

**UNIVERSITY OF THE WESTERN CAPE  
FACULTY OF LAW**

**THE RIGHT TO HEALTH CARE OF TERMINALLY ILL  
INMATES IN SOUTH AFRICA**

**Thesis submitted in fulfilment of the requirements for the LLD  
degree**

**by**

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## **DECLARATION**

I declare that The Right to Health Care of Terminally Ill Inmates in South Africa is my own work, that it has not been submitted before for any degree or assessment in any other university, and that all sources I have used or quoted have been indicated and acknowledged by means of complete references.

Chesné Joy Albertus

## TABLE OF CONTENTS

SYNOPSIS	xii
KEY TERMS	xiii
ACKNOWLEDGMENTS	xiv
DEDICATION	xv
LIST OF ACRONYMS	xvi

### CHAPTER 1

#### INTRODUCTION AND OVERVIEW

1.1 DEFINITION OF TERMS	1
1.2 BACKGROUND TO THE STUDY	2
1.3 PROBLEM STATEMENT	10
1.4 FOCUS AND OBJECTIVES	15
1.5 AIMS	15
1.6 METHODOLOGY	16
1.7 SIGNIFICANCE AND LIMITATIONS OF THE STUDY	17
1.6.1 Significance of the study	17
1.6.2 Limitations of the study	18
1.7 OUTLINE OF THE STUDY	19

### CHAPTER 2

#### THE RIGHT TO HEALTH OF TERMINALLY ILL PRISONERS: AN INTERNATIONAL AND REGIONAL LAW PERSPECTIVE

2.1 INTRODUCTION	21
2.2 THE HISTORICAL JOURNEY OF THE RIGHT TO HEALTH IN INTERNATIONAL LAW	21
2.3 UNITED NATIONS SPECIAL RAPORTEURS	26
2.4 THE RIGHT TO HEALTH IN INTERNATIONAL LAW INSTRUMENTS	29
2.5 LIMITED EXPRESS LEGAL PRINCIPLES ON TERMINAL ILLNESS	30
2.5.1 The International Covenant on Economic, Social and Cultural Rights (ICESCR)	30

2.5.2 The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	35
2.5.3 General Recommendation No 30 of 2004	36
2.5.4 The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	36
2.5.4.1 Article 12 of CEDAW	36
2.5.4.2 General Recommendation by the Committee on CEDAW	37
2.5.4.3 Concluding Observations by the Committee on CEDAW	38
2.5.5 The International Convention on the Rights of Persons with Disabilities (ICRPD)	38
2.5.5.1 General Comments regarding health and disabilities	38
2.5.5.2 Concluding Observations on health and disabilities	39
2.5.5.3 Jurisprudence on health and disabilities	39
2.5.6 World Health Assembly Resolution 67.19: ‘Strengthening of palliative care as a component of comprehensive care throughout the life course’	41
2.5.7 The International Covenant on Civil and Political Rights (ICCPR)	41
2.5.7.1 ‘Public health’ as a justifiable ground for the limitation of some first-generation rights	42
2.5.7.2 Article 6 of the ICCPR: The right to life	43
2.5.7.3 General Comments relevant to the right to life	43
2.5.7.4 Concluding Observations regarding the right to life	43
2.5.7.5 Article 7, the prohibition on torture or to cruel, inhuman or degrading treatment or punishment and article 10 the right to dignity	44
2.5.7.6 General Comments relevant to articles 7 and 10	44
2.5.7.7 Concluding Observations relevant to articles 7 and 10	45
2.5.7.8 Jurisprudence on articles 7 and 10	46
2.5.8 Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT)	48
2.5.8.1 Committee against Torture’s Concluding Observations	49
2.6 EQUAL ACCESS TO QUALITY HEALTH CARE	50
2.6.1 ICESCR Committee’s Concluding Observations on access to quality health care	50
2.6.2 CERD’s Concluding Observation on access to quality health care	51

2.7 FACTORS WHICH CONTRIBUTE TO POOR HEALTH: THE VALUE OF AWARENESS AND ATTENTIVENESS	52
2.7.1 CESCR’s Concluding Observations on prison conditions and prisoners’ health status	52
2.7.2 CESCR’s Concluding Observations on discrimination	52
2.7.3 CERD’s Concluding Observation on discrimination against minorities	53
2.7.4 CEDAW on discrimination	53
2.7.5 CEDAW Committee’s General Comments on health	54
2.7.6 Jurisprudence on discrimination in health care	54
2.8 THE IMPACT OF INSUFFICIENT RESOURCES ON VULNERABLE GROUPS	55
2.8.1 CESCR’s Concluding Observations on sufficient resources	55
2.8.2 CEDAW’s Concluding Observation on sufficient resources	56
2.9 THE RIGHT TO HEALTH IN REGIONAL LAW INSTRUMENTS	56
2.9.1 The inter-American human rights system	57
2.9.1.1 The American Declaration of the Rights and Duties of Man	57
2.9.1.2 The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)	57
2.9.1.3 The Inter-American Convention on protecting the human rights of Older Persons	58
2.9.1.4 American Convention on Human Rights	59
2.9.1.5 Jurisprudence	59
2.9.1.6 Charter of the Organization of American States	61
2.9.1.7 Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (1994)	62
2.9.1.8 Jurisprudence	63
2.9.2 The European human rights system	65
2.9.2.1 European Convention on Human Rights (ECHR)	65
2.9.2.2 Jurisprudence	66
2.9.2.3 European Social Charter	67
2.9.2.4 Conclusion of the European Committee on Social Rights	69

2.9.2.5	Jurisprudence	70
2.9.2.6	The Charter of Fundamental Rights of the European Union	70
2.9.2.7	Recommendation of the Parliamentary Assembly of the Council of Europe (PACE)	71
2.9.2.8	Recommendation of the Committee of Ministers to Member States on the Promotion of Human Rights of Older Persons	71
2.9.3	The African human rights system	72
2.9.3.1	African Charter on Human and Peoples' Rights [Banjul Charter]	72
2.9.3.1.1	Jurisprudence	73
2.9.3.1.2	Periodic Reports by States Parties	74
2.9.3.2	African Charter on the Rights and Welfare of the Child	77
2.9.3.2.1	General Comment by the African Committee of Experts on the Rights and Welfare of the Child	78
2.9.3.2.2	Concluding Recommendations	78
2.9.3.2.3	Periodic Reports by States Parties	80
2.9.3.3	Protocol to the African Charter on Human and People's Rights of Women in Africa	82
2.9.3.3.1	General Comment of the African Commission of Human and People's Rights	82
2.9.3.3.2	Periodic Reports by States Parties	83
2.9.3.4	Special Rapporteur on Prisons and Conditions of Detention in Africa	89
2.9.3.5	Recommendation of the SRP: Support networks and the right to health care	89
2.9.3.6	Selected Resolutions on health in Africa	89
2.10	'SOFT LAW' AIMED AT THE PROTECTION OF PRISONERS' RIGHT TO HEALTH CARE	91
2.10.1	Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules)	91
2.10.2	United Nations Rules for the Treatment of Women Prisoners and the Non-custodial Measures for Women Offenders (Bangkok Rules)	92

2.11 CONCLUSION	92
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## CHAPTER 3

### THE MEANING OF THE RIGHT TO HEALTH IN SOUTH AFRICA

3.1 INTRODUCTION	96
3.2 THE ROOTS OF THE MODERN SOUTH AFRICAN HEALTH CARE SYSTEM	96
3.2.1 Colonialism in South Africa	97
3.2.2 Segregation before 1948	97
3.2.3 Apartheid (1948 – 1993)	98
3.3 THE RIGHT TO HEALTH IN THE SOUTH AFRICAN CONSTITUTION	100
3.3.1 The right to health care of ‘everyone’: Section 27 of the Constitution	101
3.3.1.1 Why the focus on the constitutional right to health care of persons who are terminally ill?	102
3.3.1.2 The progressive realisation of section 27: The relevant domestic Jurisprudence	104
3.3.1.3 The legislative framework of the right to health care	112
3.4 DETAINEES’ RIGHT TO MEDICAL SERVICES AT STATE EXPENSE: SECTION 35(2)(e) OF THE CONSTITUTION	119
3.4.1 The protection of inmates’ rights	120
3.4.2 The meaning of ‘adequate medical care’ at State expense: South African jurisprudence	122
3.4.3 The legislative framework for the fulfilment of section 35(2)(e)	124
3.4.3.1 Correctional Services Act 111 of 1998	125
3.4.3.2 The Correctional Matters Amendment Act 5 of 2011	129
3.4.3.3 South African policies on prisoners’ right to health care	131
3.5 CONCLUSION	136

## CHAPTER 4

### PRISON HEALTH CARE EQUAL TO PUBLIC HEALTH CARE

4.1 INTRODUCTION	138
4.2 SHOULD ALL TERMINALLY ILL PERSONS BE REGARDED AS ‘LIKES’?	140
4.3 BEING FREE, BUT TERMINALLY ILL: THE SOCIAL CONTEXT IN GENERAL	147
4.3.1 Income inequality	147
4.3.2 Family and community care	150
4.3.3 Religious needs	151
4.3.4 Cultural needs	151
4.3.5 Access to public health facilities	152
4.3.6 Community-based and/or home care	152
4.4 BEING TERMINALLY ILL AND IMPRISONED	154
4.4.1 The <i>Lee</i> case: A depiction of the health pitfalls in the criminal justice system	155
4.4.1.1 The High Court and Supreme Court of Appeal judgments	156
4.4.1.2 The Constitutional Court judgment	157
4.4.2 Prison buildings	160
4.4.3 The impact of imprisonment on the individual	161
4.5. EQUALITY FOR TERMINALLY ILL INMATES	163
4.5.1. Sameness of treatment	164
4.5.2 Substantive equality in health care for terminally ill inmates	166
4.6 CONCLUSION	167



## CHAPTER 5

### EARLY RELEASE OF ELIGIBLE TERMINALLY ILL INMATES AND REMAND DETAINEES

5.1 INTRODUCTION	169
5.2 REMAND DETAINEES	170
5.2.1 The picture of remand detention	170
5.2.2 Release of remand detainees: Section 49E of the Correctional Matters Amendment Act 5 of 2011	174
5.2.2.1 Written advice by a medical practitioner	176
5.2.2.2 The requirement of being physically incapacitated	177
5.2.2.3 Adequate care not available	179
5.2.2.4 Cared for in the community	181
5.2.2.5 The application procedure	182
5.2.3 Section 49G: limitations on the period of incarceration of remand detainees	183
5.2.4 Section 63A of the Criminal Procedure Act 51 of 1977	186
5.3 MEDICAL PAROLE FOR SENTENCED INMATES	191
5.3.1 Section 79 before 2012	192
5.3.2 The amended section 79	197
5.3.2.1 Can inmates be assured that their applications will be given due and objective consideration?	199
5.3.2.2 How far beyond the old section 79 criterion of ‘in the final phase of a terminal illness’ does the new section 79 really extend?	204
5.3.2.3 Does section 79 reasonably ensure that inmates will lead a dignified life after their release?	208
5.3.2.4 Is the new medical parole system ‘accessible’ to all inmates?	209
5.4 DOES THE AMENDED SECTION 79 ADEQUATELY PROTECT THE PUBLIC AGAINST REPEAT OFFENDING BY INMATES WHO ARE RELEASED?	211

5.4.1 How effective is the ‘low risk of re-offending’ requirement in preventing the commission of crime by a medical parolee?	211
5.4.2 Cancellation of medical parole	213
5.5. CONCLUSION	214

## CHAPTER 6

### THE RIGHT TO PALLIATIVE CARE OF TERMINALLY ILL INMATES IN SOUTH AFRICA

6.1 INTRODUCTION	217
6.2 PALLIATIVE CARE	218
6.2.1 The description	218
6.2.2 The rationale for palliative care	2189
6.3 WHY TERMINALLY ILL INMATES?	221
6.4 DOES THE STATE HAVE A LEGAL OBLIGATION TO PROVIDE PALLIATIVE CARE TO TERMINALLY ILL INMATES?	222
6.4.1 A constitutionally entrenched residuum of basic rights	223
6.4.2 National Policy Framework and Strategy on Palliative Care 2017-2022	225
6.4.2.1 The impact of disease in correctional settings	227
6.4.2.2 The stated purpose of the NPFSPC	227
6.4.2.3 Fostering partnerships	228
6.5 AN EMERGING INTERNATIONAL HUMAN RIGHT TO PALLIATIVE CARE	231
6.5.1 The World Health Organization (WHO)	232
6.5.2. The Universal Declaration of Human Rights	233
6.5.3 International Covenant on Civil and Political Rights (1966)	234
6.5.4 International Covenant on Economic, Social and Cultural Rights	235
6.5.5 United Nations Special Rapporteur on Torture, Cruel, Inhuman or Degrading Treatment or Punishment	240
6.5.6 International instruments pertaining to inmates	241
6.5.7 WHA Resolution 67.19: ‘Strengthening of palliative care as a component of comprehensive care throughout the life course.’	243

6.5.8 United Nations Office on Drugs and Crime	245
6.7 Guidelines on Palliative Care for the Department of Correctional Services by HPCA	246
6.8 Are there lessons for South Africa?	252
6.8.1 Uganda	252
6.8.2 Pilot Projects: The need for a lasting ethos	255
6.9 CONCLUSION	
2257	

## CHAPTER 7

### CONCLUSION AND RECOMMENDATIONS

7. 1 ACKNOWLEDGING TERMINALLY ILL INMATES' PLIGHT AND RIGHTS	259
7.2 AWARENESS AND OVERSIGHT	261
7.3 UPHOLDING DIGNITY AT ALL COSTS	262
7.4 UNDERSTANDING TERMINALLY ILL INMATES' RIGHT TO HEALTH FULLY	263
7.6 CONCLUSION	263
ANNEXURE A	264
ANNEXURE B	266
BIBLIOGRAPHY	268

## SYNOPSIS

In South Africa, prison authorities are not primarily concerned with the health of the prison population. This is evidenced by *inter alia*: the vast number of complaints regarding health care received by the Judicial Inspectorate of Correctional Centres; natural deaths in prisons reported annually; litigation regarding health care and treatment in prisons; and the notoriously poor conditions of detention which inevitably have a negative impact on prisoners' health. There is as a result a noticeable difference between state provided health care to the public and health care in prisons. This thesis is therefore aimed at unpacking what the right to health means in respect of terminally ill prisoners. This question has been overshadowed by issues regarding medical parole in South Africa and intermittently by calls for palliative care in prisons. Whilst these issues are relevant to their plight, there is a need to articulate the scope of the right to health of terminally ill prisoners. This is imperative as not all prisoners who are terminally ill are eligible for medical parole and there are instances where the granting of such parole may be impractical. An analysis of the right to health in relation to terminally ill prisoners will provide legal certainty as to the legal entitlements regarding health care for one of the most vulnerable groups in society. They will know what they may legally claim and what they cannot insist upon in terms of the law.

## **KEY TERMS**

Terminally ill

Palliative care

Right to health care

Right to dignity

Prisoners

Inmates

Remand detainees

Prisons

Correctional Centres

Vulnerable

Correctional Services Act 111 of 1998

Medical parole

Early release

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## **DEDICATION**

This thesis is dedicated to my mother, Mrs Kathleen Albertus, who loves and supports me unconditionally.

## **LIST OF ACRONYMS**

CAT	CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMANE OR DEGRADING TREATMENT OR PUNISHMENT
CEDAW	CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN
DCS	DEPARTMENT OF CORRECTIONAL SERVICES
HPCA	HOSPICE PALLIATIVE CARE ASSOCIATION
ICCPR	INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS
ICERD	INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION
ICESCR	INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS
ICRPD	INTERNATIONAL CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES
NPFSPC	NATIONAL POLICY FRAMEWORK AND STRATEGY ON PALLIATIVE CARE
WHO	WORLD HEALTH ORGANISATION



## CHAPTER 1 INTRODUCTION AND OVERVIEW

### 1.1 DEFINITION OF TERMS

The following terms are used in this thesis and should be understood as defined in this section:

*'Inmates'* – Includes any person whether convicted or not, who is detained in custody in any correctional centre or remand detention facility.<sup>1</sup> This thesis uses the terms 'inmate' and 'prisoner' interchangeably.

*'Remand detainee'* – Any person detained in a remand detention facility awaiting the finalisation of his or her trial, whether by acquittal or sentence, if such person has not commenced serving a sentence or is not already serving a prior sentence.<sup>2</sup> For convenience the terms 'inmate' and 'prisoner' include remand detainees in this thesis unless indicated otherwise.

*'Right to health'* – The 'the prevention, treatment and management of illness and the preservation of mental and physical well-being through services by the health professions.'<sup>3</sup> The terms 'right to health' and 'right to health care' will be used interchangeably provided it is understood that the right to health does not guarantee a person's good health and that it is used as a convenient shorthand to cover the detailed language and references that are found in international treaties.

*'Terminal illness'* – means that the inmate was diagnosed with an illness or condition that will inevitably result in his death.<sup>4</sup> At least two medical practitioners must agree that the inmate is terminally ill. The illness must be incurable. Such a disease or condition must also cause severe physical pain, discomfort and suffering and/or negate a person's prospects of

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<sup>1</sup> Section 1(a) of the Correctional Matters Amendment Act 5 of 2011.

<sup>2</sup> Section 1(a) of the Correctional Services Amendment Act 5 of 2011.

<sup>3</sup> Mubangizi J & Twinomugisha B 'The right to health in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?' (2010) 10 *African Human Rights Law Journal* 109.

<sup>4</sup> McQuoid-Mason D & Dada M, *A-Z of Medical Law* (2011) 414.

leading a meaningful life. Some patients may be imminently and irreversibly terminally ill. This means that they will die within a relatively brief period of time.<sup>5</sup> Others are regarded as distantly terminally ill because they may have been faced with imminent death at an earlier period but were medically rescued, and are medically sustained for an indefinite period of time.<sup>6</sup>

## 1.2 BACKGROUND TO THE STUDY

The right to health of inmates and remand detainees who are terminally ill<sup>7</sup> may sound like an oxymoron, because many people who are diagnosed with terminal conditions or illnesses are not capable of regaining their health. Notwithstanding the notion of futility which may pervade considerations of terminally ill inmates' right to health, the recognition of the equal dignity of all human beings heralds the need to establish what their entitlement entails. To demonstrate the bases of the right to health of such inmates and furthermore unpack the entitlements and limitations thereof, it is imperative to contextualise the contemporary correctional setting in South Africa. To achieve the aforesaid, prisons as an institution inherited by Africa must be considered briefly as it may illuminate some of the reasons for the current state of prisons in South Africa.

The African continent's notoriety for its deplorable prison<sup>8</sup> conditions and the health implications<sup>9</sup> occasioned thereby, though not always accurate, is also not completely

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<sup>5</sup> Fleck L 'Just Caring: Health Care Rationing, Terminal illness, and the medically least well off' (2011) 39 *Journal of Law, Medicine and Ethics* 156-171.

<sup>6</sup> Fleck L (2011) 156-175.

<sup>7</sup> There is no conclusive legal definition of 'terminally ill'. See Fleck (2011) 57. The National Policy Framework and Strategy on Palliative Care (PFSPC) also provides that a 'terminal illness' is an 'irreversible life threatening or life limiting illness for which there is no cure and will result in an inevitable decline in function until death' 9.

<sup>8</sup> South African legislation no longer uses the term 'prison'. Institutions that had historically been referred to as prisons are now called correctional centres. In s1 of the Correctional Services Act 111 of 1998 a 'correctional centre' is defined as 'any place established under this Act as a place for the reception, detention, confinement, training or treatment of persons liable to detention in custody or to placement under protective custody'. In this thesis the terms 'correctional centre', 'correctional facility' and 'prison' will be used interchangeably.

unfounded. Many prisons in Africa are overcrowded, marred by extreme violence, corruption, alcohol and drug abuse, and high rates of HIV related deaths. Sarkin argues that '[w]hile many African prisons do not suffer from such extreme violence and health problems, the presence of these trends in any prisons raises concern.'<sup>10</sup> Furthermore, the fact that Africa seems to be 'shifting' ground in a 'slow and isolated manner' in the area of prisoners' rights,<sup>11</sup> should thus provide the impetus to investigate and address the dire problems in all correctional settings.

