated "safe" places where they were interrogated and assaulted for several hours (4-6-8 hours). Several Port Elizabeth respondents identified the abandoned "Fairview School" as a venue used for this purpose.

Respondents identified different types of assault and abuse by officials.

Verbal [V] - Swearing and name calling.

Threats [T] - Threats of physical injury, abduction and death to self, family or friends.

Interrogation [I] - Prolonged questioning using various techniques: the Goodman/Badman approach was often used.

Psychological [S] - Prolonged Goodman/Badman interrogation. Ongoing threats to self and family. False accusations/information and naming false sources. Offers of rewards. Sham executions. Isolation.

Physical [P] - Slapping, beating, punching, kicking, dunking, suffocation, "helicopter" and electric shocks.

In September 1985 Dr Wendy Orr brought a court interdict against the police at Port Elizabeth, which restrained them from assaulting detainees under their care. Thereafter sophisticated non-invasive methods of assault/torture were devised and used (particularly in the Eastern Cape) to minimise physical evidence of injury. Typical examples were: forced exercise, sleep deprivation, suffocation, and dunking the head under water. Suffocation was most commonly reported in the EC urban area (in 10 out of 24 assault cases, or 37%): Soap was rubbed on the face and a rubber tube pulled over the head. In several instances this was associated with electric shocks and/or the "helicopter" method (see Appendix 10 under Discussion).* When all three the latter methods were employed it was designated as everything [E] or torture (severe physical assault).

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* Rayner Mary. The Medical Response to the Problem of Torture, 1985 - 1987. In: *Turning a Blind Eye? Medical Accountability and the Prevention of Torture in South Africa.* Washington DC: American Association for the Advancement of Science, 1987: 67 - 84.

13.1 Type and number of assaults.

61 (50%) were not assaulted during detention (n=123).
35 (29%) were subjected to non-invasive abuse (verbal, threats, interrogation and psychological).
10 (8%)were physically assaulted.
17 (14%) were severely assaulted/tortured (12 from the ECape) (see **Table 13.1**)

13.2 Requested for medical care after assaults

20 (75%) of those physically abused or tortured **required** medical care for their injuries (n=27).
15 respondents **asked** for medical care:
- 6 **received** medical care
- 9 did not receive medical care.

13.3 Provision of medical care after assaults

6 who asked, **received** medical care
6 had **routine** examinations (after arrest, transfer or in Section 29).

13.4 Delays in medical care after assaults

12 respondents received medical attention (requested or routine) following assaults:
- 3 waited 0-48 hours
- 5 waited 2-7 days
- 2 waited 2 weeks
- 2 were uncertain about the time lapse (not specified).

13.5 Assault histories

9 respondents were asked how the injuries occurred:
- 6 reported that the DS kept some record
- 3 were not sure if records were kept.

One particular DS made a point of taking and recording assault histories. He gave victims the option of laying a charge. They all declined for fear of retribution.

13.6 Assault examinations

6 of the assault victims reported satisfactory or thorough examinations (see **Table 13.6 (a)**).

6 *said* that their examination was cursory (the doctor "just looked at" the area of complaint; listened to the chest; or a combination of the two) (see **Table 13.6 (b)**).

13.7 Interventions to put a stop to Assault

In 4 cases assaults were discontinued after apparent interventions by doctors (3 cases) or a Station Commander (1 cases). They included:

* 17 years old male on hunger strike (WCr), Nov 1990: He was beaten, became dizzy and fainted. After coming around he had difficulty speaking and was unable to stand. The DS warned the SP about the danger of further assaults.

* 23 year old female (WCr): She was beaten and bruised. She assumes the DS referred her to a Social Worker who came to see her and took a detailed statement. The assaults ceased.

* 29 year old male (ECu): Tortured. Requests for medical care were not responded to for 7 days (time for lesions to heal). Assaults stopped on probable recommendation of DS.

* 44 year old male (ECu): Prolonged periods (9 hours) of repeated torture (3 days). The police Station Commander intervened, putting a stop to the assaults.

Table 13.1: Types of Assault

Type	Number	Percent
None	61	50%
Non-invasive:		
Verbal	5	28%
Threats	8	
Interrogated	19	
Psychological	3	
Physical	10	8%
Torture	17	14%
Total	**123**	**100%**

Table 13.6(a): Satisfactory examination after assaults.

Patient/Area	Assault	Need Rx	Ask Rx	Exam	Hist	Record	Comments on examination.
17 yr M, WCr Sec 29	Beaten, kicked.	Yes	Yes	Yes	Yes	?	On HS. Beaten - dizzy and l.o.c. Unable to stand, difficulty speaking. Saw 3 DSs in succession. Proper exam. Daily checkups. SP warned.
27 yr M, ECu	Torture	Yes	Yes	Yes (day 2)	Yes	Yes	Shirt off. DS felt whole body - proper job. Offer to lay a charge declined.
18 yr M, ECu Cripple,	Severe torture.	Yes	No	Yes	Yes	Yes	On return to prison a warder was concerned about his appearance. Taken to front of DS queue. Examined properly.
44 yr M, ECu	Torture x 3 days. Dunked in well - vomited into hood.	Yes	Yes	Yes	Yes	?	Severe workover 9 hrs/day x 3 days. Proper exam. Declined to lay charge. Station Com intervened - assault stopped. SP warned about suicidal tendency.
24 yr M, ECu	Severe torture.	Yes	Yes	Yes	Yes	Yes	Proper examination. Didn't lay charge because warned by SP about the consequences.
49 yr M, ECu Section 29	Torture (not shocked.)	Yes	No	Routine (day 14)	Yes	Yes	DS asked re assault, details not given for fear of retribution. Recorded findings. Dr X examined me well; made a diagnoses. Dr Y refused to prescribe medicine before assailants were identified. For 3 months no medication issued.

Table 13.6(b): Dissatisfied with examination after assault.

Patient/Area	Assault	Need Rx	Ask Rx	Exam	Hist	Record	Comments on examination.
24 yr M, WCr Sec 29	Interrogated and deprived of sleep.	Yes	Yes	Routine (day 14)	No	No	Complained of stomach pain. Stomach felt while standing. 2 SP present. DS unsympathetic (not trusted).
23 yr F, WCr	Interrogated and beaten.	No	No	Routine (day 3)	Yes	?	Black eyes - no treatment. ? DS referred case to S Worker - took statement. Assaults stopped.
29 yr M, ECu	Torture.	Yes	Yes	Yes	Yes	Yes	Kept away from DS while tortured (7 days). DS felt all over body. Gave pills. Assaults stopped on ? DS recommendation.
27 yr M, ECu Sec 29	Torture.	Yes	Yes	Routine (day 7)	No	?	DS looked at and felt hand. Uncaring, unconcerned attitude.
21 yr M, ECr	Beaten.	Yes	Yes	Yes (day 4)	No	?	Taken to GP's consulting room. Waited in van while SP spoke to DS. No history taken (assume SP gave details). Touched face and shoulders.
27 yr M, ECr	Torture.	Yes	Yes	Yes (day 5)	Yes	Yes	DS asked re bruising and made notes. Only auscultated. (Mouth/ears not examined.)

14. SOLITARY CONFINEMENT

Section 29 of the Internal Security Act (74 of 1982) specifies detention in isolation, up to 180 days, for the purpose of interrogation. This period may be extended by Ministerial order (for details see Introduction).

Many State of Emergency (SOE) detainees were held alone in cells for varying periods of time under conditions which were not unlike those of Section 29 detention (incommunicado, interrogated).

To distinguish between these two forms of isolation in detention the former group are referred to as Section 29 detainees (Sec 29) and the latter as being held "alone" (A). "Alone" excludes SOE detainees held in prisons where they communicated and mingled with other detainees during the day, but were held in single cells overnight.

14.1 Incidence and conditions of isolation

83 (67%) spent time in isolation (n=123)
- 70 were SOE detainees
- 12 were Sec 29 detainees
- 1 was not told under which law he was being held. He was detained in November 1990, after the SOE had lapsed in June 1990.

14.2 Duration of isolation

83 respondents were held in isolation: see **Table 14.2** for the breakdown of periods in isolation.

20 (24%) spent more than 90 days alone in a cell (n=83) 8 of these were Sec 29 detainees.

14.3 Effects of isolation

74 (89%) suffered adverse effects (physical and/or mental) as a direct result of isolation (n=83)

9 (11%) were not effected by isolation.

14.4 Requests for medical care in isolation

38 (51%) of the 74 affected **asked** to see a doctor

36 (49%) did not ask to see a doctor.

14.5 Medical care provided in isolation

30 (79%) who asked, **were seen** by a DS (n=38).

8 (21%) who asked, were **not seen** by a DS.

23 **were seen as** part of a routine examination.
(On admission/transfer/Section 29).

14.6 Reporting effects of isolation

53 (64%) respondents in isolation saw a DS (n=83):
- 30 **complained** about isolation to the DS
- 23 **did not confide** in the DS:
  - 5 had no problems (were seen routinely)
  - 5 did not trust the DS
  - 2 feared retribution
  - 11 gave no reasons.

14.7 Medical response to the ill effects of isolation.

30 **informed** the DS about the ill effects of isolation:
- 6 said the DS was helpful **(Table 14.7(a))**
- 2 said the DS tried to help them **(Table 14.7(b))**
- 10 were given the impression that this was not a medical problem; that it was a security matter beyond the control of the DS **(Table 14.7(c))**
- 2 elicited no response
- 10 said nothing was done to help them.

The 6 (11%) who said that **the DS intervened** on their behalf to improve the situation (n=83), gave the following details:
- 2 were referred for psychiatric care.
- 2 were transferred from police cells to prisons (?hospitals) for better supervision of physical, not psychological, problems.

1 was transferred from a single police cell to a communal prison cell where he had company.

1 was given psychotropics for his "nerves" and to sleep.

Unhelpful responses from doctors and comments by detainees included the following:

* I complained of loneliness and sleeplessness, and asked for company. He gave me tablets which were unhelpful.
* He refused to do anything about my depression. The pills given for headache were useless.
* I was depressed when alone and sad after visits. The doctor did not know because I was not able tell him.
* I was afraid, lonely and sad. I was nervous, shaking and couldn't concentrate. My mind was confused. I thought I was having a nervous breakdown (30yr F, on HS). I was told that "treatment goes with food".
* I was nervous on my own (19yr M, cripple, on HS). I was told to eat and asked why I was on a hunger strike. I explained that I was prepared to die because I could not tolerate the situation of detention without trial.
* I was seen routinely in Sec 29. I complained of sleeplessness and was given pills which I discarded. I preferred to exercise.
* I complained of the psychological effects of isolation. I was offered tranquillisers which I rejected.
* I was told to "stop thinking about the people outside".
* I saw the doctor for my ear. I did not discuss solitary because "he was not a person you could trust or complain to".
* I had a routine examination at Grey Hospital, King William's Town, before I was taken to the Ciskei and held under Sec 29. During the 180 days spent in isolation I never saw a doctor.

The significance of the results in this chapter is discussed, with supporting evidence, in the following chapter.

Table 14.2: Type and duration of isolation.

	Type			
Period	**Section 29**	**"Alone"**	**Unknown**	**Total**
< 14 days	0	33	1	34 (41%)
15-30 days	1	13		14 (17%)
31-60 days	1	8		9 (11%)
61-90 daus	2	4		6 (7%)
91-180 daus	5	6		11 (13%)
> 180 days	3	6		9 (11%)
Total	**12**	**70**	**1**	**83 (100%)**

Table 14.7(a): Helped in isolation (6) - all in Western Cape Region.

Patient/Area	Type/Period	Symptoms	Consultation	Mx	Comments on intervention.
24 yr M, WCr	Alone 126 days	Depressed Suicidal	2 routine examinations (thorough).	Pills for nerves and to sleep	There was little else he was able to do.
18 yr M, WCu	Alone 56 days	Loss conc. weight loss, sleepless.	Routine examination.	Referred to Psychiatrist.	DS made psychiatrist appointment rather than prescribe tranquilisers (my request). Psychiatrist confirmed "symptoms related to detention". Suggested I return if worse.
26 yr F, WCu	Sec 29 195 days	Sleepless, lonely, depressed, crying.	Routine examination.	Referred to Psychiatrist.	Initial 30 minute appointment then 10 minute appointments. Psychiatrist recommended books and music. Recommendations ignored.
32 yr M, WCu	Alone 3 days	Proteinurea.	Routine full history and examination.	Transfer	Transferred from police station to Pollsmoor for better medical supervision.
39 yr M, WCu	Alone 49 days	Bleeding piles.	Proper exam.	Transfer	DS warned police about sick people in cells without after-hour service (police station). Transferred me to VV prison.
26 yr M, WCu	Alone 30 days	Tiredness. Slept a lot.	Told DS	Transfer	He recommended transfer to prison. In a communal cell with company I improved.

Table 14.7(b): Doctor tried to help.

Patient/Area	Type/ Period	Symptoms	Consultation	Mx	Comments on intervention.
17 yr M, Karoo	Alone 15 days	Lonely, anxious, nervous.	Complained about loneliness.	Transfer.	DS asked that I be put with others. Nothing happened.
41 yr F, WCr	Alone 335 days	Lonely, nervous, memory loss, dizzy.	Proper examination.	Referred to Psychiatrist.	DS sympathetic. Discussion for 2 hours. Made appointment but I was released 2 days before the date.

Table 14.7(c): Doctor unable to help.

Patient/Area	Type/ Period	Symptoms	Consultation	Mx	Comments on intervention.
32 yr M, WCr	Alone 42 days	Lonely, fearful, anxious.	Asked for company.	Medicine.	The doctor doesn't have the power to change things.
22 yr M, Karoo	Alone 3 days	Cold, lonely.			DS said "It's none of my business".
21 yr M, WCu	Alone 14 days	Cut-off. Concern about family.	Raised concerns.		DS said "There is nothing I can do about it".
20 yr F, WCu	Sec 29 72 days	Fears, anxiety.	Routine exam. Solitary mentioned.		DS said "These are the regulations. You can't be put with others".
18 yr M, ECu	Alone 60 days	Lonely. Horror of prison.	Routine exam.		DS said "There is nothing I can do. You wanted to be here".
20 yr M, ECu	Alone 90 days	Tired, lonely, sad, crying, depress, poor memo, conc.	Told DS.		Nothing he can do. Told me to co-operate and give evidence (as a State Witness).
32 yr M, ECr	Alone 120 days	Lonely, frustrated, psycho torture.	Solitary mentioned.		He said he could not do anything, those "were the prison regulations".
31 yr M, ECr	Alone 195 days	Alone, restless.	Told DS.		DS said "My power to do anything is limited".
31 yr M, ECr	Alone 21 days	Scared (interro & torture daily).	Told DS. Solitary mentioned.		DS said "I only do my job as a doctor". Implying that that was a security matter.
17 yr M, WCr On HS assaulted	Alone 9 days (Nov 1990)	Dizzy, fainted. Difficulty standing/speaking	Daily check		DS warned SP about my physical condition and that further weakening (from HS) would lead to hospital admission. Charges laid by lawyer.

DISCUSSION

Two core issues emerge from this study: the secrecy which has, until recently, inhibited scrutiny of prison health care in South Africa, and, related to this, the poor quality of medical service which aggravated the appalling conditions of detention prevailing in the 1980s.

For more that 3 decades (1959-1992) **(1a, 2)** regulated control of the media kept the South African public ignorant about conditions in prisons. The sole public access to prison information was through medical reports of inquest proceedings which were, and remain, a legal necessity following death in detention **(3)**. The District Surgeons responsible for the medical care of detainees were, in addition to the traditional code of doctor-patient confidentiality, further restricted by compulsory security clearance (Dr NE Kahlberg, Director of Community Health Services - personal communication, 1991); they were not free to advocate for the improvement of prison conditions generally. This system cowered individuals and stifled opportunities for prison reform.

The extensive media coverage of the inquests which followed the deaths in detention of Mr Steve Biko (1977) **(4)** and Dr Neil Aggett (1982) **(5)**, raised public alarm about the standard of health care in prisons. To salvage the international reputation of South African medical practitioners, the Federal Council of the MASA briefed an *ad hoc* committee, under the chairmanship of legal expert Prof. SA Strauss, to investigate the medical care of detainees and prisoners in 1982 **(6)**. The medical profession, however, did not insist on the implementation of the admirable proposals made by this committee **(6, 7a)**. The only achievement was the government's acceptance (20/10/85) of the formation of an "*independent panel of doctors*" to attend detainees **(8)**. MASA stated that detainees would have access to a second opinion "*if for any reason they were not satisfied with the care provided by District Surgeons*" **(9)**. By February 1987 panellists had been appointed in 20 of the 21 MASA branches **(10a)** but failed to provide the intended service because a process and date for **implementation** were never finalised **(7b, 11)**. More than two years elapsed before the Security Police were instructed (in June 1989) to inform all Section 29 detainees about the MASA panels, after which a formal declaration had to be signed by them and witnessed **(12)** (see Document 2 under Introduction). This privilege did not apply to emergency detainees who apparently already had, on the recommendation of a District Surgeon, access to a second opinion **(12)**. It is an argument which ignores the significant difference between a patient having a choice of doctors and a doctor seeking medical guidance from a specialist. Indeed one District Surgeon stated that he "*would not allow any detainee access to a private physician as he needed no second opinion to confirm his*

diagnosis" **(13a)**. In addition, prison authorities also seem to have obstructed access to medical assistance from outside. This study confirms the failure of the MASA panels to provide an alternative service:

* Among the 15 respondents who "knew" about the MASA panel, only one (detained under Sec 29 in June 1990) was officially "informed" of its existence, but no document was signed.
* The requests of 6 respondents who asked to see MASA panellists were all refused (see Results 5.4).

The medical profession as a whole were further alienated from the controversial subject of prison health care by the state's disapproval of any interference and by the negative image and stigma attached to prison doctors. Health authorities and academics also distanced themselves from taking responsibility for the health care of prisoners, again partly because of government restrictions. By law, prison health issues never featured in local medical publications **(14)**.

In the past decade, only two academic surveys related to prison health have been published **(15, 16)**. Neither stem from medical faculties, and to date both have failed to elicit public discussion. The lack of response from academics can be ascribed to their non-participation in the projects and the relative inaccessibility of the information. The more recent Human Science Research Council's report of July 1994 **(16),** is mainly a qualitative study which reflects primarily the opinions of employees within a closed system. In many instances (see cross references) the views of staff members confirm the poor care mentioned by detainees. Only about one tenth of the report discusses the perceptions of prisoners themselves, interviewed while in custody: an environment not conducive to open disclosure.

To correct the imbalance this survey is based on information freely obtained from human rights activists imprisoned for their political aspirations. It concentrates on prison health care at the point of delivery, and includes information about medical rights, access to and availability of medical care, examinations and treatment of illness and assaults, attitudes of staff and other factors which may have contributed to a poor medical service. A picture of poor quality care and service emerges, with one exception: 95% of the respondents for whom drugs were prescribed received them within 48 hours.

Conditions of Detention

It is evident from this research and other documents that the experience of detention in prison and police cells varied according to race, age and gender.

Whites, separated by law from other prisoners **(1b)**, were treated much better than blacks: they all had beds and bedding, ablution facilities (see Appendix 7: Case Report 1), decent food **(17)**, exercise, extra clothing and regular family visits. From interviews conducted by the researcher it appears that District Surgeons were embarrassed by the presence of white middle class, academic women: they were not physically examined and allegedly "*tranquillisers and sleeping pills were issued too freely*". In one instance, arrangements were made for a white scholar to see her personal psychologist in addition to the state psychiatrist. When middle class white women, held at the North End Prison, Port Elizabeth, suffered excessive weight loss (more than 28 pounds) the extremely concerned District Surgeons visited them every second day and every week fresh fruit, vegetables, milk and yoghurt were purchased for them from outside shops. In contrast, African women held at the same prison complained that from Friday to Monday they received nothing but plain samp, occasionally mouldy (see Appendix 7: Case Report 1). At the same time a distinction was made between black and "coloured" women in the same cells. The "coloured" women were given extra bread and coffee (Ivy Gcina - personal communication, 1995).

Blacks in prisons had few of the above privileges. According to the detainees, most of them slept on 1 or 2 mats on cold, and sometimes damp, cement floors (see Appendix 7: Case Report 7) **(16a)**. They were issued with 2 to 5 blankets, often dirty and infested by bugs and/or fleas (see Appendix 7: Case Report 5). No other bedding was provided **(18)**. One detainee who inadvertently spent the weekend in a "white cell" commented on the comfort of a wooden floor, sheets and warm running water (J Magwa- personal communication, 1991).

In **prisons** where the respondents were held drinking fountains, showers, toilets and exercise yards were normally provided (see Appendix 7: Case Report 6). District Surgeons visited regularly and medical orderlies were on stand by (see Appendix 7: Case Reports 1 & 6). Family visits were fairly regular (see Appendix 7: Case Report 7). Mealtimes were: breakfast at 7:30am, lunch 11am, supper between 3:30 and 4:30pm, and earlier on Sundays (2:30-3:00pm). There were frequent complaints about the poor quality of the food: lack of fresh produce; poor preparation; contaminated with worms or sand; many bones and little substance; stale and rotten (fermenting) (see Appendix 7: Case Reports 1, 2, 4 & 7) **(16b)**. At St Albans Prison, Port Elizabeth, the struggle for better food lead to 2 hunger strikes (3-25 September 1986, and 14-20 May 1988) which were carefully documented by representative detainee committees **(19a)** (see Document 4). From different parts of the country there were complaints about the cooldrink that was served in place of tea or coffee; on cold days warm soup would

have been preferable. According to the prison diet schedule the cooldrink was essential for its vitamin content **(20a)**. Detainees' complaints about poor quality food were corroborated when independent testing by the Human Science Research Council and South African Bureau of Standards proved that protein substitutes (the much disliked "somos") and vitamin enriched drinks, provided on tender, were well below standard **(21, 22)**. Access to prison tuck-shops from which dry and tinned provisions could be purchased once a week, were a poor substitute for the lack of wholesome, fresh food.

Another contentious subject was the spacing of mealtimes, particularly in relation to special diets and to young people. For example,

* no in-between snacks were made available for peptic ulcer patients (meals at 3pm and 7am) nor were special diets provided for them **(13b, 19b).**
* A gap of 16 hours to breakfast (if supper is served at 3pm) is not suitable for growing youths who require extra nutrients and calories (an extra 3,000 calories per day) (see Appendix 7: Case Report 6) **(20a)**.

There is concern that this may not have changed, despite President Mandela's inaugural statement that no child belongs in prison, and that revised programmes for the treatment and training of juveniles have been promulgated. The only children supposedly still detained in prison for a limited period (less than 48 hours), are those "children in crisis" whose parents are "unsuitable" or who cannot be traced. It is unclear if extra food (or counselling) is provided for these, often neglected, "children in crisis" when they are arrested between 4pm and 7am (Gen Jordaan - Evidence before Parliamentary Portfolio Committee of Correctional Services, 28/3/95).

As in other countries **(23)**, conditions at **police stations** were generally worse than at prisons: bedding was filthy and infested; running water and toilets were not invariably provided, buckets of water and a "balie" (slop bucket) were used instead; there were no facilities for exercise or visits (see Appendix 7: Case Report 4) **(18)**. Women in particular were distressed by the lack of privacy of toilets without doors (see Appendix 7: Case Report 2) and often situated directly opposite the peephole in the cell door. Some black detainees in skimpy dress who were arrested off the streets waited weeks before they obtained a change of clothing (see Appendix 7: Case Reports 1 & 4). Visits, if they occurred at all, were infrequent. The only advantage at police stations was that detainees frequently received meals "*equivalent to that of an unmarried white policeman*" as laid down by court ruling (see Appendix 9) **(24)**. Those less fortunate, mostly in the rural areas, received some of the worst meals in the system: dry bread (or dry porridge) and coffee three times a day. Some meals never arrived (see Appendix

7: Case Report 2). At Groot Drakenstein one detainee was not fed from Friday evening until Monday morning. Sometimes it was impossible to get help (or food) no matter how loudly detainees called or tried to attract the attention of policemen. Visits by District Surgeons were sporadic if they occurred at all. Policemen, without medical training, and coping with other demands understandably distributed medicines on an apparently *ad hoc* basis (see Appendix 7: Case Reports 1 & 5).

The official response to information of this nature was that "*(t)hose in police detention are visited by a variety of officials such as judges, magistrates and senior police officials, besides the normal visit every hour. There is therefore ample opportunity to complain about conditions, food, etc*" **(17)**.

The care of individuals held at police station and lock-ups belong to a special category: although defined under the Act (no 8 of 1959) as prisons, the health care at police stations do not fall under the ambit of the Department of Correctional Services [DCS]; they are manned by policemen and do not have medically trained custodial officers in attendance. Nevertheless, the health care of those held in custody at police stations remains essentially a medical concern.