The vast and profound nature of the challenges encountered in African prisons calls for an understanding of the genesis of prisons as an institution on the continent. This is particularly relevant to the issue of health in prisons. Though the history of the introduction of prisons and imprisonment in Africa does not in itself rationalise the contemporary health (and other) challenges experienced in prisons, it arguably assists to some extent in contextualising some of the issues.

'Africa is a vast continent with a long and complex history.'<sup>12</sup> Care should thus be taken not to generalise about African penal systems.<sup>13</sup> The brief description below is therefore not aimed at providing a complete overview of the history of African prison systems as this study is not aimed at addressing health care in African prisons in general. It is aimed solely at contextualising the health problems encountered specifically in South Africa's prisons. To

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<sup>9</sup> UNAIDS refers to prisons as 'incubators' of HIV infection and other diseases, such as hepatitis C and tuberculosis. See for example UNAIDS (2006) *Report on the Global AIDS Epidemic* 119; Todrys K & Amon J 'Criminal justice reform as HIV and TB prevention in African Prisons' 8 May 2012 available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3348151/#!PO=65.6250> (accessed 6 September 2017); WHO 'Prisons' available at <http://www.who.int/topics/prisons/en/> (accessed 6 October 2017).

<sup>10</sup> Sarkin J 'Prisons in Africa: An evaluation from a human rights perspective' 27 available at [http://www.surjournal.org/eng/conteudos/getArtigo9.php?artigo=9,atigo\\_sarkin.htm](http://www.surjournal.org/eng/conteudos/getArtigo9.php?artigo=9,atigo_sarkin.htm) (accessed 10 May 2014).

<sup>11</sup> Sarkin (2011) 27.

<sup>12</sup> Peté S 'A brief history of human rights in the prisons of Africa' in Sarkin J (ed) *Human Rights in Africa Prisons* (2008) 40.

<sup>13</sup> Milner A 'Introduction' in Milner A (ed) *African penal systems* (1969)1.

this end, the discussion which follows highlights only some of the historical aspects regarding prisons in Africa and South Africa. Furthermore, only historical developments which may have had a bearing on the state of health care in prisons are considered.<sup>14</sup> To some extent it also assists in explaining why efforts (research, advocacy, legislation, policy and other measures) have primarily been focused on some issues (such as overcrowding, prison conditions in general, violence, security and more recently HIV/AIDS) and to a lesser extent on others (such as terminally ill persons' unique health needs).

'[P]rison is not an institution indigenous to Africa' as local justice systems pre-dating the arrival of the first Europeans in Africa were largely victim-orientated and 'wrongdoing' was remedied by restitution rather than incarceration of offenders as punishment.<sup>15</sup> With the exception of Southern Africa and the Atlantic slave trade, imprisonment as a form of punishment gained prevalence only at the end of the 19th century.<sup>16</sup> The slave trade which lasted for over four centuries did not amount to the imprisonment of persons in the contemporary sense, but involved the capturing and detention of millions of Africans.<sup>17</sup> The phenomenon of imprisonment as punishment was, however, transplanted to the Cape Colony at the beginning of the 19th century and coincided with the prison reform movements in Europe and the Americas.<sup>18</sup> Between 1652, when the first colonial settlement was established at the Cape, and the early 19th century, punishment entailed 'direct infliction of

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<sup>14</sup> For a detailed historical perspective on the development of prisons in South Africa see Van Zyl Smit D *South African Prison Law and Practice* (1992) 7-43.

<sup>15</sup> Sarkin (2011) 24.

<sup>16</sup> Peté (2008) 45.

<sup>17</sup> Peté (2008) 41-3.

<sup>18</sup> Peté (2008) 45. Van Zyl Smit (1992) 7-8, notes that sufficient primary research does not exist in order to determine whether the movement away from punishment of the body (the infliction of bodily pain) to the limitation of movement through imprisonment occurred gradually.

physical pain on the body of the accused'.<sup>19</sup> Opposition to such punishment ensured that imprisonment as a punishment 'came to the fore at the beginning of the nineteenth century'.<sup>20</sup>

From its inception, imprisonment in Southern Africa became an 'integral part of a system of racial oppression'.<sup>21</sup> Prisons were institutions designed to 'confine and control the African population' and imprisonment as an instrument of colonisation resulted in chronic overcrowding in prisons.<sup>22</sup> In South Africa, prisons were dilapidated and overcrowded. The escalating prison population was occasioned by the majority of the populace's constant resistance to colonial legislation.<sup>23</sup> In Durban, for example, even the prison cells allocated to sick prisoners were overcrowded, and on 5 November 1872 the Durban Gaol Board reported that 'in some cases it is feared that life has been sacrificed for want of proper accommodation for the sick'.<sup>24</sup> The plight of infirm prisoners has historically thus not been prioritised by prison authorities.

The Prisons and Reformatories Act<sup>25</sup> established prisons as part of the Department of Justice. At the time the Department of Justice was characterised by a military nature and organised along military lines.<sup>26</sup> Senior officials aligned the Department of Justice with sections of the Government that made up the 'securocracy as opposed to those providing social services . . . to secure an increased budget and possibly to gain full Departmental status if, given the

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<sup>19</sup> Peté (2008) 45.

<sup>20</sup> Peté (2008) 45.

<sup>21</sup> Peté (2008) 46.

<sup>22</sup> Peté (2008) 46.

<sup>23</sup> Dissel A & Ellis S 'Reform and stasis: Transformation in South African prisons' available at <http://www.csvr.org.za/papers/papadse.htm> (accessed 10 May 2014).

<sup>24</sup> Peté (2008) 48.

<sup>25</sup> Act 13 of 1911.

<sup>26</sup> Commission of Inquiry into alleged incidents of alleged corruption, maladministration, violence, or intimidation in the Department of Correctional Services appointed by order of the President of the Republic of South Africa in terms of Proclamation No 135 of 2001, as amended, Final Report, 2005 available at [http://d2zmx6mlqh7g3a.cloudfront.net/cdn/farfuture/mtime:1315836139/files/docs/061016jalireport\\_0.pdf](http://d2zmx6mlqh7g3a.cloudfront.net/cdn/farfuture/mtime:1315836139/files/docs/061016jalireport_0.pdf) (accessed 31 August 2015) (Jali Commission) 42.

prevailing political climate, it were seen as . . . protecting the security of the State'.<sup>27</sup> In 1959, with the promulgation of the Prisons Act<sup>28</sup>, the Department became a 'full' State department. Its (the Department's) 'structure, mode of dress and institutional culture was military in every respect'.<sup>29</sup> The military structure emphasised safe custody as opposed to rehabilitation of prisoners and strengthened segregation (apartheid) in the Department.<sup>30</sup>

The strategy to align the Department with the 'securocracy' appears to have endorsed a culture of secrecy with regards to the performance of functions.<sup>31</sup> This culture survived the advent of democracy and bred general lawlessness in prisons; members overlooked or encouraged prison gangs, smuggling and corruption were prevalent and the rape of vulnerable prisoners became a common occurrence.<sup>32</sup> It may be questioned what had been the position of terminally ill prisoners amidst all the mentioned challenges present within the Department.

After the first national, democratic elections in South Africa, there was an urgent need to transform government departments, especially departments that had formed part of the apartheid-government's security machinery.<sup>33</sup> Pursuant to bringing the Department of Prisons in line with the democratic principles in the Interim Constitution<sup>34</sup> and subsequently the final Constitution,<sup>35</sup> transformation in the Department was broadly manifested in three

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<sup>27</sup> Jali Commission (2005) 43.

<sup>28</sup> Act 8 of 1959.

<sup>29</sup> Jali Commission (2005) 42.

<sup>30</sup> Dissel A 'The Passing-out-Parade: Demilitarisation of the Correctional Services' (1997) 10 *Acta Criminology* Available at <http://www.csvr.org.za/wits/papers/paparade.htm> (accessed 1 September 2014) 19.

<sup>31</sup> Jali Commission (2005) 44.

<sup>32</sup> Jali Commission (2005).

<sup>33</sup> Sloth-Nielsen J 'The State of South African Prisons' in Buhlungu S, Daniel J, Southall R and Lutchman J (eds) *State of the Nation: South Africa* (2007) 379.

<sup>34</sup> Constitution of the Republic of South Africa, Act 200 of 1993.

<sup>35</sup> Constitution of the Republic of South Africa, 1996. (Constitution)

ways, namely: the recognition of trade unions<sup>36</sup>; the demilitarisation of the entire Department; and the introduction of Affirmative Action.<sup>37</sup>

The military culture of the Department of Prisons which had been conducive to the use of force and authority to maintain power was not amendable to the protection of human rights. In 1996 the then Minister of Correctional Services thus resolved to demilitarise the Department by *inter alia* removing various ranks, and changing the structure and the dress code.<sup>38</sup> Additionally the name of the Department changed from the Department of Prisons to the Department of Correctional Services (DCS).<sup>39</sup> Though the DCS saw the demilitarisation of the Department as the first significant step towards transformation, there has been widespread agreement that it had been poorly planned and that it resulted in staff not knowing what their exact responsibilities were in a constitutional democracy.<sup>40</sup> Furthermore, the notable rapid increase in the number of both sentenced and unsentenced prisoners<sup>41</sup> after 1994 exacerbated the challenge of transformation for the DCS.

Unlike many other countries in the world, the DCS accommodated (and continues to do so) awaiting-trial-prisoners. The DCS perceived this mandate as falling outside the ambit of its core business (which was primarily to keep prisoners in safe custody and later to rehabilitate them) and argued that awaiting-trial-prisoners ought to be accommodated by some other department.<sup>42</sup> Despite DCS's reluctance, the unsentenced or remand prison population increased almost three-fold in the 1990s; between 1993 and 2001 the unsentenced prison

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<sup>36</sup> The DCS had to recognise trade unions as sections 27 and 23 of the interim and final Constitutions, respectively recognise employees' right to belong to a trade union.

<sup>37</sup> Jali Commission (2005) 46.

<sup>38</sup> Jali Commission (2005) 47.

<sup>39</sup> Jali Commission (2005) 48.

<sup>40</sup> See Luyt W 'The Transformation of Corrections in South Africa' (2001) 14(3) *Acta Criminologica* 27; Sloth-Nielsen J 'Overview of Policy Developments in SA Correctional Services 1994-2002' *CSPRI Research Paper* No 1 July 2003.

<sup>41</sup> Sloth-Nielsen (2007) 384.

<sup>42</sup> Sloth-Nielsen (2007) 384.

population grew from 21 540 to 68 000.<sup>43</sup> Though these prisoners are not eligible for participation in rehabilitation programmes,<sup>44</sup> their presence contributed to the phenomenon of overcrowding which had a negative impact (and still does) on the conditions in prisons.<sup>45</sup> This occurred and (continues to do so) in the face of international and domestic guidelines and prescripts which call for pre-trial detention to be used as a last resort.<sup>46</sup>

In 2002 former President Mbeki appointed<sup>47</sup> a judicial commission of inquiry, chaired by Judge Jali, to investigate allegations of corruption, maladministration and intimidation in the DCS.<sup>48</sup> The Commission (better known as the Jali Commission) investigated nine management areas<sup>49</sup> and found that corruption and maladministration were ‘rife’ amongst DCS staff.<sup>50</sup> A general culture of violating prisoners’ rights was also observed in most of the prisons investigated. The Jali Commission reported that when the demilitarisation was implemented no new management principles and procedures were put in place.<sup>51</sup> Furthermore, staff had not been trained to maintain order and discipline through means other than military methods.<sup>52</sup> Though this does not justify corruption, maladministration or human rights abuses within the DCS, it arguably contributed to the state of affairs.

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<sup>43</sup> Sloth-Nielsen (2007) 384.

<sup>44</sup> See Open Society Justice Initiative *Pretrial Detention and Health: Unintended Consequences, Deadly Results A Global Campaign for Pretrial Justice Report* 2011 32, where it is stated that if health services are available to pre-trial detainees the effectiveness of such services are undermined by the lack of exercise, educational and vocational programmes for such detainees.

<sup>45</sup> See Open Society Justice Initiative (2011)11-12 where it is mentioned that the excessive use of pre-trial detention leads to overcrowded, unhygienic, violent environments and heightens the risk of contracting disease.

<sup>46</sup> For a more detailed discussion of the phenomenon of unsentenced prisoners see Schonteich M ‘Pre-trial detention and human rights in Africa’ in Sarkin J (ed) *Human Rights in Africa Prisons* (2008) 2008: 93 – 116.

<sup>47</sup> The President exercised his powers under s84(2) of the Constitution read with section 1 of the Commissions Act 8 of 1947.

<sup>48</sup> The Commission was appointed in terms of Proclamation No. 135 of 2001.

<sup>49</sup> Jali Commission (2005)38.

<sup>50</sup> Jali Commission (2005)17.

<sup>51</sup> Jali Commission (2005) 51.

<sup>52</sup> Jali Commission (2005) 51.



Some of the violations included depriving prisoners of receiving visitors, and serving lunch and dinner simultaneously at midday and thereafter locking prisoners in their cells to enable staff to leave work early. The abuse of power by the DCS staff was also observed with regards to medical practitioners' recommendations about prisoners' health. DCS staff often ignored and/or overrode decisions by both general medical practitioners as well as specialists.<sup>53</sup> The Jali Commission reported that medical parole for terminally ill prisoners was highly problematic as there had been many cases where prisoners were in the final stage of a terminal illness, but had been refused release on medical grounds and consequently died in circumstances described as 'undignified'.<sup>54</sup>

It seems that the gravity and prevalence of the problems faced by the DCS had attracted the primary focus of role players in the prisons sector.<sup>55</sup> Consequently, in 2004 the Correctional Services Act<sup>56</sup> (the CSA) came into force. The CSA had been developed to give effect to the constitutional standards guaranteed in section 35(2)(e) of the Constitution which states:

'Everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including at least exercise, and the provision, at State expense, of adequate accommodation, nutrition, reading material and medical treatment.

The new provisions of the CSA required that upon admission every sentenced prisoner must be medically assessed to determine their health status.<sup>57</sup> Their accommodation must be adequate for detention under conditions of human dignity. Prisoners of specific age, health categories or security risk categories must be kept separately. Each prisoner must be provided with an adequate diet to promote good health and such diet must make provision for the

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<sup>53</sup> Jali Commission (2005) 22.

<sup>54</sup> Jali Commission (2005) 51.

<sup>55</sup> At the end of March 2016 South African correctional centres had 119,134 beds available for 161,984 inmates. Makou G, Skosana I & Hopkins R 'Factsheet: The state of South Africa's prisons' 18 July 2017 available at <https://africacheck.org/factsheets/factsheet-the-state-of-south-africas-prisons/> (accessed 9 October 2017).

<sup>56</sup> Act 111 of 1998.

<sup>57</sup> Section 6(5)(b).

nutritional requirements of *inter alia* those whose physical condition requires a special diet. Adequate health care services, based on the principles of primary health care must be provided and prisoners must be encouraged to maintain contact with the community, family, chosen religious counsellors and chosen medical practitioners.<sup>58</sup> The DCS may also provide development and support services even when not required to do so by the CSA. In all instances when the DCS does not provide such services, the Commissioner must inform prisoners of services available from other sources and put prisoners who request such services in touch with appropriate agencies.<sup>59</sup> The Commissioner may grant permission in writing on such conditions and for such periods as he or she may specify, for a sentenced prisoner to leave prison temporarily for the purpose of compassionate leave, treatment, development or support programmes.<sup>60</sup> These were just some of the improvements contained in the CSA.

Legislative improvements do not automatically guarantee progress in practice. This was indeed the case with regards to the CSA. It has consequently been stated:

‘Given the general conditions related to overcrowding, the lack of reintegrative services, the poor physical conditions prevalent in many prisons, the numerous complaints about inadequate health care, all areas in which the Act specifies prescribed norms and standards, it can be concluded that the DCS is facing enormous challenges in working towards compliance with its legislated mandate.’<sup>61</sup>

### 1.3 PROBLEM STATEMENT

Overcrowding in prisons and the ensuing problems associated therewith persisted throughout the apartheid regime and remained almost unabated by the advent of democracy. In 1995, a year after the inception of democracy, some prisons were overcrowded by more than 100 per

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<sup>58</sup> Sections 7(1), 7(2)(d), 7(3), 8, 12, and 13, respectively.

<sup>59</sup> Section 16.

<sup>60</sup> Section 44.

<sup>61</sup> Sloth- Nielsen (2007) 390.

cent.<sup>62</sup> That same year the then new South African government authorised the release of certain categories of prisoners as the levels of overcrowding in some prisons had reached catastrophic proportions.<sup>63</sup> Five years after this crisis, in 2000,<sup>64</sup> the Inspecting Judge of Prisons, Judge Fagan, expressed the view that the intolerable conditions in prisons due to the high levels of overcrowding required immediate attention.<sup>65</sup>

From 1996 to 2005, the number of prisoners dying from natural causes per year increased from 211 to 1507.<sup>66</sup> HIV/AIDS contributed to this increase.<sup>67</sup> The Cape High Court's order in *Van Biljon*<sup>68</sup> ( a case reported in 1997) that HIV-positive inmates should be provided access to antiretroviral treatment appeared not to have had a significantly positive impact on prison health. This was confirmed in the later decision of the Supreme Court of Appeal in *Magida v S*<sup>69</sup> where it had been accepted that such treatment is not available to prisoners.

On 6 September 2005 the DCS briefed the Portfolio Committee on Corrections on its 'HIV/AIDS Policy for Offenders'.<sup>70</sup> At that stage it was not known how many offenders were on anti-retroviral treatment. The DCS admitted that it faced major challenges due to the

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<sup>62</sup> Peté S 'The Politics of Imprisonment in the Aftermath of South Africa's First Democratic Election' (1998) 11 *SACJ* 54.

<sup>63</sup> Peté S 'The good, the bad and the warehoused': the politics of imprisonment during the run-up to South Africa's second democratic election' (2000) 13 *SACJ* 54.

<sup>64</sup> Penal Reform International conducted a survey in 2000. It revealed that prisoners typically suffer from illnesses caused by poor living conditions, inadequate diet and inadequate health care. Such illnesses included tuberculosis, respiratory tract infections, skin diseases, and various water-borne diseases, such as, cholera, typhus and diarrhoea. See Tapscott C 'Challenges to good prison governance in Africa' in: J Sarkin (ed.), *Human Rights in African Prisons* (2008) 73.

<sup>65</sup> Peté (2000) 9.

<sup>66</sup> Muntingh L and Mbazira C 'Prisoners' access to anti-retroviral treatment' *CSPRI Newsletter No 18 of 2006*.

<sup>67</sup> See *Stanfield v Minister of Correctional Services and Others* 2004 (4) SA 43 (CPD) para 128; *S v Brophy and Another* 2007 2 SACR 56 (W) para 18; *S v Jacobs* 2011 (1) SACR 490 (ECP) at para 12; HIV and Prisons in sub-Saharan Africa: Opportunities for Action available at [http://www.unodc.org/documents/hiv-aids/Africa%20HIV\\_Prison\\_Paper\\_Oct-23-07-en.pdf](http://www.unodc.org/documents/hiv-aids/Africa%20HIV_Prison_Paper_Oct-23-07-en.pdf) 21. (accessed 11 August 2014).

<sup>68</sup> *Van Biljon v Minister of Correctional Services* 1997 (6) BCLR 789 (C).

<sup>69</sup> *Magida v S* (SCA Case No. 515/04).

<sup>70</sup> The unofficial minutes of the Portfolio Committee meeting of 6 September 2005 and the submissions made by the Department of Correctional Services are available on the website of the Parliamentary Monitoring Group at <http://www.pmg.org.za/viewminute.php?id=6232> (accessed 6 September 2014).

increasing prevalence of the pandemic. In short, the DCS indicated that due to resource constraints, such as, limited staff capacity and transport problems (prisoners had to be commuted to accredited sites where the treatment can be accessed), not all eligible prisoners had access to such treatment.