For **children** it was particularly stressful to be locked up with common criminals, as the following vignettes from this research reveal:

* As he pushed a 15 year old into a cell, the warder asked, "*Het julle elkeen 'n wyfie vir vanaand?*" The child lived in constant fear of assault and rape by the Twenty Eight Gang. He "panicked" during the entire month he spent among criminals; back among detainees he felt "safe" (see Appendix 7: Case Report 5).
* A 26 year old, described how youngsters were assaulted before they were raped. One was a child of 12. In the morning when the officer in charge unlocked and asked for "klagtes", nobody dared complain. Despite evidence of assault, facial bruising and black eyes, nothing was mentioned by prisoners or warders. For their own safety rape victims remained silent. The risks of opposing the gangs were well known: one's life was at stake (see Appendix 7: Case Report 7).

Women with infants faced the additional stress of trying to secure proper care for their children. Both the mothers interviewed in this study, incarcerated with breast-fed infants (respectively 2 and 16 months old), were detained under Section 29 of the ISA (see Appendix 7: Case Reports 2 & 3). Despite the provision that prisons should provide food, clothes and medical treatment for babies **(16c, 25a)**, both mothers complained about:

1) the unpredictable and erratic response to requests for additional feeds and extra nappies
2) the lack of sleeping facilities for the infants
3) the lack of play areas and the fact that cold cement floors were unsuitable for infants to crawl around on.

The only nursing facilities mentioned were those at Pollsmoor prison.

The uneven and appalling conditions of imprisonment described above affect both the physical and mental heath of inmates; they do not, however, in any way affect security. To ensure that prisoners are provided with proper living conditions, to which they are entitled **(26a)**, certain basic aspects of promotive health must be addressed and uniformly applied.

Detention Patterns.

It has generally been accepted that repression and detention was, with the exception of the PWV triangle (now Gauteng), worst in the Eastern Cape **(27, 28)**. By June 1987 25,000 people had been detained nation-wide, 9,000 of them in the Eastern Cape **(29)**. Of the Eastern Cape towns monitored, Alexandria had the highest detention rate at 8% of the black population **(27)**. This survey confirms that repression was harsher in the Eastern than in the Western Cape (WC), as illustrated by the prolonged periods of detention and the frequent moves to which Eastern Cape (EC) detainees were subjected (see Tables 2.4 and 2.5 under Results).

Respecting the period of detention, only 2 of the respondents polled in the Western Cape were detained for more than 9 months, whereas in the Eastern Cape 10 spent more than 30 months and 6 more than 33 months in detention. The Eastern Cape figures are not surprising in view of the fact that 87 detainees, named in the Eastern Province Herald of 24/12/88, were spending their third Christmas in detention (see Document 5) **(30)**. Four more names were later added to this list **(31)**. These individual had spent more than 30 uninterrupted months in detention since the onset of the Emergency on 12/6/86. The Eastern Cape was the only region where most of the first-tier political activists were detained for the entire emergency, from June 1986 until after the national hunger strike early in 1989 **(27, 32)**.

Transfers disrupt the routine of prison life and increase the stress of imprisonment. It takes some time for an inmate to adapt to the prison environment. Knowing that a specific bed or area has been allocated to him, provides the inmate with a sense of

belonging and stability. Being moved from known to unknown quarters leads to insecurity and anxiety **(33)**. The interviews confirmed that the disruption of moves was particularly stressful for those detained activists who set about forming cohesive support structures, organised political education and co-ordinated petitions for better living conditions, exercise, education and health care. The authorities discouraged these activities by deliberate disruptions. Unannounced and frequent transfers of leadership figures was used to break the solidarity among detainees. Known as "ghosting", this process of moving prisoners frequently throughout the prison system is a method used to discipline "disruptive" prisoners. Prison monitoring groups have condemned this practice as an "intimidation tactic" **(34)**.

There appears to be a link between the length of detention and the number of times a detainee was transferred. Possibly the common factors were the political profile and the organisational skills of specific individuals. In the Western Cape only 2 respondents were held in more than 4 places. But it was the Eastern Cape urban detainees, in particular, who were transferred frequently; 31% (8) were held in 4 to 7 different places, and 31% (8) in 8 to 12 different places. One juvenile of 18 experienced the most transfers, 11 altogether.

The majority of respondents (86%) were initially held at police stations: the rest were taken directly to prisons after arrest. All the detainees from the Karoo spent most of their incarceration in police cells. In the Western Cape only 11% spent their longest period of detention in police cells, compared with the 20% in the Eastern Cape. Despite the harsh conditions and poor facilities at police lock-ups, what concerned detainees most was the easy access the security police had to them throughout the day and night; abuse of detainees was more likely at police stations **(35)**. Women, who reported waking up alone in a cell surrounded by security police, lived in constant fear of being raped (see Appendix 7: Case Reports 1 & 2). So great was the fear of further interrogation and torture that one Section 29 detainee held at Louis le Grange police station, Port Elizabeth, refused under any circumstances to summon help at night.

Although in prisons the movement of inmates is closely monitored, this did not necessarily guarantee freedom from abuse (see Appendix 8: Report on North End Prison). Any movement beyond the confines of the "cell" (including the eating and exercise area) must be recorded in a log-book. The time and duration of movement outside cells, to sick-bay or for interrogation, are noted **(36a)**. Detainees who were taken away to be interrogated by the security police had to be back at the prison before lock-up time (4:30pm) or signed out for the night. This system provided detainees in prisons with a measure of protection from security police harassment throughout the

night (see Appendix 7: Case Report 3). It also explains parliamentary statements that "*nobody was tortured in prison*"; they were technically signed out from the prison, even if they were only taken down the passage to a separate room for interrogation (and torture). At the same time the declaration of the 1988 Emergency which stipulated that no detainee could be held "*in a police cell or lock-up for a **continuous** period in excess of 14 days*" (my emphasis) **(37)**, afforded detainees little relief; they could simply be transferred form one police station to another.

A medically significant aspect of detention not explored was detainees' anxiety about the period of incarceration. Robben Island political prisoners (with a fixed date of release) became acutely aware of the damaging effects of uncertainty after they were promised release on 2 February 1990. Anticipating their release studies and political discussion groups were discontinued, but a year later only 10% of the 1,500 had been released. Levels of anxiety were further raised by the precipitous manner of some releases. It is well documented that several were given no more than a few hours notice to pack up years of their lives and to part with close friends before being released into a different world. All attempts to provide information and independent counselling in order to smooth their reintegration into society, were blocked. This waiting period of "*confusion, uncertainty, heightened expectations and lack of information*" was described by one prisoner as "*more traumatising for him than his arrest, his detention, his torture and his imprisonment combined*" **(38)**. It can be assumed that indeterminate detention had a similar destabilising effect on detainees in this study.

Medical Rights

The Internal Security Act, of 1982, dealt with the medical rights of Section 29 detainees **(39a)**. The medical rights of emergency detainees were first set out in "Prison Emergency Regulations", proclaimed by the State President on 26 June 1987. It stipulated that a medical examination should take place "*as soon as may be practicable after arrest (and) as soon as possible before . . . release from detention*"; treatment prescribed by a District Surgeon or dentist should be carried out promptly; treatment by a doctor other than the District Surgeon, depended on a referral by him **(40)** (see Table C under Methodology).

In this study very few respondents were informed of their medical rights: only 10 (8%) were told they had a right to see a District Surgeon (state doctor) when ill. This was the only information given to 6 of the respondents. For details of the other 4 cases, see Table 5.2 under Results.

Similarly, Saxe and Elsworth reporting on visits to 4 prisons (1986), expressed concern that juveniles awaiting trail knew little about prison regulations or about their rights in prison **(20b)**. And, in a recent survey of South African prisons, Human Rights Watch reported (1992/93) that none of the prisoners they interviewed had been informed about disciplinary rules as stipulated by law **(41)**.

In contrast, the chapter of the (Interim) Constitution of 1994 that deals with fundamental human rights, states that:

1) all detained persons have a right to medical care at state expense **(42a)**, and
2) all detainees may communicate with or be visited by a medical practitioner of his/her own choice **(42b)**.

Medical Screening

Generally the respondents in this survey were sceptical about the so-called screening process which was intended to detect illness or to provide treatment for possible injuries **(16d)**. They perceived it as a rubber stamp of "fitness" which was applied in one of two ways: either they were kept away from the District Surgeon until most signs of assault had resolved, or they were, immediately after arrest, taken directly to the District Surgeon for a "fitness certificate" which left them vulnerable to subsequent assault without further "outside" scrutiny (see Appendix 7: Case Report 4).

The attitudes of several District Surgeons suggested collusion with "the forces". For example, one District Surgeon was described as "*behaving like a policeman*" because he "*marched passed*" a line of detainees "*inspecting our eyes and the inside of our mouths*". After 2 days of assault, another detainee was left waiting in the police van while the policemen went to talk to the District Surgeon. The District Surgeon never spoke to him; he only listened to his chest **(16e)** "*to endorse my fitness to travel*". In yet another case the police confiscated a detainee's anti-TB pills; the District Surgeon told him that detainees were not allowed "*their own medication*" **(16f)**, and that his lawyer could "*take the matter up*". What astonished him was the fact that the District Surgeon was the same doctor who had treated him at the SANTA clinic. Lack of consideration was demonstrated by another District Surgeon's annoyance at a simple request for a vegetarian diet.

The negative attitudes of District Surgeons diminished the use inmates made of their service. Confirmation of this was the post-release medical screening of a sample of 23 Robben Island prisoners from the urban Western Cape. Hidden health problems that varied from asthma, diabetes and myopia to improperly healed fractures were diagnosed in a quarter (26%) of them. The prisoners connected failure of diagnosis

with the doctors' attitudes, stating that they stayed away from sick parade because they mistrusted the unsympathetic, uncaring and incompetent District Surgeons **(43)**.

Generally the District Surgeons were given the benefit of the doubt; as in the case of a young woman who was asked (but not examined) whether she was pregnant; a gesture she described as caring. A few District Surgeons demonstrated compassion:

* A 76 year old man with 'flu (ECu) was taken directly to the District Surgeon after his arrest. The District Surgeon sent him straight back home to collect his medicines before being admitted to a local police station.
* A young asthma sufferer (19), waited 9 months before he encountered a District Surgeon who organised regular anti-asthma treatment for him simply by instructing the officer in charge that all future requests for treatment should be granted.

From experiences like these the detainees soon learnt which, if any, District Surgeons they could trust.

To this category belong, most likely, the 3 District Surgeons who recorded the assaults and injuries suffered at the time of arrest. A detainee who was beaten, hooded, choked and suffocated for 3 consecutive days, assumed that the District Surgeon who documented his condition, used this information to stop further assaults.

Neglect of the medical needs of newly arrested detainees usually occurred at police stations. Delays (3 days to 3 months) and failure to re-instate treatment occurred more often (in 7 of 9 cases) at police stations where requests for further treatment were ignored by the police. In all, bar one, of these cases treatment was restarted after transfer to prisons, weeks to months later. The one exception was a detainee, suffering from epilepsy, who knew the magistrate who employed his wife. When they met in passing, he asked for and received his anti-convulsion pills. He was allowed to keep them in his cell but they were never reissued.

Screening examinations were reported as "thorough" or "satisfactory" by 29 (41%) respondents (n=70) and a quarter described the examination as "standing in a row with your shirt pulled up while the District Surgeon listened to your chest" (27%) **(16e)**. In a few cases (4%) the site of medical symptoms was also examined; an arm, leg or ear. In 2 cases (3%) this was the only examination. For details of screening examinations described as rushed see Table 6.5 under Results.

Medical screening obviously became even more perfunctory when the number of arrested detainees escalated dramatically, for instance, following mass arrests at church

services or of people returning from political funerals. Consequently District Surgeons had to screen vast numbers in short sessions of 2-3 hours. Amongst these, Dr Wendy Orr was the only one who protested publicly about the impossibility of having to cope with numbers of over 300 per day **(10b)**. She commented that "*examinations amounted to little more than waving a stethoscope around*" (Dr Wendy Orr - personal communication, 1989).

The Presentation of Illness in Prison

The 96 physical and 87 psychological complaints reported covered a wide range and varied in frequency. A check-list was used to determine the prevalence and severity of symptoms (see Results: questions 7 and 8), but discrepancies arose in response to the general and the detailed questions. This occurred more frequently in relation to psychological symptoms and among younger detainees who equated "*breaking under the stain*" with weakness. For example, one youngster who had spent frequent spells in isolation said that he had become "*accustomed to solitary*" and that it "*no longer affected (him)*". He then turned the page and proceeded to tick off every one of the psychological symptoms on the list. For details see table attached to Case Study 5 in Appendix 7.

The 4 most **common physical complaints** (>40%) were: headache, tiredness, loss of appetite and of weight (see Tables 7.1 and 7.2 under Results). Attempts to distinguish between a decreased desire to eat or rejection of poor quality food, failed. It was also not clear if weight loss was due to the inadequate prison diet or whether it was a result of the stressful prison situation. Loss of weight and appetite were therefore not reliable result. Headache and tiredness on the other hand were **severe** in the majority of cases (60%).

The **common psychological symptoms** (see Tables 8.1 and 8.2 under Results) which occurred in about half (49%) the respondents were: depression, loneliness, nervousness, and more than a third (37%) complained of being sad or restless or having difficulty in concentrating and remembering. Difficulty in concentrating and remembering, and loneliness were **severe** in 3 out of 4 (77%) cases.

Although this study did not correlate symptomatology with torture there is a resemblance in the clusters of common (and severe) symptoms reported by respondents and those recorded at the Danish Rehabilitation and Research Centre for Torture Victims (see Table D) **(44a)**. The higher incidence of such symptoms in the Danish sample, in the nineties, can be attributed to the fact that all their patients had been torture victims who were (self-)selected and presented for treatment. The

research sample here, on the other hand, was not "corrected" for mistreatment or torture, nor were short term detentions excluded.

Most of the common symptoms were of psychosomatic origin due to stress, and only a few due to physical illness (see Appendix 7: Case Report 2). This corresponds with the high ranking of imprisonment as a stressful life event (4th most stressful life event with a scale impact score of 63 out of 100) **(45)**. There is always ambiguity about diagnosing psychosomatic symptoms. Yet, in prisons generally, medical orderlies with rudimentary psychological training, if any, decide whether inmates require treatment or not.

The general disregard or ignorance of mental stress as an aetiological factor prevailed at the highest level of medical care and negated therapy. Two examples illustrate the difficulties encountered by respondents in the study:

1) A 26 year old female, held in isolation (ECu), felt that solitary confinement was psychologically damaging and asked the District Surgeon for help. He did not *"see solitary as a problem"* and because she *"had no physical problems"* he said she *"was fine"*. Eventually, however, she was deemed acceptable for admission to the Psychiatry Department at Groote Schuur Hospital.
2) A 17 year old female (WCu) had difficulty sleeping and was depressed. The District Surgeon informed her that he could *"not diagnose, record or treat depression"* because he was *"not a psychiatrist"*. She rejected his offer of sleeping pills which he could provide by recording *"sleeplessness"*.

At the recent World Conference on Prison Health Care in Harare (4-9 June 1995) the effects of imprisonment on health came under close scrutiny by delegates from the United States, Norway and Britain. They all emphasised the seriousness of mental symptoms related to prison stress **(16g)**, which should never be shrugged off as mere malingering.

Dr Kim Thorburn from Hawaii **(46)** made a strong case on behalf of victims trapped in a closed and abusive system where they are in a vulnerable relationship with perpetrators. Prisoners' veiled appeals for help are likely to be misinterpreted when they present repeatedly as appearing withdrawn with vague complaints, implausible stories, evasiveness and secrecy. They use these confusing strategies to avoid retribution. When presented with cases like this, the doctor has a duty to establish whether he is dealing with "bad" or "sad" individuals. The "malingering syndrome", often perceived as manipulative **(16h)**, should always be handled professionally as an illness, because unless attention seeking behaviour is questioned, potential suicides may be missed. It is a diagnostic process which requires counselling skills, more empathy

and more time. In general terms it means better training and awareness, and involves a change in attitude from that of enforcing order and discipline to that of offering understanding and support.

As demonstrated in a British study of the early eighties, imprisonment has a negative impact on health: the general population makes 3 visits per 100,000 population per year to the doctor, compared to 26 male prisoners and 102 female prisoners of the same age. Inflated prison consultation figures can be ascribed to the stress and depression related to imprisonment, separation from and concern about family, lack of support and the need for doctor's script to obtain time off work, an Aspirin for a headache or such extras as special shoes or warmer clothing **(47)**. In recent years some countries have relaxed this strict control to relieve the pressure on health care providers. In parts of Australia prisoners have direct access to:

* first aid provisions (disinfectant, band aid, dressings)
* over-the counter drugs (analgesics, antacids, etc)
* "day packs" of short and long term scripts e.g. antibiotics, hypotensives, diabetic agents **(48)**.

At most prisons in the UK it is now policy to provide prisoners with 5 to 7 day courses of medication which they hold in their cells and take as prescribed. Dire warnings that prisoners would abuse this privilege have been disproved. Over two years only 3 cases of overdosing have been recorded at Brixton Remand Prison (Dr Somasundaram, Director of Health Care, HM Prison, Brixton - personal communication, 1995). The Department of Correctional Services would be well advised to introduce such time and cost effective practices into our prisons health services.

Obtaining Health Care in Prison

Detainees in search of medical care experienced the relentless and frustrating obstacles of many seeking medical attention or of having their symptoms dismissed as trivial. The Emergency situation exacerbated both these problems. Prisons had to accommodate large numbers of political dissidents (over 50,000 during the eighties **(49)**) over and above the criminal population. Many of these political detainees were subjected to torture or solitary confinement or both and therefore particularly prone to symptoms of mental stress.

Detainees also had to overcome their distrust of the militaristic management style and dress of the prison personnel. The role of health care providers is compromised in that trained nurses and medical orderlies (warders) are uniformed members of the correctional staff. Since this implies that they are custodial officers, it leads to

confusion about their caring role and undermines the situation of trust between patients and providers of health care. This is receiving attention **(50, 51)**.

During the State of Emergency further ethical issues arose in relation to state security. Prison personnel had always, by virtue of their office, been categorised as policemen **(1c)**. But according to the emergency proclamation "the forces" which included the army, police and the **prison services** had unbridled powers of search and arrest **(52a)**. This situation served to increase the "them" and "us" divide that occurs between custodians and inmates. Even prison doctors, the only health providers appointed and paid by the Department of Health, did not escape this kind of polarisation: all doctors working in prisons were subject to clearance by the security police, at least, apparently, until 1992 (Captain Mike Green, Regional Commissioner, WC - personal communication 1995). This raises serious questions about the independence of District Surgeons and their purported allegiance to prisoner-patients. At an interpersonal level these factors had an overt or covert effect on detainees seeking medical care.

According to prison regulations the heads of prisons and police stations are required to visit every prisoner daily in order to identify and deal with all problems **(26b, 16i)**. Traditionally this is an early morning visit. At police stations it may be the only certain opportunity a prisoner has to request medical care (see Appendix 7: Case Report 1). Prison inmates, however, can also approach warders, medical orderlies or nurses (on treatment rounds) for medical appointments (see Appendix 7: Case Reports 6 & 7). These requests put in motion a screening process from medical orderly, to nurse before the inmate reaches the doctor. Medical orderlies are permitted to treat "simple" conditions like coughs, colds, headache, stomach pains, etc. usually with cough syrup, Panado, or "white medicine" in single doses (see Appendix 7: Case Report 6) **(16j)**. Some detainees complained that certain individuals "*dished out the same medicine*" no matter what the complaint. In practice it is thus the least qualified person (who is also a custodial officer) who exercises the greatest control over medical access **(16k)**. There has been no significant improvement in this situation: the idea that prisoners have access to suggestion boxes for written medical complaints, has not yet been implemented (Colonel Kaminga, Pollsmoor - personal communication, 1995) and there is no indication what process will be used to expedite these requests.

At prisons the next step in the process is a medical assessment by a trained nurse. Sometimes nurses and others were described by interviewees as caring. For instance,

* A detainees (ECu), who returned from interrogation obviously injured, was taken to the front of the medical queue by a nurse for immediate attention.

* A nurse referred a patient (ECr), whose cough did not respond after 3 weeks of treatment, to the District Surgeon for management.
* The officer in charge brought the District Surgeon to see a detainee (WCr) who had complained of loneliness and depression.

More often the ancillary staff were unhelpful. In the report submitted by detainees to the SAMDC **(13c)** mention was made of two nursing Sisters who "*regularly intervened during consultations, thus influencing the doctors final diagnosis and management*"; and there were complaints that they "*have unlimited power and regularly over ruled . . district surgeons*" **(13d, 16m)**. This type of behaviour was reported by 15 (12%) respondents who said that their complaints were read off the "prison card" or presented by the nurse in charge, so that the District Surgeon never spoke to them. There were times when even District Surgeons found the nurses uncooperative. Some nurses were reported as fussing about unlocking the "consulting" room and changing linen when a doctor asked for the use of an examining couch. Apparently examining couches were not available at all prisons, e.g. North End prison, Port Elizabeth (Dr Wendy Orr - personal communication, 1989) **(16n)**.

Once medical orderlies and/or nurses agreed to the respondent's need for medical care **(16o)**, there were more obstacles before the District Surgeon could be reached. The patient's name was put on the appointment list and, depending on the frequency of the District Surgeon's visits to the prison, further delays were encountered **(16p)**. District Surgeons conduct sick parade at prisons or sections of prisons (depending on size) once or twice a week. Most respondents (60%) were seen within 48 hours of asking, some (30%) waited 3 to 14 days, and a few were seen weeks to months later. Eleven were never seen by a District Surgeon.

The requested consultation did not necessarily always solve the patient medical problem. Nearly three quarters (73%) were dissatisfied with the treatment they received. Some of the dissatisfaction was due to the fact that complaints were not taken seriously, but shrugged off as "malingering" (see Table 10.7 under Results). A case in point, was a patient who was passed over with "*not you again*" when he presented for a third time with unrelieved stomach pains, later to be investigated and diagnosed as a peptic ulcer.

Respondents identified the negative attitudes of District Surgeons (65%, n=251) as the basis of poor management. Although 1 in 3 (36%) were satisfied with their consultations, only 10% felt that the consultation approximated the caring understanding expected from a doctor **(16q)**. It can be argued that it is not that

uncommon for patient to be dissatisfied with their medical management. The difference is that the general public can seek help elsewhere; prisoners have no choice.

In both the Eastern and Western Cape the behaviour of "good" and "bad" doctors was compared. The uncaring doctors were known by reputation and detainees demonstrated their refusal to be seen by one of them by boycotting sick parade whenever he was on duty. This drastic action was taken because the attending District Surgeon was wearing a gun holster at examinations as reported by 2 respondents (see Table 10.8 under Results); an incident reiterated in the debriefing reports of the Black Sash (unpublished files). In reports submitted to state authorities the detainees singled out one doctor whose *"examination amounted to a cursory look at the file of the detainee and a passing glance at the detainee himself"* **(13e)**, and another who "*by simply asking questions arrives at a diagnosis without the use of diagnostic equipment*" **(13f, 19c, 16r)**.

Reports of this nature cannot be attributed to uncaring attitudes alone. It is possible that some of the neglect could be ascribed to patient numbers **(16s)**. However, bearing in mind that the state is obliged to provide medical care for prisoners, numbers are no excuse for poor care. In the case referred to above, detainees recorded that the District Surgeons concerned saw 30 patients in less that 30 minutes **(19c)**. More caring doctors, however, also complained about having to see, on average 80 **(20c, 16t)** to 100 patients per 2 to 3 hour session (Dr Wendy Orr - personal communication, 1995). According to Dr Orr the case load fluctuated between 2 and 400 per day at St Albans prison in 1985. A District Surgeon cannot be expected to cope whatever the circumstances; the onus is on the state to provide care consonant with the legislation **(20d, 53)**. The onus is, however, on the District Surgeon to draw attention to the untenable situation.

Working under extreme pressure was bound to affect the quality of consultations. Poor service was something about which respondents complained bitterly. For instance, medical history taking was perfunctory. Only 11 (13%) respondents were asked past medical histories (see Tables 10.4.1 under Results). Histories of current illness were taken from 14 (17%) respondents, half of them in considerable detail (see Tables 10.4.2 under Results). As expected, the more caring District Surgeons who took past histories well were also the ones who took detailed present histories (7 cases).