In *N*<sup>71</sup>, (a case reported in 2006) 15 HIV/AIDS positive inmates sought an order compelling the State to *inter alia*, give them access to anti-retroviral treatment in accordance with the government Operational Plan for Comprehensive HIV and AIDS Care (Operational Plan). The Court held that it was ‘regrettable that prisoners, being a class, very vulnerable to infection, were not given special consideration in the Operational Plan . . . .’<sup>72</sup> It was ordered that inmates be granted access to the programme.

In 2006 the DCS announced that it would conduct a national HIV and syphilis prevalence survey amongst its staff and prisoners.<sup>73</sup> The results of this survey were released at the end of January 2008 in a Report entitled *Department of Correctional Services HIV Prevalence Survey (2006)*. This study (as will become clear below) is illustrative of the fact that some of South Africa’s most vulnerable prisoners are sometimes overlooked in the quest to address the more common challenges in prisons. The sample included 3024 DCS staff members and 8649 sentenced offenders. Actual participation in the national survey was 29 per cent for staff and 46.4 per cent for offenders.

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<sup>71</sup> *N and Others v Government of the Republic of South Africa and Others (No1)* 2006 (6) SA (D).

<sup>72</sup> *N and Others v Government of the Republic of South Africa and Others (No1)* para 30.

<sup>73</sup> Muntingh L ‘ The prevalence of HIV in South Africa’s prison system: Some but not all the facts, at last CSPRI Newsletter No 26 of May 2008 .

It is reported<sup>74</sup> that between 2588 and 5392 of the 38 268 DCS staff members were HIV-positive and between 623 and 2629 of the 38 268 members were infected with syphilis. Additionally, between 20 909 and 25744 of the 113 567 sentenced prisoners were HIV-positive, while between 5533 and 8466 of the 113 567 were infected with syphilis.<sup>75</sup> Thus one in ten DCS officials was HIV-positive and one in five sentenced prisoners was HIV-positive.

The DCS is indeed presented with significant challenges. This does, however, not obviate the needs of marginalised and vulnerable groups, nor does it relieve the DCS of its duty to give effect to their rights. Much has been said to confirm the vulnerable position of terminally ill persons in society. It is also known that the HIV/AIDS pandemic often directly affects this group. Illnesses such as cancer, diabetes and other chronic conditions, if left untreated or not properly addressed medically, also affect the prison population and may result in terminal illness. Thus in prison, during remand and while they are serving sentences, their position as marginalised individuals may render them even more vulnerable than those who are able to integrate into the general prison population. It is likely that due to their already weak health status they would suffer significantly, unless cognisance is taken of their specific health needs and full effect is given to their right to health. The national survey commissioned by the DCS, however, omitted to give specific attention to terminally ill prisoners infected with HIV/AIDS or syphilis, and consequently to gain insight into their plight. There were also not other notable studies on those affected by chronic other conditions. Remand inmates, a highly mobile sector of the total prison population as they are

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<sup>74</sup> Muntingh (2008).

<sup>75</sup> It has been noted that during pre-test counselling a number of prisoner respondents stated that they know that they are HIV-positive but refused to participate in the study as it would remind them of their condition which they were reluctant to accept. See *Department of Correctional Services HIV Prevalence Survey (2006)* 27.

frequently released (either on bail or are acquitted or are released and then re-arrested), were completely excluded from participation in the study.

Furthermore though the survey reports on the gender, age, race and geographical spread of the prisoners, it is silent on ‘length of sentence, imprisonment history, period in detention (unsentenced), gang membership, sexual assault victimisation, health history, tattoos and history of substance abuse’.<sup>76</sup> Such information would not only have been invaluable in developing a deeper understanding of HIV/AIDS in South African prisons, but it could also have resulted in a better understanding of the actual and specific health issues which render terminally ill inmates vulnerable in prison.

At this juncture it may be mentioned in summation that the oppressive origins of prisons in Africa, perpetual chronic overcrowding and the resultant problems associated with it and more recently, the HIV/AIDS pandemic, limited attention to chronic diseases are but some of the common factors that render all prisoners vulnerable to health problems. Corruption and maladministration as discussed earlier deepens the vulnerability of prisoners. Over the past few decades these themes (prison as an oppressive institution, overcrowding and HIV/AIDS) have by and large enjoyed the spotlight insofar as research initiatives are concerned. Efforts to improve the de facto nature of imprisonment thus focused significantly on these themes (rightfully so) in the quest to address the vulnerability of the general prison population. This is evident from the White Paper on Corrections in South Africa (2005) which provides:

‘HIV/AIDS and other communicable diseases such as TB and sexually transmitted infections will be addressed as integral to provision of comprehensive health care services and health care education to inmates. The department should focus on programmes to reduce the impact of HIV/AIDS

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<sup>76</sup> Muntingh (2008).

and other communicable diseases to allow people under correction to leave the system as healthy as possible.<sup>77</sup>

The goal expressed in this policy seems patently geared towards the introduction of curative and preventative initiatives to assist those affected by serious illnesses. The intention to introduce such initiatives cannot be criticised. However, policymakers framed these goals in a manner that suggests an unspeakable obliviousness to the reality that there are prisoners for whom curative and preventative health measures are not viable options. For many terminally ill prisoners the goal of leaving the system as healthy as possible, is simply unattainable. It may as a result be inferred that the unintended consequence of attending to the systemic problems of prisons has been that the challenges experienced by the most marginalised and vulnerable groups, such as the terminally ill, are often overlooked.

#### 1.4 FOCUS AND OBJECTIVES

The primary focus of this thesis is to establish legal certainty with regards to the health care of terminally ill prisoners. Terminally ill prisoners should know what they are entitled to or not entitled to claim, based on their right to health. Thus the objectives of the study are:

- To determine what the right to health means to a prisoner diagnosed with terminal illness; and
- To determine whether the health care provided to terminally ill prisoners constitutes unfair discrimination against them, and if so how this may be remedied.

#### 1.5 AIMS

The study has two major aims:

1. To give a detailed discussion of the law with regards to the right to health care of inmates in South African correctional centres.

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<sup>77</sup> At Department of Correctional Services (2005) *White Paper on Corrections in South Africa* 5.

2. To discuss the history and development of law on health care which pertain to persons who have been diagnosed with a terminal illness who are not detained as well as those who are detained.

## 1.6 METHODOLOGY

The study primarily employed desk research. International and regional legal instruments were considered. Domestic legislation, case law and policies, as well as secondary sources, such as, law journals, government reports, reports by non-governmental organisations and oversight bodies such as the Judicial Inspectorate of Correctional Services, were analysed to gauge the current legal position of terminally ill prisoners. Additionally, although to a very limited extent, informal, semi-structured, one-to-one interviews were conducted with former DCS staff, non-governmental organisations that work in prisons as well as with former prisoners.<sup>78</sup> Interviews were recorded on an electronic recording device and subsequently transcribed. Such interviews and discussions were held solely to augment desk research and to provide more context to matters which affect terminally ill inmates.<sup>79</sup> The interviews were conducted with 12 former inmates, 12 former DCS officials and 15 representatives of organisations that work in prisons. The interviews were conducted in KwaZulu-Natal, the Eastern Cape and the Western Cape. Interviews and discussions were aimed at determining whether inmates were aware of fellow inmates who had been diagnosed with terminal illnesses and what their understanding and experiences (if any) were of the health care and treatment that would be afforded to such inmates. The interviews were all conducted face-to-face. The dates of the interviews appear in the relevant footnotes of the study.

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<sup>78</sup> The researcher was granted ethical clearance by the University of the Western Cape Humanities and Social Sciences Research Ethical Clearance Committee.

<sup>79</sup> The researcher was mindful that data collected from interviews are recollections of the interviewees who may be unable to recall events or experiences accurately. See Remenyi D *Field Methods for Academic Research: Interviews, Focus groups & Questionnaires* (2013) 3. The data collected was therefore not treated as conclusive evidence regarding any of the issues discussed during the interviews.



## 1.7 SIGNIFICANCE AND LIMITATIONS OF THE STUDY

### 1.7.1 Significance of the study

In South Africa the plight of prisoners in general is often highlighted. This has resulted in a number of positive steps towards defining and strengthening their rights. However, it cannot be overlooked that in practice the sentiment that ‘ . . . prisoners either get better than they deserve or deserve as bad as they get’,<sup>80</sup> still applies. A detailed and considered strategy to comprehend and address the contemporary challenges of prisoners appears to be lacking. Consequently, many of the less common, yet profound challenges experienced by prisoners are afforded inadequate attention or are completely ignored by role players who are in a position to change the *status quo*.

With regards to health care, important issues, such as, the prevalence of HIV/AIDS amongst correctional staff as well as prisoners, consequent litigation to enforce the right to access antiretroviral drugs for prisoners, and the controversies related to medical parole, have captured the public’s and government’s attention. Whilst this study does not aim to criticise the fact that the aforementioned issues had been the subject of debate as well as State action, it is aimed at expressing the need for similar focus and action in relation to the plight of terminally ill prisoners.

The study furthermore seeks to contribute to an evolving recognition that consideration of prisoners’ issues is imperative in a constitutional democracy. To date it appears that discussions about terminally ill prisoners are limited to questions about medical parole. This study seeks to demonstrate that medical parole is but one aspect of the discussion on the position of terminally ill prisoners. What ought to happen when a prisoner is diagnosed with

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<sup>80</sup> Berkman A ‘Prison Health: the Breaking Point’ (1995) 85 *American Journal of Public Health* 1616 -17.

a terminal illness? For various reasons, including that a terminal illness does not automatically make an inmate illegible for medical parole, the response to the question cannot be limited to a discussion of medical parole. The terminally ill prisoner must understand the complete slate of claims he may legitimately make. Importantly, the State should understand its duty vis-à-vis terminally ill prisoners to ensure that the right to health, which is closely related to the right to dignity, is respected.

In South Africa ‘[and] in too many other countries, health researchers are discouraged from studying conditions of detention . . . Universities and professional societies should work to raise the profile of detention-related health concerns in teaching and research’.<sup>81</sup> This study is a modest attempt at doing the latter.

### 1.7.2 Limitations of the study

The proposed research will be limited to understanding the meaning of the right to health of terminally ill prisoners and remand detainees in South African correctional centres. Whilst other jurisdictions may be considered for purposes of gaining greater insight into the issue of health care and terminally ill prisoners, this study is not aimed at defining the meaning of the right to health in other countries. Consequently, cognisance will be taken of legal developments, relevant lessons in this regard, as well as challenges experienced in prisons outside South Africa, solely to enhance the prospects of making reasonable proposals for the strengthening of the legal position of terminally ill prisoners in South Africa.

Due to ethical and practical considerations, the researcher was not able to conduct interviews with inmates who are terminally ill or those who were still serving sentences at the time of

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<sup>81</sup> Open Society Justice Initiative (2011)14.

the study. Similarly, the study excluded current correctional staff who may be constrained by issues of confidentiality and objectivity.

This study does not consider the question of euthanasia. Though cognisance is taken of the fact that women and children may also require special treatment insofar as their health care is concerned, this study does not deal with their right to health care. The limited references made to women and children are only for the sake of comprehensiveness.

### 1.8 OUTLINE OF THE STUDY

In Chapter 2 the conceptual bases of the right to health are discussed. The history and development of the right to health as a normative standard is considered. International, and regional law relevant to the right to health in general as well as specific international legal instruments regarding health in prisons are reviewed with a view to sketching a background to the right to health of terminally ill prisoners.

Chapter 3 commences with a discussion and analysis of the domestic law and policies that gives rise to prisoners' right to health care. In turn, case law, official and in limited instances, unofficial reports on conditions and health in prisons and statistics regarding deaths in prisons are discussed. This may arguably assist in reasonably depicting the situation regarding the care and/or treatment of prisoners who are terminally ill. The discussion is also imperative to gauging some of the legal challenges with regards to health care for terminally ill prisoners.

Chapter 4 focuses on equality in the realisation of the right to health. The primary aim is to show that terminally ill inmates do not have equal access to appropriate health care as persons who are free. It is therefore argued that there ought to be substantive equality in giving effect to terminally ill prisoners' right to health. In this regard reference will also be made to care provided to terminally ill persons who are not incarcerated.

Chapter 5 discusses the early release of eligible sentenced inmates and remand detainees who are terminally ill. The law on medical parole is therefore considered in this chapter. It also highlights challenges presented by the current system of medical parole. In this chapter it becomes evident that medical parole is not always the best or appropriate solution for terminally ill prisoners. The release of remand detainees on grounds of terminal illness is also analysed. Chapter 6 considers the right to palliative care. It builds on the substantive equality argument presented in Chapter 4. Arguments are made that the State has a duty to provide palliative care to all inmates diagnosed with a terminal illness. The concept of palliative care will consequently be explained and the bases for claiming it as a right which accrues to all terminally ill prisoners will be unpacked. Chapter 7 is the concluding chapter which will reiterate the need for comprehensive palliative care provision in prisons and concrete legal regulation in this regard. It will also re-emphasise the importance of an effective medical parole system based on giving effect to prisoners' right to health and the interrelated right to dignity.

## CHAPTER 2

### THE RIGHT TO HEALTH OF TERMINALLY ILL PRISONERS: AN INTERNATIONAL AND REGIONAL LAW PERSPECTIVE

#### 2.1 INTRODUCTION

The realisation of the right to health care greatly depends on the domestic context of the bearer of the right. This is particularly true for terminally ill prisoners. They may suffer due to their illnesses, but also because they are ostracised and regarded as either deserving of their pain and/or undeserving of adequate health care. Furthermore, poor prison conditions may cause the deterioration of health or exacerbate existing health problems to the extent that inmates do become terminally ill. This chapter therefore focuses on what the right to health means for terminally ill inmates in terms of international and regional law. The discussion will commence with a brief overview of the history of how the right to health came to be recognised as a normative standard in international law.

#### 2.2 THE HISTORICAL JOURNEY OF THE RIGHT TO HEALTH IN INTERNATIONAL LAW

A myriad of events, ideologies and actors have had an influence on the acceptance of health as a normative standard.<sup>1</sup> Hence it is beyond the scope of this chapter to provide an exhaustive description of how this right gained legal recognition. Only *some* of the main contributions to the development of the right are highlighted here. This is important as ‘. . . an account of the historical . . . journey . . . of the right to health has the potential to reveal insights into the intended meaning of this right’.<sup>2</sup>

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<sup>1</sup> Tobin J *The Right to Health in International Law* (2012) 9.

<sup>2</sup> Tobin J (2012) 8.

Historically, States did not automatically accept the obligation to ensure the well-being of people.<sup>3</sup> The right to health was first articulated in the Constitution of the World Health Organisation (WHO) in 1946.<sup>4</sup> Later, in December 1948, when the United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR), it provided in Article 25(1) that '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services'.

Before the adoption of the right to health in the Constitution of the WHO and in the UDHR responses to illnesses came largely from private entities, such as, churches and charities.<sup>5</sup> State interventions in health problems consisted of laying down forms of quarantine in cases of epidemic and pandemic diseases.<sup>6</sup> During the 18<sup>th</sup> century, awareness of the importance of public health began to grow rapidly, but the 'modern concept of public health only developed in the days of the industrial revolution.'<sup>7</sup> Mass production had contributed to unhealthy working conditions and led to epidemics and other health problems. Governments attempted to strengthen collective measures to prevent and control the spread of diseases. In England, for example, in 1839, Sir Edwin Chadwick, Secretary to the Poor Law Commission, presented a Report entitled *Report on the Sanitary Condition of the Labouring Population of Great Britain*.<sup>8</sup> Chadwick used the findings in this Report to draw attention to and to create policy measures to improve sanitary conditions and public health in the country.

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<sup>3</sup> See Loughlin K & Berridge V *Global Health Governance: Historical Dimensions of Global Governance* Discussion Paper 2, March 2002 26.

<sup>4</sup> See Riedel E 'The Human Right to Health: Conceptual Foundations' in Clapham A, Robinson M (ed) *Realizing the Right to Health* (2009) 21.

<sup>5</sup> Riedel (2009) 21.

<sup>6</sup> Riedel (2009) 21.

<sup>7</sup> Riedel (2009) 21. See Kelley L *The World Health Organization (WHO)* (2009) 3.

<sup>8</sup> Kelley L (2009) 3.

Based on Chadwick's Report, the government passed the Public Health Act of 1848 which dealt with sanitary conditions in England and Wales and was regarded as 'a great milestone in public health history'.<sup>9</sup> Fee and Brown State that '[f]or the first time, the State became the guarantor of standards of health and environmental quality and provided resources to local units of government to make the necessary changes to achieve those standards'.<sup>10</sup>

While addressing health issues domestically, governments recognised the need for greater co-operative action across countries<sup>11</sup> as the spread of epidemics beyond national borders posed a threat to international trade.<sup>12</sup> This resulted in discussions at the first international conferences on sanitation<sup>13</sup> and to the establishment of the Office International d'Hygiène Publique (OIHP) in Paris, France, in 1907. The OIHP was established to oversee the quarantining of ships and ports to prevent the spread of plague and cholera.<sup>14</sup>

According to Tobin, the ultimate adoption of the right to health in international law is intimately connected with war and the strategic role of health in achieving global peace.<sup>15</sup> He explains that the World War 1 which raged from 1914 to 1918 provided the stimulus for the creation of the League of Nations (LON). The LON Health Organisation was created under the LON in 1923 and co-existed with the *Office International d'Hygiene Publique*,<sup>16</sup> which had been established in 1907 largely to address the spread of communicable diseases. Both

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<sup>9</sup> Fee E & Brown T 'The Public Health Act of 1848' *Bulletin of the World Health Organization* (2005) 866.

<sup>10</sup> Fee & Brown (2005) 866.

<sup>11</sup> Kelley (2009) 3.

<sup>12</sup> The Right to the Highest Attainable Standard of Health, UN Committee on Economic Social and Cultural Rights General Comment No 14, UN Doc E/C/12/2000/4 CESCR 2000 para 1 (Hereafter CESCR 2000). See also Kelley L (2009) 3.

<sup>13</sup> Tobin (2012) 25-26.

<sup>14</sup> Iriye, A, *Global Community: The Role of International Organizations in the Making of the Contemporary World* (2002) 21.

<sup>15</sup> Tobin (2012) 23.

<sup>16</sup> Beigbeder Y, Nashat, Orsini, M and Tiercy, J 'The World Health Organization' in *Organization and the evolution of the World*, (1998) 4-5.

bodies were replaced by the World Health Organisation (WHO)<sup>17</sup> which had been established in 1948 after World War II (1939-1945).

Five years prior to the establishment of the WHO, Sir Hersch Lauterpacht, the international law scholar, proposed an International Bill of Rights which covered civil and political rights as well as economic and social rights.<sup>18</sup> He also suggested the inclusion of an obligation on States within the limits of their economic capacity to provide for *inter alia* public assistance in the case of sickness and disablement. The acceptance of social and economic rights by a prominent liberal jurist, such as Lauterpacht, demonstrated the ‘changed mood throughout Europe’.<sup>19</sup>

In 1944, a committee appointed by the American Law Institute prepared a *Statement of Essential Human Rights*.<sup>20</sup> The committee borrowed extensively from national constitutions, including those of Latin American States, to produce a declaration that was intended to reflect universal trends.<sup>21</sup> John Humphrey, head of the UN Human Rights Division, responsible for the first draft of the UDHR, wrote that the best of the texts from which he drew extensively, was what had been submitted by the American Law Institute.<sup>22</sup>

The United Nations (UN) Charter was adopted in 1945. Article 55 of the Charter provided, *inter alia*, that it is necessary to find solutions to health problems to ensure peaceful and friendly relations between States. In the same year as the adoption of the UN Charter, a recommendation at the San Francisco Conference that an international health organisation be

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<sup>17</sup> See Beigbeder *et al* (1998) 9-13.

<sup>18</sup> Tobin (2012) 26.

<sup>19</sup> Tobin (2012) 26.

<sup>20</sup> Normand R & Zaidi S *Human Rights at the UN: The Political History of Universal Justice* (2007) 99.

<sup>21</sup> Tobin J (2012) 26.