The manner of taking histories and doing physical examinations for complaints of illness corresponded, by and large, to those described under screening examinations. In most cases the history consisted of variations of "What's wrong?" The average

examination was done with respondents standing in a line with their shirts pulled up for the District Surgeon to listen to their chests in turn, an exercise described as "tut-tut-tut" on the chest wall by 3 respondents from different regions **(16n)**. Most respondents said the physical examination was superficial (54.2%), or rushed (6.4%), if it occurred at all (16.0%). Only 22 (23.4%) reported satisfactory examinations. Descriptions of rushed examinations varied from "*no real communication*", to "*just prods you*", "*used a stethoscope only if patients were seriously ill*", "*stethoscope applied over clothes*" or "*seeing up to 30 patients an hour*". Respondents objected strongly to being examined with the (earpiece of the) stethoscope around the District Surgeon's neck (for details see Table 10.5.1 under Results).

Examinations done "down the line" were obviously not private. Privacy was not generally respected. Only 1/3 of the respondents (33%) were alone with the District Surgeon and could speak to him privately. The other 2/3 mentioned the presence of a nurse, medical orderly, policeman or the security police (see Appendix 7: Case Report 2) **(16u)**. Privacy depended, largely, on the District Surgeon's insistence that he be alone with the patient and, to a lesser extent, on the availability of examining rooms **(13g, 16v)** In the absence of consulting space, "examinations" on occasion took place in the open.

At the conclusion of the "consultation", only 21 (20%) respondents received a diagnosis **(16w)**. Yet despite the fact that most (72%) received no diagnosis, 85% were given treatment (n=94). In this instance the legal requirement that states "*treatment. . . shall be carried out promptly*" **(40)** was adhered to and 95% of those patients received their medication within 48 hours. Nevertheless, only half of them found the treatment helpful.

Hospital or Specialist Care

All second opinions, including referrals for specialist and/or hospital care, depended on a referral by the District Surgeon. These referrals were not always granted: 37% of the requests for hospital referrals and 42% of the requests for specialist care were turned down. Despite these figures, unsolicited reports were that it was more difficult to reach the place for an appointment than to get one, the reason being that the police had to provide transport and guards for all "outside" trips. Apparently, difficulties co-ordinating police escorts and guards was a common excuse given for (deliberately) being late and having to postpone appointments. Information about the availability of transport or the District Surgeon's insistence on reliable transport was, unfortunately, not sought **(16x)**.

Access to hospital care was essential in view of the fact that 23% of those who requested hospital treatment underwent some or other surgical intervention. To deal with this problem the Department of Correctional Services has, in the past 2 years, adopted a new policy and accordingly established 11 regional prison hospitals **(54)**. They offer investigations and specialist services (from 1 to 4 times monthly depending on the speciality) and are equipped to do minor surgery (Colonel Kaminga, Pollsmoor - personal communication 1995). This sensible approach does away with the need for guards (6 out of 7 hospitalised respondents had 1, 2 or 3 guards) and, hopefully, supersedes the controversial matter of shackling patients to beds. To-day both Pollsmoor and St Albans provide regional hospital services (Colonel Kaminga - personal communication 1995).

Three important aspects of prison medical care warrant special mention:

* After-hours emergency care
* Treatment for assaults
* Care of those in solitary confinement

After-hours Emergency Care

Individuals who are locked away obviously cannot go in search of help, therefore accessible medical help is an essential part of their care. Many respondents (75%) recognised that the prison services had some policy of providing after-hours emergency care. These safeguards included bells, intercom systems, routine cell rounds and, in some cases, cell guards (see Table E). Yet, when inmates needed help the system broke down in at least 50% of cases. The most glaring example is the North End Prison case (See Appendix 8). A system which fails in 1 out of 2 cases, calls for serious review.

Further research into this aspect of prison care may reveal that the situation is worse at police lock-ups than in prisons **(16y)**. Police have a duty to serve and protect the public, that is their first priority. As demands on their time increase, charge offices become noisier and inmates' calls for help are drowned out (see Appendix 7: Case Report 2). Cries for help are also muffled by the considerable distance between lock-ups and charge offices. Policemen are further hampered because they do not have medical training and are unable to assess the gravity of illness, the importance of certain medication or the need for regular check-ups. Police cells and lock-ups are in law defined as "prisons" **(1d)** and the Department of Correctional Services should therefore be obliged to provide day and night observance for those inmates held in lock-ups.

Even at prisons, where medically trained staff are available, the system sometimes broke down because some staff were unfamiliar with after-hours procedures **(16z)**. This was illustrated by a variety of practices evident from the interviews:

* Verbal responses to intercom appeals for help without ever assessing the patient's condition - New Male Prison, East London.
* Holding women in prisons where no female staff do night duty and where men are not permitted to enter the female section - Caledon Prison (see Appendix 7: Case Report 3).
* Warders responding to calls for help, but not being able to unlock the cell doors (see Appendix 7: Case Report 6) or unable to help because medicines are not available at night.
* Reluctance to unlock cells for the purpose of giving injections or assessing the patient's condition **(16n)**.
* The delays in unlocking cells in order to remove ill patients to the sick bay (around 3 hours) **(16aa)**.
* Patients who were ill enough to be removed from the cell to the sick bay (prison hospital), waited until morning before they were seen by the District Surgeon **(16ab)**. Somerset East was the one exception where the District Surgeon came out at night.
* Detaining a person at a remote farm "prison" where the staff lock-up and go home for the night, is a violation of accepted international norms (see Appendix 7: Case Report 4).

These examples do not meet the claims made by the Department of Correctional Services that it provides a health service "*equal to that which is available in the community*" **(55)**.

Assaults while in Detention

As mention earlier, interrogation, assault and torture did not "technically" take place in prison, but was at the hands of interrogating authorities (see Appendix 7: Case Report 3). However, victims of interrogation and torture eventually returned to their cells where the treatment of any mental or physical injury, as a result of torture, was unquestionably the responsibility of prison personnel.

From the data collected it seems that this duty was not meticulously executed. At the very least there was a legal obligation that any Section 29 detainee who alleged assault or was injured be "forthwith" examined **(39b)**. Yet, of the 4 Section 29 respondents, who were deprived of sleep, beaten or tortured and who requested treatment, 3 had

only (routine) fortnightly check-ups after 7 to 14 days. Had this legal requirement not been in place, they may well not have received any medical attention. Evidence of failure to provide medical care is provided by the finding that 6 out of 15 requests for medical care of injuries were not granted. Neither was medical attention promptly provided: of the 12 respondents who saw a District Surgeon, 7 waited 3 to 14 days. This casual approach to injured inmates does not conform to the "community" standard of care espoused by the Department of Correctional Services.

District Surgeons were not scrupulous about their role as protectors and advocates of prisoner-patients. Although in the majority of cases (75%) a history of assault was taken, the information was recorded in only half of the cases. With respect to records, the ethical matter of confidentiality arose. Many District Surgeons are apparently not concerned that medical files are not confidential **(16ac)**. It appears that nurses, medical orderlies and possibly other warders had free access to the records. This has ramifications related to the staff's allegiance to the "forces", explained earlier.

Even in those cases where District Surgeons supported victims and where there was a measure of trust between them, the victims all declined to lay charges against their assailants. The reason for this was that any complaints against a member of the forces had to be submitted to the Divisional Commissioner for investigation **(39c)**: a matter of "*who will police the policemen?*" In some instances respondents were actually warned that they would be punished if they "*told stories*". Similar circumstances were exposed in the Orr affidavits **(56a)** where the police relied on the protection from prosecution provided by the Emergency declaration **(52b)**. The respondents, therefore, gained the impression that, although the prison personnel did not participate in assaults, there was collusion among the "forces" and that in some instances District Surgeons were guilty of ignorance or "omission" of duty and ethical responsibility.

Isolation, Solitary Confinement and Torture

The United Nations, together with other human rights organisations, has condemned prolonged solitary confinement and has expressed the hope of having it abolished in the near future. Prolonged isolation of more than 30 days, it says, is not lawful **(57)**. The main reason why human rights bodies condemn isolation is that torture always takes place in secret; that prisoners removed from public scrutiny are vulnerable and more prone to mental and physical abuse. Apart from secret mishandling, mental health experts, with experience in managing torture victims, recognise solitary confinement, and the associated social and sensory deprivation, as an exquisite form of psychological torture (see Appendix 7: Case Reports 1, 2 & 4) **(44b)**.

This study confirms the close links that can exist between isolation and torture. During interviews "torture" was understood to be the more extreme forms of assault causing severe pain and anguish. In the minds of respondents it was always associated with electric shocks and the much feared "helicopter" method (see Appendix 10). This concept tallies with the preamble of the Tokyo Declaration, adopted by the World Medical Association in 1975, where torture is described as the deliberate infliction of severe pain or suffering in order to obtain information **(58)**. Among the detainees interviewed in this research, about one in seven (14%) were subject to torture (see Table 13.1 under Results). Apart from causing intense physical suffering, torture creates in victims feelings of extreme helplessness and terror.

The fear and helplessness of Section 29 detainees (in isolation for the purpose of interrogation) was exacerbated by inhuman living conditions which further diminished their self-esteem. In this situation District Surgeons were the only contact detainees had with persons other than officers of the law and jailers. They therefore had an important medical and ethical duty to protect and provide care for ill or injured detainees in isolation. The safeguards which were intended to curb abuses in isolation had little effect:

* Visits by the Inspector of Detainees were infrequent and visits by judges were rare; only District Surgeons and magistrates were mandated to visit Section 29 detainees every 14 days **(39d)**.
* All complaints had to be reported to the Divisional Commissioner and/or the Office of the Director of Security **(39e)**.
* Except for the occasional District Surgeon who insisted on confidentiality, warders or policemen were present at all interviews. There are even reports of unidentified "sham magistrates" visiting detainees **(59)**; a practice which did not engender trust.
* Complaints submitted were seldom acted upon **(20e)**.

In this study 83 (67%) respondents spent time in isolation, either as Section 29 detainees (12) or as emergency detainees (70, 1 unknown) in very similar circumstances (incommunicado, interrogated). About one third of them (30%) spent between 30 to 180 or more days in isolation. It is no surprise that 90% said that isolation affected them mentally and/or physically. The younger respondents spoke about being lonely, crying, uncertainty (re detention and interrogation), fears, difficulty sleeping and confusion. The older politically experienced respondents referred more to "depression" and "psychological torture". At the Louis le Grange police station, Port Elizabeth, respondents were subjected to additional tribulations while in the cells: noisy "fans" which were set on hot in the heat and cold when it was freezing; detainees were

woken up every 90 to 120 minutes during the routine nightly rounds of policemen to signal that they were "alive". These methods disturbed their sleep and increased their levels of exhaustion and stress (see Appendix 7: Case Report 4). More subtle forms of torture were used with increasing frequency after the 1985 court interdict put a stop to Security Police brutality **(56b)**.

The majority of those who were in isolation (64%), were seen by a District Surgeon. More than half of them (57%) complained about solitary confinement. The reasons given for not confiding in the District Surgeon were, lack of trust and fear of retribution. The District Surgeons' responses to the 30 complaints about isolation have important medical and ethical implications. Twelve respondents were ignored and 10 were left with the impression that "isolation" was a security rather than a medical matter. This revealed much about the attitudes of the doctors concerned: *"These are the rules", "There is nothing I can do", "This is none of my business", "You wanted to be here"*, and in one case the respondent was even advised to cooperate with the police. According to the Declaration of Tokyo (1975) the preceding remarks violate either the clinical independence or the political neutrality of the District Surgeon **(58)** and call into question his allegiance to the prisoner-patient. The reasons for these violations can be sought in:

* ignorance and lack of training
* political affiliations
* fear of rejection and censure by the profession
* fear of loss of income.

Of gravest concern was the failure of professional organisations to support those doctors who took an ethical stand on behalf of detained patients as entrenched in the amendment recently adopted by the 47th World Medical Association General Assembly, 1996 **(60)**.

Ignorance was, until recently, more the result of prison policy than of indifference on the part of doctors: strict control over prison information was the main obstacle. For decades neither prisoners, the public nor academics had access to Departmental Orders which were issued by the Commissioner and regulated the daily prison regime. They only became public knowledge when prison legal expert, Van Zyl Smit, published his book on *SA Prison Law and Practice* in 1992 **(26c)**. The *Prisoners Handbook* of rules, related to treatment and conduct, was generally also not available. District Surgeons might therefore be excused if they were not aware that "*complete segregation at work and rest shall not be ordered if the medical officer certifies that it will be dangerous to physical or mental health*" **(25b)**. This tacit acknowledgement that isolation is mentally damaging could have been challenged in court for the benefit

of detained patients. District Surgeons failed to make use of their right to prescribe treatment: company for the lonely, rest for the exhausted, extra cloths or blankets, better food, enough clean water, reading matter or proper exercise for patients in isolation. In fact they could have insisted on the statutory right of Section 29 detainees to humane treatment, and to ample sleep and exercise **(39f)**. All of these are important factors in the management of cases in solitary confinement.

Significant too were the perceptions of the 6 respondents who regarded interventions by the District Surgeon as "helpful". Only one patient was transferred from a single police cell to a communal prison cell where he had company. Another was given "*pills for nerves and to sleep*"; the underlying cause of his suicidal depression was not addressed. Two were transferred to prison (hospitals) for physical, not mental, care. The other two were referred for psychiatric care (see Appendix 7: Case Report 2). The quality of psychiatric care in itself was cause for concern. For a psychiatrist to admit that "*symptoms (are) related to detention*" and then to advise a detainee to "*come back if things get worse*" does not do the caring professions justice. There appeared to be some discrepancy between the accepted management of private psychiatric patients and that of severely depressed detainees whose initial appointments lasted 15 to 30 minutes, with follow-ups of 5 to 10 minutes **(36b)** (see Table 14.7.(a) under Results).

Detention in isolation for the purpose of interrogation was abolished in April 1994 **(61)**. Although solitary confinement may be a thing of the past and unlikely to resurface, the above incidents raise questions about human rights and dignity and contain lessons which can help in the development of a medical code of ethics of which all South Africans can be proud **(62)**.

So far this discussion has focused on the health care perceptions and the experiences of inmates. In addition to this information, the researcher gained insights into how the Department of Correctional Services functioned. While the operation of a closed system like prisons is presumably subject to internal audit, for decades no citizen dared venture into the secret domain or criticise the methods of the then Department of Prisons **(1a)** and its quasi-political role: the law saw to that. The protracted process which prevented the researcher from obtaining secondment to the post of a District Surgeon (see Appendix 5 under Methodology), was illuminating. It seems to confirm that prison authorities generally fear exposure. What is particularly disturbing however, is the manner in which senior health authorities colluded to obstruct all attempts to gain access to the prisons. This in spite of the enthusiastic response from senior District Surgeons to the researcher's plan to assess their work situation and

make possible practical recommendations. That this happened after the democratic process in South Africa had been initiated, is indicative of the degree of entanglement between the Departments of Health and Prisons which still persists. It is a serious matter of medical accountability which must remain high on the priority list if prison reform in this country is to succeed.

The picture that unfolds from this research is profoundly discouraging. It reveals that the health care of South African detainees in the late 1980s was characterised by:

* a disregard for the well-being of and failure to provide adequate health care for individuals at the mercy of detaining authorities. This was evident from rushed superficial examinations, delays in treatment, indifference to stress related symptoms, and care in solitary confinement and for victims of torture that verged on neglect, if it occurred at all. It is distressing that no exception was made in the case of children, women or mothers with infants;
* collusion among the "forces" and District Surgeons, who were to some extent coopted into the system, thereby compromising the role of doctors as confidants and advocates of detainee patients.

This situation was compounded by:

* academics distancing themselves from the unrewarding shadow of prison health, a tendency which continues even to-day;
* the failure of professional organisations to take a strong and public stand on ethical issues related to imprisonment in general and to isolation and torture in particular.

Ways to address these issues are suggested in the recommendations that conclude this study.

Appendices 7 and 8

Case Reports: Introductory notes

These case studies were selected to highlight the experiences of women and children in detention. The bulk of this study reports on information obtained from adult men. Women made up 15%, children under eighteen 8% and women with infants less than 2% of the interviewees. The Case Reports are therefore an attempt to give a voice to that group of detainees hitherto neglected by researchers and the media. It also illustrates the plight of children held with adults in communal cells.

The Case Reports are based on actual interviews and are a semi-verbatim record of these interviews. Direct quotations of particularly striking statements are given in italics. The recommendations at the end of each report were suggestions made by the individuals, and illustrate the spectrum of their concerns.

Comments by the subjects were, where they applied, also incorporated into the Tables of the Results. For example:

* **Table 3.3 Delays in Treatment after Arrest.**

  Female, aged 54. At the time of arrest she was on tablets for high blood pressure (three times a day) and asthma (twice a day). Requests to see a doctor were ignored at the police station (Caledon Square). Two weeks later she was transferred. She made several requests before she saw a District Surgeon.

* **Table 10.4.1 Details about Past Medical History.**

  Woman, aged 36 with a 2 month old baby. Presenting with an ill baby, she was asked details about feeding and inoculations.

* **Table 13.6(a) Satisfactory Examination after Assault.**

  Male, aged 17. He was on a hunger strike. After he was beaten he became dizzy and lost consciousness. He was unable to stand and had difficulty speaking. He was seen by 3 doctors in succession. He was properly examined and had daily checkups. The Security Police were warned about the seriousness of his condition.

Appendix 7

CASE REPORTS

1) Chronically Ill Elderly Woman (54)
2) Woman (36) with Infant, Section 29 Detainee
3) White Woman (35) with Infant, Section 29 Detainee
4) Youth (20) Held in Isolated Farm Police Station
5) Child (17) on Hunger Strike, Assaulted and Alone
6) Child (15) among Criminals and later among Detainees
7) Surviving among Convicted Criminals

Appendix 8

A further CASE STUDY

NORTH END PRISON, PORT ELIZABETH: The Experiences of Female Detainees.

Appendix 7.

Case Report 1:

CHRONICALLY ILL ELDERLY WOMAN

I was born in 1933. At the time of my arrest in 1987 I was attending the Khayelitsha Day Hospital and I was on treatment for high blood pressure and arthritis.

I was detained early in 1987. I was first held at Caledon Square (police station) for a week, and then transferred to the Ravensmead police station for 2 months. At these 2 police stations I spent around 70 days in isolation. Then I was transferred to Pollsmoor prison for 4 months. I was finally released in June.

When I was detained I didn't have my pills with me. I had no routine examination after my arrest. In fact I never had any routine examinations, nor was I ever informed of my rights in prison. At Caledon Square all my demands for medication were ignored.

Being held at Caledon Square was a dreadful experience, "*I do not wish it on my worst enemy*". I was isolated in a "white cell". On the cell door were about 6 notices saying DO NOT SPEAK TO THIS WOMAN. The advantage of a white cell was that I had a bed, a mattress and blankets (no sheets), an inside and an outside toilet, and a hot and cold shower outside in the yard. All I had with me were the clothes I was wearing. I didn't even have a comb, so I combed my hair with a plastic fork. I received no toiletries; no towel, no soap and no toothbrush. But worst of all was the food. For breakfast they gave me cold mealiemeel. Lunch was usually bread and soup. More often than not the soup was sour and fermenting, occasionally this was replaced by stew which was also off. Supper consisted of bread and something to put on it.

Although I remained alone at Ravensmead, thing were slightly better. The food which came form the hotel was a much better, and I could request produce to be bought from the shops. They provided me with a mattress and 4 blankets as well as toiletries - towel, soap, tooth paste and a toothbrush. They also provided an Afrikaans Bible. There was a toilet inside the cell and a cold water tap and shower in the yard. The hot water tap was only fixed shortly before I was transferred to Pollsmoor. The cell door was never closed so I had access to the yard day and night which was very nice. Eventually, after 14 days I had my first family visit and they brought me extra clothes. From then on I had regular family visits every 2 weeks and they were able to bring my Xhosa Bible from home.

Every morning when they unlocked at Ravensmead the station commander did a round and asked for "klagtes". I told him I had a headache and joint pains and that I wanted to see a doctor. I had already spent 14 days in detention before two policemen took me in a van to see the doctor, I was not shackled. While in the waitingroom I looked at magazines. Later I asked the doctor for some of them and he referred me to the policemen who were too embarrassed to say no in his presence. During the examination I was alone with the doctor and his nurse. The doctor was very nice and chatty, he even asked where I came from. He was the kind of man one could talk to. I sat on the bed half dressed, while he put the stethoscope under my clothes and listened to my chest. My blood pressure and urine were also tested. He said I was "alright". He handed my pills to the police. I was not allowed to keep them with me. At the police station they were not careful about distributing pills, sometimes they skipped a dose. Then they lost the pills and had to take me back to the doctor. I used this opportunity to ask for 2 more magazines. Unfortunately the pills were not sent along when I was transferred to Pollsmoor 2 months later.

In isolation I lived in fear. Anything could have happened to me and nobody would have known about it. I was afraid they might kill me. Especially after 2 Security Policeman came into the cell at 1 o'clock one morning while I was sleeping. They stood on either side of the mattress and stared at me. Nothing was said. After 5 minutes they whispered something and left. I made me very scared. I told the doctor, but all he said was "*What else do you expect if you are in prison*". He did, however, offer me sleeping pills which I refused. I was afraid if I slept too deeply I would not hear people entering the cell at night. In my opinion isolation is a form of torture.

At Pollsmoor I shared a cell with 4 other women. There the District Surgeon did sick parade for the women once a week. Because my pills stayed behind at Ravensmead another plan had to be made. Fortunately I had my Khayelitsha Day Hospital card with me. The date of my follow-up appointment was on it, but they refused to take me there. Instead, they phoned and checked on my medication which they ordered. Some days later I restarted treatment which continued regularly after that.

If one wished to see a doctor at Pollsmoor the routine was to ask the officer who did the morning "klagtes" round. Otherwise you could ask the medical orderly who did the medicine trolley round. The medical orderly would either treat your complaint with pills, or put your name on the waiting list to see the doctor at his next visit. I saw the District Surgeon because I complained of headaches, joint pains, and "strong" urine. A medical orderly assisted the doctor. *"Without looking up he would ask what was wrong, and while still writing he would say, "Panado, next," We, the patients,*

were virtually ignored. I felt as if I was being processed". It was so bad that we called him "Panado". By constant determined nagging some detainees who were concerned about their state of health managed to obtained permission from the Special Branch to be taken to Wynberg Hospital for treatment. Detainees who were seriously ill were also transferred to Wynberg Hospital.

Recommendations

* The ill-treatment of inmates should be stopped. They should be entitled to decent living, proper food, health care, regular exercise and visits.
* Proper health care means a thorough examination, diagnosis and treatment.
* The treatment of individuals generally should be improved. They should be treated with respect, not like animals. People should not be treated according to their misdeeds. Bad treatment will not improve their behaviour. Only by treating people decently may they be persuaded to change their ways.
* Detainee should either be charged or released. Indeterminate detention is not acceptable.

Case Report 2:

WOMAN WITH INFANT, SECTION 29 DETAINEES.

I was born in 1952.

In September 1988 I was detained with my 2 month old baby, who had been delivered by caesarean section. I was breast feeding him.

I was arrested under the State of Emergency and held at Pollsmoor for 4 weeks. About mid-October my conditions of detention were changed to Section 29 (solitary confinement for interrogation). The baby and I were transferred to Sea Point police station where we remained there for 6 weeks. Towards the end of November were transferred back to Pollsmoor and I was kept in solitary confinement for 21 weeks, until late April. Altogether I spent 195 days in isolation.

The Security Police took us straight from home to the District Surgeon at the city office. I had a routine examination in the presence of the Security Police within 2-3 hours of my arrest. I was asked if I had any complaints, high blood-pressure or if I was on medication. I undressed and the doctor examined me thoroughly. The police held the baby while I was being examined. The doctor completely ignore the baby; he did not examine of mention the baby. We were then taken to Pollsmoor prison. Four weeks later my detention status was changed to Section 29 of the Internal Security Act which meant isolation for the purpose of interrogation. I was immediately transferred to the Sea Point police station where I was held in solitary confinement.

On two previous occasions I had been held as an emergency detainee. This was my first experience as a Section 29 detainee. I was scared because there are many horror stories about Section 29 and I was not sure what to expect.

The cell was guarded 24 hours a day. I was observed all the time. The toilet had no door, there was no privacy. Throughout the night the lights stayed on in order for them to watch me. I never felt safe. I woke up one night with 2 Security Policemen standing beside me. It was terrified. I was not sure if my life was is danger or if I would be raped. I felt even more vulnerable because the Security Police never identified or introduced themselves. I didn't even know their ranks, every time it was just a different face. I was scared because anybody could enter the cell and do whatever they wanted to me..

In the beginning I was particularly nervous and fearful because I had no idea what to expect. I was always tired. I had great difficulty sleeping while being watched. I didn't trust the police. They had the key to the door, they could enter whenever they pleased and I was scared of being raped. I was lonely, I became depressed. Apart from the fact that I was anxious about having the baby with me, this was mental torture. While I was at the police station I lost about 3 kilograms a week.