<sup>22</sup> Adalsteinsson R and Thorhallsón P ‘Article 27’ in Alfredsson, G, & Eide, A ‘*The Universal Declaration of Human Rights: A Common Standard of Achievement*’ (1998) 527.



established was accepted.<sup>23</sup> The WHO was subsequently established. The adoption of the Constitution of the WHO in 1946 is ‘of major significance to the emergence of the right to health in international law’.<sup>24</sup> The preamble to the WHO Constitution introduced the right to the highest attainable standard of health into international law for the first time. Though the UDHR includes both social and political rights as inalienable in international law, there had been ‘significant opposition in the drafting committee’ especially from the United Kingdom and the United States of America.<sup>25</sup>

After the Second World War, the right to health was firmly established in many international, regional and domestic instruments.<sup>26</sup> At least 115 constitutions around the world have entrenched the right to health.<sup>27</sup> By November 2012, every country, with the exception of South Sudan, had become a party to at least one human rights treaty that addresses the right to health or other health-related rights.<sup>28</sup> Articles 57 and 62 of the UN Charter refer to ‘health’ as one of the fields of responsibility of the Economic and Social Council (ECOSOC).

The protection of public health workers’ and their families’ health and peaceful international trade led to the acceptance of the right to health. Unfortunately, the lenses through which these achievements had been viewed did not sufficiently bring into focus the position of prisoners. This evokes questions about the right to health of various groups of prisoners.

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<sup>23</sup> *Origin and development of health cooperation* available at [http://www.who.int/global\\_health\\_histories/background/en/index.html](http://www.who.int/global_health_histories/background/en/index.html) (accessed 3 July 2013).

<sup>24</sup> Tobin (2012) 27.

<sup>25</sup> Tobin (2012) 30.

<sup>26</sup> Riedel (2009) 22. See Byrne I *Making the Right to Health a Reality: Legal Strategies for Effective Implementation* Commonwealth Law Conference London September 2005 4-6.

<sup>27</sup> See Durojaye E ‘The relevance of health rights litigation in Africa’ in *Litigating the Right to Health in Africa: Challenges and Prospects* Durojaye E(ed) 2016 1.

<sup>28</sup> Young K & Lemaitre J ‘The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Columbia and South Africa’ *Harvard Human Rights Journal* 2013 (26) 179. In 2015, however, South Sudan acceded to the Convention on the Rights of the Child. This denotes that the right to health of children as provided for in the Convention must be protected. Additionally, in 2015, South Sudan adopted both the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment.

Terminally ill prisoners are arguably one of the most vulnerable groups in any prison population as their plight is not sufficiently highlighted. It is not clear what such prisoners may and may not legitimately claim from States on the basis of their right to health care. Before grappling directly with this question, it is worth highlighting the position of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health as well as that of the Special Rapporteur on Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment. This serves to demonstrate the crucial status of the right to health in international law and the need for greater focus on terminally ill prisoners.

### 2.3 UNITED NATIONS SPECIAL RAPPORTEURS

The United Nations Human Rights Council promotes and monitors human rights through the establishment of special procedures called ‘Special Rapporteurs’.<sup>29</sup> Special Rapporteurs are independent individuals or groups with human rights expertise. They have specific thematic or country mandates and serve in their personal capacities. Each Special Rapporteur’s mandate is defined in the Human Rights Council’s resolutions. They may undertake the following activities in fulfilling their mandate: Do country visits to assess human rights violations; make recommendations to States on how to improve compliance with human rights; convene expert consultations; raise awareness; and receive information from individuals and civil society.

Special Rapporteurs are not United Nations staff and do not receive a salary for their work. They also do not represent their country of origin. They have the support of the Office of the

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<sup>29</sup> The Human Rights Council’s Special Procedures available at [www.ijrcenter.org/un-special-procedures/](http://www.ijrcenter.org/un-special-procedures/) (accessed 11 November 2017).

High Commission for Human Rights and the Human Rights Council oversees their work. Their position is structured in this manner to ensure their independence.

The 2005 Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Special Rapporteur on Health) is noteworthy. It mentioned that conditions in prisons, such as, overcrowding, lack of privacy and violence, exacerbate mental health disabilities.<sup>30</sup> Though the comment is not made in relation to terminally ill inmates, it is important as the same conditions which impact on the health of all inmates could debatably have more serious implications for those who are terminally ill. This may mean that vulnerable groups, such as terminally ill inmates, face the risk of even graver violations of their right to health care than inmates who are not terminally ill. Arguably, vulnerable groups' (like terminally ill prisoners) level of access to health care is indicative of the success of the system.

The Special Rapporteur on Health's statement in his 2007 Report emphasised that States should refrain from denying or limiting equal access for all persons, including prisoners, to preventive, curative and palliative health services.<sup>31</sup> This bolsters the abovementioned contention that terminally ill inmates' level of access to health care reflects on the success of a system. In this 2008 Report to the Human Rights Council, the Special Rapporteur on Health, indicated his commitment to creating sound health systems globally by stating that a

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<sup>30</sup> UN Commission on Human Rights *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (Paul Hunt). UN Document E/CN.4/2005/51 available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/108/93/PDF/G0510893.pdf?OpenElement> (accessed 1 December 2014).

<sup>31</sup> UN Human Rights Council 2007 available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G07/102/97/PDF/G0710297.pdf?OpenElement> (accessed 1 December 2014).

national health care system is a ‘core social institution’ in a society.<sup>32</sup> Everyone should thus have access to such a health system.

Almost a decade later, in an open letter, in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which took place in April 2016, the Special Rapporteur on Health mentioned that international human rights law places an obligation on States to guarantee health and health-related services, which includes the provision of essential controlled medicines for the management of pain, including in palliative care.<sup>33</sup> It seems thus that there is an acknowledgement that access to medications used in palliative care (needed by terminally ill persons and to be discussed in greater detail later) may be problematic in some countries.

The work of the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (Special Rapporteur on Torture) may also be relevant to terminally ill inmates. The Special Rapporteur on Torture has reported that the *de facto* denial of access to pain relief, ‘if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment’.<sup>34</sup> Some terminally ill persons do experience severe physical pain and therefore require access to pain relief medication and treatment. Based on the Special Rapporteur of Torture’s report, the denial of medication to terminally ill prisoners may constitute cruel, inhumane or degrading treatment.

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<sup>32</sup> Hunt P available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/105/03/PDF/G0810503.pdf?OpenElement> (accessed 30 October 2014).

<sup>33</sup> Pūnas D ‘Open Letter by the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Pūnas, in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which will take place in New York in April 2016’ (7 December 2015).

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<sup>34</sup> Nowak N ‘Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the right to development’ A/HRC/10/44, 14 January 2009 para 72.

Though terminally ill prisoners are not expressly mentioned by the abovementioned Special Rapporteurs, they are by implication entitled to health care that is appropriate to their actual health conditions. There is also recognition thereof that both inmates and persons who are terminally ill are generally vulnerable. Ideally though, there should be acknowledgment of the dual vulnerability (this means that they are marginalised because they are offenders and due to their illness) of terminally ill inmates as they can be an almost unnoticeable minority within prison populations.

#### 2.4 THE RIGHT TO HEALTH IN INTERNATIONAL LAW INSTRUMENTS

Though the health care challenges of terminally ill prisoners are not widely known, a slate of reasonably obvious challenges experienced by such inmates will be employed as a lens through which the law relevant to their right to health will be analysed. These challenges include: limited laws expressly pertaining to their health; the need for equal access to quality health care<sup>35</sup>; the impact of resource constraints on vulnerable groups; and States' ignorance of the factors that contribute to poor health.<sup>36</sup>

The above issues do not constitute an exhaustive list of the main and apparent questions affecting the health care of terminally ill prisoners. The instruments, General Comments,

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<sup>35</sup> Attitudes and behaviours significantly inhibit development of appropriate care for terminally ill persons, hence it is imperative to consider access to quality health care. Fraser B, Powell R, Mwangi-Powell F, Namisango E, Hannon B, Zimmermann C and Rodin G 'Palliative care development in Africa: Lessons for Uganda and Kenya' (2017) *American Society of Clinical Oncology* 4.

<sup>36</sup> During interviews conducted between October and November 2016, each of the former inmates in Kwazulu-Natal, the Western Cape and Eastern Cape, three provinces within South Africa, mentioned problems or issues which they believed could have negatively affected their health, but which the DCS was not aware of or was not attentive to. They mentioned, for example, that inmates who smoked were often accommodated in cells with non-smokers, and which may have included persons with conditions like asthma and other respiratory conditions. Several inmates also mentioned that the blankets they had been given irritated their skin and were not adequate to protect them against the cold even during the warmer seasons. They further mentioned that the prioritisation of security over all other issues sometimes compromised access to food and medication and that this consequently impacted negatively on their health. Some stated that concerns regarding their safety or other personal issues contributed to anxiety and had a negative impact on health as they had been deprived of sleep. Though these examples do not conclusively confirm that the prison authorities lack awareness of or overlooked issues affecting inmates' health, there is a reasonable possibility that these are issues which may impact on the health of inmates, and which do not enjoy adequate attention from correctional staff.

jurisprudence and Concluding Observations discussed under each of the selected issues are also not inclusive of all the relevant laws. What is presented constitutes no more than a synopsis of some of the international laws and principles that exemplify how the main issue (the right to health of terminally ill prisoners) is dealt with (or not).

## 2.5 LIMITED EXPRESS LEGAL PRINCIPLES ON TERMINAL ILLNESS

A survey of binding international law instruments which explicitly deal with the right to health of terminally ill persons or inmates yielded almost negligible results. An attempt is therefore made below to highlight some of the salient international law principles which may apply to terminally ill prisoners.

### 2.5.1 The International Covenant on Economic, Social and Cultural Rights (ICESCR)

Discursively, it seems that the idea of drafting an instrument like the ICESCR<sup>37</sup> began to germinate around the time that the UDHR was drafted. Even prior to the adoption of the UDHR, there had already been broad agreement that the rights in the UDHR were to be transformed into legally binding obligations through the negotiation of other treaties.<sup>38</sup> The UDHR, though a non-legally binding instrument, included civil and political rights as well as economic, social and cultural rights. During the Cold War, however, human rights became polarised; The West argued that civil and political rights should be prioritised and that economic and social rights were mere aspirations. Contrarily, the Eastern bloc deemed the rights to food, health and education as primary rights and argued that civil and political rights were less important.<sup>39</sup> The ICESCR and the International Covenant on Civil and Political

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<sup>37</sup> 993 UNTS 3; 6 ILM 368 (1967).

<sup>38</sup> WHO, Regional Office for the Eastern Mediterranean *Health and Human Rights: International Covenant on Civil and Political Rights* available at [http://www.who.int/hhr/Civil\\_political\\_rights.pdf](http://www.who.int/hhr/Civil_political_rights.pdf) (accessed 26 May 2014).

<sup>39</sup> WHO *Health and Human Rights - A Historical Perspective* available at <http://www.unspecial.org/UNS673/t24.html> (accessed on 26 May 2014).

Rights (ICCPR) were consequently adopted in 1966, after almost 20 years of negotiation.<sup>40</sup> These instruments make no reference to terminally ill prisoners, yet it will be shown below that they are relevant to upholding their right to health.

The ICESCR came into force on 3 January 1976.<sup>41</sup> It includes Article 12 which affords to everyone the right to the highest attainable standard of physical and mental health.<sup>42</sup> The WHO had played a ‘significant role in the initial drafting’ of Article 12.<sup>43</sup> In 1953 the change of leadership in the WHO resulted in the ceasing of its involvement in the drafting of Article 12. By the time the text of Article 12 had been finalised, the ‘WHO claimed no ownership or responsibility over the new Covenant's obligation on health’.<sup>44</sup> Despite the WHO’s claim of having had no input in drafting the final text of Article 12, it has been argued that the article ‘draws heavily on the initial contribution of the WHO before 1953 and remains the most detailed in the Covenant’.<sup>45</sup>

To gain an understanding of Article 12 and how it may apply to terminally ill inmates, it is necessary to consider the work of the Committee on Economic Social and Cultural Rights (CESCR). The CESCR<sup>46</sup> monitors the implementation of the Covenant by its States Parties.<sup>47</sup> State Parties, in turn, must report on a regular basis to the CESR on their progress in implementing the ICESCR. Economic and Social Council Resolution 1985/17 obligates

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<sup>40</sup> WHO, Regional Office for the Eastern Mediterranean *Health and Human Rights: International Covenant on Civil and Political Rights* available at [http://www.who.int/hhr/Civil\\_political\\_rights.pdf](http://www.who.int/hhr/Civil_political_rights.pdf) (accessed 26 May 2014).

<sup>41</sup> Fact Sheet No.2 (Rev.1), *The International Bill of Human Rights* available at <http://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf> (accessed 26 May 2014).

<sup>42</sup> South Africa ratified the ICESCR on 18 January 2015 and it came into force on 12 April 2015.

<sup>43</sup> Marks S, ‘*The Emergence and scope of the human right to health*’ in Zuniga J, Marks, S, and Gostin L (ed) *Advancing the Human Right to Health* (2013) 7-8.

<sup>44</sup> Marks (2013) 7-8.

<sup>45</sup> Marks (2013) 7-8.

<sup>46</sup> It was established under The Economic and Social Council Resolution 1985/17. The CESCR comprises 18 experts. See <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIndex.aspx> (accessed 1 February 2014).

<sup>47</sup> See <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIndex.aspx> (accessed 1 February 2014).

the CESCR to meet annually to examine States Parties' reports. The CESCR presents its concerns about and recommendations on States Parties's progress in the form of 'Concluding Observations'.

'[T]hrough its Concluding Observations, the CESCR has been able to establish the parameters of conduct that would constitute violations of ICESCR provisions.'<sup>48</sup> The Concluding Observations also provide insight into how States Parties have attempted to give effect to Article 12 as well as to how the CESCR envisions compliance with the obligations which arise from the Article.<sup>49</sup> Importantly, the CESCR publishes its interpretations of the ICESCR provisions as<sup>50</sup> 'General Comments' which are important in shaping States Parties' understanding of the ICESCR provisions. Some of the CESCR's General Comments will be discussed below. Unfortunately, there are no Concluding Observations by the Committee which directly address terminal illnesses.

In Article 12, the right to health was crafted as a right on its own. The right goes 'well beyond health care to cover a positive definition of health' and it enumerates steps to be taken to give effect to the right.<sup>51</sup> Article 12 reads as follows:

- '1. The State Parties . . . recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
  - (b) The improvement of all aspects of environmental and industrial hygiene;
  - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

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<sup>48</sup> Olowu D, *An Integrative Rights-based Approach to Human Development in Africa* (2009)139.

<sup>49</sup> The CESCR's Concluding Observations are not legally binding on the States Parties. The opinion of the CESCR is, however, invaluable given the expertise of its members. Sheet No.16 (Rev.1), The CESCR available at <http://www.ohchr.org/Documents/Publications/FactSheet16rev.1en.pdf> (accessed 1 May 2014).

<sup>50</sup> See <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIntro.aspx>. (accessed 1 May 2014)

<sup>51</sup> Marks (2013) 7-8.



(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.’

Article 12 does not make direct reference to terminal illnesses or prisoners. Despite this the CESCR’s General Comment No 14 of 2000, discussed next, suggests that it applies equally to terminally ill persons.

The CESCR acknowledged that every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life with dignity. Additionally ‘the highest attainable standard’ denotes that actual health statuses vary amongst individuals. An individual’s biological and socio-economic preconditions and a State’s available resources must be considered to determine his or her highest standard of health achievable.<sup>52</sup> The ‘highest standard’ must be determined on a case-by-case basis.

The CESCR provides that the right to health includes the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.<sup>53</sup> Vulnerable groups, like terminally ill prisoners, therefore should not be overlooked when a State Party makes a determination of what constitutes the highest standard of health attainable. The right to health is not limited to the provision of health care.<sup>54</sup> Consequently, the ICESCR can be relied upon to advance socio-economic conditions and environments which are conducive to upholding the dignity, and in turn the right to health, of terminally ill persons.

The right to health is not an absolute right. Yet States Parties can never be absolved from giving effect to the right to health. The ‘health’ of human beings is a means to an end, that

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<sup>52</sup> CESCR General Comment No 14 of 2000 para 9.

<sup>53</sup> CESCR General Comment No 14 of 2000 para 8.

<sup>54</sup> CESCR General Comment No 14 of 2000 para 4.

end being dignity. Terminally ill prisoners have entitlements which arise due to their right to health. The CESCR has stated that ‘attention and care’ must be afforded to ‘chronically and terminally ill’ older persons. Such care should be aimed at ‘sparing them avoidable pain and [enabling] them to die with dignity’.<sup>55</sup> This comment should be extended to all persons including prisoners regardless of whether or not they are elderly persons to ensure that the rights to dignity and equality of everyone are upheld.

The CESCR has recognised the increase in degenerative and chronic diseases as well as the high costs of hospitalisation as a result.<sup>56</sup> The CESCR urged States Parties not to invest solely in curative treatment and to introduce approaches to health care that take cognisance of health during the entire lifespan of citizens.<sup>57</sup> This confirms an awareness of the realities of terminal illnesses. Terminal illnesses affect both young and older people regardless of their social origin or status.

The CESCR urged States Parties to take a ‘comprehensive view ranging from prevention to the care of the terminally ill’<sup>58</sup> and to consider Recommendations 1 to 17 of the Vienna International Plan of Action on Ageing<sup>59</sup> as it provides guidelines on the health policy to preserve the health of elderly people. It is noteworthy that the aforementioned Plan of Action, though not legally binding, indicates to some extent the international community’s awareness of some of the challenges associated with terminal illnesses. This is evident from the acknowledgment that ‘[e]pidemiological studies suggest [that] as men and women live to increasingly greater ages, major disabilities will largely be compressed into a narrow age

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<sup>55</sup> CESCR General Comment No 14 of 2000 para 25.

<sup>56</sup> CESCR General Comment No 6 of 1995 para 35.

<sup>57</sup> CESCR General Comment No 6 of 1995 para 35.

<sup>58</sup> CESCR General Comment No 6 of 1995 para 35.

<sup>59</sup> See *Vienna International Plan of Action on Ageing* 1983.

range just prior to death'.<sup>60</sup> The awareness of some of the needs of those who are terminally ill is equally recognisable from Recommendation 5 of the Plan of Action. It provides:

Attentive care for the terminally ill, dialogue with them and support for the close relatives at the time of loss and later require special efforts which go beyond normal medical practice. Health practitioners should aspire to provide such care. The need for these special efforts must be known and understood by those providing medical care and by the families of the terminally ill and by the terminally ill themselves. Bearing these needs in mind, exchange of information about relevant experiences and practices found in a number of cultures should be encouraged.

The work of the CESCR demonstrates that the ICESCR affords the right to health to everyone regardless of their health status. However, those who are terminally ill are not given explicit consideration unless they are older persons. Though this is not criticised, the right must be extended beyond elderly persons as people of all ages can be and are affected by terminal conditions. It is also evident that there are no substantial legally binding principles or guidelines to address the plight of persons, including inmates, who are affected by terminal illnesses. This is of concern as the conditions of terminally ill persons who are free may differ vastly from those of inmates.

### 2.5.2 The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)

Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)<sup>61</sup> provides that States Parties should guarantee to everyone without distinction as to race, colour or national or ethnic origin, the right to public health and medical care. This is arguably relevant to terminally ill persons, including those who are prisoners, and who may be susceptible to discrimination on the grounds mentioned.

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<sup>60</sup> *Vienna International Plan of Action on Ageing* (1983) para 53.

<sup>61</sup> 660 UNTS 195; 5 ILM 32 (1966).

### 2.5.3 General Recommendation No 30 of 2004

The Committee on the Elimination of Racial Discrimination (CERD) emphasised that States Parties should respect the right of non-citizens to an adequate standard of physical and mental health by, *inter alia*, refraining from denying or limiting their access to preventive, curative and palliative health services.<sup>62</sup> Terminally ill persons often require palliative care<sup>63</sup>, and the CERD had therefore debatably considered the right to health of such persons. Whilst this is positive, an explicit reference to persons who suffer from a terminal illness may have been an even stronger affirmation of their right.

### 2.5.4 The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

The Convention on the Elimination of All Forms of Discrimination Against Women of 1979 (CEDAW) affords all women the right to access health care. Though this instrument does not refer to terminally ill persons who are imprisoned it can be inferred that it is relevant to women who may fall into this category as no explicit exceptions to the entitlement is mentioned.

#### 2.5.4.1 Article 12 of CEDAW

Article 12 of the CEDAW provides that women should have access to health care and that States Parties should eliminate discrimination against them in this regard.<sup>64</sup> As already submitted above, it can be argued that CEDAW may be relied upon to enforce the right to health care of terminally ill women prisoners. To prevent such women from accessing appropriate health care will constitute discrimination and therefore defeat the very object of this instrument.

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<sup>62</sup> Committee on the Elimination of Racial Discrimination 2004.

<sup>63</sup> 'Palliative care' is briefly discussed later in this Chapter. A more detailed discussion of the concept appears in Chapter 6 of this thesis.

<sup>64</sup> 1249 UNTS 13; 19 ILM 33 (1980).

#### 2.5.4.2 General Recommendation of the Committee on CEDAW

The Committee on CEDAW has emphasised that women require health care throughout their lives.<sup>65</sup> The Committee expressed concern about the conditions of health care for older women as women often live longer than men and are more likely to suffer from disabling and degenerative chronic diseases.<sup>66</sup> It therefore urged States Parties to take appropriate measures to ensure that older women have access to health services that address the disabilities associated with ageing. The Committee's emphasis on health care throughout the lives of women and particularly during their later years of life affirms that there is some recognition of the potential impact of terminal illnesses on women.

More directly related to the plight of terminally ill persons are the Committee's comments on pain relief and palliative care in General Recommendation 27. The Committee recommended that States Parties adopt a comprehensive health care policy aimed at protecting the health needs of older women, 'including care that allows for independent living and palliative care'.<sup>67</sup>

The CEDAW Committee's Concluding Observations, discussed below, demonstrate further that many women can be affected by terminal illnesses and that they do therefore require appropriate health care.

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<sup>65</sup> UN Committee on CEDAW (1999) para 8 available at <http://www.refworld.org/docid/453882a73.html> (accessed 7 July 2014).

<sup>66</sup> UN Committee on CEDAW (1999) para 24 available at: <http://www.refworld.org/docid/453882a73.html> (accessed 7 July 2014).

<sup>67</sup> See CEDAW General Recommendation No. 27 of 2010 available at <http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW-C-2010-47-GC1.pdf>. (accessed 13 October 2017).

#### 2.5.4.3 Concluding Observations of the Committee on CEDAW

The Committee on CEDAW noted that cervical cancer and circulatory diseases are major causes of female deaths in Fiji and that the incidence of sexually transmitted diseases, including HIV/AIDS, was growing.<sup>68</sup> The State Party should perhaps have reported on how it addressed the needs of terminally ill persons, but omitted to do so.

The Committee on CEDAW noted that breast cancer was the most common cause of death amongst women in Italy.<sup>69</sup> The State Party should thus have introduced programmes to address the needs of woman for whom the disease had reached a terminal stage. It is unfortunate that the Committee had not recommended such initiatives. This and the above Concluding Observation are just some examples which highlight the seeming reticence on the issue at the international level.

#### **2.5.5 The International Convention on the Rights of Persons with Disabilities (ICRPD)**

Article 25 of ICRPD provides that States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. It is commendable that persons with disabilities are afforded this right expressly. Like terminally ill prisoners, persons with disabilities possibly also experience: physical constraints which impede access to health care; a lack of suitable health care; and discrimination. Terminally ill prisoners should therefore also be able to find protection under Article 25.

##### 2.5.5.1 General Comments regarding health and disabilities

The Committee on the Rights of Persons with Disabilities (CRPD) confirmed that the built environment, transport systems, information and communication are often inaccessible to

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<sup>68</sup> Concluding Observations of CEDAW on Fiji, CEDAW, A/57/38 part 1(2002) 62 - 63.

<sup>69</sup> Concluding Observation of CEDAW on Italy, CEDAW, /C/ITA/CO/6 (2011) para 42.

persons with disabilities.<sup>70</sup> These challenges also exist for terminally ill prisoners who may be immobile and have an equally limiting effect on their access to health care.

#### 2.5.5.2 Concluding Observations on health and disabilities

The CRPD noted its dissatisfaction at the lack of statistical information on persons with disabilities who belong to national minorities in Azerbaijan.<sup>71</sup> Such information is vital for addressing the needs of vulnerable groups. This is also true for terminally ill prisoners. States Parties must be aware of their presence in prisons in order to address their needs appropriately. Prison authorities should therefore continuously conduct health screenings. Arguments that such screenings may be too costly and onerous for a State to bear may be refuted as a State's interests must be balanced against the rights of individuals. This principle is demonstrated in the case below.

#### 2.5.5.3 Jurisprudence on health and disabilities

In *H.M v Sweden* the applicant required hydrotherapy at home to improve her health.<sup>72</sup> The local authorities denied her permission to build a pool as this would interfere with their development plan.<sup>73</sup> The CRPD noted that the departure from the development plan would not result in a 'disproportionate or undue burden' on the local authorities.<sup>74</sup> The refusal to grant permission to build the pool had a discriminatory effect that adversely affected the author's access, as a person with a disability, to the health care required. This reasoning may also be applied to terminally ill prisoners. Though the regular assessment of prisoners' health

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<sup>70</sup> Committee on the Rights of Persons with Disabilities, General Comment No 2 (2014) Article 9: Accessibility Eleventh Session 31 March - 11 April 2014 para 7.

<sup>71</sup> Concluding Observations of the Committee on the Rights of Persons with Disabilities on the initial report of Azerbaijan 12 May 2014 para 14.

<sup>72</sup> *H.M v Sweden* Committee on the Rights of Persons with Disabilities, 7th Session, 16-27 April 2012 Communication No.3/2011 para 2.1.

<sup>73</sup> At *H.M v Sweden* para 8.

<sup>74</sup> At *H.M v Sweden* para 8.5.

may prove onerous to States Parties, the failure to do so may result in violations of their right to health.

In 2014 the CRPD heard a matter concerning an Argentine prisoner with serious health problems which rendered him unable to perform daily tasks including self-care.<sup>75</sup> The prisoner applied to be placed under house arrest, but was unsuccessful. The CRPD, however, upheld his right under Article 25. The prisoner required daily medical attention to improve his mobility. To assist the prisoner, the correctional authorities allowed him to be transported by ambulance to a hospital every day. The correctional authorities also made certain adjustments to the prison building to accommodate the prisoner. Despite this, the CRPD found that these adjustments were not sufficient.<sup>76</sup> The CRPD emphasised that the State Party is under an obligation to ensure that prison authorities afford access to health care to all prisoners with disabilities.<sup>77</sup> Such access must be granted to prisoners with disabilities on an equal basis with others. This is an important ruling as it may be relied upon to refute possible arguments that appropriate care cannot be provided in prisons due to poor infrastructure or the architectural design of buildings. The CRPD certainly held the prison authorities to a high standard in terms of the effort and resources that ought to be invested in giving effect to prisoners' rights. Furthermore, the Committee requested that the State Party ensure that the prisoner has 'access to suitable, timely health care that is in keeping with his state of health as well as full access to suitable rehabilitation therapy on a regular basis'.<sup>78</sup>

Though the CRPD's comments above relate to prisoners with disabilities, they are relevant to terminally ill prisoners as they too may experience physical limitations. Additionally the

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<sup>75</sup> Committee on the Rights of Persons with Disabilities Communication No 8 of 2012 CRPD/C/11/D/8/2012 Views adopted by the Committee at its eleventh session (31 March–11 April 2014) para 8.

<sup>76</sup> At Committee on the Rights of Persons with Disabilities Communication No 8 of 2012 para 8.

<sup>77</sup> At Committee on the Rights of Persons with Disabilities Communication No 8 of 2012 para 8.

<sup>78</sup> At Committee on the Rights of Persons with Disabilities Communication No 8 of 2012 para 2.27.



CRPD's request that the prisoner be afforded suitable and timely health care consistent with his actual state of health, may be relied upon to support the claim for appropriate health care to terminally ill prisoners. A prisoner's detention should after all not be used as a punitive measure. The CRPD's decision in this matter is a powerful source of support for prisoners' rights as it takes cognisance of those who may be marginalised due to their physical limitations and health status.

#### 2.5.6 World Health Assembly Resolution 67.19: 'Strengthening of palliative care as a component of comprehensive care throughout the life course'

In 2014, the World Health Assembly adopted this Resolution 64.19 which describes palliative care as an approach that improves the quality of life of patients (adults and children) and their families, who face life-threatening illness, by preventing and alleviating unnecessary suffering. Whilst this is a positive step towards giving effect to terminally ill persons' right to health, it may arguably not advance the plight of terminally ill prisoners. This will, however, be discussed in greater detail in Chapter 6 of this thesis.

In summary, it may be clearer that the right to health of persons who are terminally ill, and particularly those who are imprisoned, has historically not been afforded significant attention in international law. Though the phenomenon of people suffering and experiencing severe pain for extended periods before they die is not new, international law and enforcement bodies have not treated the plight of those affected as a matter of great interest and a cause for intervention.

#### 2.5.7 The International Covenant on Civil and Political Rights (ICCPR)

It is trite that prisoners experience violations of many of their rights and that certain rights are intertwined. The right to health, for example, is 'closely related to and dependent upon the

realisation of other human rights'.<sup>79</sup> In the prison context the failure to fully acknowledge the connection between the right to health and other rights can have a negative impact on prisoners including those who are terminally ill. The importance of the link between health and other rights and the consequences of failing to protect this link will become clearer below. The interconnectedness between the right to health and other rights also serves to demonstrate that although there are limited explicit international law principles which deal with the right to health of terminally ill persons, it is possible to claim protection of their right.

#### 2.5.7.1 'Public health' as a justifiable ground for the limitation of some first-generation rights

Unlike the instruments discussed under section 2.6 of this Chapter, the ICCPR<sup>80</sup> does not give anyone the right to health and it does not directly or indirectly refer to persons who are terminally ill. Yet the ICCPR protects some aspects of the right to health.<sup>81</sup> Article 12(3) provides that the right to freedom of movement and to choose a residence may not be limited unless such limitation is necessary to *inter alia* 'protect public health'. Articles 18, 19, 21 and 22 provide that everyone has the right to freedom of thought, conscience and religion, the right to freedom of expression, the right to peaceful assembly and the right to freedom of association respectively. All of these rights may be limited for the protection of public health. The ICCPR thus elevates the status of health as a right. Arguably this is a principle which ought to be considered in prisons where security is often prioritised over prisoners' rights to health and dignity.

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<sup>79</sup> CESCR General Comment No 14 of 2000 para 3.

<sup>80</sup> 999 UNTS 171; 6 ILM 368 (1967).

<sup>81</sup> See WHO, Regional Office for the Eastern Mediterranean available at [http://www.who.int/hhr/Civil\\_political\\_rights.pdf](http://www.who.int/hhr/Civil_political_rights.pdf) (accessed 26 May 2014).

In addition to the above, the ICCPR protects the right to life and the right to dignity. It also prohibits torture or cruel, inhuman or degrading treatment or punishment. The link between these rights and the right to health care will be discussed below.

#### 2.5.7.2 Article 6 of the ICCPR: The right to life

Article 6, which provides that every human being has the inherent right to life and prohibits the arbitrary deprivation of life, may also be discussed here as a loss of life due to the withholding of health care may constitute a violation of the Article.

#### 2.5.7.3 General Comments relevant to the right to life

The Human Rights Committee (HRC) stated that the right to life should not be narrowly interpreted.<sup>82</sup> A broad interpretation of this right may thus lend itself to an acceptance that effect be given to the right to health care. This is demonstrated by the HRC's Concluding Observations below.

#### 2.5.7.4 Concluding Observations regarding the right to life

The HRC's consideration of Georgia's Report demonstrated the link between the right to life and health. Many deaths in detention had been reported. The HRC recommended that Georgia should take urgent measures to protect the right to health of detainees ' . . . as provided for in [Article] 6'. The HRC also recommended that Georgia should improve conditions of detention and provide appropriate medical treatment.<sup>83</sup>

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<sup>82</sup> Human Rights Committee General Comment No 6 of 1982 para 1.

<sup>83</sup> Concluding Observations of the Human Rights Committee on Georgia, ICCPR, A/57/40 vol. I (2002) para 78(7).

The HRC considered the prevalence of tuberculosis in prisons in the Republic of Moldova disquieting as it posed a danger to the life and health of prisoners. The HRC stated that ‘[i]t reminds the States Party of its obligation to ensure the health and life of all persons deprived of their liberty. Danger to the health and lives of detainees . . . may also include a violation of [Article] 6’.<sup>84</sup> Based on the aforesaid there can be no doubt that the ICCPR can be relied upon to protect the right to health of prisoners.

#### 2.5.7.5 Article 7 ( the prohibition on torture or to cruel, inhuman or degrading treatment or punishment ) and Article 10 (the right to dignity)

Article 7 provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. Article 10(1) provides that all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person. It is well-known that prisoners are vulnerable to abuse. The legal recognition of detainees’ right to dignity is therefore imperative and may be regarded as a means of bolstering the protection of the right to health.

#### 2.5.7.6 General Comments relevant to Articles 7 and 10

The HRC emphasised that Article 7 prohibits acts that cause physical pain and mental suffering.<sup>85</sup> Based on the aforesaid it may be argued that the withholding of appropriate health care from a terminally ill prisoner, who requires such care, could result in a violation of Article 7 and may even hasten death.

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<sup>84</sup> Concluding Observations of the Human Rights Committee on the Republic of Moldova, ICCPR, A/57/40 vol. I (2002) para 84(9).

<sup>85</sup> Human Rights Committee General Comment No 21 of 1992 on article 10 (Humane treatment of persons deprived of their liberty) Forty-Fourth session para 5.

Many detainees are subjected to abuse and thus require the additional legal protection afforded in Article 10(1).<sup>86</sup> The HRC has called on States Parties to report on the legal measures aimed at protecting this right. Such measures arguably must include a focus on health. The HRC has stated that '[t]he humane treatment and respect for the dignity of all [prisoners] is a basic standard of universal application'.<sup>87</sup> Inadequate health systems therefore encroach upon prisoners' dignity and are like the Achilles heel of effective prisons.

The HRC<sup>88</sup> indicated that detainees may not be 'subjected to any hardship or constraint other than that resulting from the deprivation of liberty [and] respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons'.<sup>89</sup> The HRC therefore encouraged States Parties to report on their compliance with international instruments aimed at the protection of detainees' rights.<sup>90</sup>

#### 2.5.7.7 Concluding Observations relevant to Articles 7 and 10

The ICCPR's protective nature towards the right to health is evident in the HRC's Concluding Observations on Senegal's 1997 report. The HRC drew attention to the recurring problems of overcrowding in prisons which result in poor health.<sup>91</sup> By stating that these conditions are incompatible with Article 10(1) of the ICCPR, the HRC confirmed the inseparability of the right health from Article 10.

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<sup>86</sup> Human Rights Committee General Comment No 6 of 1982 para 2.

<sup>87</sup> Human Rights Committee General Comment No 6 of 1982 para 1.

<sup>88</sup> Human Rights Committee General Comment No 21 of 1992 on article 10 (Humane treatment of persons deprived of their liberty) Forty-Fourth session.

<sup>89</sup> Human Rights Committee General Comment No 21 of 1992 on article 10 (Humane treatment of persons deprived of their liberty) Forty-Fourth session para 3.

<sup>90</sup> Human Rights Committee General Comment No 21 of 1992 on article 10 (Humane treatment of persons deprived of their liberty) Forty-Fourth session para 5.

<sup>91</sup> Report of the HRC Senegal 1998 para 64 [http://www.ccprcentre.org/wp-content/uploads/2012/04/A\\_53\\_40Vol-I\\_en.pdf](http://www.ccprcentre.org/wp-content/uploads/2012/04/A_53_40Vol-I_en.pdf) (accessed 23 June 2014).

#### 2.5.7.8 Jurisprudence on Articles 7 and 10

As some terminally ill prisoners may be faced with death in the near future the principles upheld in the cases below may be equally relevant to them.

In *Setelich/Sendic v Uruguay*<sup>92</sup> the prisoner was unable to walk, could not consume solid foods, suffered from heart disease, and needed an operation for his hernia. He was held in solitary confinement in an underground cell and was ‘denied the medical treatment his condition require[d]’.<sup>93</sup> The HRC held that there had been a violation of both Articles 7 and 10(1) of the ICCPR. The case demonstrates that the actual physical constraints on and health needs of a prisoner should be considered in order to uphold his right to health.

In *Henry and Douglas v. Jamaica*<sup>94</sup> the applicants were on death row. Mr Henry, had cancer and died later. Despite the fact that the prison authorities had been aware of his terminal condition, he was detained in a cold cell with no facilities to accommodate his needs. The HRC held that this constituted a violation of Articles 7 and 10(1). The physical conditions under which a terminally ill prisoner is detained must therefore be suitable for his needs.

In *Pinto v Trinidad and Tobago*<sup>95</sup> it was confirmed that respect for the dignity of the detainee ‘encompasses the provision of adequate medical care during detention’.<sup>96</sup> The HRC held that the obligation to provide adequate medical treatment to detainees ‘obviously’ extends to

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<sup>92</sup> *Setelich v. Uruguay* (R.14/63), ICCPR, A/37/40 (28 October 1981) 114 para 20.

<sup>93</sup> At *Setelich v. Uruguay* para 20.

<sup>94</sup> In *Henry and Douglas v. Jamaica* (571/1994), ICCPR, A/51/40 vol.II (25 July 1996) 155 (CPPR/C/57/D/571/1994) para 9.5.

<sup>95</sup> *Pinto v. Trinidad and Tobago* (232/1987), ICCPR, A/45/40 vol. II (20 July 1990) 69 para 12.7.

<sup>96</sup> *Pinto v. Trinidad and Tobago* para 12.7.

persons on death row.<sup>97</sup> Despite the certainty of death in the near future, terminally ill prisoners too, have a right to adequate medical treatment.

The HRC had to consider in *Leslie v. Jamaica*<sup>98</sup> the applicant's claim that warders had told him that 'there was no point in providing him with medical treatment, because he was about to be executed'.<sup>99</sup> The HRC found the manner in which he had been treated to be inconsistent with his rights in terms of Articles 7 and 10(1) of the ICCPR.<sup>100</sup> This case, like *Pinto* above, affirms that the certainty that a prisoner's death will occur in the near future cannot negate the State's duty to treat them with dignity by *inter alia* respecting their right to health care. These cases also indicate the connection between the right to health, the right to life, and the right to dignity.

The case of *Morales Tornel v Spain* may have greatly advanced the plight of terminally ill prisoners had the HRC had sufficient evidence to support all the claims of the complainant. During his imprisonment, Mr Tornel was diagnosed with the Human Immunodeficiency Virus (HIV) and later with the Acquired Immunodeficiency Virus (AIDS).<sup>101</sup> He died on 1 January 1990. It was alleged that he had not received medical treatment prior to his death as he had decided to stop taking his tuberculosis medication.<sup>102</sup> It was therefore alleged on behalf of Mr Tornel that his right to life had been violated. It was also alleged that his family was not informed by prison authorities that his condition had become terminal and that this omission constituted a violation of the prohibition on inhumane treatment under article 7 as well as of article 17 which prohibits arbitrary interference with family life.

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<sup>97</sup> *Pinto v. Trinidad and Tobago* para 12.7..

<sup>98</sup> *Leslie v. Jamaica* (564/1993), ICCPR, A/53/40 vol. II (31 July 1998) 21 (CCPR/C/63/D/564/1993) para 3.5

<sup>99</sup> *Leslie v. Jamaica* para 3.5.

<sup>100</sup> *Leslie v. Jamaica* para 9.2.

<sup>101</sup> *Morales Tornel v .Spain*, Comm. 1473/2006, U.N. Doc. CCPR/C/95/D/1473/2006 (HRC 2009) 4.

<sup>102</sup> *Morales Tornel v .Spain* 4.