I never felt that special concessions were made on behalf of the baby. However, it helped me having him there. I gave me something to do and something to think about. It also helped while I was being interrogated. I was never shackled. They shouted, but they never touched me. But having the baby there also had drawbacks. A major difficulty was coming to terms with the fact that the police and security were the only people my baby came into contact with. Some days they took the baby on rounds with them. Sometimes one Security Policemen would hold my baby while another interrogated me. *"My dilemma was that these were not our people, they were our enemies and I was unable to protect my baby from their influence".*

In the police cell I had a bed, mattress, sheets (changed weekly), 2 blankets, and a pillow. I was able to ask for more blankets. I asked for a cot but they did not provided one. The baby and I shared a single bed. Everything had to be done on the bed. The baby could not even play on the cold cement floor. Later, when they brought in a second bed for the baby, we were terribly cramped.

Inside the cell there was a toilet, but no tap. Every morning they brought warm water for me and the baby to bathe. I could ask the cell guard when I needed more water. In the courtyard there was a sink with a cold water tap. Between 9-10 in the morning the yard was unlocked so that I could wash the nappies. A washing line was provided to hang the nappies out to dry. Later in the day when they were dry, I was again unlocked in order to collect them. Originally I had seven or eight nappies. It was not easy to get more. Whenever I asked for anything I would get something quite different two weeks later. I was completely at their mercy. It all depended on the attitude of the person I asked. It was some time before I received disposable nappies.

Meals were a problem. The food was terrible. Breakfast at 7 consisted of uncooked porridge and black coffee, sometimes with sugar. For a whole week I was given the same kind of food at lunch time. If it was sausage, peas and rice, the rice would be off and sour by the end of the week. Supper consisting of bread, jam and margarine arrived at 6 or not at all if the shift change was running late.

The baby was 3 months old and only on the breast when we arrived at Sea Point. At times that I felt that he was not getting enough. I informed the Security Police and asked them for a flask and a baby bath. It took them 3 weeks to "fetch" the flask. I was also given a tin of Lactogen. After that I was then able to fill the flask and prepared an extra feed every morning and evening. There was, however, no guarantee that the milk powder would be replaced once the tin was empty.

I was never ill. At one stage the baby developed a cold and became chesty. I asked the station commander on his morning round to see a doctor. The next afternoon the Security Police fetched us and took us to the District Surgeon in town. I was not shackled. We saw a lady doctor. She asked about inoculations and details about feeding. She seemed to be aware of the poor conditions in the cell. She examined the baby thoroughly. She thought the blocked nose and chestiness were due to the dust and cold of the cell. She was dissatisfied with the baby's condition and she wanted to have it seen at Red Cross Hospital. She insisted that the Security Police take us straight there. They were not pleased. They warned me that if I tried to run away, they would shoot. At the hospital they first went to inform the authorities that I was a Section 29 detainee. General anxiety about this, sped things up. The nursing staff were scared and somewhat apprehensive. The doctor was sympathetic. While he was busy with the baby, the Security Police waited outside. The baby was given oxygen (nebulised), bloods were taken and a chest X-Ray done. I was satisfied with the treatment the baby received.

At the Sea Point police station a District Surgeon visits section 29 detainees routinely every fortnight. On one such occasion I asked a male doctor for a psychiatric assessment which he simply ignored. A similar request made to a female District Surgeon was taken up.

I was, however, back at Pollsmoor before the psychiatrist saw me. My first consultation lasted 30 minutes. I told him I was sleeping badly, getting more and more depressed, and crying a lot. I cried at night because I did not want the warders to know how distressed I was. I also told him that I had nothing to read and no radio. He promised to make recommendations, but nothing ever came of them. He arranged for me to be relieved of the constant care of the baby, and the baby started spending the mornings at the prison crèche. It gave me time to wash and exercise. Subsequently I had fortnightly consultations lasting ten minutes with the psychiatrist. He prescribed Prothiadin which helped me to sleep. He also brought a child-psychiatrist to the last visit I had with him. Seeing a psychiatrist was useful. It was a

relief to occasionally have someone to talk to and it helped a lot to be treated humanely.

The main difficulties in detention are the attitudes of the people around you. In their eyes detainees are guilty without proof or trial. Most doctors and the inspector of prisons fall into this category. They don't have to beat you physically to hurt you, their comments are humiliating enough. Their view is that women should stay home, not fight for their rights. They implied that I was irresponsible because I was not home with my children. *"They blamed me for Ken's death.* They said I was responsible because in my absence he mixed with the wrong people. It left an indelible mark on me".*

Recommendations

* Discontinue long periods of detention in isolation. Two session of interrogation can be done in 1 to 2 weeks. Spending long periods in isolation is mental torture.
* Be allowed to see your own doctor who knows you family and in whom you have confidence. He won't be politically biased against you. It is important that there is trust between a doctor and a patient.
* The attitudes of doctors who further their own aims related to government. Problems arise when doctors cannot consider requests without first referring them to the Security Police. It might be difficult for the government to appoint neutral doctors, but District Surgeons should be able to act independently without Security Police sanction.

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* During a previous detention her teenage son, a student activist, was killed in a car accident when returning from a conference.

Case Report 3:

WHITE WOMAN WITH TODDLER, SECTION 29 DETAINEE.

I was born in 1955.

In July 1990 I was detained in the Karoo with my 16 month old baby under Section 29 (in isolation for the purpose of interrogation) and held for 64 days. I was arrested with the baby in his pushcart.

We were transported to Cape Town and held at Tableview police station for a day. The next day we were taken to the Wynberg court building where a District Surgeon saw us. He asked me about assaults and injuries. He also wanted to know if I wished to keep the child with me, and whether I thought it was in his best interest (to be kept in prison). I was determined to keep the baby with me. We were both weighed and we both had a chest examination, crudely done. From there we were taken to the Wynberg police cells.

I knew that while I was in Section 29 the District Surgeon and the magistrate had to visit me once every 14 days. I was told that a District Surgeon would see me if I was ill. I was also told about a list of doctors from which I could select one if I was prepared to pay for the service. I did not see or sign a statement. While in detention I had minor ailments like a fever blister and dry skin. But being in isolation I suffered mainly from stress related symptoms. Although I was lonely, sleepless and severely depressed I refused to complain because I didn't trust the doctors and I didn't want to take pills. During the first week we were taken to the District Surgeons rooms for an AIDS test. It was very unpleasant to be placed in that situation. Fortunately the doctor respected my wish not to be tested.

Towards the end of the first week an official arrived with an order from the Department of Health and Welfare to remove the child to a place of safety in Wynberg. They said he was "at risk in prison". My family argued that as he was still on the breast he should be with his mother and they refused to take him. The family then appealed to the Supreme Court who ruled that the child should be returned to his mother. Eight days later he was returned to me. By that time I had been transferred to the Caledon prison. I noticed that he was much thinner because he had eaten very little and had been without the breast. I was worried that he might be dehydrated because his eyes were sunken and his fontanel down. He had also become anxious. Even after our release he continued to suffer from separation anxiety.

Two days later, over a weekend, he started having loose stools and I asked for a doctor who only came to see him the following day (see later). "*The doctor said there was nothing wrong with the baby, there was only something wrong with me. I felt that that was an abuse of his position as a doctor*". Soon after he left, the child began vomiting. By the next morning I insisted on seeing a doctor again. This time the baby was given Lomotil to stop the diarrhoea.

Two doctors attended to the baby. The second one was sweet. He sat on the bed talking while he examined the child. "*He was a Christian. He couldn't look me in the eye*".

In prison the child developed "acid erosion" of his front teeth. We were taken to a dentist escorted by a warder and a Security Policeman. I was hand-cuffed. The shackles were removed at the dentist's rooms. The child's tooth was built up. When the filling fell out, we returned to have it replaced. Later it fell out again.

Conditions at Caledon prison: The court order forced the Security Police to find "better facilities" for us which they did at Caledon. We were held in the prison hospital section. There were 3 hospital cells, a bathroom with hot and cold water, and a toilet. The cell were left open and I was able to wash any time of the day or night. The floors were of cement and covered with linoleum. It was very, very cold. The window bars were sharp and at the level of the child's head. I had to watch him all the time to prevent him from hurting himself. Most of the time we played on a mattress on the floor. We had some toys: a box of crayons, 5 baby books, a dragging toy, a ball, and building cups to play with in the bath.

We were allowed out in the courtyard twice a day to exercise; 30 minutes in the morning and 30 minutes in the afternoon. While we were in the courtyard we were always under supervision. The child had contact with the wardresses then and when we ate. Around the courtyard ran a small gutter which the child could just step over, but it was also hazardous. There wasn't much opportunity for him to run and play and fall like ordinary children.

The Caledon prison is small and serviced by a few "coloured" and Asiatic wardresses. During the week they knock off at 5 and over the weekend at 4pm. At night there was no female supervision (in the female section of the hospital). There was a night bell in the cell. When I rang it my cell number would show up in an office elsewhere. Over the intercom a male warder would ask why I rang. They asked form outside because the men were not allowed into the women's section. One night when the baby had diarrhoea, I asked to see a doctor. I asked a second time but nothing happened; the

wardress was not called and the doctor did not come. The doctor only came the following morning. Being alone like that with a sick baby was frightening. Apparently the wardresses make random night checks but I never saw them.

Nappies were not freely supplied. I had a few when we were detained. Sometimes I washed in the middle of the night to keep my supply going. During the winter it was a nightmare trying to get the nappies dry. In the courtyard at Caledon there was at least a circular washing line, but at Wynberg they refused to supply me with one and I had to hang the nappies over a grid to dry them. After much nagging I grudgingly obtained 40 disposable nappies. It was only by an appeal through my lawyers that I received more nappies.

Food and eating are major prison problems. "*My head reinforced my actions. In Section 29 I ate to stay strong*". The baby ate very, very little. He was practically on the breast only. After our release it took months before he regained his appetite. Apparently the prison was supplied with vegetables from the Helderstroom farm prison. We were served sweetened carrots and pumpkin, and sweetpotato, but never anything green. Mealtimes were at 7:30 am, 11am and supper between 2:30 and 3:30 pm. Lunch consisted of peanut butter sandwiches and rooibos tea. We had no shopping privileges. I requested and received 1 litre of cow's milk and one litre of orange juice a day. (The court order may have had something to do with that.)

The court order led to my transfer to Caledon. It was a move that complicated thing for the Security Police. If they wanted to interrogate me they had to drive the 130 kilometres from Cape Town to Caledon. At the prison I was taken to the admission room with a grid opening to be interrogated. There was thus less privacy for the Security Police at this "unorganised" prison. Apart from which the prison locked up for the night by 3:30pm and I had to be back in my cell by then. I refused to let the baby out of my sight, so I always took him with me (when I was interrogated). During the interrogation my attention was often on him. I also never stopped him when he fiddled with their papers. All this impeded them and made them very angry.

Recommendations

* Inmates should be allowed a doctor of their own choice. (A doctor of own choice for the baby came up in the court case.) A medical relationship is not purely clinical, there also need to be trust before a patient reveals information to a doctor.
* The prison environment is not conducive to rehabilitation. All the women do is shine the floors. There is no constructive learning or skills training and people

leave prison without better abilities for gainful employment. Constructive employment in prison would also develop healthy bodies and minds.

* The diet is not balanced and it is not appetising. Everything including meat, fish and vegetables are mushed together.
* The environment is harsh and emotionally blunting. It is also very cold. The only view of the world is a small patch of blue sky, and at Wynberg that was covered with a grid. Contact with the outside world is important.

Case Report 4:

YOUTH HELD IN ISOLATED FARM POLICE STATION.

I was born in 1967.

I was detained in April 1987 walking down the street on a Monday afternoon at 2 o'clock. I was wearing a T-shirt, trousers, shoes and socks.

Two hours later I was "examined" at the District Surgeon's consulting rooms in the town. "The District Surgeon did not speak or ask questions. I took my T-shirt off and he listened to my chest".

From there I was taken to a small farm police station in the Suurberg (known as Keevespos), where I was held alone in a cell for 60 days. My only contact was with the 2 officers who worked there: the Station Commander and a policeman. Every evening the 2 staff members locked up and went home for the night. They returned to unlock the next morning. At night the place was deserted.

The cell measured about 3.5 x 4 meters. There was no running water, shower or toilet. In the mornings they brought me a bucket of cold water for drinking and to wash myself and my clothes. A "balie" (slop bucket) was provided. I was given soap, but no towel, toothbrush or toothpaste. I had only the clothes I was wearing (when arrested).

I never had any exercise. I had nothing to do or read. I asked for a Bible, but was ignored. When I asked for a change of clothing I was told it was "a security police matter". Nobody visited me because my parents didn't know where I was. It took them about 2 months to trace me before they could visit me. Two days after their visit I was transferred to St Albans prison in Port Elizabeth.

On my own I was lonely, I thought a lot and I became forgetful. At other times I felt proud and elated. I had all of those (on the check list of psychological symptoms). Every day I suffered badly from loneliness, difficulty remembering and difficulty sleeping. Next to my cell there was a generator which was switched on every night from 6pm to 8am. It made a terrible noise and kept me awake. After my release I still had psychological problems and was severely depressed.

During my 60 days in isolation I never saw a doctor or a nurse. Fortunately I was never ill, but I felt unwell while I was on a hunger strike.

My two main problems were loneliness and very bad food. For breakfast I had mieliemeal and black coffee with sugar. For lunch and supper I usually had "stywe pap" or occasionally bread, jam and margarine. I never had meat or vegetables.

I decided to go on a hunger strike. On the 5th day I felt dizzy and had difficulty walking. I think I tried to use the "balie" during the night and that I "collapsed" because, when I came around, I was lying on the floor with my fly undone. That day I asked to see a doctor. Instead the Security Police in Cradock (were informed and) came to interrogate me. They said that if I answered their questions I would be released. Because I refused to give them answers they said I would rot in jail. After they left the food improved and I started to eat again.

"They use this place for punishment. For 2 months I saw nobody but the 2 policemen. I became severely depressed. Matthew Goniwe was held at the same place for 6 months" (translated from Afrikaans).

Recommendations

* Detainees and prisoners should have a right to medical care.
* Prison hospitals should be improved.
* There should be some routine by which medical care is provided at police stations, even in remote places. It must not be in the hands of (security) police.
* Solitary confinement is unacceptable especially for lengthy periods with nothing to do or to read.
* Clean bedding should be a prison regulation. We were given filthy flea infested blankets, which they sprayed occasionally but would not allow us to wash because it was "against prison regulations".

Case Report 5:

CHILD ON HUNGER STRIKE, ASSAULTED AND ALONE.

I was born in 1972.

In 1986 I was detained for the first time. I was 14 years old and in Std 5. Every year since then I have been detained three to four times for short spells; for anything from 2 weeks to 2 or 3 months. I was detained so often I cannot remember exactly how many times.

Because I was detained I could not write my Std 7 year-end exams. Enclosed with my school report was a note to say that I would not be re-admitted to the school, and that my books should be returned. The following year I attended school in Mitchells Plain. I was doing Std 8. I was again detained and expelled. At the time I was an organiser for the Bo-land UDF, BOSCO. At present I am an Advice Office worker. I study part-time.

My first detention was bad. I was held alone, I was bored, I was homesick, I cried a lot and at times I felt suicidal. I was sweating day and night, so much so that my cloths were soaked. Although there was very little water, I washed my T-shirt to a frazzle just to have something to do. Sometimes I felt detached. At other times I become agitated walked around and around in circles. I slept badly. When nobody knew where I was, I had fears about what could happen to me. Later I became used to detention and was OK if I was with friends. I was held alone so often it no longer bothered me. My last detention did not effect me psychologically. (He then turned the page and ticked off every one of the psychological effects listed - see illustration page 174). But I do suffer from severe headaches and have difficulty remembering, even to-day. Since my last detention, six months ago, I have had three blackouts. I think they may be psychological.

My most recent detention was in November 1990. (The Emergency lapsed in June 1990.) I was 17 years old. At eight one morning thirty policemen arrived at our house, kicked the door open and stormed in looking for me. I had left earlier (4am) to attend a meeting. They traced us and broke in to the house where the meeting was held. Thirteen of us were arrested. They immediately recognised me and handed me over to the army. I was hit and punched, kicked in the groin, and my right cheek burnt with a cigarette.

At the police station I was taken into a separate room to be interrogated. Three policemen and three soldiers interrogated me for approximately 30 minutes. My wrists were twisted, I was winded (my wind uitgeskop), and threatened with a gun held to my head. I was accused of hoarding ammunition and explosives.

The others were detained under Section 50 (of the ISA). They held me alone without telling under which section. I knew I had the right to see a doctor. I asked, but they simply refused. From that moment I refused to eat or drink. Later I demanded to see a doctor, and the local District Surgeon came to see me. "*Waarvoor le die vark hierso?*" he asked the police. "*Jy's sommer 'n gemors*," he said to me.

The next day I was transferred to a town [T] some distance away. When I refused to confess, I was beaten with a shambok across my legs, choked, and hit about the head. I was dizzy for about 15 minutes. I am not sure if I was fully conscious. After this incident I was unable to stand and to speak properly. It could have been because I had nothing to eat or drink for 24 hours. I asked to see the commanding officer. I informed him that I intended laying a charge against the police. I also asked to see a doctor.

Three different doctors came to see me at about ten minute intervals. I was asked about the incident, and how seriously I had been injured. The doctor examined me thoroughly while I lay down with my top off. He inspected the marks around my neck carefully. The doctor made no notes in my presence. The police told me later that he had handed in a report. I was given the pills he prescribed once. The next day I asked him about them and he promised to look into the matter; nothing happened. Two doctors took turns to visit me every morning. I think they were partners. They spoke to me and told me about the other's findings. I was usually examined me while sitting down. At that stage I was not able to stand. They mentioned hospitalisation if I became weaker.

The police and the doctors only changed their attitude towards me after the dizzy spell following my assault. I suspect the doctor warned the police that it was serious and that if anything went wrong it could lead to trouble. Everybody was concerned about my hunger strike. Throughout the 9 days of my detention, I refused all food or water. They insisted that I eat. As I became weaker they changed their approach and suggested that I eat. They said that it would count in my favour. They warned me that many people had died as a result of hunger strikes.

The day after I spoke to the commanding officer my lawyer arrived. We went to court straight away. I laid a charge of assault against the police. After that, it seemed to me,

the police were much nicer. They asked me to withdraw the charges. Although they offered to bring me hotel food, but I refused to budge.

Cell conditions: I never received extra clean clothing during any one of my detentions. In 1986 and 1987 I was given hotel food. In 1989 the food was the same as that of the criminals: "*katkop (half a dry bread) en moer koffie*" three times a day. I was never allowed food from home. I received extra food from a shop on one occasion only.

At T I was issued one mat with a hole in it, and 4 stinking blankets. I threw them out the moment my cell door was opened. I insisted on having a bed. There were no beds, instead I was given a mattress and new blankets. The flush toilet inside the cell was broken and there was no running water. They brought me water in a bucket about every third day. I used the water to rinse my mouth, brush my teeth and to flush the toilet.

I had no exercise. I had no family visits. I was not given a Bible although I asked for one. They brought me a few old copies of Die Huisgenoot to read.

I was allowed to see a lawyer. He brought me a face-cloth and clean underwear. He requested toiletries which I never received. It was only after I asking the doctor that I received soap, a towel, a face-cloth, a toothbrush and toothpaste. It was the first time ever that I received toiletries in prison.

After 9 days in detention I was released. I was not told why I was arrested and I was never charged.

Recommendations

* Prisoners and detainees should be informed about their rights.
* Before admission, every person should have the right to phone a lawyer, and a doctor of his/her choice.
* Unfit and ill people should not be held in cells.
* No child should be confined to a cell.
* Political prisoners should separated from criminals.
* Visits, clean clothing, exercise, reading and study materials, and radios should be a right not a privilege.
* An independent body should pay regular visits to check on prisons conditions.
* The State of Emergency should be scrapped. Before being detained a magistrate should decide if there are grounds to incarcerate you.

PHYSICAL AND PSYCHOLOGICAL EFFECTS OF DETENTION REPORTED BY A 15 YEAR OLD.

PHYSICAL PROBLEMS:

	Never	Mild (some-times)	Moderate (often)	Severe (most of the time)
feeling ill/sick		✓		
tiredness				✓
hyperactive (over active)				✓
rapid heart rates/beats		✓		
shivering/trembling				
sweating				✓
pains (back, around my loins)				✓
headaches/tightness				✓
chest pain/tightness				
stomach pain				
poor appetite (off food)				✓
nausea				
constipation			✓	
diarrhoea				
weight loss				

PSYCHOLOGICAL PROBLEMS (WITH YOUR NERVES)

lonely				✓
withdrawn			✓	
disinterested			✓	
detached (don't belong)				✓
depressed				✓
sad				✓
like crying			✓	
listless				✓
restless				✓
agitated				✓✓
mood swings				✓
irritable				✓
nervous				✓
fears when nobody knew where I was			✓	
sleep disturbances ↑/↓				✓✓
difficulty remembering				✓
difficulty concentrating				✓

Case Report 6:

CHILD AMONG CRIMINALS AND LATER AMONG DETAINEES

I was born in 1970.

I was a standard 8 pupil when I was detained twice in 1986. After my release my schooling was frequently interrupted by police harassment. I had to leave school but continued to study by correspondence. In 1990 I obtained a matric pass with a university exemption.

I was 15 years old when I was first detained. I was held at Worcester prison from March to the end of June 1986. We were 5 children under 18 held in a cell among adults. These men were criminals; murderers, house-breakers, gangsters and rapists. Staying among them made me feel like a criminal.

My first night in prison was the worst of all. When the warder put me in the cell with "Gang 28" (rapists) he said, "*Het julle elkeen 'n wyfie vir vanaand?*" That night they tried to rape me. We argued the whole night. Fortunately one of the men took sides with me and the matter was settled. During my stay I witnessed several young people being assaulted, beaten and raped. The month I spent in that cell "*I panicked all the time*".

Two weeks after my arrest five of us were charged with intimidation. The others had applied for bail before my arrest and were released. I was refused bail. When I asked to see my mother or a lawyer, they laughed at me. Towards the end of June, the charges against us were dropped and I was released.

After my first release I was very nervous. Every time I entered a supermarket, I was so afraid I would steal something that I had the shakes. I hated being inside (the house), it depressed me. I walked around the streets for hours and hours, and came home late at night.

"Criminals have a hard time in jail. They are not really educated, they don't say much, because they don't know their rights. They are often beaten for minor offences (infringements) such as swearing at a warder.
Detainees are more educated and articulate. They also know their rights and that gives them some protection". (translated from Afrikaans)

In July I was detained a second time for three months. I was held at the Worcester prison for 14 days before I was transferred to Victor Verster prison in Paarl.

Immediately after my arrest I was taken to a doctor. He asked if I was ill, then he took my blood pressure and looked inside my mouth. There were five of us in a group and none of us took off our clothes to be examined.

At the Worcester prison we were held in a big cell the size of a classroom. Once when we were singing the warders warned us to stop. When we carried on, they threw two teargas canisters into the cell and closed the door. "*Ek dog ek gaan dood.*" They also sprayed us with water. We were soaking wet throughout the night. (In mid-winter it can be very cold in Worcester.) One of my cell-mates developed asthma from the teargas. He had to be admitted to the prison hospital for three days.

While in prison I repeatedly had tonsillitis. Because Worcester prison is smaller, it is easy to gain access to the medical orderly who did a medicine trolley round every morning and evening. The orderlies seldom objected to requests; they usually gave me what I asked for. If someone was very ill he was admitted to the prison hospital. I was never seriously ill. At night, if something happened and we called for help, the warders came to find out what was wrong. They only came as far as the cell, they never opened the door to come in, not even after someone was assaulted.

Fourteen days later I was transferred to Victor Verster prison in Paarl. That day, before going to the cell, I saw the doctor. He asked if I was sick, and I said no. The doctor never examined me; he didn't use a stethoscope at all. The nurses checked my blood pressure and urine.

The first 7 days at Victor Verster I was in a cell by myself. I think at Victor Verster it was routine to be kept alone for a certain period before being allocated to a general cell. Inside the single cell there was a shower and a toilet. I slept on 4 mats and had enough blankets (5). We were allowed to exercise, one by one, for an hour a day. On my own I was lonely and depressed. Most of the time I lay around trying to sleep but I couldn't sleep because I was thinking too much. I thought about people I usually never bothered about. I was bored. I asked to see the doctor, because I wanted to be moved out of the single cell and I thought he would be able to help me. I never saw a doctor during the 7 days I spent alone in that cell.

At Victor Verster the detainees under 18 were held separately from the adults. Groups of three were allocated to separate cells. Here I never felt afraid or panicky; I knew I was among comrades. I also knew that I had done nothing wrong.

Our mealtimes were badly spaced, especially supper was very early (lunch at 11:30, supper at 3:30). We could supplement our meals by placing orders for provisions

which the warders bought "outside". We kept the extra food for late suppers. We were allowed exercise or games for an hour every day. Some warders were kind and, depending on their mood, would allowed us out to play games until lock-up time in the afternoon. We played games like table-tennis, but I had no interest in them. For a while I was not even interested in joining the regular political debates.

At Victor Verster we passed the medicine depot on our way to breakfast. If we were ill, we could ask the medical orderly for an appointment to see the doctor. (He came to the prison once a week.) There were always so many people for him to see, they were in and out in a minute. I saw him very late one day. I told him my throat was sore and all he did was look at it. It seemed to me that the doctor did not care, "*Hy kyk jou maar net so. Jy het die indruk gekry hy het nie tyd vir jou nie*". He prescribed pills for me (Panado). Every morning, on the way to collect food, I fetched them and was given the whole day's supply. They didn't help. Several times I asked the medical orderly for other treatment. After much nagging he finally gave me a red gargle which helped my throat.

Recommendations

* Allow detainees to see a private family doctor.
* Nobody should ever be kept in solitary confinement.
* People should not sleep on the cement floor, beds should be provided.
* Regular weekly family visits should last one hour.
* Permit access to a lawyer. We could not ask to see a lawyer, they had to apply to see us.
* Provide descent toiletries, not only blue soap.
* Improve the food, not just "*pap en mielies*".
* Nothing the state does will make much difference unless prisoners are educated about health care and their medical rights.

Case Report 7:

SURVIVING AMONG CRIMINALS

I was born in 1962.

In 1985 I was detained for 2 week and held at victor Verster prison in Paarl. It was an experience that prepared me to cope with the conditions I encountered among criminal in 1989. The detainees were a group of activists with a common cause who stood together and supported each other. In 1989 I was among criminals who held completely different views. They were concerned mainly with dagga, money and sex. "*To survive you had to have your wits about you*".

I was arrested during the 1989 pre-election period. One morning at 3 am the police stormed into our house demanding to know where I had been as the car's engine was still warm. I refused to answer them. Although nothing was stated I assumed that this was a political matter and that I was an emergency detainee. I spent one day at Grassy Park police station before appearing in court where I was charged with malicious damage to property; for spray painting walls which at the time was a political offence.

All awaiting trialists are searched at the courthouse for money. At Pollsmoor I was subjected to further searches. All the first timers were ordered to strip naked in front of the others. Our clothes were searched and our shoes knocked together. They looked inside my mouth and my ears and they inspected my anus to see if I had hidden anything in my rectum. To do this I was instructed to bend forward and to pull my buttocks apart. They did not examine me internally (do a rectal examination).

That first night at Pollsmoor I should have been held with first time offenders, but I was put in a cell with convicted criminals. The following morning I was allocated to the cell where I would stay. Before entering the cell I was once again searched.

The cell was large and contained 16 lockers so I concluded that it was meant for 16 prisoners. In fact there were no less than 40 people in the cell. Fortunately among the criminals was one I knew from Grassy Park. For protection I stuck with him. It is important to understand how criminals operate in gangs in prison: gang 26 deal with money, gang 27 with violence and money, and gang 28 with sex and money. The "Huisbaas" (leader) in my cell was a "26". He also came from my area. As protection I gave him my money and any money the family left me after visits. I decided never to ask for cigarettes of extra food because that would increase my vulnerability.

Our cell was suppose to be for adults over 20 (legally 18 year old and over is classified adult). However when the nightly head count was done there were often children as young as 12 among us. On several occasions I witnessed sexual harassment and rape. It was extremely unpleasant. The way they went about it was first to identify the victim, the to weaken him by assault and then to rape him. If you opposed any gang activity your life was at stake. Punishment for minor offences was metered out by the gangs (criminals). The offender had to bow down and was kicked about the head with an iron-tipped boot. Nobody was safe: neither prisoners nor warders.

Every morning the senior warder unlocked the cells and asked for "klagtes". It was most unwise to complain especially if you were the one who had been assaulted. For their own safety rape victims remained silent. Despite evidence of assault, facial bruising and black eyes, nobody dared complain. The warders, if they noticed anything did not let on. While in that cell "*my major concern was to survive the 13 days, illness and seeing the doctor were of minor importance*". Later in the day a medical orderly did a round to hand out medicines. It was an opportunity to ask for such things as cough medicine and headache pills, or to request a doctor's appointment. Nobody was so foolish as to ask to see the doctor.

Conditions in Pollsmoor: The cell was overcrowded; a minimum of 40 in a cell apparently designed for 16. Every evening they did a head-count. In the mornings the warders checked to see that the cells were clean and tidy. Our blankets had to be rolled up and folded. Once a week they did a major "clean-up". That is, they searched the cells for dangerous weapons and removed them.

We had no exercise at all. Reading material was not provided and my request for a Bible was ignored. As an awaiting trial prisoner I had visiting rights; my family could visit for 30 minutes every day. I was therefore in a position to ask the family to bring me books. I had taken extra clothes and toiletries with me. However, the extra clothes were often taken away from one to make fires in the cell. I tried to see to it that I at least had a change of clean underwear and socks.

The gangs separated and slept in groups, each with his own territory. There were no sleeping mats. We had to share a pile of blankets; about three rough grey woollen blankets per person. The cell contained one flush toilet and one shower with hot and cold water, neither had doors. It was possible to shower every day. A strict code of cleanliness was enforced (? by the authorities). Most prisoner had a number 1 haircut with hair 1 centimetre long.

Mealtimes were at 7, 11 and 3 O'clock. For breakfast we got pap and sugar, a mug of coffee with very little milk and less sugar. Lunch consisted of bread and jam, or peanut butter, and coffee. Once a week we had a treat; an apple or an orange. Supper was a mess of vegetable stew and sometimes somos (meat substitute), and coffee.

Recommendations

Indefinite detention without trial must be outlawed.

1) Prisoners should be allowed to see a doctor of their own choice.
2) Requests for medical care should immediately be attended to.
3) The doctors should be more thorough. All complaints should be taken seriously and patients properly examined.
4) All prisoners should be informed of their rights.
5) A medical review board should be established.
6) The prison system should aim at rehabilitation and prisoners have the option of using their time usefully.
7) Treat all inmates physically and mentally with respect.
8) Psychologists and psychiatrists should play a more prominent role. Prison social workers are sympathetic people to speak to, unfortunately they have a negative image as they are viewed as part of state machinery and policies.

Appendix 8.

NORTH END PRISON, PORT ELIZABETH:

A Case Study of the Experiences of Female Detainees

This is a report of conditions in detention experienced by women held at North End prison between June 1986 and April 1989. The report was complied from interviews with 2 ex-detainees, two sworn affidavits and a postmortem pathology report.

Black female detainees held at North End Prison, Port Elizabeth, (known as Rooi Hel) had a hard time. One of the detainees with nursing experience reported that the nurses behaved badly. Their attitude was that the inmates "were pretending". Even those who were genuinely sick were told they were "malingering". It was only possible to see a doctor after making a big fuss. The doctor's attitude was much the same. With a history of previous illness, complaints would be taken more seriously and patients examined, otherwise they were dismissed. Without an examination he decided that patients were "playing at being sick so that they could be released".

At one stage 12 women shared a cell. One of them (G) had a "nasty cough, produced green sputum, sweated profusely and often complained of tiredness". Her appetite was generally poor and occasionally she vomited. Every time she complained the nurse gave her cough medicine. When one of the detainees tried to convey her concern and fears that G had TB to the nurse, she was told that "she was a detainee not a nurse". Months later G was diagnosed as suffering from TB. None of the other detainees were tested for TB. When they asked to be tested, the nurses replied that they "don't have to be told what to do (they) know (their) job".

One of the women (F) often had stomach trouble; her appetite was poor and she had colic (cramps like vomiting). Nobody seemed to care about her, all she was given were pain pills. Eventually she went on a hunger strike. For a whole day she refused to take food or water. The next day she was seen by the doctor who prescribed Mucaine. She took it regularly until the bottle was empty, but it made no difference. Her constant complaints of tiredness and listlessness were ignored. Finally a group of detainees decided to write to their own doctors for help. The letters were all handed to the head of the prison. This resulted in arrangements being made for them to be seen by an outside specialist at the Oassa Medical Centre in Rink Street. The specialist was the choice of the prison authorities. After being examined F was told her heart was normal. A few weeks later she was diagnosed and treated for high blood pressure.

The women's struggle for better conditions continued. They went on a hunger strike (18 September to 10 November 1986) objecting to poorly prepared food. During that period they were never examined by a District Surgeon, nor were they told anything about the effects of hunger strikes. On several occasions they were asked to sign a document about the hunger strike. They refused to sign. On the tenth day of the hunger strike they were weighed and had their urine tested for the first time. Attempts to force them to "finger print" the document were again made. Because they suspected an ulterior motive they resisted this. They also refused to be transferred to the Uitenhage Provincial Hospital.

Most distressing, however, was the case of Nobanda Elda Bani, a fifty eight year old female. Elda Bani was detained on 29 August 1986 and held at North End Prison. She was a known "sugar diabetic" who attended Livingstone Hospital for regular check-ups. At the time of her arrest she appeared to be well controlled on twice daily injections of Insulin and pills [for hypertension or diabetes?]. She usually inject herself before eating regular diabetic meals.

Fellow detainees claim that she was held in the prison hospital, where detainees slept on beds, from September to December 1986. She was probably held in a single cell until about March/April 1987 when she was moved to a communal cell. These cells had no beds. Detainees slept on an underfelt and mats on the cement floor. Each detainee had 5 blankets but no pillow. In the cell with Elda was another diabetic, S. It was around May that Elda was taken to the Provincial Hospital in Uitenhage for a check-up. [By this time Livingstone Hospital was out of bounds for detainees.] At the hospital she was informed that there was nothing wrong with her, her treatment was stopped and she was advised to take sugar and eat sweets. It was most likely at this stage that her Medic Alert [Diabetic] bracelet was removed. After eating the sweetmeats recommended, she complained that they made her tongue "shrink". The others advised her to stop taking them. Captain Nel, head of the female section, was informed about this development.

At the beginning of the second Emergency, on 11 June 1987, the female detainees, who were not released, were moved to cell number 14. They included Elda Bani, S, A, L, Q and M. That night Elda seemed confused; she was singing, humming and muttering. She kept on drinking water. This disturbance kept everybody awake. Some thought she had a tight chest. When they called for help the night warder came to the window to find out what was wrong. A suppository [Aminophylline?] was brought for Elda but it made no difference. Her urine continued "running out".

The following morning Elda's troublesome night was reported to Captain Nel, ["klagtes"]. The detainees felt they were not competent to look after Elda. They asked that she be transferred to the hospital where she would be under twentyfour hour observation. The special nurse [medical orderly], Mrs Williams, regarded Elda's illness as nothing more than homesickness. Her cell-mates repeatedly requested treatment for Elda. At one stage Q and M insisted that Elda, then still ambulant, be treated. Together the three of them were taken to a separate room where Elda was told not to worry about her health and that the others were too sympathetic and fussing unnecessarily. When Elda was removed from the communal cell some days later "they claimed we had chased Elda away because we didn't like the smell of urine".

With ever increasing concern her cell-mates regularly enquired about Elda. They were told that she was in the prison hospital. From the common criminals they learned that she had been placed in a single cell. In order to find out where Elda was, the detainees embarked on a hunger strike. This action may have resulted in Elda once again being transferred to the Uitenhage Provincial Hospital where she was admitted.

Approximately a week later Elda was discharged and returned to the communal cell. Elda's condition had visibly deteriorated. Her first words were that she had been assaulted. But she was rambling so much that nobody took much notice of her. She kept on fidgeting with a filthy, wet, woollen cap which had been used to clean the police van. Because Elda returned in a wet and soiled gown and not wearing panties, S helped her change into clean clothes. It was then that she discovered three marks across Elda's back. She called the others to come and look. "Three marks like those of a sjambok lay across Elda's back" [raised vertical weals]. There was blood on the left side of her gown and her left hand was swollen. The night staff [Sgt McClean and another] were called to come and inspect Elda's back. Sgt McClean's reaction was "My God, is she from the hospital like this?" Q asked the staff to record the incident. The staff had no pen and paper with them therefore the detainees were not sure whether the incident was recorded.

It appears that when Elda was discharged from hospital she and was taken to a police station in an ambulance. At the police station she was beaten. After that Elda was transported back to prison in a van. The next morning all the details were reported to Captain Nel on her regular round. She was shocked when she saw Elda's back. Her words were "Why in hospital?" Captain Nel promised to investigate the matter, but nothing came of it.

By this stage Elda was much worse, in fact, she was seriously ill. She was mentally confused, dizzy and fidgeting a lot. She couldn't answer questions properly and at

times not at all. Sometimes she would stare blankly in front of her or cry like a baby. She was no longer able to wash herself and occasionally she would not even allow the others to wash her. Her urine was dribbling out with the result that her inner thighs became red and raw. The detainees appealed to Sister Williams "as a nurse" to do something for Elda. They asked for urine bags which M, a nurse, was prepared to change. Sister Williams said that Elda was fine. She called another warder [April?] to confirm that the doctor, who had seen Elda, found nothing wrong with her, the point being, that without a doctor's prescription the staff were not allowed to issue urine bags. Captain Nel, however, promised that Elda would be taken to hospital.

Elda and S were taken to Outpatients at Uitenhage Provincial Hospital for a second time. Elda, by now unable to walk, was in a wheelchair. After examining S the doctor wanted to admit her, but she refused. She felt that the bed should rather be given to Elda, who was seriously ill. Elda was apparently not seen by the doctor on this occasion. It seems that her inability to climb on to the examining couch by herself was interpreted as being deliberately obstructionist. It irritated the staff who refused to assist her.

On her return, Elda was taken back into a single cell instead of to the prison hospital. The staff wanted to remove S from the communal cell and put her in the single cell with Elda. The responsibility of looking after Elda in her confused state frightened S. She refused to share with Elda on the grounds of the rule of one or three persons per single cell. Under the pretext that she ate too much of the other prisoner's extra food [provisions they had bought], S was forcibly moved from the communal cell and placed in a single cell next to Elda. From here she could hear but not see Elda. With increasing frequency Elda failed to respond to S's calls.

The other women were also concerned because they knew how little Elda was able to do for herself. Q volunteered to wash Elda's clothes. Every day a big bundle of washing arrived. The clothes were often soaked in urine and soiled. It was obvious that Elda was incontinent of urine and faeces. One morning when the washing failed to arrive, they became anxious. They worried that Elda may be in a coma. They asked for the washing. Only a few things were fetched: a nightie stained with vomit, a clean skirt and a clean towel.

Around midnight on Monday 28 August 1987, strange things began to happened at the prison. The senior staff in full uniform were joined by five white Security Policemen at the North End Prison. S, L and A were taken from the cells to the Captain's office. For the next hour they were questioned in turn about Elda Bani's illness. This made the others highly suspicious.

The next morning the detainees were told that Elda had suffered a stroke the day before and died on 29 August 1987.

A stop was immediately put to all family visits in order to prevent the detainees from getting outside information. Fortunately they spotted Elda's husband and son who had come to collect her clothes. One of the young detainees was able to climb up to a window to ask about funeral arrangements. With that information they planned to hold a service on the day of her funeral. Captain Nel gave detainees, from two cells, permission to hold a service. On the day of the funeral the women, dressed in their best clothes, gathered in the yard. As they began to sing the first hymn the warders rushed in and wrote down "everything, or whatever they were able to understand". In a tribute lasting two hours the story of Elda's detention and illness was told, detention without trial and the callous treatment detainees received were condemned. Elda's death upset her comrades, for the next week none of them were interested in food.

Not without reason, the women felt their detention was a health hazard. They felt they were not safe there. Q approached the prison authorities with a proposal: if they released the others she would remain in prison for as long as they wished to keep her. This proposal was turned down. For their own protection the women felt that it was important that the events leading up to Elda Bani's death in detention become more widely known. They wrote the story on the inside of a petticoat and managed to smuggle it out of prison in among their dirty clothes.

M and Q were released after the 1989 nation-wide hunger strike having spent twenty nine and thirty five months respectively in detention.

Mrs Elda Bani, postmortem examination report:

> *"There can be little doubt that the immediate cause of death was pulmonary embolism as a result of deep vein thrombosis in the left calf. The changes in the pancreas suggest a form of chronic relapsing pancreatitis. The changes found in the kidneys were those of diabetic nephropathy. By and large the other changes could be attributed to circulatory problems and problems of maintaining adequate blood pressure levels. Trophic changes were found in the sections of skin examined and these were obviously due to a nursing problem presented by this patient as a result of her gross obesity."*

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signed Angus Hofmeyr

Appendix 9: Specifications of Meals at Police Stations and Prisons

Ngqumba v Minister of Justice/Minister of Law and Order, August 198

Diet at Police Stations, according to the Commanding Officer at Berlin police station:

Breakfast: 170gm dry brown bread **or** 225gm porridge and coffee
Lunch: 170gm dry brown bread **or** 225gm porridge and special soup
Supper: 170gm dry brown bread **or** 225gm porridge and coffee

Comment by a qualified dietician: The above diet which provides 844 calories (3,544 Kilojoules) and 25.6gm of protein is deficient in Vitamin A, Vitamin B Complex, Vitamin C, and in calcium. The daily requirements for an adult man are 2,700 calories (11,300 Kilojoules).

(Argus 14/8/86)

The undertaking (1987 1 SA 456 E) given in the matter of Ngqumba was that **detainees held at police stations would receive meals equivalent to that of an unmarried white policeman**.

Prepared by Legal Resources Centre, PE.
Legal Rights under Emergency Regulation,
no 10.1. 23/11/87

Specifications of Meals at Prisons

For the legal requirements of food prescribed for emergency detainees, see the written reply (below) of the Minister of Justice to question 1322, put by Mrs Helen Suzman during 1988.

QUESTION 1322

MRS H SUZMAN ASKED THE MINISTER OF JUSTICE

(1) Whether the diet of detainees held in prison cells under the emergency regulations complies with the standard of recommended daily allowance (RDA) laid down by the Department of National Health and Population Development; if not, (a) why not and (b) what standard of diet is used;

(2) what (a) type and (b) quantity of prepared food is provided to such detainees at each specified meal;

(3) whether the diet of such detainees differs with regard to (a) race, (b)(i) age and (ii) health and (c) detainees held in prison cells as opposed to police cells; if so, (aa) why and (bb) what are the differences in each case;

(4) whether St Albans Prison, Port Elizabeth, complies with the above provisions regarding detainees held under emergency regulations; if not, (a) why not and (b) in what ways do they differ?

REPLY

(1) The diet provided to all prisoners (including emergency regulation detainees) is compiled by experts of the South African Prisons Service in co-operation with dieticians of the Department of National Health and Population Development and falls within the limits laid down by the American Recommended Daily Allowance.
(a) and (b) fall away.

(2) (a) and (b)
The ration scale provides for different meal plans. Therefore, the choice of the majority of prisoners at each separate prison is applied. The preference of every individual prisoner/detainee naturally cannot be satisfied.

Breakfast and lunch is served according to a rotation menu of 7 days whilst the evening meal is provided on an eleven day cycle. In this manner a greater variety is obtained to prevent monotony as far as possible.

The following types of food may, for instance, be served as indicated:

BREAKFAST

Item	Servings/week	Raw quantities	
		Men	Women
Maize meal	3 x	120g	80g
Maltabella	3 x	120g	80g
Oats	1 x	120g	80g
Bread	7 x	80g	40g
Margarine	7 x	10g	10g
Coffee	7 x	2g	2g
Powder milk	7 x	22.5g	22.5g
or			
Fresh milk	7 x	225ml	225ml
Sugar	7 x	30g	25g
Jam or syrup	7 x	10g	10g

Gravy	0 - 7 x	15g	15g
Fresh fruit	1 x	115g	115g
or			
Dried fruit	1 x	50g	50g

LUNCH

Item	Servings/week	Raw quantities	
		Men	Women
Bread	5 x	200g	160g
Margarine	5 x	30g	30g
Peanut butter	2 x	20g	20g
Syrup or jam	2 x	30g	30g
Eggs/egg powder	1 x	50g/12g	50g/12g
Maize meal/samp/ Mealie rice	2 x	160g	100g
Soup	4 x	280ml	280ml
Fruit drink	3 x	300ml	300ml
Gravy	2 x	19g	15g

DINNER

Item	Servings/11 day cycle	Raw quantities	
		Men	Women
Maize meal	4 x	60g	40g
Mealie rice	3 x	60g	40g
Samp	4 x	60g	40g
Vegetables	8 x	290g	235g
*Vegetables	3 x	225g	182g
Beef	1 x	180g	180g
Pork	1 x	180g	180g
Fish	2 x	165g	165g
Chicken	2 x	208g	208g
Eggs/egg powder	2 x	100g/24g	100g/24g
Bolognaise	1 x	50g	40g
Textured vegetable protein	2 x	50g	40g
Tea	11 x	2g	2g
Sugar	11 x	10g	10g
Powder milk	11 x	7.5g	7.5g
or			
Fresh milk	11 x	75ml	75ml
Gravy	8 x	15g	15g

* On the days that textured vegetable protein products (including Bolognaise) are issued, the quantity of vegetables issued is reduced because the texturised plant protein products also contains vegetables.

Items such as salt, sugar, tomato puree, oil, bread flour, baking powder, curry, pepper, vinegar, etc. are used additionally in the preparation of the food.

Therefore it is clear that detainees, like all other prisoners, receive a balanced diet, prepared in well equipped and hygienic kitchens under strict supervision.

(3) (a) No

(b) (i) and (ii)

Medical officers may in terms of Prisons Regulation 114(3) order, in respect of a specific prisoner, a deviation from the prescribed diet should it prove to be necessary for medical reasons. This implies that the medical officer may order that additional food should be provided due to health requirements which could be attached to age. These orders are meticulously complied with.

(c)

The honourable member is referred to the reply to question 1316 put to the Minister of Law and Order which should be read in conjunction with the details furnished in this reply.

(4) Yes

(a) and (b) fall away

Appendix 10: The "Helicopter" Method of Torture

The affidavit of Mkuseli Jack in the *Wendy Orr Case*: "He took out a towel and tied towelling around each of my wrists and placed handcuffs over the towelling. He screwed the handcuffs tight. I was told to sit on the floor and to place my handcuffed arms over my legs. A short stick was then inserted below my knees and above my forearms locking me into a permanent crouch. . . . Both men then lifted me up by means of the stick and suspended me between the tables.

This form of torture is known as the "helicopter". Apart from being quite helpless and exposed, one hangs upside down with all one's weight being taken by one's knees and forearms. It is extremely uncomfortable; the blood rushed to one's head and there is the constant strain of permanently bending one's neck to see what is happening and to avoid throbbing. . . . After a while I began to cry out because of the severe pain resulting from the suspension alone. . . . (They) removed the stick between my legs and replaced it with . . . a tick broomstick. (N) rocked me so as to expose my buttocks between the 2 tables. (B) struck me with a shambok. . . (W)hile each blow was not inflicted with full force, the overall effect of the blows to the head and to the buttocks, together with the rocking motion was so painful and disorientating that I still have nightmares about it. . . . (I) was placed on the floor. The broomstick, the handcuffs and the towel were removed. I could not stand up The strain on the muscles behind the knees was such that I was temporarily paralysed. . . I was completely powerless and

very weak. I could not move at all."

Rory Riorden. *Port Elizabeth and Politics - a working paper.*
Port Elizabeth: Human Rights Trust, 1987: 40-53

"(T)hey handcuffed me having made sure to place newspapers around my wrists to prevent visible marks, forced my legs through my arms, and pushed a stick in between, placing it on two high chairs. And there I was, hanging in the air. The pains were indescribable. (They) disappeared . . I had started groaning. . . For the first time in twenty years I cried like a young girl, letting loose all the tears that had been clogged for years . . This time my silent pain had the upper hand over the screams in the adjoining offices, the rooms known as truth rooms when interrogations were in session. Again I was alone, and lonely . . . except for the uncompromising pain. . . .

When I regained consciousness only the black fellow was in the room. . . I had only leg irons. The stick and the handcuffs had been removed, leaving rings of blood on my wrists and ankles. "

Tshenuwani Simon Farisani. *Dairy from South African Prison.*
Philadelphia: Fortress Press, 1987: 43-44.

TABLE D:

COMPARISON OF SYMPTOMS REPORTED IN THE SURVEY AND DANISH FIGURES OF SYMPTOMS RELATED TO TORTURE.