Unfortunately, the HRC did not have sufficient evidence to find that there had been a violation of the right to life. Had enough evidence existed that he had been denied medical treatment, the HRC would have had to consider the personal autonomy of a patient who has a right to be included in decisions regarding his own treatment, and the fact that he ought not to be penalised for his personal preferences. Put differently, if a patient rejects the recommended treatment, he should not be deprived of other forms of reasonable treatment which may have reduced his suffering. It was found that by not informing Mr Tornel's family that he was terminally ill there had been an arbitrary interference with his right to a family life under Article 17.<sup>103</sup> Having given its decision on Article 17 the HRC found it unnecessary to rule on the alleged violation of article 7.<sup>104</sup> Arguably, this demonstrates the connection between the right to health and other rights; When the prisoner's health failed, it became important that effect be given to his right to family life. The right to health should therefore as far as possible not be considered in isolation from other rights.

#### 2.5.8 Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT)

Article 16 of CAT obligates States to prevent acts that constitute cruel, inhuman and degrading treatment or punishment. The denial of pain relief medication to terminally ill prisoners may constitute cruel, inhuman or degrading treatment. There is thus a definite connection between the right to health and the right not to be subjected to cruel, inhuman or degrading treatment or punishment. This connection is further demonstrated by the Concluding Observation discussed below.

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<sup>103</sup> *Morales Tornel v .Spain* 12.

<sup>104</sup> *Morales Tornel v .Spain* 12.



### 2.5.8.1 Committee Against Torture's Concluding Observations

It is noteworthy that the Committee Against Torture observed that the extreme overcrowded conditions in Cameroonian prisons poses a threat to prisoners' health.<sup>105</sup> This implies that the Committee requires that prison conditions should be conducive to prisoners' health. It may stand to reason therefore that the availability of appropriate medical care can be claimed under CAT as this would enhance conditions conducive to the health of prisoners. Since upholding prisoners' right to health is important in giving effect to the CAT it may be argued that the right to health may also be closely linked to the right against torture, cruel and inhumane and degrading treatment.

By considering the intertwined nature of the right to health with other rights the importance of respect for the right to health is revealed. At times other rights must be limited to give effect to the right to health, but more often the protection of the most fundamental human rights, such as. to life and dignity will assist in upholding the right to health. In respect of terminally ill inmates this is particularly true. Their declining health may require that other rights be given effect to as was demonstrated in this section.

## 2.6 EQUAL ACCESS TO QUALITY HEALTH CARE

In many countries, prisoners do not have access to quality health care or equal access to health care as persons who are free. In the light of the aforesaid, terminally ill prisoners may have limited access to appropriate health care. Notwithstanding this reality, binding international instruments do not address terminally ill prisoners' challenges in accessing quality health care. Other groups' limitations on accessing quality health care will therefore be considered as it may assist in addressing the plight of terminally ill prisoners.

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<sup>105</sup> Report of the Committee Against Torture Thirty-First Session (10-21 November 2003), Thirty-Second Session (3-21 May 2004) General Assembly Supplement No 44 A/59/44 (2003) 23 at para 40 b.

### 2.6.1 ICESCR Committee's Concluding Observations on access to quality health care

In 2012 the CESCR expressed concern over Togo's illegal market for pharmaceutical products and that the quality of such products could not be guaranteed.<sup>106</sup> Though the existence of such markets may seem irrelevant to the plight of terminally ill inmates, it may arguably be submitted that illegal pharmaceutical markets can present grave risks to terminally ill prisoners. If they are unable to legally access quality health products and services, their desperation may make them susceptible to accessing illegal markets. Products of poor quality may pose a heightened threat to their well-being. There is thus in general a need for all States not only to combat illegal pharmaceutical markets, but also to ensure that quality health products are reasonably accessible to prisoners particularly those who are terminally ill as they may experience extreme pain and suffering.

In 2007 the CESCR expressed concern that persons in Belgium belonging to vulnerable groups had their right to health limited to access to urgent medical care.<sup>107</sup> The Committee thus recommended that Belgium should take all appropriate measures to ensure equal access.<sup>108</sup> Though this seems unrelated to terminally ill inmates, the Committee's decision can be used to support the contention that vulnerable groups like terminally ill prisoners must be given equal access to the range of services that are freely available to other persons. Affording such access to vulnerable groups may necessitate additional measures by States. Such measures may be justified, however, as they would be aimed at creating a reasonable health system since health systems that do not accommodate the most desperate and vulnerable persons cannot be said to be reasonable.

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<sup>106</sup> Concluding Observations of the CESR on the initial report of Togo 2013 para 30.

<sup>107</sup> Concluding Observations of the CESCR on Belgium (2007) para 21.

<sup>108</sup> Concluding Observations of the CESCR on Belgium (2007) para 31.

The CESCR's Concluding Observations on Australia's Report in 2009<sup>109</sup> stated that Australia had failed to address the consistent high levels of ill health amongst indigenous people. The Committee recommended that Australia should: take immediate steps to improve the health of indigenous people by implementing a human rights framework that ensures access to the social determinants of health; and identify health indicators and appropriate national benchmarks in relation to the right to health in accordance with CESCR General Comment No.14.<sup>110</sup> In relation to creating equal access to health care for terminally ill prisoners, there is much to glean from the Committee's recommendations. First, efforts to create equality in accessing quality health resources must be tangible and, secondly, progress must be measurable. This means that States are obligated to introduce concrete plans and programmes to ensure that such prisoners are afforded access to quality health care. In particular, the need to duly include prisoners in such plans and programmes will be discussed in greater detail in Chapters 3 and 6 of this thesis.

### 2.6.2 CERD's Concluding Observation on access to quality health care

CERD's Concluding Observations regarding the Roma, a marginalised group, may assist in the plight of terminally ill inmates. CERD requested States Parties to refrain from placing Roma in camps where health facilities were inaccessible.<sup>111</sup> States Parties were reminded to ensure equal access to quality health care and to eliminate discriminatory practices in health systems.<sup>112</sup> As with the Roma communities, terminally ill prisoners should not be accommodated in facilities where access to appropriate health care is limited. As mentioned earlier in terms of *Tornel*, adjustments should be made and efforts be employed to give prisoners with physical limitations access to facilities and appropriate health care.

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<sup>109</sup> Committee on Economic, Social and Cultural Rights Forty-Second Session Geneva, 4 to 22 May 2009 Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant para 1.

<sup>110</sup> At CESCR (2009) para 28.

<sup>111</sup> General Recommendation XXVII on Discrimination against Roma (2000) para 31.

<sup>112</sup> General Recommendation XXVII on Discrimination against Roma (2000) para 31.

Additionally, like the Roma communities, prisoners are also often subjected to discriminatory practices. Consequently care should be taken to protect terminally ill prisoners against such practices in health care systems.

## 2.7 FACTORS WHICH CONTRIBUTE TO POOR HEALTH: THE VALUE OF AWARENESS AND ATTENTIVENESS

As mentioned earlier in this Chapter, it appears that at times States are not aware of, or attentive to, the factors which may impact negatively on prisoners' health. Below some factors which may affect the fulfilment of terminally ill prisoners' right to health care are considered.

### 2.7.1 CESCR's Concluding Observations on prison conditions and prisoners' health status

It is trite that overcrowding in prisons may cause grave health problems. It is therefore unsurprising that the CESCR mentioned that overcrowding in prisons in Azerbaijan resulted in a 'disproportionately high rate of tuberculosis and other health problems among prisoners'.<sup>113</sup> The CESCR recommended that the State Party should continuously improve conditions in prisons and ensure that the physical and mental health of all prisoners is respected.<sup>114</sup> These recommendations suggest that prison authorities must constantly be aware of conditions in prisons which impact negatively on health, and of the health status of prisoners. Regular health screenings and prison inspections may assist in this regard.

### 2.7.2 CESCR's Concluding Observations on discrimination

States must be attentive to the grounds on which prisoners experience discrimination when accessing health care. The CESCR<sup>115</sup> referred to discrimination against women, migrants, Internally Displaced Persons (IDPs), poor people, disabled people and persons affected with

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<sup>113</sup> Concluding Observations of the CESCR Azerbaijan 2004 para 31.

<sup>114</sup> Concluding Observations of the CESCR Azerbaijan 2004 para 31.

<sup>115</sup> CESCR *Consideration of Reports submitted by State Parties under Articles 16 and 17 of the Covenant* Forty-first session Geneva, 3-21 November 2008.

HIV/AIDS in Angola.<sup>116</sup> Although prisoners are not mentioned, they share many characteristics with some of the listed groups and are as a result often discriminated against not only due to factors, such as, poverty and their health status, but also because they are prisoners.

It is contended here that States may become more aware of the grounds on which persons are discriminated against if there are sound oversight institutions to address discrimination. This is evident as the CESCR commended Azerbaijan for conferring the duty to supervise prison medical doctors upon the Ministry of Justice and because human rights violations could be immediately reported to the Office of the Commissioner for Human Rights.<sup>117</sup>

#### 2.7.3 CERD's Concluding Observation on discrimination against minorities

CERD's Concluding Observations on Slovakia allude to the possibility that minority groups that are unfairly discriminated against may be vulnerable to poor health due to their living conditions. In Slovakia, the Roma communities' health situation was described as 'critical' and the CERD thus recommended that the State should introduce health initiatives which take account of the extreme poverty of the Roma. This affirms that endemic discrimination against a group can impact upon health. This is also true for terminally ill prisoners. Their complete dependence on the State and their poverty must be considered to prevent discrimination and allow them equitable access to health care. The failure of States to focus on identifying discriminatory practices and eliminating them can contribute to poor health.

#### 2.7.4 CEDAW on discrimination

Article 12 of CEDAW provides that women should have access to health care and that States Parties should eliminate discrimination against them.<sup>118</sup> Women represent between 3 and 9

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<sup>116</sup> CESCR *Consideration of Reports submitted by State Parties under Articles 16 and 17 of the Covenant* Forty-first session Geneva, 3-21 November 2008 para 15.

<sup>117</sup> Concluding Observations of the CESCR Azerbaijan (2004) para 31.

<sup>118</sup> 1249 UNTS 13; 19 ILM 33 (1980).

per cent of the world's prison population.<sup>119</sup> Additionally, women who are imprisoned usually have disadvantaged backgrounds and have not enjoyed adequate health care prior to their incarceration.<sup>120</sup> As a minority group within the prison population, their needs might easily be overlooked.<sup>121</sup> The potential for diseases to develop is consequently intensified. These considerations should also be applied to terminally ill prisoners as failure to do so may contribute to poor health.

#### 2.7.5 The CEDAW Committee's General Comments on health

The CEDAW Committee<sup>122</sup> indicated that States should give special attention to the health needs of women belonging to vulnerable and disadvantaged groups.<sup>123</sup> Furthermore, according to the UN Special Rapporteur on Violence Against Women health services for males should not be replicated as such services would not be suitable for women.<sup>124</sup> These comments indicate that health care approaches should include an emphasis on the unique needs of persons with special needs, such as prisoners who are terminally ill. A one-size-fits-all approach is likely to be unsuitable for some prisoners and may even be detrimental to their health. States should therefore be attentive to the unique or special needs of vulnerable prisoners.

#### 2.7.6 Jurisprudence on discrimination in health care

In *Pimentel v Brazil* the applicant's pregnant daughter, a Brazilian national of African descent, died after she was left almost unattended in the hospital for 21 hours.<sup>125</sup> The Committee on CEDAW held that the deceased's status as a woman of African descent and

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<sup>119</sup> See Harm Reduction International 'Drug Offences, access to justice and the penalisation of vulnerability' Submission to the UN Committee on the Elimination of Discrimination Against Women, General Discussion on "Access to Justice" 18 February 2013 2-3.

<sup>120</sup> Harm Reduction International (2013)1- 3; See also Agboola C 'Memories of inside: The conditions in South African women's prisons' (2016) 56 *SA Crime Quarterly* 21.

<sup>121</sup> United Nations Office on Drugs and Crime 2009 3 available at [http://www.euro.who.int/\\_data/assets/pdf\\_file/0004/76513/E92347.pdf](http://www.euro.who.int/_data/assets/pdf_file/0004/76513/E92347.pdf) (accessed 24 June 2014).

<sup>122</sup> UN Committee on CEDAW (1999) available at <http://www.refworld.org/docid/453882a73.html> (accessed 7 July 2014).

<sup>123</sup> UN Committee on CEDAW (1999) para 6 available at <http://www.refworld.org/docid/453882a73.html> (accessed 7 July 2014).

<sup>124</sup> Lines R 'The right to health of prisoners in international human rights law' (2008) 4 *International Journal of Prisoner Health* 13.

<sup>125</sup> *Pimentel v Brazil* (CEDAW/C/49/D//17/2008) para 7.7.

her socio-economic position placed her in a vulnerable sector of society. Similarly, some terminally ill prisoners may also be vulnerable due to their social origin and indigence. These are thus factors which States must be cognisant of when addressing health care needs.

In summary there may be a myriad of factors which contribute to poor health in prisons. Authorities must therefore employ special efforts to stay abreast of such issues and address them to avert health problems and ameliorate current conditions.

## 2.8 THE IMPACT OF INSUFFICIENT RESOURCES ON VULNERABLE GROUPS

State resource constraints affect vulnerable groups in a population differently than it does other groups.<sup>126</sup> The discussion below focuses on how State imposed budgetary constraints can affect vulnerable groups.

### 2.8.1 CESCR's Concluding Observations on sufficient resources

In 2001 Colombia reduced State subsidies for health care.<sup>127</sup> The CESCR commented that this adversely affected citizens', and especially those residing in rural areas, access to health care. The CESCR urged Colombia to ensure that its system of subsidies does not discriminate against 'the most' disadvantaged and marginalised groups.<sup>128</sup> This denotes that all groups are not equally affected by a State's reduction of resources. Indigent groups, like many terminally ill prisoners, may be worse affected when budget reductions occur.

The CESCR noted its concern that free antiretroviral treatment was not available throughout Togo and that in 2009 and 2010 such treatment had been interrupted.<sup>129</sup> The CESCR encouraged Togo to adopt legislation to protect persons against HIV/AIDS and ensure that vulnerable groups have equal access to treatment.<sup>130</sup> This too demonstrates that vulnerable

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<sup>126</sup> Hendriks A 'The Right to Health' (1994) *European Journal of Health Law* 195.

<sup>127</sup> Concluding Observations of the CESCR on Colombia, ICESCR (2001) para 775.

<sup>128</sup> Colombia, ICESCR (2001) para 796.

<sup>129</sup> CESCR *Concluding observations of the CESR on the initial report of Togo* (2013) para 31.

<sup>130</sup> CESCR *Concluding observations on the initial report of Togo* (2013) para 31.

groups are worst affected when State budgets and resources for health are reduced as they are more dependent than others on State resources.

### 2.8.2 CEDAW's Concluding Observation on sufficient resources

The Committee on CEDAW commented on Angola's poor health infrastructure which limited access to health services and gave rise to the low health status of women.<sup>131</sup> The Committee's comment strengthens the assertion that vulnerable groups experience graver consequences when health resources are limited.

The discussion in this section demonstrates that when States place limitations on health budgets, such limitations have a more severe impact on vulnerable groups. Care must therefore be taken to ensure that the most vulnerable groups are expressly included in State plans, programmes and budgets.

## 2.9 THE RIGHT TO HEALTH IN REGIONAL LAW INSTRUMENTS

Regional human rights systems are more closely connected to national systems than international instruments.<sup>132</sup> Some of the legal instruments and enforcement bodies' work which protects the right to health care in the Inter-American, the European and the African human rights systems, respectively, will be discussed. The health care challenges which terminally ill inmates experience may differ depending on their context and the region they may find themselves in. Hence, the thematic approach adopted in the previous section will not be followed here.

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<sup>131</sup> Concluding Observations by CEDAW on Angola, CEDAW para 162.

<sup>132</sup> Herrera C and Viljoen F 'Danger and Fear in prison: Protecting the most vulnerable persons in Africa and the Americas by regional human rights bodies through interim measures' 2014 *Netherlands Quarterly of Human Rights* 163.



## 2. 9.1 The inter-American human rights system

### 2.9.1.1 The American Declaration of the Rights and Duties of Man

The American Declaration of the Rights and Duties of Man,<sup>133</sup> also known as the Bogota Declaration predates, the UDHR by less than a year.<sup>134</sup> It was adopted by the nations of Americas at the ninth international conference of American States in Bogota, Colombia, in April 1948.

Article XI of the American Declaration of the Rights and Duties of Man provides that ‘[e]very person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources’. Though the instrument is non-binding, Article XI postulates that the preservation of health thus extends beyond medical care and to the extent that resources are available. This must be applied to terminally ill inmates as they may require more than medical treatment. The American Declaration helps to strengthen the argument for holistic health care for terminally ill inmates.

### 2.9.1.2 The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador)

The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights<sup>135</sup> (Protocol of San Salvador) was adopted in San Salvador in 1988 by the Organization of American States at its 18th regular session. The Protocol of San Salvador came into effect in 1999 and protects second-generation rights.

Article 10 of the Protocol of San Salvador provides that the right to health should be understood to mean ‘the enjoyment of the highest level of physical, mental and social well-being’. Article 10 also stipulates that States Parties should adopt certain measures to ensure

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<sup>133</sup> Inter-American Commission on Human Rights 1948 available at <http://www.refworld.org/docid/3ae6b3710.html> (accessed 8 January 2014).

<sup>134</sup> Morsink J *The Universal Declaration of Human Rights: Origins, Drafting and Intent* (1999) 131.

<sup>135</sup> OAS Treaty Series No. 69; 28 ILM 156 (1989).

that right including that States Parties should satisfy the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.<sup>136</sup> Based on Article 10, terminally ill inmates' health needs must be satisfied by States as they are vulnerable and at high risk of poor health.

### 2.9.1.3 The Inter-American Convention on Protecting the Human Rights of Older Persons

The 2015 Inter-American Convention on Protecting the Human Rights of Older Persons came into force in January 2017.<sup>137</sup> It is the first treaty to refer to palliative care and terminal illnesses. Article 2 provides a detailed definition of palliative care. It reads as follows:

‘Active, comprehensive, and interdisciplinary care and treatment of patients whose illness is not responding to curative treatment or who are suffering avoidable pain, in order to improve their quality of life until the last day of their lives. Central to palliative care is control of pain, of other symptoms, and of the social, psychological, and spiritual problems of the older person. It includes the patient, their environment, and their family. It affirms life and considers death a normal process, neither hastening nor delaying it.’

Furthermore, Article 6 obligates States to take steps to ensure that private and public institutions offer palliative care to older people without discrimination. In terms of this article, States should avoid isolation, appropriately manage problems related to the fear of death of the terminally ill and pain; and prevent unnecessary suffering, and futile and useless procedures, in accordance with the right of older persons to express their informed consent. Article 19 expressly refers to palliative care, thus implying that it is part of the right to health care within the context of the Convention.

The introduction of this instrument is positive. The fact that it applies only to older persons may imply that older persons who are serving time in prison should also be afforded

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<sup>136</sup> Article 10(f).

<sup>137</sup> See [www.oas.org/en/sla/dil/inter\\_american\\_treaties\\_a-70\\_human\\_rights\\_older\\_persons.asp](http://www.oas.org/en/sla/dil/inter_american_treaties_a-70_human_rights_older_persons.asp) (accessed 14 October 2017).

palliative care should they require it. This has, however, not been made explicit in the Convention and indicates that perhaps the needs of older prisoners had not been considered by the drafters of the Convention. Article 31 urges States to ensure that prison staff should receive training in the protection of the rights of older persons. Arguably this does not suffice in ensuring that comprehensive palliative care programmes are introduced in prisons.

#### 2.9.1.4 American Convention on Human Rights

The American Convention on Human Rights<sup>138</sup> does not expressly provide for the right to health, but states that persons deprived of their liberty shall be treated with respect for the inherent dignity of the person.<sup>139</sup> The fulfilment of the right to dignity, particularly in the prison context, often requires the provision of appropriate health care to inmates as discussed below. Additionally, the American Convention protects the right to life<sup>140</sup> and the right to humane treatment and not to be subjected to torture or to cruel, inhuman or degrading punishment or treatment.<sup>141</sup> These rights are widely regarded as indivisible from the right to health. In respect of terminally ill inmates the withholding of appropriate health care services may negate or limit all of the aforementioned rights.