SYMPTOMATOLOGY

SURVEY FIGURES		Early DANISH FIGURES (Seventies)		Recent DANISH FIGURES (Seventies)	
73%	Sleep disturbance	66%	Difficulty concentrating	88%	Sleep disturbance
59%	Depressed	63%	Headaches	82%	Nightmares
54%	Lonely	63%	Nightmares	78%	Memory impairment
49%	Nervous	60%	Sleep disturbance	76%	Difficulty concentrating
46%	Headache	60%	Depression	72%	Identity changes
46%	Tiredness	42%	Anxiety	70%	Low self esteem
46%	Difficulty concentrating	26%	Emotional liability	13%	Signs of psychosis
38%	Sad	26%	Tiredness		
37%	Difficulty remembering	22%	Sexual problems		
37%	Restlessness				

Figures from:
Vesti P, Somnier F, Kastrup M. *Psychotherapy with Torture Survivors*. Copenhagen: International Rehabilitation Centre for Torture Victims, 1992:27-36.

Table E: Type of help available after hours.

AT PRISONS		
Intercom/bell system	**Regular Nightly Rounds**	**Cell Guards**
Pollsmoor Prison, Cape Town Victor Verster Prison, Paarl St Albans Prison, Port Elizabeth Graaff Reinet Prison Waainek Prison, Grahamstown Middelburg Prison George Prison (female section) Caledon Prison(female section) New Male Prison, East London*	JC Steyn Prison, Kirkwood North End Prison, Port Elizabeth Robertson Prison George Prison (male section)	Worcester Prison Brandvlei Prison
AT POLICE STATIONS		
10 pm and 6 am Shift Rounds	**Regular Nightly Rounds**	
Brackenfell Kensington Milnerton Ravensmead Stellenbosch Beaufort West Somerset West	Louis le Grange, Police Station, PE**	

* The intercom was answered, but nobody came to check.

** Louis le Grange police station in Port Elizabeth was the security police headquarters and had a well regulated night patrol system. Cells had angled glass (window) ceilings and police guards patrolled along a wall at the window level. In passing they knocked on every window and expected inmates to respond (wake up and wave) in order to demonstrate that they were alive (had not committed suicide).

DOCUMENT 4:

MEALS DOCUMENTED BY DETAINEES AT ST ALBAN'S PRISON, PORT ELIZABETH: 11 - 28 August 1988.

DATE	TIME	MENU	HOT COLD	PREPARATION	GENERAL COMMENT	DATE	TIME	MENU	HOT COLD	PREPARATION	GENERAL COMMENT
11 AUG 88	THIS	BREAD MARGARINE (JAM) MILK COFFEE	N/A N/A HOT	WATERY WITH LUMPS STANDARD SUGAR, MILK INSUFFICIENT	BELOW STANDARD CONSUMABLE UNCONSUMABLE	B/FAST 11:08:88	8:30	BREAD MEALIE OATS MILK COFFEE BREAD MARGARINE	N/A N/A HOT C/W HOT N/A N/A HOT	— — STANDARD SUGAR INSUFFICIENT — — IMPROVED	— — CONSUMABLE CONSUMABLE BELOW STANDARD — — CONSUMABLE
"	11:30	BREAD MARGARINE CORNFLAKE SOUP	N/A N/A HOT	— — — STANDARD	— — — CONSUMABLE	LUNCH	11:00	SOUP	HOT	IMPROVED	CONSUMABLE
"	3:10	CORNFLAKE SOUP	COLD HOT	OVERCOOKED & TASTELESS HOT SLOPPED	UNCONSUMABLE UNCONSUMABLE	SUPPER	3:00	SAMP CARROT CABBAGE TEA	WARM " " "	STANDARD STANDARD STANDARD SUGAR INSUFFICIENT	CONSUMABLE " " BELOW STANDARD
12 AUG 88	8:30	BREAD MARGARINE PORRIDGE (MILK) MILK COFFEE	N/A N/A HOT	— — WATERY WITH LUMPS FLAVOURING SUGAR, MILK INSUFFICIENT	— — BELOW STD UNCONSUMABLE UNCONSUMABLE	B/FAST 13:08:88	7:10	BREAD MARGARINE PORRIDGE MILK COFFEE	N/A N/A HOT C/W HOT	— — STIFF WITH LUMPS STANDARD STANDARD/IMPROVED	— — BELOW STANDARD CONSUMABLE CONSUMABLE
"	11:30	BREAD MARGARINE BANANA	N/A N/A N/A	— — POWDER FORM	— — —	LUNCH	11:30	BREAD MARGARINE DRINK	N/A N/A C	— — POWDER FORM	— — — INSUFFICIENT
13 AUG 88	3:15	PORRIDGE MEALIE RICE CABBAGE CARROT FISH	HOT HOT COLD HOT	IMPROVED STANDARD BUT WATERY POORLY PREPARED IMPROVED SUGAR INSUFFICIENT	CONSUMABLE BELOW STANDARD UNCONSUMABLE CONSUMABLE BELOW STANDARD	SUPPER	4:00	MEALIE CABBAGE CARROT FISH TEA	COLD " " HOT HOT	POORLY PREPARED & TASTELESS OVERCOOKED & TASTELESS SANDY & POOR POORLY PREPARED & SMELLING STANDARD	BELOW STANDARD UNCONSUMABLE UNCONSUMABLE UTTERLY UNCONSUMABLE CONSUMABLE
14 AUG 88	8:30	BREAD MARGARINE PORRIDGE MILK MARGARINE COFFEE	N/A N/A HOT	— — POOR & WATERY WEAK SUGAR INSUFFICIENT	— — BELOW STANDARD UNCONSUMABLE BELOW STANDARD	B/FAST 16:08:88	7:15	BREAD MARGARINE MALTABELA MILK COFFEE	N/A N/A HOT C/W HOT	— — STANDARD WATERY, WEAK & SEDIMENTARY STANDARD	— — CONSUMABLE UNCONSUMABLE CONSUMABLE
"	11:15	BREAD MARGARINE SOUP	— — HOT	— — WEAK & TASTELESS	— — UNCONSUMABLE	LUNCH	11:30	BREAD MARGARINE SOUP	N/A N/A HOT	— — IMPROVED	— — CONSUMABLE
15 AUG 88	3:15	SOUP CARROT CABBAGE	ER ER ER	STANDARD SANDY IMPROVED	CONSUMABLE UNCONSUMABLE CONSUMABLE	SUPPER	3:15	CHICKEN SOUP CARROT CABBAGE TEA	HOT " " "	STANDARD IMPROVED " " "	CONSUMABLE " " "

	Time	Menu	Hot Cold	Preparation	General Comment	Date	Time	Menu	Hot Cold	Preparation	General Comment
IST		BREAD	N/A	—	—	B/FAST 20:08:88	7:30	BREAD	N/A	—	—
:58	7:20	MARGGRINE	N/A	—	—			MARGERINE	N/A	—	—
		PORRIDGE	HOT	STANDARD	CONSUMABLE			PORRIDGE	HOT	IMPROVED	CONSUMABLE
		COFFEE	-41	MILK INSUFFICIENT	BELOW STANDARD			MILK	C/W	STANDARD	"
		MILK	C/W	—	—			COFFEE	HOT	STANDARD	"
H	11:3	BREAD	N/A	—	—	LUNCH	11:35	BREAD	N/A	FRESH	
		MARGGRINE	N/A	—	—			MARGGRINE	N/A	—	
		SYRUP	C	—	—			SOUP	HOT	STANDARD	
								ORANGE	—	—	
R	3 35	POWDER EGG	WARM	POORLY PREPARED	UNCONSUMABLE	SUPPER	3 30	SAMP	HOT	POORLY PREPARED	BELOW STANDARD
		M. RICE	"	BELOW STANDARD	VERY POOR			CABBAGE } MIXED	"	POORLY PREPARED	"
		CABBAGE	"	OVERLOOKED & TASTELESS	UNCONSUMABLE			CARROT }			
		CARROT	"	POOR & SANDY	UNCONSUMABLE						
		TEA	HOT	STANDARD	CONSUMABLE			TEA	"	WEAK	"
2ST		BREAD	N/A	—	—	B/FAST 21:08:88	7:50	BREAD	N/A	FRESH	CONSUMABLE
5:38	7:45	MARGGRINE	N/A	—	—			MARGERINE	N/A	—	—
		PORRIDGE	HOT	WATERY WITH LUMPS	BELOW STANDARD			OATS	HOT	STANDARD	CONSUMABLE
		MILK	C/W	POORLY MIXED	BELOW STANDARD			MILK	C/W	POOR & WEAK	BELOW STD
		COFFEE	HOT	SUGAR INSUFFICIENT	"			COFFEE	HOT	SUGAR INSUFFICIENT	" "
H	11:2	BREAD	N/A	—	—	LUNCH	11:35	BREAD	N/A	—	—
		MARGERINE	N/A	—	—			MARGERINE	NA	—	—
		SOUP	HOT	STANDARD	CONSUMABLE			SOUP	HOT	STANDARD	CONSUMABLE
R	4:1	SAMP	WARM	STANDARD	CONSUMABLE	SUPPER	3 35	BEEF	COLD	DRY	NO GRAVY
		CARROT	"	STANDARD	CONSUMABLE			M. RICE	"	POORLY PREPARED	BELOW STD
		CABBAGE	"	POOR AND SANDY	UNCONSUMABLE			CABBAGE	"	" "	" "
		TEA	HOT	SUGAR MISSING	BELOW STANDARD			CARROT	"	" "	" "
								TEA	HOT	NO SUGAR	" "
ST		BREAD	N/A	—	—	B/FAST 22:08:88	7:10	BREAD	N/A	FRESH	CONSUMABLE
:35		MARGERINE	N/A	—	—			MARGERINE	N/A	—	—
		MILK	C/W	IMPROVED	CONSUMABLE			PORRIDGE	HOT	IMPROVED	CONSUMABLE
		COFFEE	HOT	SUGAR, MILK INSUFFICIENT	UNCONSUMABLE			MILK	C/W	STANDARD	"
								COFFEE	HOT	LITTLE SUGAR	BELOW STD
H		BREAD	N/A	—	—	LUNCH	11:15	BREAD	N/A	FRESH	—
		MARGERINE	N/A	—	—			MARGERINE	N/A	—	—
		ORANGE	V	—	—			DRINK	C	—	—
R		M. RICE	WARM	POORLY PREPARED	BELOW STANDARD	SUPPER	3 30	M. RICE	WARM	POORLY PREPARED	BELOW STD
		CABBAGE	WARM	OVERLOOKED, BROWN	UNCONSUMABLE			CABBAGE	H	STANDARD	CONSUMABLE
		CARROT	"	IMPROVED	CONSUMABLE			CARROT	"	POOR & SANDY	UNCONSUMABLE
		TEA	HOT	SUGAR MISSING	BELOW STD			TEA	"	VERY LITTLE SUGAR	BELOW STD

DATE	TIME	MENU	HOT/COLD	PREPARATION	GENERAL COMMENT
[illegible] 13.10.88	7.20	BREAD	N/A	FRESH	—
		MARGERINE	N/A	—	—
		PORRIDGE	HOT	STANDARD	CONSUMABLE
		MILK	L/W	IMPROVED	"
		COFFEE	HOT	SUGAR LITTLE	BELOW STANDARD
LUNCH	11.15	BREAD	N/A	—	—
		MARGERINE	N/A	—	—
		SOUP	HOT	WEAK	UNCONSUMABLE
SUPPER	3.35	FRIED FISH	WARM	STANDARD	CONSUMABLE
		& MP	"	STANDARD	"
		CABBAGE	"	"	"
		BEETROOT	"	"	"
		TEA	HOT	LITTLE SUGAR & MILK	UNCONSUMABLE
B/FAST 26.08.88	7.20	BREAD	N/A	FRESH	—
		MARGERINE	N/A	—	—
		MALTABELLA	HOT	STANDARD	CONSUMABLE
		MILK	L/W	IMPROVED	"
		COFFEE	HOT	LITTLE SUGAR & MILK	BELOW STANDARD
LUNCH		BREAD	N/A	FRESH	—
		MARGERINE	N/A	—	—
		ORANGE	✓	—	—
SUPPER	3.35	M RICE	WARM	POORLY PREPARED	BELOW STANDARD
		CABBAGE	"	OVERCOOKED	" "
		CARROT	"	POOR & SANDY	UNCONSUMABLE
		COFFEE	HOT	LITTLE SUGAR	BELOW STD
B/FAST 27.08.88	7.20	BREAD	N/A	—	—
		MARGERINE	N/A	—	—
		PORRIDGE	HOT	WATERY WITH LUMPS	BELOW STANDARD
		MILK	L/W	IMPROVED	CONSUMABLE
		COFFEE	HOT	LITTLE SUGAR, MILK	UNCONSUMABLE
LUNCH	11.35	BREAD	N/A	—	—
		MARGERINE	N/A	—	—
		SOUP	HOT	IMPROVED	CONSUMABLE
SUPPER	5.20	CHICKEN	WARM	IMPROVED	CONSUMABLE
		SAMP	"	STANDARD	"
		CABBAGE	"	STANDARD	"
		TEA	HOT	LITTLE SUGAR, MILK	UNCONSUMABLE
B/FAST 24.08.88	7.10	BREAD	N/A	—	—
		MARGERINE	N/A	—	—
		MILK	L/W	POORLY MIXED	BELOW STANDARD
		COFFEE	HOT	LITTLE SUGAR	" "
LUNCH	11.25	BREAD	N/A	—	—
		MARGARINE	N/A	—	—
		DRINK	✓	—	—
SUPPER	3.25	PICKLED FISH	WARM	STANDARD	CONSUMABLE
		M. RICE	"	POORLY PREPARED	BELOW STD
		CABBAGE	"	IMPROVED	CONSUMABLE
		CARROT	"	POOR & SANDY	UNCONSUMABLE
		TEA	HOT	LITTLE SUGAR, MILK	"
B/FAST 27.08.88	7.20	BREAD	N/A	FRESH	—
		MARGERINE	N/A	—	—
		PORRIDGE	HOT	POORLY PREPARED	BELOW STANDARD
		MILK	L/W	IMPROVED	CONSUMABLE
		COFFEE	HOT	SUGAR INSUFFICIENT	BELOW STD
LUNCH	11.15	BREAD	N/A	—	—
		MARGERINE	N/A	—	—
		SOUP	HOT	IMPROVED	CONSUMABLE
		DRINK (ORANGE)	✓		
SUPPER	3.00	CHICKEN	WARM	STANDARD	CONSUMABLE
		SAMP	"	IMPROVED	"
		CARROT	"	OVERCOOKED	UNCONSUMABLE
		CABBAGE	"		
		TEA	HOT	LITTLE SUGAR	BELOW STD
B/FAST 25.08.88	8.15	BREAD	N/A	—	—
		MARGERINE	N/A	—	—
		OATS	HOT	STANDARD	CONSUMABLE
		MILK	L/W	IMPROVED	"
		COFFEE	HOT	SUGAR LITTLE	BELOW STD
LUNCH	11.00	BREAD	N/A	—	—
		MARGERINE	N/A	—	—
		SOUP	HOT	POORLY PREPARED	UNCONSUMABLE
SUPPER	3.00	SAMP	WARM	STANDARD	CONSUMABLE
		CARROT	"	POOR & SANDY	UNCONSUMABLE
		CABBAGE	"		
		TEA	HOT	LITTLE SUGAR	BELOW STD

DOCUMENT 5:

NAMES OF DETAINEES SPENDING THEIR THIRD CHRISTMAS IN PRISON.

WE STILL REMEMBER THOSE DETAINED IN 1986

Aaron Bobotyana; Sithembele Bono; Michael Bonya; Michael Captain; Buyiswa Fazzie; Henry Mutile Fazzie; Vukile Feni; Benson Fihla; Sipho Gadeni; Sakhiwo Gaxa; Ivy Gcina; Sipho Gogela; Zandisile Gojela; Mbulelo Goniwe; Samson Gotyi; Luyanda Henene; Mkhuseli Jack; Mlungwana Jacob; Ma doda Jacobs; Dalinxolo Jekwa; Thenene Jordan; Yongama Kaizer; Wiseman Klimbasha; Fikile Kobese; Tango Lamani; Siseko Lutywantsi; Patrick Madalana; Themba Madoda; Mzwandile Magaba; Lindila Makana; Xola Makapela; Lucky Makeba; Mtutuzeli Makupula; Vuyisile Malangeni; George Mangali; Themba Mangqase; Phakamisa Maqaqa; Dumo Mathambeka; Lulamile Matoto; Collin Mbikanye; Hartley Mbombo; Vuyisile Mciteka; Lungelo Mclean; Xolela Mdatyulwa; Jackson Mdongwe; Sandile Memani; Zixolene Boyce Mini; Temba Mpofu; Bonisile Mtana; Zola Mtatsi; Silas Mntongana; Michael Mpofu; Thembekile Mtengwana; Majolandile Mvula; Nelson Winkie Ndlebe; Dennis Neer; Thembani Ngcume; Zwelakhe Ngesi; Michael Ngobongwana; Edgar Ngoyi; Mangaliso Ngxokwana; Lindile Ngxube; Khayalethu Nikani; Phila Nkayi; Thozamile Nkwentsha; Sizwe Nondumo; Michael Nzotoyi; Andile Ntiyana; Mpumelelo Odolo; Ihron Lester Rensburg; Mkhululi Sam; Nomathemba Sidandala; Mncedisi Sithotho; Sonwabo Siwula; Stone Sizani; Brian Sokutu; Ayanda Somgqeza; Zola Tesana; Michael Tofile; Melile Teyise; Andile Patrick Tom; Themba Tsoko; Nelson Twanga; Mpumelelo Veto; Mbulelo Williams; Solomzi Williams; Michael Xhego; Archie Yana.

GRAHAMSTOWN BLACK SASH

PORT ELIZABETH BLACK SASH

EAST LONDON BLACK SASH

GRAHAMSTOWN DEPENDANT'S CONFERENCE

CONCLUSIONS

Reforming prison health care entails transforming the whole system of which it is an integral part. Offenders are sentenced to imprisonment as punishment and not for punishment. The duty of prison staff, therefore, is to keep safely in custody those committed by the courts. They perform this function best by providing humane care under conditions that do not add to the suffering of inmates. The tax-paying public can only be sure that this is the case by constantly monitoring conditions of imprisonment.

Transparency is a new concept for South African citizens who by law for decades (1959 to 1992) were barred access to all prison information. This kept South Africans ignorant about local prison conditions reputed to be the most violent on the continent **(1,2)**. There are 3 main reasons for our prisons being breeding grounds of violence:

1) The strict discipline maintained by humiliation and intimidation. Officers have had unrestricted power over inmates by virtue of legally sanctioned physical and dietary punishment for in-house infringements **(3a)**. Corporal punishment was stopped only very recently by the Constitutional Court in 1994.
2) In institutions ruled by force violence is thus seen as the only solution to disagreements. The gang related violence for power and control among prisoners has become a subculture which extends beyond the prison walls **(3b,4a)**.
3) The war for control between prison personnel and gangs based on military rank, has exacerbated the violence within prisons.

Brutalisation causes resentment and anger which spills out into the community when prisoners are released and give vent to their feelings through more violence. In the present system it is not unusual for prisoners to leave prison more angry and violent than when they entered.

To transform the prison system from one of discipline and control to one based on respect for human dignity involves change in many areas, ranging from legislated powers and obligations to health care auditing, administration, staffing, and procedures for health management. Transformation of this nature depends on a political culture which engages constructively with penal reform, as in Britain **(5,6,7)**, rather than exploiting prison issues for party-political pointscoring, as in the 1988 USA presidential election campaign **(8,9)**.

PRISON LAW

The Correctional Services Act

The law that governs imprisonment generally is central to transformation. The restrictive and punitive rules of the Prisons Act no 8 of 1959, renamed the Correctional Services Act in 1990, are not in line with human rights as described in the (Interim) Constitution of 1994 or the Working Draft of the New Constitution (1995). Since 1990 several adjustments have been made to the harsh and generally less acceptable aspects of the Act. They include:

* the abolition of racial segregation in prison, 1990 **(10)**.
* the abolition of media restrictions, June 1992 **(11)**.
* the abolition of corporal punishment by the Constitutional Court in 1994 **(12)**.

In spite of these amendments, the Act remains seriously flawed. For example, it deals with prison rule and management rather than with conditions of imprisonment. Conditions of daily living in jail was regulated by prison Departmental Orders arbitrarily promulgated by the Commissioner. The contents of these Orders as well as those of the "Guide for Prisoners" (excerpts from the Prisons Act and Prison Regulations) **(3c)** were, until recently, not available to inmates, academics or the public **(4b)**. Presumably consideration will be given to incorporating relevant Orders in law and regulating the powers of the Commissioner.

A redraft of the Correctional Services Act is currently under discussion, with the White Paper (21/10/94) **(13)** meeting with criticism from an Alternative White paper by the Penal Reform Lobby Group **(14)**. As with the case of the earlier Act, both reform proposals address mainly general aspects of prison management and fail to identify matters of medical concern. But it is crucial that the neglected subject of prison health care become part of the debate on prison reform, given the evidence in this and other studies **(15,16)** of the gross mismanagement of the health needs of detainees that has prevailed until now.

Constitutional Guarantees

During the Emergency there were repeated calls for prison health regulations to be described in a single law which could be challenged in court if not enforced **(17)**. This may no longer apply. In terms of prison health care, some injustices of the previous dispensation will be curtailed by constitutional human rights. Both the Interim Constitution (28/1/94) and the Working Draft of the New Constitution (16/12/95) guarantee human dignity **(18a)** and equality by abolishing racial and sexual

discrimination **(18b)**, freedom of security by abolishing detention without trial **(18c)** and arbitrary search and seizure **(18d)**. South African citizens may no longer be subjected to torture or cruel, inhuman or degrading treatment or punishment **(18e)**. A free press and flow of information is guaranteed **(18f)**. For the first time ever detained, arrested, accused and sentenced persons have constitutional rights to:

* conditions consistent with human dignity including accommodation, nutrition, reading material and medical care at state expense **(18g)**
* information about and reasons for arrest **(18h)**
* the choice or provision of a legal representative **(18i)**
* access to family, religious instruction and a doctor of personal choice **(18j)**
* challenge the lawfulness of detention **(18k)**
* a fair trial **(18m)**
* not to be forced to confess **(18n)**

Children, if detained, are to be held separately under conditions suitable for their age **(18o)**.

These constitutional rights protect all inmates from most of the excesses and grievances raised by detainees in the late eighties. A further clause allows anyone, on behalf of another group, to appeal to the courts to defend these rights **(18p)**. However, the problem remains of how to enforce such prescriptions within a closed institution.

In addition, these comprehensive guarantees of prisoners' rights deal only peripherally with health care. Nevertheless, there is some doubt whether a law dealing specifically with prison health care would provide the most suitable means for ensuring proper care for prisoners. Industrialised countries have taken a different course by developing health care standards for prisons and monitoring their implementation by regular audits.

Quality Assurance

The American state prisons are probably furthest developed in this respect. In view of the similarities between the South African and the American prisons systems there are logical grounds for looking to the American example:

* America rates 2nd and South Africa 3rd in the (known) world imprisonment figures, with 513 and 368 prisoners per 100,000 population respectively **(19)**.
* South African prison conditions in the late eighties/early nineties mirrored circumstances in the United States before prison reforms commenced there.

In the early seventies the American Medical Association did a survey of remand jails in states which revealed poor quality health care where it was available. In tandem with an active civil rights movement, medical organisations began to acknowledge the rights of prisoners to a healthy environment and proper medical care. From this premise evolved an information centre, standards of health care and an accreditation system. Out of it grew the National Commission on Correctional Health Care [NCCHC], representative of medical organisations (32 in 1992), that set out to improve health care in correctional facilities **(20)**. They achieved this by establishing detailed standards for all types and levels of health care **(21, 22, 23)** subject to an audit. Prisons apply and pay for this service. Those that comply with 80% to 90% of the standards, qualify for accreditation. This process has raised the standard of health care in the (state) Departments of Correctional Services considerably.

Some sceptics question the reasons why prisons apply for accreditation, suspecting an element of self protection:

1) Court judgements, in which the health care of a particular prison is found to be of poor quality, can order it to obtain accreditation to upgrade the service;
2) Facilities apply for accreditation in the knowledge that they will find favour if challenged in court (personal communication, 1992)

These concerns are mostly laid to rest when observers report the thoroughness of the scrutiny (NCCHC - personal observation, 1993).

Other countries have attempted similar approaches without the same favourable results. Cost is the likely reason for this. In the USA prisoners are the only citizens, who through court action, obtained a constitutional right to medical care **(24)** and so they are in the front of the queue for health care. By contrast, in South Africa all now qualify for this right, and consequently prisoners may well be last in line for health care. But they can, through class action suits, realistically challenge inadequate provisions for health care in prison. Providing quality care is not cheap. But, should the state neglect to do so, it could face high damage claims and at the same time be ordered to improve the service within a specified period at exorbitant cost **(24)**. Financial expenditure which enhances the self-esteem of inmates can be defrayed by the Departments of Health, Corrections and Justice and will be well spent if it results in the release of responsible citizens.

Administration of Prison Health Care

Interdepartmental responsibility for prison health must, however, be approached with clarity of purpose. Provision of health services for prisoners is entirely a medical

matter and should be the exclusive responsibility of the Department of Health. The functional boundaries and the authority of this Department for the health care in prisons and at police stations need to be spelt out, for reasons discussed below.

The Prisons Act (1959) made provision for a resident medical officer, a prison services employee, at every prison or group of prisons **(25a)**. In practice and over time this function was taken over by either full-time or part-time District Surgeons who service the prisons on a sessional basis. In 1986 the Health Directorates of the Provincial Administrations were made responsible for prison medical care by cabinet decision **(26)**. As a result District Surgeons, dentists and psychiatrists came under the control of regional health authorities, while specialists and mental health workers (psychologists and social workers) remained prison employees (Colonel Kaminga, Pollsmoor - personal communication, 1996). The consequence was confused lines of authority. Even recently, the Department of Health seemed to be uncertain about its responsibility for prison health care when it directed correspondence related to this matter to the Department of Correctional Services (Dr N Zuma, Minister of Health - personal correspondence, 1994).

This problem of dual authority also affects those detained at police stations. Although police cells and lock-ups are defined as prisons according to the 1959 Act **(25b)**, the people held in police cells do not have access to the kind of health infrastructure available at prisons. Their health care depends on a District Surgeon being called in by police officers, or on routine visits by nurses to police stations (in the Eastern Cape)(Dr Ivor Lang, retired Regional District Surgeon, EC - personal correspondence, 1996). To ensure quality health care at police stations attention should be given to nursing care, prescribed drugs and their distribution, diets, sleeping arrangements, exercise and general hygiene **(27)**.

Another problem is that no clear distinction is made between custodial and health care roles. All full-time prison health care providers (registered nurses, auxiliary nurses and medical orderlies) have been uniformed prison employees with military rank. This causes confusion about their caring role and undermines the situation of trust which should exist between patients and providers of health care. Apart from the question of military rank and dress, a further matter to address is the relationship between the prison service and the armed forces. The Proclamation of the State of Emergency re-enforced this link by again including prison personnel among the forces of law and order with powers of search and seizure **(28)**. This situation served to increase the "them" and "us" divide that separates custodians and prisoners. It is also cause for concern that health authorities , professional organisations and District Surgeons never

challenged the notion that doctors who work in prisons were subject to clearance by the security police, at least, apparently, until 1992 (Captain Mike Green, Regional Commissioner, WC - personal communication 1995). This raises serious questions about the independence of District Surgeons and their declared allegiance to prisoner-patients **(27)**.

Political changes have not yet prompted health authorities to take a closer look at their role as guardians of health care. But now that prison law, health services and the role of District Surgeons are under review, the Department of Health has an opportunity to assume its full responsibility for prison health care. This covers a wide spectrum ranging from a healthy prison environment to medical care that meets community standards.

First and foremost, all aspects of the health care of prisoners should be the responsibility of the Department of Health. This includes administration, facilities (hospitals, sick-bays, consulting rooms and equipment) and personnel. There must be no doubt in the minds of prisoners or staff about the employer of health providers and where their loyalty lies. The message it conveys is that their prime task is the care of patients. A meaningful change, however, entails more than loyalty to a new administration; it primarily involves a change in attitudes.

HEALTH CARE PERSONNEL

Laws only have value when they are put in practice. Here the staff who implement health care play a pivotal role. Attention must be paid to the qualifications, appointment, training, duties and responsibilities of all health care personnel.

At present the key players in the chain of referral are nursing assistants (previously medical orderlies), auxiliary nurses (staff nurses) and professional nurses (nursing sisters) and District Surgeons. Although ancillary medical services are not the focus of this study, some comments about training and case loads are worth making.

Nursing Assistants (Medical Orderlies)

This name was adopted in 1992 when the hospital training of custodial officers as health care assistants was increased from 6 to 12 months (Colonel Kaminga, Pollsmoor - personal communication 1995). When the respondents in this study were in custody the term "Medical Orderly" was used and for the sake of consistency will be used throughout.

It is disturbing that medical orderlies with the least training function as gate keepers to medical care. Their ability to identify acute illness and physical injury is not questioned. More worrying is that the mental effects of a stressful prison environment, which are so difficult to diagnose, could easily be overlooked or missed. As respondents reported, illness which was not acute was frequently dismissed as malingering. The fact that medical orderlies are custodial officers whose primary responsibility is security and for whom health care is of secondary importance is further cause for concern.

If the Departments of Correctional Services [DCS] and of Health plan to follow the Primary Health Care model and appoint the equivalent of Community Health Workers in prison, then training and commitment are of prime importance. Custodial officers should not assume clinical duties unless they are appointed by the Department of Health and trained to meet specific health care standards. It is imperative that all future programmes include psychiatric training, which is not taught at present.

A training programme which could be modified to suit South African requirements is that of the Illinois Department of Correctional Services. The Cook County Jail, Chicago, has a rapid turnover of remand prisoners, with 150 to 200 individuals passing into the jail every day (capacity 700). Their initial screening process involves the following (personal observation, 1993):

(i) Emergency Medical Technicians (licensed paramedics) take a detailed history and fill in a "bruise sheet" to screen out those who require immediate attention. This is followed by each new admission having a routine Chest X-Ray to detect TB, and a vaginal or urethral swab, if indicated, to detect Sexually Transmitted Disease.

(ii) The next morning new inmates are examined by a Physician's Assistant [PA] who can also prescribe drugs. Inmates take their medicines and their scripts to the cells (and to court) with them.

The University of St Lewis offers a 2 year Physician's Assistant training course: one year of lectures and one year of clinical training with fourth year medical students. At the end of their training Physician's Assistants sit board examinations which allows them to practice in prison under the supervision of a qualified doctor in the State of Illinois (Brian Prunty, PA - personal communication, 1993).

At the same facility, medical emergencies are handled by the Emergency Station which is manned by 2 doctors and 1 Physician's Assistant twenty-four hours a day.

Nurses

The South African prison services employ Professional Nurses (registered nurses) and Auxiliary Nurses (enrolled nurses).

Demilitarisation, in the form of abolishing military rank and dress, commences from April 1996 **(29)**. For prison services, however, to make a complete break with military tradition implies separating themselves in law and in practice from the "forces". From the interviews conducted it is clear that caring was not always the primary concern of prison nurses. Shedding military rank and dress might satisfy ethical niceties, but does not change attitudes **(30a)**. Only a fundamental change in the whole approach to prison health care could possibly achieve this (see below under alternative approaches).

From recent annual prison reports it seems that increasing numbers of nurses will be involved with care at the newly established regional prison hospitals. These hospitals were established to receive, from smaller prisons, patients in need of acute care, post-operative care and observation. They are staffed by nurses who "provide around the clock care" **(31)**. At Port Elizabeth the regional prison hospital has 142 beds. During the day 16 registered nurses and 14 auxiliary nurses are on duty. After hours one (auxiliary) nurse does the 15:45 to 23:45 shift, and is relieved by another who does the next 7 hour shift (Dr Ivor Lang, - personal correspondence, 1996). It is unlikely that one nurse looking after 142 patients meets standards of health care equivalent to those in the community. The regional hospital at Pollsmoor employs 32 nurses to look after 54 beds. At night a medical orderly (nursing assistant) does the first 7 hour shift, and is relieved by another who does the second 7 hour shift. The nursing assistant is covered by a trained nurse on call for 5 prisons (Colonel Kaminga - personal communication, 1996). Again, the adequacy of these provisions is highly questionable.

District Surgeons

The role of the District Surgeon is probably the most controversial of all the staff who provide health care in prisons, given the dilemma they face as state employees **(32)**. It could be that, as the only members of the health team who are appointed and directly accountable to the provincial health authorities, expectations are high that District Surgeons should honour the doctor-patient relationship as confidant and advocate of the prisoner-patient. Yet the findings of this and other studies are that District Surgeons "*are perceived negatively by prisoners as part of the government system*" **(30b)** and it raises concerns about the attitudes of District Surgeons. This could change when the Health Department assumes full responsibility for the delivery of

health care, abolishes military connections, and establishes an unambiguous line function.

Apart from the ambiguous perceptions about their role, District Surgeons encounter work place difficulties **(33a)** such as the enormous caseloads discussed earlier. Until the Department of Health becomes directly accountable for health this will not change, because the Department of Correctional Services is primarily concerned with custodial matters, and District Surgeons alone cannot solve the problem.

The Role of the Prison Doctor

The Prisons Act of 1959 makes provision for full-time prison doctors, but none have held this post since the fifties (Dr IJ Coetzee, retired Chief District Surgeon, Cape Town - personal communication, 1991). Instead, full-time "state doctors" and part-time appointees do regular sessions at large prisons. The rural areas are serviced by part-time "state doctors". These doctors, known as District Surgeons, provide services for *pro deo* patients on behalf of the state. They look after old-age and children's homes, baby clinics, inoculations, disability grants, categories of military personnel and prisoners. They also do clinical forensic work (drunken driving, assault, sexual abuse and rape) and post mortems **(33b)**. It is mainly in connection with their forensic work that the public have become familiar with District Surgeons.

As with other practices, the contradiction between the clinical and pathological duties of District Surgeons has not been queried by colleagues. It appears that most South African practitioners are not aware of the internationally accepted norm that

> *"a prison doctor's function should not be combined with that of a forensic physician acting for the sake of police investigation"* **(34)**.

There may indeed be an ethical conflict between the dual roles a District Surgeon is obliged to fulfil. For example, in a case of assault, rape or murder a particular doctor may be required to look after the well-being of a detained suspect, **as well as** to examine the victim in order to give expert evidence in court for the prosecution. This may affect the quality of care provided for the suspect.

Ethical contradictions like this have been overcome in the American medico-legal system by appointing, in the case of murder, Forensic Medical Examiners (qualified forensic pathologists) whose special function is to investigate and do post mortems on cases of unnatural death **(35)**. They are not in any way involved in the health care of detained persons.

Because prisoners are part of the criminal justice system, it appears that South African policy-makers find it difficult to separate the clinical care of prisoners from the investigative duties of state doctors. The committee reviewing the duties of part-time District Surgeons in the Western Cape has recommended dividing their duties into:

1) Community Medical Officers whose clinical duties are to be rendered by trained Primary Health Care doctors **(33c)**;
2) Forensic Medical Officers who are responsible for post mortems, investigations and the care of prisoners **(33d)**.

No reason is given for including the clinical care of prisoners with forensic duties, a practice which would be contrary to international norms. A service of international standing will require:

* training forensic pathologists with pathology and medicolegal qualifications for police investigation purposes;
* training prison doctors specifically to render care at jails and at police stations.

General medical services at police stations are more complex and will be discussed later under alternative services.

The recommendations put forward by the Western Cape Working Party refer, rightly, to under- and post-graduate training **(33d)**. At the moment, doctors have had little, if any, preparation for assuming prison medical duties. Dr Wendy Orr graphically described the intimidating effect the prison environment had the first day she reported for duty (personal communication). As is the case at any hospital or clinic, it is necessary to become familiar with the routines of the institution. Without previous experience, the novice District Surgeon is taught, consciously or subconsciously, by the regular staff to handle cases "their way". Without any training for what is without doubt the most fraught clinical and ethical situation, District Surgeons are expected competently to handle the 400,000 odd inmates who move through the system each year.

Until 1994 it was nearly impossible to obtain information from or about District Surgeons. They were, after all, subject to security clearance and sworn to silence. After 1994, when the country was divided into 9 provinces, information belonging to the old Cape Provincial Administration could no longer be readily found. From the available evidence, however, it seems that full-time and part-time District Surgeons working in urban settings were encouraged to obtain Diplomas in Forensic Science; to acquire medico-legal competence by doing a one month in-service forensic elective; and to attend geriatric courses (Dr IJ Coetzee - personal communication, 1991). It would have been helpful to know how many District Surgeons availed themselves of these opportunities.

To compensate for the shortfall in training, Refresher Courses were introduced, in 1985, for full- and part-time District Surgeons working for the Cape Provincial Administration. Similar courses were later started in Natal (1989), the Free State and the Transvaal (1990). Despite the need for instruction, these courses were apparently not well attended. The reasons put forward were the difficulty and cost of finding locums to cover the duties of District Surgeons while away. For instance, the 3 day course held at Port Elizabeth in 1991 was attended by only 25 doctors of whom two were academics and another a senior administrator **(36)**. Of more relevance is the content of the programmes (only 9 of which were traced). Common topics covered circumstances where District Surgeons were subject to scrutiny at public hearings and covered cause of death, bullet wounds, head injuries, drunkenness, sexual abuse, the Inquest Act and expert witness. Only 6 of the 149 presentations (one by a member of the South African Police) dealt with the rights and care of prisoners and detainees. From this it appears that additional training for District Surgeons deals mostly with incidents after the event. Little attention is paid to the active role of the District Surgeons in preventing illness and promoting health care in closed institutions which could improve the quality of life for tens of thousands of prisoners hidden from the public eye.

Now that the South African Medical and Dental Council has introduced compulsory post-graduate training prior to practice, the time is ripe to introduce training in prison health for all future general practitioners. This is not altogether a novel concept. In 1986 Saxe and Elsworth reported that District Surgeons were no longer working at the Worcester prison. Instead, 2 medical officers employed by the Provincial Hospital were on a 3 months rotation duty roster at the prison **(37)**. The report by the Human Science Research Council takes this a step further and suggests that young graduates could do part of their internship at prisons **(26b)**, presumably under supervision. The South African Medico-Legal Society has suggested that forensic medical

> "*educational principles need to be standardised throughout the country, so that a country-wide qualification and syllabus is in place, both for diploma courses and post-graduate qualifications*" **(38)**.

There is evidence that prison work under supervision can increase recruitment into the service. This happened when the Department of Family, Community and Emergency Medicine at the University of New Mexico offered students a weekly clinical attachment over several months at a maximum security prison. Despite initial reluctance by staff who were concerned that prisoners would manipulate students and abuse their goodwill, three years later they agreed with inmates and students that it was a valuable service which should be continued. Because of the stigma attached to

prison work the students themselves were apprehensive to begin with. But they soon warmed to the appreciation prisoners had for the thorough and caring quality of service they provided. With a better understanding of the need and kind of prison health problems, several students considered prison work as part of their future careers **(39)**.

A policy decision to separate the clinical and the pathological duties of District Surgeons should recognise the value of on-site clinical training. It will have to be complemented by a human rights programme **(40)**. The findings of this research demonstrate a poor understanding of ethical conduct with reference to assault, torture and solitary confinement. All doctors should know that their duty to the patient comes before their duty to the state, that they should act as advocates of the prisoner-patient and do everything in their power to put an end to all forms of abuse and torture. They should be aware that, depending on the type of abuse, they have the right to prescribe quiet, rest, sleep, exercise, stimulation (visual, auditory and mental) or company for the patient. And they should verify that their instructions have been followed as the law prescribes.

The recent history of the apartheid era demonstrates that South African doctors generally have a poor track record of defending human dignity and taking an ethical stand (see Appendices 1 and 2 of the Introduction). To prevent history from repeating itself, human rights activists are lobbying support for a truth commission for doctors and victims of mental and physical abuse **(41)**.

Of medical concern is the role of health care providers during and after the State of Emergency. Professional organisations should be encouraged to establish their own truth commission to deal with mismanagement and neglect that falls outside the scope of the Truth and Reconciliation Commission. This could create a forum in a safe place where everybody (victims and perpetrators) will be given an opportunity to talk about the constraints, frustrations and hardships they faced and suffered, where doctors can unburden themselves of the guilt, actions or omissions of the past, and where the empathic hearing of the stories of victims could restore their dignity. It may be necessary to keep the names of witnesses secret, but the information can be used to develop a code of ethical norms and human rights for doctors. The alternative is that the anger of victims may surface and motivate them to submit complaints of unprofessional conduct to the Interim National Medical and Dental Council of South Africa. Three or four such cases could damage the reputation of South African doctors as much, if not more, than the harm done by the Biko case **(41)**.

HEALTH CARE PROCEDURES

During the 6th World Conference on Prison Health Care, delegates had an opportunity to visit 2 prisons in Harare. Many were appalled at the overcrowding, lack of facilities and inhuman treatment of prisoners. Yet, the very next day Zimbabwean representatives presented their policies which could have come straight off the pages of South African prison documents. It was a stark reminder to be ever mindful that policy does not automatically translate into practice, and that there is a compelling need to constantly evaluate the quality of service provided.

It is therefore essential to develop standard procedures as guidelines for evaluating practice. They should include:

* Screening on admission
* Obtaining medical care for illness or injury
* Access to emergency services after hours
* Management of chronic illness
* Facilities for and management of the disabled and the aged
* Management and care of women, children and infants
* Management of infectious diseases, in particular HIV\AIDS and TB
* Management of conditions peculiar to closed institutions such as physical and mental abuse, isolation and hunger strikes
* Prescribing and distributing medicines
* A grievance procedure which guarantees a response within a set period without retribution.

INFORMATION

Information about health care practice and procedure in prison should be freely available to every prisoner, his family and the public. The Chapter on Human Rights gives prisoners a constitutional right to access of kith and kin, a lawyer, a doctor, religious instruction and freedom from torture **(13)**. This does not necessarily diminish the suffering and denigration of daily prison routines. For prisoners to make sense of their incarceration and to use their time fruitfully, they also need to know how to gain access to the facilities provided. A valid case can be made for every prisoner's legal right to information about practice and procedure (see Appendix 11).

In England and Wales this information was provided in a joint venture by the Prison Reform Trust and HM Prison Services. They published the "Prisoners Information Pack" which covers most of the processes mentioned above as well as details about contact with the outside world and reintegration **(42)**. A similar South African

publication should, in addition, include information about education and recreation. It would do much to ease the stress of daily prison life.

PUBLIC SCRUTINY AND INVOLVEMENT

The worst abuses take place in secret, away from the public eye. Experiences of detainees held under conditions of absolute secrecy confirm the need for a more open prison system. The only assurance that the South African Correctional Service can give the community against physical, mental and emotional abuse is to open the prisons to public scrutiny.

A distinction can be made between formal and informal scrutiny. Formal scrutiny can only be done by a completely independent body that has free access to institutions and their management at all levels. The outstanding example of this was the installation in the late eighties of HM Chief Inspector of Prisons in England and Wales who is appointed and reports directly to parliament. He performed this task with great skill: he praised where praise was due but he never hesitated to criticise defects in the system. His reports on Brixton prison **(43, 44)** and on suicide prevention **(45)** were highly acclaimed.

With regard to informal scrutiny, human rights organisations play an important role, the reported poor opinion of them by District Surgeons notwithstanding **(26c)**. In the United States the American Civil Liberties Union and in Britain the Prison Reform Trust both produce magazines (National Prison Project Journal and Prison Report respectively) that keep prisoners informed about public and political opinion, laws and prison policy generally. They also provide a forum where prisoners can bring complaints, make suggestions, publish articles and meet pen-friends. But it is as a source of information and as watchdogs over policy that they contribute most. Compiling and publishing the *Prisoners' Information Pack* has been the Prison Reform Trust's most valuable contribution. It was so well received that it is now published jointly by them and HM Prison Service **(37)**. It illustrates how independent monitors can become a resource for state institutions.

To maintain standards of decency and to aim at improvement the Department of Correctional Services should welcome and encourage research by social workers, psychologists, medical doctors and others. Recently the British identified research as the best way to determine the health needs of prisoners and delivery requirements of the service **(46)**.

Here a word of caution must be added regarding the release of research findings, particularly where they concern sensitive matters like child abuse. The sexual abuse of children persists as a hidden practice in society, and prisons are no exception. Human rights organisations, requested to investigate the activities of state institutions responsible for the care of children, cannot accept the imposition of conditions of secrecy as part of their contract **(47)**. Keeping unsavoury findings secret is not in the best interest of the children; it does not protect them nor does it root out the evil.

Prisons also benefit by opening their doors to community services. Adult literacy, street law, music, art, AIDS awareness and Life Line are the types of organisations that come to mind. Involvement with service organisations not only improves the quality of the time spent inside; it also provides closer links with the outside world and eases the integration of released prisoners back into society. In some cases inmates develop skills which are marketable outside (see later, under Bedford Hills).

CHANGING APPROACHES AND ATTITUDES

Few if any of these recommendations will have an impact unless they go hand in glove with a change in attitudes. Different institutions and systems have introduced approaches which contain lessons for transformation. Five of them have been selected for further discussion:

1) "Opportunity and Responsibility", an initiative of the Scottish Prison Service
2) The Children's Programme, Bedford Hills, New York
3) The "Buddy" Programme, Federal Medical Center, Rochester
4) Treating Young Offenders, Salt Lake City, Utah
5) Clinical Forensic Medical Services at Police Stations.

"Opportunity and Responsibility"

In the late eighties the Scottish Prison Service started to look afresh at the notion of rehabilitating prisoners. They queried whether the service had managed, through discipline and hard labour, to turn offenders into law-abiding citizens. It was the traditional approach based on the assumption that one individual or group could force change on to another. But they concluded that no amount of control produced rehabilitation; it only achieved obedience through coercion. Recidivism figures among released prisoners (up to 90% at some South Africa prisons: Carl Niehaus, Chair of the Parliamentary Portfolio Committee on Correctional Services - personal communication, 1996) are proof that rehabilitation, when imposed by one on another,

has failed. Real rehabilitation depends on change that comes from within, rather than from external regulation **(48a)**.

In 1990 the Scottish Prison Service published "Opportunity and Responsibility" **(49)**, a management plan for long term prisoners, stating boldly that:

> *"It is clear that the old objectives of 'treatment and training' have failed. A new approach is required, which will recognise the mutual responsibilities of the prisoner and the prison authorities to ensure that the long term prisoner is encouraged to address his offending behaviour and offered an appropriate range of opportunities to use his time in prison responsibly for personal development."*
>
> Malcolm Rifkind
> Secretary of State for Scotland

This new approach recognises that prisoners have a right to a humane and safe environment and that they are individuals with a free will. Its philosophy is that prisoners should be given options but that they are also responsible for the choices they make. It rests on the assumption that the chances of a positive outcome are better if institutions substitute "treatment and training" with provisions for the development of the prisoners' personal resources. To achieve this goal a prime duty of management is to train and support staff, since the key to successful reform is the extent to which the staff become involved. This is because a safe environment requires mutual respect between custodians and inmates. For radical transformation of this nature to succeed, full use has to be made of the potential of every prison, its staff and the prison population.

The above principles of good prison management had been tried and tested at Greenock and Stotts Prisons in Scotland, where they were successfully introduced between 1986 and 1991 **(48a)**. Meanwhile the "austere, miserable and negative" conditions at Brixton Remand Prison, London, had reached crisis proportions **(43)**. To rescue the situation it was decided to transfer the governor who implemented the above reforms to Brixton. He realised that public opinion and support was crucial for success. To this end the written and electronic media were given free access to report fully on the situation in Brixton. The consequent public outrage provided the backing which, in conjunction with a policy document, transformed an overcrowded mental observation dungeon **(48b)** into a model of prison mental health management **(44)**.

Measures which brought about this transformation included:

* Psychotic patients being transferred to mental hospitals for proper psychiatric care
* Staff being allocated to specific patients, constantly in attendance and able to mingle and engage with patients
* A disturbed patient being placed in secure ward, rather than a "strip cell", and under the care of nurses with safe access to him to calm him down, for example by chatting to (counselling) patients over a cup of tea or cigarette
* The establishment of a suicide management team who could observe and attend to patients, intent on selfharm, in an observation ward
* Allowing telephonic access to outside support from family members and the Samaritans (equivalent to Life Line) who regularly visit and counsel patients
* Open, airy and properly furnished wards (with curtains and posters), plus a games room and patio where patients can spend time out of doors and cultivate plants (personal observations, 1995).

These innovations illustrate how a humane environment, characterised by decent facilities and an attitude of concern towards prisoner-patients by the health care staff, may be created. Crucial to their implementation, however, was the powerful appeal for public support.

The Children's Programme

The Bedford Hills Correctional Facility is a maximum security prison for female prisoners in New York state and accommodates approximately 700 prisoners. About 80% of the women have children **(50)** two thirds of whom are ten years and younger. Two decades ago, Sister Elaine, a nun employed as a social worker, identified the lack of facilities for children visiting their mothers at the prison as a major problem. She then set about developing a visiting programme for the children, which represents a progressive model for dealing with the issue of imprisoned mothers and their children **(51)**.

To-day the children can visit their mothers for weekends or during the school holidays for 5 days (9 to 3:30) and stay overnight with local host families. Female prisoners are granted special permission to await their children in the visiting room in order to welcome them **(51)**. Libraries were established from which mothers can borrow books and toys to entertain the children. A literacy programme encourages mothers to improve their reading ability and enables them to record bed-time stories on tape to send to their children (personal observation, 1993).