#### 2.9.1.5 Jurisprudence

Between 1996 and 2012 the Inter-American Commission on Human Rights was aware of 771 prisoners with health problems and who had not been afforded access to medicines, but it afforded protection to only 25 of these prisoners.<sup>142</sup> The lack of protection is problematic as most prisoners are absolutely dependent on the State to fulfil their health care needs. The negligible number of prisoners whose right to health care had been protected denotes the lack

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<sup>138</sup> 1144 UNTS 123; 9 ILM 99 (1969).

<sup>139</sup> Article 5(2).

<sup>140</sup> Article 4.

<sup>141</sup> Article 5

<sup>142</sup> Herrera & Viljoen (2014)178.

of will of the States concerned.<sup>143</sup> It is also of concern that some of the prisoners who sought protection suffered from serious illnesses such as cancer, a tumour, diabetes, a kidney disease, or HIV/AIDS.<sup>144</sup> The lack of protection of prisoners' right to health care may contribute to prisoners becoming terminally ill.

Notwithstanding the limited cases in which prisoners' right to health care had been protected, there are decisions which demonstrate that such protection is possible. In *Miranda Cortez et al v. El Salvador*,<sup>145</sup> for example, the Commission on Human Rights decided that the right to health is protected under Article 26 (economic, social and cultural rights) of the American Convention and the Commission therefore has the power to hear cases of violations. The Commission also held that although it does not have the power to establish violations to Article 10 of the Protocol of San Salvador, the standards referring to the right to health were considered in analysing the merits of the case in respect of Articles 26 and 29 of the Convention. This decision affirms the status of health as a right; the Commission appears to have found the basis to protect the right in the absence of an explicit guarantee in the American Convention.

In *Albán-Cornejo et al v. Ecuador* the petitioners' alleged that their daughter had died due to an overdose of morphine administered in a private hospital.<sup>146</sup> The Court referred to the right to health as protected in Article 10 of the Protocol of San Salvador. It held that Article 2 of the American Convention obligates States Parties to adopt laws and other measures to protect the rights and freedoms guaranteed. It furthermore found that the State Party should have established 'a legal system which effectively respects and guarantees the exercise of such

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<sup>143</sup> Herrera C and Viljoen F (2014) 179.

<sup>144</sup> Herrera C and Viljoen F (2014) 179.

<sup>145</sup> (Case 12.249).

<sup>146</sup> See [http://www.corteidh.or.cr/docs/casos/articulos/seriec\\_171\\_ing.pdf](http://www.corteidh.or.cr/docs/casos/articulos/seriec_171_ing.pdf) para 117 (accessed 20 October 2013)

rights, and which supervises permanently and effectively the rendering of services on which life and humane treatment depend.<sup>147</sup> This may be relevant to terminally ill prisoners who are afforded access to private health care facilities or who receive health care from non-governmental organisations.

The preceding discussion demonstrates that while there is protection of the right to health there is a definite need to strengthen the position of vulnerable groups, such as terminally ill prisoners. Laws which explicitly address the health needs of terminally ill prisoners are required.

#### 2.9.1.6 Charter of the Organization of American States

The Charter of the Organization of American States<sup>148</sup> is a Pan-American treaty. It was signed at the ninth international conference of American States held in Bogota, Colombia. The Charter came into effect in 1951.

The Charter of the Organization of American States deals with a host of rights that are closely linked to the right to health. Article 34, for example, sets specific basic goals that are closely related to the right to health, namely, the protection of man's potential through the extension and application of medical science,<sup>149</sup> proper nutrition<sup>150</sup>, adequate housing<sup>151</sup>, and urban conditions that offer the opportunity for a healthful, productive and full life.<sup>152</sup> Arguably these provisions allude to the link between health and the fulfilment of other socio-economic rights.

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<sup>147</sup> See [http://www.corteidh.or.cr/docs/casos/articulos/seriec\\_171\\_ing.pdf](http://www.corteidh.or.cr/docs/casos/articulos/seriec_171_ing.pdf) para 121 (accessed 20 October 2013).

<sup>148</sup> 119 UNTS 3. <http://www.refworld.org/docid/4680cd212.html> (accessed 7 January 2014).

<sup>148</sup> Inter-American Commission on Human Rights 1948 available at <http://www.refworld.org/docid/3ae6b3710.html> (accessed 8 January 2014).

<sup>149</sup> Article 34(i).

<sup>150</sup> Article 34(j).

<sup>151</sup> Article 34(k).

<sup>152</sup> Article 34(l).

In respect of terminally ill inmates the achievement of the goals of Article 34 are imperative to maintaining their dignity. Despite an inmate's diagnosis of having a terminal disease, certain individualised and reasonable health goals should still be set. Based on Article 34 terminally ill prisoners are entitled to a dignified life.

#### 2.9.1.7 Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (1994)

The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (1994)<sup>153</sup> was adopted in Belém do Pará in 1994. This treaty entered into force in 1995 and is the first binding treaty to recognise that violence against women is a violation of human rights.

This Convention does not contain a provision which affords the right to health, but it defines violence against women as any act that has a negative effect on women's physical, sexual or psychological well-being.<sup>154</sup> This Convention indicates that violence against women include physical, sexual and/or psychological violence that occurs in health facilities.<sup>155</sup> Women who are prisoners and who are terminally ill must therefore be protected against actions, conditions and decisions that may limit the fulfilment of their right to health care in health facilities.

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<sup>153</sup> Organization of American States (OAS) 1994 available at <http://www.refworld.org/docid/3ae6b38b1c.html> (accessed 14 January 2014).

<sup>154</sup> Article 1.

<sup>155</sup> Article 2(b).

### 2.9.1.8 Jurisprudence

The Court in *Albán-Cornejo et al v. Ecuador*<sup>156</sup> mentioned that there is a close connection between the right to life, human treatment (guaranteed under the American Convention on Human Rights) and to health. This affirms the importance of the right to health and States' inescapable duty to uphold the right.

In *Andrea Mortlock v United States of America*<sup>157</sup> the petitioners relied on the right to health and the right not to be subjected to cruel, infamous or unusual punishment under Articles XI and XXVI of the American Declaration.<sup>158</sup> The alleged victim had been in conflict with the law and faced deportation to Jamaica, her home country. She had been diagnosed with AIDS and was terminally ill, but had received extensive medical treatment to improve her quality of life in the United States of America where she and her family had lived for 30 years. In Jamaica she would not have received the same quality of health care and familial support as in the USA and this would hasten her death. It was contended on her behalf that her deportation to Jamaica would constitute a violation of her right to health care and the right not to be subjected to cruel, infamous or unusual punishment under the American Declaration.<sup>159</sup>

The Commission held that immigration policy should not impinge upon the right to life, physical and mental integrity and family.<sup>160</sup> The Commission also held that the enforcement of immigration policy should not violate the right against cruel, inhuman and degrading treatment.<sup>161</sup> The Commission referred to the European Court of Human Rights' reasoning

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<sup>156</sup> See [http://www.corteidh.or.cr/docs/casos/articulos/seriec\\_171\\_ing.pdf](http://www.corteidh.or.cr/docs/casos/articulos/seriec_171_ing.pdf) para 117 (accessed 20 October 2013)

<sup>157</sup> Report No 63/08 Case 12.534.

<sup>158</sup> At para 23.

<sup>159</sup> At para 23.

<sup>160</sup> At para 78.

<sup>161</sup> At para 78.

that a foreign national who faces deportation cannot evade expulsion because he or she received medical assistance from the State.<sup>162</sup> An exception to the aforementioned rule is if there are compelling humanitarian reasons which would result in the expulsion giving rise to cruel or inhumane treatment.<sup>163</sup>

In the present case Ms Mortlock's deportation would have resulted in cruel, inhumane and degrading treatment. The Commission further stated that the question was whether the humanitarian appeal of the case was so powerful that the authorities of a civilised society could not overlook such an appeal.<sup>164</sup> In conclusion the Commission found that Ms Mortlock's deportation would have resulted in cruel, infamous or unusual punishment.<sup>165</sup>

The *Mortlock* case demonstrates the close link between the right to health and the right to be free from cruel, infamous and unusual punishment, the right to family life, the right to life and the right to dignity. Terminally ill prisoners' right to health should therefore be understood in this broader context. Given the powerful humanitarian call to maintain and improve their existing health and quality of life where reasonably possible, States ought to consider carefully how they treat such prisoners.

In *Marcela Alejandra Porco v Bolivia*<sup>166</sup> the alleged victim was an Argentine citizen who suffered from an acute case of schizophrenia. She had been detained for approximately one year on charges of violating certain drug laws without having been provided appropriate treatment for her mental condition.<sup>167</sup> She had also been denied parole for the purpose of

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<sup>162</sup> At para 81.

<sup>163</sup> At para 81.

<sup>164</sup> At para 91.

<sup>165</sup> At para 102.

<sup>166</sup> Report No 8/08 Case 11.426.

<sup>167</sup> At para 1



receiving medical treatment.<sup>168</sup> Her mental and physical health deteriorated as a result of the subhuman conditions and lack of appropriate medical treatment in the prison. It was consequently alleged that there had been violations of *inter alia* the alleged victim's right to humane treatment (Article 5), right to personal liberty (Article 7), right to a fair trial (Article 8), and protection of honour and dignity (Article 11).

The Commission held that the State's failure to provide adequate health treatment tended to establish a possible violation of Articles 5(1) and 11(1).<sup>169</sup> Though the victim was not terminally ill the case illustrates the importance of respecting the interconnectedness of the right to health with other rights.

## 2.9.2 The European human rights system

### 2.9.2.1 European Convention on Human Rights (ECHR)

The ECHR<sup>170</sup> was drafted by the Council of Europe in 1950 to protect human rights in Europe and came into effect in 1955. It does not contain a provision on health. Some rights in the ECHR may, however, be interpreted to protect health. Examples of such rights include Article 3<sup>171</sup> which prohibits cruel, inhuman and degrading treatment or punishment, Article 8 which protects the right to privacy and family life and prohibits public authorities from interfering with this right, Article 9 which provides for freedom of thought, conscience and religion, and Article 10 which gives everyone the right to freedom of expression. This demonstrates the close link between the right to health and other rights. Given the fundamental nature of these rights, it may be contended that the right to health has a prominent place in the European system.

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<sup>168</sup> At para 31.

<sup>169</sup> At para 70.

<sup>170</sup> ETS 5; 213 UNTS 221.

<sup>171</sup> ETS 5; 213 UNTS 221.

### 2.9.2.2 Jurisprudence

The cases discussed here demonstrate the importance of respecting the relationship between the right to health and some of the ECHR rights.

In *Dybeku v. Albania*<sup>172</sup> the European Court of Human Rights held that States must ensure that detainees are held in conditions which are compatible with human dignity. Such conditions arguably include that prisoners should receive appropriate health care according to their State of health. Terminally ill prisoners should therefore be afforded health care which will assist in giving effect to their right to human dignity.

The European Court of Human Rights in *Dybeku* furthermore held that detainees should also not be subjected to hardships or deprivations beyond those that are an unavoidable consequence of, and inherent to, detention itself. This implies that inmates' dignity should be treated as a right and a value which buttresses the operation of the correctional system.

In *Enhorn v Sweden*<sup>173</sup> the Court held that the isolation of a person with an infectious disease is lawful if the spread of the disease would be harmful to public health and safety. It also held that isolation must be used as a last resort. Though this case does not deal with terminally ill inmates, the principle of isolation as a last resort is relevant to the care of such inmates. Many inmates do establish relationships with one another. When they are diagnosed with terminal diseases such connections may become even more valuable to them. The isolation of a terminally ill prisoner should therefore not be based on arbitrary reasons. Due consideration should be given to the dignity of the prisoner as well as that of his peers. It is unfortunate that this important principle is not explicit in the European system.

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<sup>172</sup> [2007] ECHR 41153/06 (18 December 2007).

<sup>173</sup> Application no. [56529/00](https://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-68077#{), Judgment date: 25 January 2005 available at [http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-68077#{"itemid":\["001-68077"\]}](https://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-68077#{) (accessed 1 November 2013).

In *D v The United Kingdom*<sup>174</sup> the European Court of Human Rights considered the lawfulness of deporting a convicted person who was diagnosed with HIV. The Court held that the primary consideration should be whether the humanitarian appeal of the case is so powerful that the authorities of a civilised State cannot reasonably expel the person.<sup>175</sup> The Court considered whether equivalent medical care and social support would be available in the person's home country and concluded that to deport him would hasten his death and therefore violate Article 3 of the European Convention. This case appears to suggest that there can be a humanitarian dimension to addressing terminally ill inmates' plight. More importantly, though States must take action to fulfil their legal duty to uphold the right to dignity, life and security of the terminally ill person.

### 2.9.2.3 European Social Charter

The European Social Charter was adopted in 1961 and revised in 1996.<sup>176</sup> It is a Council of Europe Treaty. Together with the European Convention on Human Rights, it guarantees fundamental economic and social rights.

Article 11 of the Charter gives everyone the right to benefit from any measures 'enabling him to enjoy the highest possible standard of health attainable'. The European Committee of Social Rights has emphasised that restrictions on the application of Article 11 may not hinder disadvantaged groups' exercise of the right to health.<sup>177</sup> This implies that terminally ill inmates must be protected under article 11 as they are a disadvantaged group highly dependent on the State to meet their health needs.

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<sup>174</sup> 24 Euro. Ct. H.R. 423 (1997).

<sup>175</sup> At para 91.

<sup>176</sup> Council of Europe, *European Social Charter (Revised)*, 3 May 1996, ETS 163.

<sup>177</sup> Council of Europe Digest 2008 81-82.

In interpreting Article 11, the European Committee of Social Rights provided that access to treatment must not be unnecessarily delayed.<sup>178</sup> Criteria for access to treatment must be transparent, agreed upon at national level, and the risk of deterioration in either patients' clinical condition or quality of life must be considered when arranging access to such treatment.<sup>179</sup> These recommendations may be applied to terminally ill prisoners. They should know the criteria for accessing treatments and if eligible have reasonable access to it without undue delays to avoid preventable pain and suffering. Delaying their access to treatment may be fatal in that an inmate may die. The rights to life, health, dignity and security of the person will consequently be negated.

Article 13 of the European Social Charter stipulates that anyone without adequate resources has the right to social and medical assistance. This Article is undoubtedly relevant to prisoners as many have limited or no personal resources. In respect of terminally ill inmates the State's duty to provide assistance is essential given the impact that the failure to assist may have on such inmates.

Article 19 of the European Social Charter provides that to ensure the effective exercise of the right of migrant workers and members of their families to protection and assistance, Contracting Parties undertake to adopt appropriate measures to provide services for health, medical attention and good hygienic conditions. Though this article applies to migrant workers it exemplifies the treatment that should be afforded to terminally ill inmates. Their status as prisoners should not affect their access to health care and their enjoyment of sanitary conditions.

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<sup>178</sup> Council of Europe Digest 2008 81-83.

<sup>179</sup> Council of Europe Digest 2008 81-83.

Article 23 provides that elderly persons must be afforded housing suited to their needs and their state of health. They should have access to the health care and the services necessitated by their state. The European Committee of Social Rights stated that health care should include palliative care.<sup>180</sup> It is a positive development that the possible needs of terminally ill elderly persons are foreseen in Article 23; the reference to palliative care and suitable housing for elderly persons makes this a reasonable inference. Such care afforded to elderly persons must be encouraged and is not criticised here. Article 23 assists in drawing attention to the silence on the position of terminally ill inmates. Some inmates are elderly persons, yet no provision is made for them.

#### 2.9.2.4 Conclusions of the European Committee of Social Rights

In 2007 the Ministry of Health of the Slovak Republic issued a policy for the health care of the elderly.<sup>181</sup> The State noted that specialised health care was provided by doctors with a specialisation in geriatrics and by other specialist doctors depending on the needs of the patient. Geriatric health care included *inter alia* terminal care.

The European Committee's Conclusion on Sweden also confirms that terminally ill persons may require substantial and constant care. Sweden reported that some residences for elderly persons were being used for short-term care partly relief for the next-of-kin of those who were terminally ill.<sup>182</sup> Terminally ill inmates too may require constant care. In prisons, where fellow prisoners provide care, support or comfort to terminally ill prisoners they (fellow prisoners) ought to be afforded similar assistance as the next-of-kin of free persons. There may be instances where inmates have established a surrogate family unit or have a 'family of

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<sup>180</sup> Council of Europe Digest 2008: 149.

<sup>181</sup> European Committee of Social Rights Conclusions: Slovak Republic 2009.

<sup>182</sup> European Committee of Social Rights, Conclusions: Sweden 1997.

choice’ as discussed below in Chapter 6. Prison authorities should be mindful of this when making decisions regarding measures to support the health care of terminally ill prisoners.

#### 2.9.2.5 Jurisprudence

In *International Federation of Human Rights Leagues v. France*<sup>183</sup> the European Committee of Social Rights held that any ‘legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the [European Social] Charter’. States should ensure that all foreign nationals regardless of their legal status are not unfairly discriminated against when they access health care. Though terminally ill prisoners are not mentioned this argument can be applied to them. They should be afforded health care regardless of their status as persons with criminal records and as being terminally ill. States should have measures in place to prevent discriminatory practices and attitudes from hampering prisoners’ access to health care.

#### 2.9.2.6 The Charter of Fundamental Rights of the European Union

The Charter of Fundamental Rights of the European Union<sup>184</sup> became binding in December 2009. Article 35 provides that everyone has a right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. The entitlement to preventive health care applies to terminally ill persons too as they also need protection against further preventable illnesses.

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<sup>183</sup> Complaint No 14/2003 para 32 available at [http://www.coe.int/t/dghl/monitoring/socialcharter/complaints/cc14merits\\_en.pdf](http://www.coe.int/t/dghl/monitoring/socialcharter/complaints/cc14merits_en.pdf). (accessed 1 November 2013).

<sup>184</sup> European Union, Charter of Fundamental Rights of the European Union 2000 available at <http://www.refworld.org/docid/3ae6b3b70.html> (accessed 20 January 2014).

### 2.9.2.7 Recommendation of the Parliamentary Assembly of the Council of Europe (PACE)

The PACE does not have the power to pass binding laws, but due to its continuous discussions with governments, international organisations and civil society it draws attention to issues which need to be addressed.<sup>185</sup> The PACE's texts also have an impact on laws and practices in Europe.<sup>186</sup> It is therefore worth mentioning Recommendation 1418 of 1999 entitled Protection of the Human Rights and Dignity of the Terminally Ill and the Dying. This Recommendation acknowledges that the plight of terminally ill persons is not afforded the attention it requires and that emphasis is largely placed on the curing of illnesses and the prolonging of life.<sup>187</sup> This instrument, albeit non-binding, affirms the position of terminally ill persons within the European system. Whilst the limited attention given to the fulfilment of terminally ill persons' right to health care is not acceptable, the seemingly complete silence regarding terminally ill prisoners' right to health care is even worse. Their vulnerability is deepened by the failure to formally recognise their right to health care.

### 2.9.2.8 Recommendation of the Committee of Ministers to Member States on the Promotion of Human Rights of Older Persons.

In 2014 the Committee of Ministers<sup>188</sup> recommended to Member States that they should offer palliative care to older persons who suffer from life-threatening or life-limiting conditions.<sup>189</sup> It was also recommended that such care must be provided without undue delay and in a setting preferred and required by the older terminally ill person.<sup>190</sup> The family members and friends of terminally ill persons must also be encouraged to accompany them and they should be afforded professional support.<sup>191</sup>

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<sup>185</sup> See [http://website-pace.net/en\\_GB/web/apce/Powers](http://website-pace.net/en_GB/web/apce/Powers) (accessed 21 March 2015).

<sup>186</sup> See [http://website-pace.net/en\\_GB/web/apce/Powers](http://website-pace.net/en_GB/web/apce/Powers) (accessed 21 March 2015).