Other initiatives which grew out of this include:

* The establishment of **foster homes** for children who have nowhere else to stay. To spare the children embarrassment they are known as "My Mother's Home" **(52)**.
* A **Foster Care Committee**, made up of inmates and outsiders, renews and maintains contact with families by phone or visits; provides legal information and advice; runs support groups for mothers and prepares them for dealing with informing children about imprisonment, separation and termination of parental rights (Precious Bedell (8090280) - personal communication, 1993).
* A **Parenting Center** (American spelling) offers workshops on pregnancy, infant care, training, development and health care.

Bedford Hills is the only prison in the United States that, historically, allows nursing mothers to keep infants in prison for a year after birth. A prison nursery with kitchen was established in the medical wing to house up to 16 nursing mothers. The babies are provided with clothes, cots, formula, prams and toys. A crèche, called the **Infant Day Care Center**, was launched with a dual purpose in 1990: during working hours it frees mothers to work or study; it also provides the practical training required for inmates enrolled in Child Development Associate Courses. With experience plus writing and reading assignments trainees qualify to work in any registered nursery school in the United States (personal observation, 1993).

All these interventions prepare mothers to return to the free world with confidence in their ability to interact positively with their children and society. It builds self-esteem and the skills necessary to withstand, hopefully, the temptation of further crime.

The Buddy Programme

The "buddy" system developed at the Federal Medical Center, Rochester, provides ill, dying and vulnerable prisoners with a fellow inmate to speak to ("buddies" learn basic counselling skills), to lean on and a watchful eye to guard against self-mutilation. Although participation in "buddy" training programmes is voluntary, it is so popular that there is always a waiting list of volunteers (Dr Ruth Westrick, Associate Warden, FMC - personal communication 1993). One buddy mentioned that "*it makes one feel useful and good about helping others. It gives meaning to the time in jail*" (prisoner - personal communication 1993). Responding to the emotional needs and vulnerability in others touches prisoners and has a humanising effect on them. This system is another example of the way that prison experience can be made more humane and conducive to self rehabilitation.

Treating Young Offenders

Psychiatrists attached to the Utah School of Medicine, Salt Lake City, have devised specific treatment programmes to curtail the criminal behaviour of young offenders (below 18 years of age). A distinction is drawn between sociopathic violence and the violence related to post traumatic stress disorder [PTSD]. They postulate that childhood exposure to chronic and multiple trauma damages selfworth and delays emotional development. Antisocial behaviour in young adults most frequently occurs against this background **(53)**.

Whereas the management of adult PTSD focuses on recovering traumatic memories, for the young to revisit these damaging experiences evokes intense distress often associated with negative emotional effects or outbursts. Adolescents should only be required to recall traumatic incidents indirectly, for example by writing or drawing. Health management aims at "*healing the damage to self that has resulted from the trauma*" **(54)**. This occurs best in a safe, respectful, sympathetic and trusting environment where the individual can learn new ways of coping with and containing day to day obstacles and frustrations. Tolerant and sensitive prison staff can learn simple techniques which create new opportunities for young offenders to (re)experience significant development events in a positive and healing way. An outcome which enhances self-esteem and develops healthy coping abilities has the best chance of reducing irrational violent outbursts **(55)**.

This approach is far in advance of the punitive and authoritarian attitudes of custodial institutions in South Africa. Yet, in order to reduce current levels of violence, creative new ways must be found to overcome the repeated emotional damage inflicted on young township dwellers during the apartheid years.

Medical Care at Police Stations

Health care for suspects and detainees in police cells poses a complex challenge for medical ethics. The sensitivity surrounding this issue prompted the British Medical Association to publish specific guidelines for Police Surgeons **(56)**. They define care as "*meeting basic requirements for food, drink, human contact, warmth, sleep, exercise, personal hygiene and protection*" and medical treatment as "*all forms of medical intervention*", on the premise that the patient's interests come first.

For Police Surgeons the ethical dilemma is that clinical findings can be used as court evidence against patients in cases of impaired judgement due to alcohol or drugs, or physical or mental illness. Under these circumstances informed consent and

confidentiality, as well as consent to disclose information on transfer, are vital. A distinction is made between confidential clinical records and the brief instructions to custodial staff responsible for the proper care of detainees. To meet these standards of care, well equipped and secure but private consulting rooms are essential for examining patients and keeping records safe **(56)**.

The difficulties related to obtaining valid and useful clinical information from intellectually impaired individuals are recognised and doctors are cautioned against treating alcohol or benzodiazepine withdrawal, head injuries associated with alcohol consumption and psychoses at police stations, where nursing care is rudimentary or absent. Acknowledgement of the subtleties of ethical clinical management with its legal implications led to the introduction of special training courses for Police Surgeons in Britain in 1990 **(56)**.

With regard to clinical forensic services the practice in Melbourne, Australia, is instructive. As elsewhere, Forensic Medical Officers [FMO] are responsible for examining victims of crime (physical and/or sexual), establishing fitness for questioning and/or detention, and providing care for those in custody, as well as for administration, recruitment and training. It is the training of police officers, to raise their level of awareness about the hazards of clinical evaluation (mentioned above), that is of particular interest. Officers are taught to recognise illness, to assess the intellectually impaired and in particular to identify the effects of alcohol and drugs, agitation, psychological disturbance or intellectual disability. Sensitive to their role as the link between the community and the criminal justice department, FMOs take their responsibility for raising awareness and educating the public, about community issues such as domestic violence, sexual abuse and alcoholism, seriously. The training programmes for rural FMOs available on CD-ROM may be a starting point for committees concerned with the establishment of forensic clinical services at South African police stations and lock-ups (Dr Faika Jappie, Chief FMO, Melbourne - personal communication, 1995).

Human dignity is the foundation on which these various programmes are based. To initiate them strong leadership, with vision and the courage to take risks, is necessary in order to achieve the objectives. Staff need to be valued and supported to build a healthy team spirit. All these factors contribute towards developing an ethos of mutual respect between personnel and prisoners, which is the ultimate condition on which prison transformation rests.

Appendix 11: Right to Prison Practice and Procedure

UNIVERSITY OF CAPE TOWN

Department of Primary Health Care

Faculty of Medicine
Observatory 7925 Cape South Africa

16 February 1996

The Executive Director
Constitutional Assembly
P O Box 1192
Cape Town 8000

Dear Sir

The Right of Detained and Sentenced Persons to Information about Prison Procedure and Practice

I am writing to you to raise my concerns about the rights of detained, arrested and accused persons. These concerns have come to mind in writing up my thesis on Prison Health Care based on extensive field research during 1991 (123 lengthy interviews with ex-detainees from the Eastern and Western Cape).

I wish to draw attention to Section 34 of the Draft Constitution which deals with "Arrested, detained and accused persons". Should it not read "Arrested, detained, accused **and sentenced** persons"? It would then deal with:

"34.(1) Everyone who is arrested for allegedly committing an offence has the right . . ."

"34.(2) Everyone who is detained, **including every sentenced prisoner**, has the right . . ."

As regards the content of this section, my main concern relates to conditions of incarceration. Individuals confined to total institutions can only actualise their rights if they know the procedures and practice of the facility. My suggestion, therefore, is that in addition to their present rights, individuals also need to be informed about how to gain access to those rights while imprisoned.

In this connection, I draw your attention to the excellent "Prisoners' Information Pack" produced jointly by the Prison Reform Trust and HM Prison Service. This information is freely available to all prisoners and their families in England and Wales. It includes information about:

* Starting your sentence
* Visits
* Requests and complaints
* Race relations
* Social security and discharge grants
* Welfare
* Health and hygiene
* Discipline
* Unconvicted prisoners
* Women prisoners
* Young offenders
* Life sentence prisoners
* Release
* Visiting prisoners
* Useful information.

Perhaps the guidelines in this pack pertaining to "Visits" could be modified to "Access to family and friends" because it would be more explicit about maintaining contact with the outside world through visits, letters, and phone calls. Given the commitment to rehabilitate prisoners, it would be crucial to add information about education and vocational training as well as recreation available in prisons.

Rights only have value when they are put into practice. Cut off from society, prisoners should also have the right to information about daily living conditions and how to make use of available facilities. Lack of information compromises human rights and has a detrimental effect on the physical, mental and emotional health of detainees and prisoners. This is confirmed

by my own research and other reports of the experiences of prisoners in South Africa and elsewhere.

I would gladly provide more information if necessary.

Yours sincerely

Signed by candidate

Signature Removed

Dr Judith van Heerden

cc Mr Dullah Omar, Minister of Justice
Mr Trevor Manuel, Minister of Trade and Industry
Mr Govan Mbeki, Deputy President of the Senate
Mr Carl Niehaus, MP
Mrs Judy Chalmers, MP
Mrs Ivy Gcina, MP
Rev T S Farisani, MP

RECOMMENDATIONS FOR IMPROVED HEALTH CARE DELIVERY IN PRISONS

In conclusion, the main recommendations discussed in Chapter 5 are summarised below:

1) The **laws governing prison services** need to be set out in easily accessible language and made available to institutions, professionals, prisoners and the public. The present Statuary Law (Correctional Services Act 8 of 1959) has management limitations. Directives relating to conditions of imprisonment formerly contained in Departmental Orders and the "Guide for Prisoners" should, together with medical guidelines, be incorporated in a law that can be enforced on appeal to the courts.

2) The letter as well as the spirit of the **Bill of Rights** in the Interim and Draft Constitutions should be fully implemented. The Chapter on Human Rights should include a clause on the right of detained and sentenced persons to information about prison procedure and practice.

3) The ultimate objectives should be to promulgate **standards of health care** at all levels for prisoners (including women, infants, children and young offenders) and to develop an **audit** mechanism in order to ensure that these standards are met and maintained. Standards must be developed in conjunction with constitutional rights. Going this route will more likely guarantee the implementation of adequate health care than a specific law regulating prison health, which will not be subject to audit.

4) **Medical Accountability**:

   * All health care in prisons should be divorced from the custodial domain and should fall directly **under the Department of Health**.

* The role of individuals responsible for **health care at police stations and lock-ups** must be clearly described and health care personnel identified and trained.

* **A line of authority** should be established to advise, guide and support District Surgeons and health care personnel facing controversial ethical decisions.

* Professional organisations should, possibly by way of a medical truth commission, establish and publish those **moral and ethical standards** they are willing to uphold and defend.

* **Forensic clinical duties** of doctors (District Surgeons) should be **separated** from **forensic pathological duties**, in line with international norms.

5) **Health Care Training**:

* Introduce **in-house training and peer review**. Post-graduate training for general practice should include a prison rotation. It would also enable future District Surgeons to be more assertive for the benefit of their prisoner-patients. These innovations may improve the recruitment figures of doctors prepared to work in prisons.

* Compulsory **refresher courses** for forensic clinicians should focus specifically on prison health care duties, responsibilities and ethics. This is in addition to the largely forensic courses in morbid pathology and court procedure already offered.

* **Teaching the medical ethics** of prison care, abuse, torture (including solitary confinement) and hunger strikes, at under- and post-graduate level, is essential.

* All prison staff involved in the health care of inmates should receive **psychiatric training** to enable them to understand and deal with the mental stress of imprisonment.

Implied in all these recommendations is the need for greater accountability among institutions and academics in the health field with regard to the delivery of appropriate and responsible education and training for prison health care.

6) **Prison staff** (custodial and health personnel) should be sufficiently **trained** in prison law, their duties and responsibilities, and in ethics.

7) Create a new civilian *esprit de corps* to **replace the military image** (under review) and mentality of the prison services.

8) Replace the present policy of "treatment and training" of prisoners with that of "**opportunity and responsibility**".

9) Prisons have to be **opened to public scrutiny**:
   * *information* should flow freely in and out of prisons
   * invite *community organisations* to participate in the support of and share in the training of prisoners
   * *community links* will ease the reintroduction of released prisoners back into public life.

10) **Information packages** which set out clearly and simply prisoners' rights, prison procedure and practice should be available to all prisoners, their families and the public.

11) All prisons should be subject to **monitoring by an independent body** who reports directly to parliament, like HM Inspector of Prisons in England and Wales.

12) **Watchdog organisations** (like Amnesty International, Prison Reform Trust, American Civil Liberties Union, Physicians for Human Rights, Rehabilitation and Research Centre for Torture Victims) should be encouraged and their important role in providing prison information and initiating penal reform recognised.

What is required, in sum, is a creative, humane and holistic approach to rectifying serious deficiencies in health care delivery identified in this study, as part of the general

overhaul of the South African prison system. The lesson to be drawn from the experience of countries like Britain and the United States is that proactive intervention to secure decent conditions of imprisonment is preferable to crisis management induced by prison upheavals. Provision of adequate health care is indubitably expensive, but it is likely to be less costly than the consequences of successful class action suits brought by prisoners against the State. Moreover, with the human rights and dignity of prisoners affirmed by the Bill of Rights, there are compelling moral and legal values to inspire the much-needed reform of prison health care in South Africa.

Postscript

It is hoped that the findings of this research, on prison conditions in South Africa during the previous dispensation, can inform changes appropriate for an accountable transformation of prison policy and practice.

Central to the reform of prison health services in this country is the complete separation of health from custodial care. This principle has, with the support of non-governmental organisations, already been accepted by the Portfolio Committee on Correctional Services of the New South African Parliament. Along with several of the other recommendations arising from this study, it has been submitted to the Minister of Correctional Services for incorporation into law. If promulgated such changes should, together with the establishment of standards of prison health care subject to regular audit, transform South African prisons.

At the same time, constant scrutiny and ongoing research remain essential to ensure that decent living and health care are maintained in future in our urban and rural prisons.

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Appendix 12:

Questionnaire Used for Interviews

This Questionnaire deals with medical care in detention. Although it appears long the questions have a special order. If you understand the order it may help you to give clear answers.

- General information about
  - Yourself
  - Your conditions of detention
- Illness before your detention
- Did your arrest: make you ill?
  result in injury?
- Your medical rights
- Illness while in detention
- Referrals (specialist treatment
  or
  admission to hospital)
- Assaults
- Solitary confinement

Please note that whenever possible detailed replies will be helpful.

To bring about change your replies will have most value if they are completely honest. Exaggerations are NOT helpful.

AIMS

The aim is :

1) to determine the quality of medical services provided for detainees
2) to improve these services where possible
3) to educate the public about the medical rights of detainees

This questionnaire is **confidential.** For your own protection all information will be kept under a code.

All medical care should be unbiased. To explore the manner in which detainees of different race groups are treated, we are forced to ask for racial classification.

CONFIDENTIAL

QUESTIONNAIRE

NUMBER [_____]

NAME ..... CODE [_____]

ADDRESS .....

.....

CODE [_____]

DATE OF BIRTH [__/__/__]

SEX [_____]

RACE [_____]

GENERAL:

1. EMPLOYMENT

At present are you employed /a scholar/a student/ a housewife/unemployed (part-time or full-time).

Before detention did you have a job ?

[No]

[Yes] --->What kind of work did you do ? :.....

.....

.....

Who did you work for ? : .....

.....

.....

Did your detention lead to a change in your job?

[No]

[Yes] ---> What kind of change? : .....

---> Why? (physical injury/political reason?)

.....

.....

DETENTION

2. When were you detained? ___/___/19____.

What law /section were you held under ? .....
Was this changed ?
[No]
[Yes] ---> When ? .....

---> To what ? .....

When were you released ? ___ / ___ / 19___

For how long were you detained ? (held) Months [_____]
Weeks [_____]
Days [_____]

At the beginning were you held in a Prison or Police Station ?

(Prison) Name : .....Place :.....

(Police Station) Name : ..... Place :.....

Did this change ?
[No]
[Yes] ---> How did it change ? .....

Name:.....Place:.....

Were you detained at any other time ?
[No]
[Yes]---> When .....

	Date	Place	District	How long	Outcome
1.					
2.					
3.					
4.					

3. PRE - DETENTION ILLNESS

At the time of your detention, were you sick ?
[No]
[Yes] ---> specify .....

.....

Were you taking any medicine for this illness before your detention ?
[No]
[Yes] ---> specify .....

.....

Did this treatment continue while you were in detention ?
[Yes]
[No] ---> Why not ?.....

.....

Did you wait to get this medicine in prison/police cells ?
[No]
[Yes] ---> How long Hours [ ]
Days [ ]
Weeks [ ]

Why did you have to wait ? .....

.....

Did you ask for this treatment ?
[No]
[Yes] ---> Who did you ask ? .....

What kind of response was there to your request ?

.....

.....

THE ARREST

4. While you were being taken in :

Did anything happen to make you sick ? (Make your ill)
[No]
[Yes] ---> explain.....

.....
Were you injured ?
[No]
[Yes] ---> explain .....

.....
If Yes did you need treatment for the illness/injury?
[No]
[Yes] ---> explain .....

.....
Did you ask for treatment ?
[No]
[Yes] ---> Who did you ask ?.....

.....
Did you get treatment ?
[No]
[Yes] ---> What kind of treatment ?.....

.....
Did you wait from the time of asking until you were seen ?
[No]
[Yes] ---> How long did you wait ? Hours [ ]
Days [ ]
Weeks [ ]

Why did you have to wait ? .....

.....

5. **RIGHTS**

Were you told that you had medical rights as a detainee ?
[No]
[Yes] ---> who told you : .....

.....

what were you told :.....

.....

.....

Did you know that a doctor must see you shortly after you were detained ?
[No]
[Yes]

Were you told about the M.A.S.A*. panel of doctors ?
[No]
[Yes]

Did you know about the M.A.S.A. panel before your detention?
[No]
[Yes]

Did you ever ask to see one of the MASA doctors?
[No]
[Yes] ---> If Yes, what happened?

.....

.....

.....

* M.A.S.A. is the Medical Association of South Africa

IN DETENTION

6. How soon after you were taken in, did the doctor do your **routine examination**?

Hours [ ]
Days [ ]
Weeks [ ]

Did you ask to see the doctor ?

[No]
[Yes]

Were you seen by a doctor ?

[No]
[Yes]---> Did he take a history (ask about past illnesses?)

[No]
[Yes]---> What did he ask ?.....

.....

.....

Did the doctor examine you ?

[No]
[Yes]---> Give details .....

.....

.....

7. While in detention, did you have any **physical** problems (illnesses)?
[No]
[Yes] ---> specify : .....

.....

.....

.....

.....

8. While in detention, did you have any **psychological** problems? (problems with your nerves?)
[No]
[Yes] ---> specify :.....

.....

.....

How did you feel in yourself ? : .....

.....

What was your mood like ? :.....

.....

.....

.....

PHYSICAL PROBLEMS:

	Never	Mild (some-times)	Moderate (often)	Severe (most of the time)
feeling ill/sick				
tiredness				
hyperactive (over active)				
rapid heart rates/beats				
shivering/trembling				
sweating				
pains				
headaches/tightness				
chest pain/tightness				
stomach pain				
poor appetite (off food)				
nausea				
constipation				
diarrhoea				
weight loss				

PSYCHOLOGICAL PROBLEMS (WITH YOUR NERVES)

lonely				
withdrawn				
disinterested				
detached (don't belong)				
depressed				
sad				
like crying				
listless				
restless				
agitated				
mood swings				
irritable				
nervous				
fears				
sleep disturbances ↑/↓				
difficulty remembering				
difficulty concentrating				

9. While in detention were you seen by a :

	How many times (dates)	Names	Place / Hospital
District surgeon			
District dentist			
Specialist / Hospital doctor			
M.A.S.A panel			
Psychologist			
Psychiatrist			
"Other"			
(Dr, don't know type)			

10. Did you ever **ask** to see a doctor ?
[No] ---> Why not [never ill, scared, intimidated]

.....

[Yes]* ---> Who did you ask ? (include the number of

times you asked).....

.....

---> Were you seen by a doctor ?
[No]
[Yes] ---> What was his / her name ?

.....

.....

---> How long did you wait for the doctor ?
Hours [_____]
Days [_____]
Weeks [_____]

What were your medical complaints ? specify:.....

.....

.....

Did the doctor ask about your illness ?
[No]
[Yes] ---> past illnesses : what:.....

.....

.....

present illness : what.....

.....

.....

Did the doctor examine you ?
[No]
[Yes] ---> what did he/she examine :.....

.....

Measure your weight ? [Yes] [No]
Take your temperature ? [Yes] [No]
Measure your blood pressure ? [Yes] [No]

Listen with a stethoscope to your chest (heart/lungs) ?
[Yes] [No]
Feel your tummy ? [Yes] [No]

Test your reflexes with a patella hammer ?
[Yes] [No]

Test your sense of feeling with pin/cottonwool ?
[Yes] [No]
Test your strength ? [Yes] [No]
Check your eyes/vision ? [Yes] [No]
Check your ears/hearing ? [Yes] [No]
Test your urine ? [Yes] [No]

Were you satisfied with the way you were treated by the doctor ?

[Yes]
[No] ---> Why not ? .....

.....

What did the doctor say was wrong with you (diagnosis) ?

.....

Did you agree with this (diagnosis) ? : .....

.....

What was the doctors attitude to you as a person?

very caring & understanding your problems — caring — disinterested & uncaring — rude, abusive, judgemental

4 3 2 1

<----------->

comment on specific interactions & / incidents .....

.....

.....

.....

Were you alone with the doctor while (s)he examined you ?
[Yes]
[No] ---> Who was with you ? .....

.....
Did you have any time alone with the doctor to talk privately ?
[Yes]
[No] ---> Who was with you ? .....

.....

Was treatment prescribed for you ?
[No]
[Yes] ---> What kind of treatment(s)/medicine ?

.....

.....
Were you given this treatment(s)?
[No]
[Yes] ---> How long did you wait for the treatment ?
Weeks [_____]
Days [_____]
Hours [_____]

Were you satisfied with this treatment/medicine ?
[Yes]
[No] Why not ?.....
.....
.....

11. If you were sick during lock-up time (at night) could you call for help ?
[No]---> Why not .....
.....
[Yes]---> Did you call for help?
[No]
[Yes]
Did someone come to help you?
[No]
[Yes]---> Who came to help you? .....

.....

Did you wait for help?
[No]
[Yes]---> Why .....

.....

12. **REFERRALS**

Did you ever think you should go to **hospital**?

[No]
[Yes] ---> Were you sent to hospital ?
[No]
[Yes] ---> What for ? .....

.....

Which hospital did you go to ?

.....

What were conditions like in the hospital e.g. (were you policed or shackled ?)

.....

.....

Describe what it was like for you in the hospital :.....

.....

.....

Did you ever think you should see a **specialist**?

[No]
[Yes] ---> Were you referred to a specialist ?
[No] ---> Why not? .....

.....

.....

[Yes] ---> What sort of specialist ?

.....

.....

Where:.....

.....

How long did you wait to go to hospital & / for specialist attention?

Hours [_____]
Days [_____]
Weeks [_____]

Why were you referred to a hospital / specialist ? .....

.....

Did he ask you to have any special tests done ?
(investigations) e.g. X-Rays ?
[Yes] ---> What kind ? .....

.....

--->Were you given the results of
these tests ?.....

.....

[No] ---> Do you think you needed any tests?
[No]
[Yes] What kind of tests?

.....

.....

13. **ASSAULTS**

Were you assaulted while in detention ?
[No]
[Yes] ---> What kind of assaults (verbal, physical,

psychological)? .....

What happened? .....

.....

As a result did you need medical care/to see a doctor?

[No]---> Why not : Not serious?.....
Did not want to see doctor?.....
Weren't allowed to see doctor?.....
Other?.....

[Yes]---> Did you get care/see a doctor?
[No].....
[Yes].....

Did the doctor ask what happened (take a history)?
[No]
[Yes]---> What did the doctor ask/say?.....

.....

.....

Did the doctor make a record of the assault?
[No]
[Yes]---> What did he write down? .....

.....

.....

Did the doctor examine you?
[No]
[Yes]---> What did he examine?.....

.....

.....

Did the doctor say you needed medicine or treatment ?
[No]
[Yes]---> Did you get medicine or treatment?
[No]---> Why not?.....

.....

[Yes]---> What kind of medicine or treatment did you get? .....

.....

Did you wait for it?.....
[No]
[Yes]---> How long?
Hours [ ]
Days [ ]
Weeks [ ]

---> Was the medicine/treatment helpful?

[No]---> Why not? .....

.....

[Yes] .....

.....

Did (s)he do anything to prevent further assaults ?
[No]
[Yes] ---> What was done ?

.....

.....

.....

SOLITARY

14. Were you ever in solitary confinement ?
[No]
[Yes] ---> For how long ?

Days [_____]
Weeks [_____]
Months [_____]

---> Did this cause you any problems ?
[No]
[Yes] ---> explain:.....

.....

.....

---> Did the doctor do anything about it?
[No]
[Yes]---> What .....

.....

.....

Do you think that was helpful ?

.....

.....

.....

15. What do you think can be done to improve medical services for people in detention / jail?.....

.....

.....

.....

.....

.....

.....

.....