<sup>187</sup> Parliamentary Assembly 1991: Recommendation 1418 available at <http://assembly.coe.int/documents/adoptedtext/ta99/erec1418.htm> (accessed on 13 March 2015).

<sup>188</sup> Recommendation of the Committee of Ministers to Member States on the Promotion of Human Rights of Older Persons 2014 available at <https://wcd.coe.int/ViewDoc.jsp?id=2162283&> (accessed on 16 March 2015).

<sup>189</sup> See para 44.

<sup>190</sup> See para 45.

<sup>191</sup> See para 46.

The Recommendation calls for patients' rights to be fully respected,<sup>192</sup> that education programmes on palliative care should be incorporated into the training of all health and social workers, and that co-operation of professionals in palliative care should be encouraged.<sup>193</sup> It furthermore provides that 'Member States should ensure the adequate availability and accessibility of palliative-care medicines'.<sup>194</sup> The Recommendation provides a comprehensive approach to the health care of terminally ill persons; notably, however, even this soft law overlooks prisoners who are terminally ill. The Recommendation may be helpful in addressing some of the needs of terminally ill inmates, but cannot be replicated without due consideration of inmates' experiences and circumstances in prison. Age-related health considerations may also be important in devising appropriate health care for terminally ill prisoners as not all of them are elderly persons.

### 2.9.3 The African human rights system

#### 2.9.3.1 African Charter on Human and Peoples' Rights [Banjul Charter]

The African Charter on Human and Peoples' Rights of 1981<sup>195</sup> (African Charter) is intended to promote and protect human rights and basic freedoms on the African continent. Article 16 of the African Charter recognises that everyone 'shall have the right to enjoy the best attainable state of physical and mental health'. Article 16(2) furthermore obligates States Parties to take the necessary measures to protect the health of their people and to ensure that they receive medical treatment when they are sick.

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<sup>192</sup> See para 47.

<sup>193</sup> See para 48.

<sup>194</sup> See para 49.

<sup>195</sup> Organization of African Unity (OAU) 21 I.L.M. 58 (1982) available at <http://www.refworld.org/docid/3ae6b3630.html> (accessed 20 January 2014).



#### 2.9.3.1.1 Jurisprudence

The African Commission on Human and Peoples' Rights (African Commission) was created in terms of Article 30 of the African Charter and was established in 1987 to oversee, interpret and protect the rights in the African Charter. Under Article 55 of the African Charter, the African Commission may consider individual communications alleging violations of human rights.

In *Media Rights Agenda and Others v Nigeria*,<sup>196</sup> it was alleged that the Editor-in-Chief of TELL magazine was denied medical assistance during detention despite his deteriorating health.<sup>197</sup> The government of Nigeria made no response to this allegation.<sup>198</sup> The African Commission had to make a decision based on the facts as presented by the complainant. It held that to deny a detainee access to doctors when his health is deteriorating is a violation of Article 16 of the African Charter.<sup>199</sup> This finding indicates that medical care should be afforded to an inmate if it is needed and especially where the individual's state of health is declining. Implicitly there is thus a duty on States to maintain prisoners' health.

In *International Pen and Others (on behalf of Saro-Wiwa) v Nigeria*<sup>200</sup>, a prison doctor's request that hospital treatment be afforded to the inmate was ignored. The inmate's condition became life threatening. The African Commission had to consider whether there had been a violation of Article 16. It held that when a person is in custody his integrity and well-being is absolutely dependent on the authorities. The government therefore has a direct responsibility to protect the inmate's well-being.<sup>201</sup> The African Commission found that Article 16 had

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<sup>196</sup> (2000) AHRLR 200 (ACHPR) 1998.

<sup>197</sup> At para 9.

<sup>198</sup> At para 90.

<sup>199</sup> At para 90.

<sup>200</sup> (2000) AHRLR 212 (ACHPR 1998).

<sup>201</sup> At para 112.

been violated. States should therefore afford inmates appropriate medical treatment which is predicated on their physical condition.

In *Purohit and Another v The Gambia*<sup>202</sup> the complainants were mental health advocates. They alleged that the Lunatic Detention Act was outdated. The Act did not establish safeguards during diagnoses, certification and detention of a patient. The complainants also alleged that the psychiatric unit at Royal Victoria Hospital was overcrowded and that consent for treatment was not required.

The African Commission held that the right to health is vital to all aspects of a person's life and well-being. The right includes the right to health facilities, and access to goods and services to be guaranteed to all without discrimination.<sup>203</sup> The African Commission, however, took cognisance that millions of people in Africa are not enjoying the right to health optimally due to the problem of poverty. The African Commission read into Article 16 the obligation on States Parties to 'take concrete and targeted steps, while taking full advantage of its available resources, to ensure the full realization of the right to health'.<sup>204</sup> A lack of resources may therefore not serve as a justification for a State to refrain from the realisation of the right to health.

#### 2.9.3.1.2 Periodic reports by States Parties

The periodic reports of States Parties may offer insight into the practices of States in giving effect to the right to health. They may also provide information on conditions in prisons and whether prisoners' right to health is being given effect to. Consequently some of the recent Reports will be briefly discussed below.

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<sup>202</sup> (2003) AHRLR 96 (ACHPR 2003).

<sup>203</sup> At para 80.

<sup>204</sup> At para 84.

The Periodic Report for 2014-2026 of the Republic of Niger indicated that the government had provided prisons with materials for maintenance, bedding and clothing to improve the conditions of prisoners.<sup>205</sup> The government had also renovated the ablution facilities of various prisons in the country. Unfortunately prisoners are only provided with two meals a day, namely, lunch and dinner. In terms of the provision of health care, almost all prisons have a dispensary. However, in the cases of severe illness, the prisoner is referred to a public hospital or an integrated health centre. In all other cases the State provides sick prisoners with full medical care.

Whilst the above appears to be positive in upholding the right to health of prisoners, it is of concern that prisoners are only provided with two meals per day. Prisoners who, for example, should take medication with food in the mornings may be adversely affected by this. This is an indication that prison authorities should take into account the actual health needs of individual prisoners in order to avoid violations of their right to health.

In Rwanda, the Rwanda Correctional Services was established during the reporting period. It is responsible for the promotion and protection of the rights of detainees in terms of Rwandan and international laws.<sup>206</sup> The Presidential Order governing prisons in Rwanda provides that each prison must have dormitories, suitable toilets, sports courts, a health centre, guest halls, a kitchen, water and electricity, as well as an appropriate air conditioning system for the welfare of detainees and the preservation of a safe environment. Each prison in Rwanda has a health facility with medical personnel and in case of serious illness, prisoners are transferred to district hospitals; if the illness requires specialised care and treatment, the prisoners are referred to the provincial hospitals.

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<sup>205</sup> Periodic Report of The Republic Of Niger 2014-2016 33.

<sup>206</sup> Periodic Report of The Republic of Rwanda 2009-2016 17.

These provisions are positive. They indicate that the right to health of prisoners is as important as the right to health of free persons as during cases of serious illness they are referred to the same facilities as free persons. This also bodes well for their right to dignity and the possibility of reintegrating them into society after they are released from prison.

In addition to the positive health measures discussed above, Rwanda has also made efforts to reduce overcrowding in prisons. Such efforts include the building of new prisons, the rehabilitation of old prisons and the conditional early release of some prisoners. These efforts are commendable given that overcrowding both contributes to and exacerbates health problems in prisons.

To improve conditions of detention, the Democratic Republic of Congo's (DRC) Minister of Justice and Human Rights issued a Judicial Organisation Order on 28 January 2013 on the establishment, organization and functioning of local supervisory committees for the Budgetary Management of Provincial, Central Prisons and Detention Camps.<sup>207</sup> The Order establishes a Management Committee to oversee the spending of funds allocated to every prison facility for the feeding of prisoners. Other measures to improve prison conditions include: regular inspection of prisons by the magistrates from the public prosecutor's office; monitoring of places of detention by the Protection Department of the General Human Rights Secretariat; and capacity building of judicial investigation police officers on the rights of detainees. The National Human Rights Commission is responsible for periodic visits to places of detention across the whole country.

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<sup>207</sup> Periodic Report of the Democratic Republic of Congo 2008-2015 14.

The efforts of the DRC to improve prison conditions are laudable. There appears to be a realisation that oversight and monitoring of measures aimed at improving the general prison environment are necessary. As mentioned earlier in this chapter, prison authorities are often not aware of the some of the challenges faced by prisoners. Constant monitoring and oversight may therefore assist in identifying such challenges.

In its Second Report to the African Commission, South Africa reported that concerted efforts had been made to improve health care services to inmates. Such improvements included: that all inmates undergo a general health assessment on admission; awareness sessions, training for officials, and isolation facilities are in place to manage and prevent the spread of communicable diseases; inmates are provided with nutritionally balanced meals, and therapeutic diets are available for those who require them; and there have been improvements in the management of HIV/Aids and TB.<sup>208</sup> While these improvements are commendable, the Report also indicates that corruption in prisons persists. The failure to maintain prisoners in safe custody and to strengthen rehabilitation programmes as well as high levels of gang-related violent crimes in prison, continue to stifle progress.<sup>209</sup>

#### 2.9.3.2 African Charter on the Rights and Welfare of the Child

Article 14 of the African Charter on the Rights and Welfare of the Child<sup>210</sup> (African Children's Charter) provides that every child shall have the right to enjoy the best attainable State of physical, mental and spiritual health. It also obligates States Parties to undertake efforts for the full implementation of the right. Viljoen argues that though these provisions echo Article 5 of the African Charter, the African Children's Charter places a clearer duty on

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<sup>208</sup> Combined Second Periodic Report of South Africa 2002-2013 25.

<sup>209</sup> Combined Second Periodic Report of South Africa 2002-2013 25.

<sup>210</sup> Organisation of African Unity (OAU) July 1990 available at <http://www.refworld.org/docid/3ae6b38c18.html> (accessed 20 January 2014).

State Parties by using the words ‘to ensure’.<sup>211</sup> Additionally Article 30 deals with children of imprisoned parents and primary caregivers. It obligates States Parties to provide special treatment to expectant mothers and to mothers of infants and young children who have been accused or found guilty of committing a crime. This indicates that special treatment should be afforded to vulnerable inmates.

#### 2.9.3.2.1 General Comment by the African Committee of Experts on the Rights and Welfare of the Child

The General Comment by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) indicates that children can be affected by the stigma and trauma of their parent’s or caregiver’s involvement with the criminal justice system<sup>212</sup> There is also an acknowledgement that children living in prison with their mothers experience violations of their right to health.<sup>213</sup> Such children should be afforded health care services that are equivalent to the services enjoyed by children whose parents are not incarcerated.<sup>214</sup> The discrimination against children of prisoners presumably means that prisoners, and particularly terminally ill prisoners in all likelihood experience worse limitations of their rights. Arguably they should be afforded special protection of their right to health care.

#### 2.9.3.2.2 Concluding Recommendations

In 2014 the ACERWC made Concluding Recommendations on the Initial Report of South Africa. The Committee noted that in South Africa some children still had poor access to food, suffered from undernutrition and malnutrition and that this contributed to child mortality.<sup>215</sup> The ACERWC recommended that South Africa safeguard and undertake measures to realize children’s right to basic nutrition in its programs and actions. Children

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<sup>211</sup> Viljoen F ‘The Special Rapporteur on prisons and conditions of detention in Africa: Achievements and possibilities’ (2005) 27 *Human Rights Quarterly* 134.

<sup>212</sup> African Committee of Experts on the Rights and Welfare of the Child General Comment 1 of 2013 para 3

<sup>213</sup> At para 4.

<sup>214</sup> At para 20.

<sup>215</sup> Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of South Africa Initial Report on the Status of Implementation of the African Charter on the Rights and Welfare of the Child (October 2014) 11.

were also to be given access to medical care without discrimination on the basis of the rural and urban divide and race.<sup>216</sup>

The ACERWC furthermore urged South Africa to consider its General Comment No.1, discussed above, to extend special treatment for mothers in detention. South Africa should take into account the best interests of the child beginning from arrest, up to the ultimate conviction, sentencing, imprisonment and reintegration phase of the criminal justice system. The ACERWC also recommended that South Africa build separate prison facilities for mothers to provide basic facilities, such as, playing area, equipment, and cribs for the holistic development of children.<sup>217</sup>

In 2017 the ACERWC in its Concluding Recommendation acknowledged the programmes and strategies to improve the basic health and welfare of children in the Republic of Cameroon.<sup>218</sup> Despite this the African Commission expressed concern at the reduction of the health budget and the inadequacy of health facilities and trained health professionals. The ACERWC therefore urged Cameroon to increase the budget allocation for health services, improve and expand health infrastructure and train more health professionals. This Concluding Recommendation may be instructive to all governments. It affirms that though programmes and strategies on health care are important, such measures must be complemented with an adequate budget and necessary resources in order to give effect to the right to health.

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<sup>216</sup> At 11.

<sup>217</sup> At 14.

<sup>218</sup> Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of Cameroon's Report on the Status of Implementation of the African Charter on the Rights and Welfare of the Child 2017 6.

The ACERWC noted in its Concluding Recommendations on Uganda, that the State had done much to improve health care for people infected and affected by HIV/AIDS. Such efforts in respect of vulnerable and orphaned children are particularly laudable.<sup>219</sup> The Committee noted, however, that to evaluate the health status of a State Party, the following needed to be provided: data on the numbers of doctors, midwives and nurses; the number of public, private and community health centers by district; the state of prenatal and infant mortality; the vaccination coverage; and the accessibility of health care and health centres.<sup>220</sup> These Recommendations are invaluable. They provide guidance to countries on what ought to be considered in evaluating their health status.

#### 2.9.3.2.3 Periodic Reports by States Parties

South Africa indicated in its Second Report to the ACERWC that the DCS had initiated the concept of Mother and Baby Units in 2009.<sup>221</sup> These Units are separate from the general female prison population and are designed to meet the needs of detained mothers and their babies. The Correctional Services Amendment Act 25 of 2008 provides that detained mothers are allowed to keep their babies until they are two years old. This applies to both remand detainees as well as sentenced prisoners. The DCS has also established early childhood development centres in some of the Units to ensure the development of babies. Mothers have access to parenting skills programmes. Mothers and babies also have access to health care. At the time of the Report there were 16 Mother and Baby Units in South Africa

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<sup>219</sup> Recommendations and Observations sent to the Government of the Republic of Uganda by the African Committee of Experts on the Rights and Welfare of the Child on the Initial Implementation Report of the African Charter of the Rights and Welfare of the Child 5.

<sup>220</sup> At 5.

<sup>221</sup> Periodic Report of the Republic of South Africa 2013-2016 73



Based on the Report it may be inferred that it is reasonably possible for the South African government to provide for the special needs of vulnerable persons in the prison system. Presumably this inference may also reasonably apply to terminally ill prisoners.

Like South Africa, Tanzania strives to protect and assist children born in prisons and those accompanying their mothers in prisons.<sup>222</sup> The policy to this effect has thus been introduced. The policy endeavours to provide an enabling environment to ensure that all children who find themselves in prisons are provided with health care. The Report indicates that this policy will be incorporated in the Prisons Standing Orders as well as in the Prisons Curriculum for Prisons Colleges. This indicates that the health care of prisoners and even of their children is the responsibility of the State. Furthermore, States should reasonably accommodate the special needs of vulnerable groups.

Similarly to South Africa and Tanzania, Rwanda also affords special protection to mothers with children in prisons. Rwanda's Report to the African Committee of Experts provides that when pregnant women and mothers, with children younger than three years, are prosecuted for an offence, the courts will do their 'utmost to impose against such a mother a penalty other than imprisonment'.<sup>223</sup> If it is impossible to pronounce a penalty other than imprisonment, a pregnant woman or a mother of a child under three years is detained in a special ward of the prison reserved for mothers with children. This is an indication that the health and well-being of young children is of paramount importance. In the case where the imprisonment of mother is unavoidable, such a mother may be detained in a 'special prison for women who have children under three years'. Such children may also benefit from early childhood development programmes which have been set up in such prisons.

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<sup>222</sup> Periodic Report of the United Republic of Tanzania 2008-2015 53.

<sup>223</sup> Periodic Report on the Republic of Rwanda 2006-2013 47.

### 2.9.3.3 Protocol to the African Charter on Human and Peoples' Rights of Women in Africa

The Protocol to the African Charter on Human and Peoples' Rights of Women in Africa (Maputo Protocol) was adopted in 2003 and entered into force in 2005.<sup>224</sup> In Article 1 of the Maputo Protocol 'harmful practices' are defined as conduct, attitudes and/or practices which negatively impact on fundamental rights. Article 2 obligates States Parties to employ legislative and regulatory measures to combat discrimination against women and in particular harmful practices which endanger their health and general well-being. Article 14 provides for health and reproductive rights of women. Arguably the protection afforded under this instrument extends to female prisoners. Furthermore, it is possible that there are few women in prison who are terminally ill. As a small minority their rights may be severely limited. The enforcement of the Maputo Protocol in the prison environment is therefore vital.

Viljoen emphasises that the Maputo Protocol goes beyond the African Charter in protecting women as it requires that they be categorised as 'women in distress'.<sup>225</sup> Article 24(b) places a duty on States Parties to ensure that women are detained in an environment suitable to their condition and are to be treated with dignity. Herrera and Viljoen argue that the Maputo Protocol indicates that when States exercise their duty to protect the well-being of prisoners, they must consider any special vulnerability of a detained person arising from being women.<sup>226</sup>

#### 2.9.3.3.1 General Comment of African Commission of Human and Peoples' Rights

The 2012 General Comment of the African Commission of Human and Peoples' Rights on Articles 14(1)(d) and (e) of the Maputo Protocol<sup>227</sup> states that the Protocol serves to complement the African Charter. It expands the substantive protection of women's rights in

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<sup>224</sup> African Union 2003 available at <http://www.refworld.org/docid/3f4b139d4.html> (accessed 21 January 2014).

<sup>225</sup> Viljoen (2005) 134.

<sup>226</sup> Herrera & Viljoen (2014) 166.

<sup>227</sup> General Comments on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2012.

Africa.<sup>228</sup> The African Commission notes that women are discriminated against on grounds, such as, race, sex, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices, and/or religion.<sup>229</sup>

Though the General Comment does not refer to women in prisons, such women are at high risk of being discriminated against because they do manifest many of the characteristics mentioned by the African Commission. Measures to protect them must be intensified especially with regards to their health rights.

#### 2.9.3.3.2 Periodic Reports by States Parties

The DRC's Report for the period 2005 to 2015 notes that the Ministry of Women, Family and Children's Affairs takes the lead in implementing the Maputo Protocol.<sup>230</sup> One of the responsibilities of the Ministry includes that it collaborate with other Ministries on issues, such as health, in order to improve the status of women. This is important as women constitute a vulnerable group and their health and well-being may be affected by a myriad of circumstances. Collaboration between different Ministries thus speaks to this reality.

The DRC's Report also indicates that many 'legislative measures' have been introduced to prohibit and punish all forms of discrimination and harmful practices which undermine the health and the general well-being of women. These legislative measures are commendable and may ensure that women's right to health is protected. The DRC's Report also acknowledges that health problems have a distinctive effect on vulnerable and marginalised social groups such as women. This is so despite the fact that women account for the majority of the population of the DRC (52 per cent). According to the Report uneducated women

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<sup>228</sup> See para 2.

<sup>229</sup> See para 4.

<sup>230</sup> Report to the African Commission on Human and Peoples' Rights on the Implementation of the African Charter on Human and Peoples' Rights and of the Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women 2005-2015 44-45

(79.9 per cent) are more frequently confronted with health problems and an inability to pay for health care.

Rwanda noted in its Report to the African Commission that several strategies had been introduced to improve access to health care for women. These included the Universal Community Health Insurance scheme (*Mutuelle de santé*). The scheme makes quality health care affordable for the poor, especially women. Rwanda also sought to improve access and proximity to health services. This is particularly important as significant travel time to a health facility may in practice constitute a major hurdle to accessing health care. To limit the expense of travelling to health facilities the government has launched an intensive construction of health centres. The aim is to ensure that health facilities can be accessed within one-hour's walking distance. Additionally, it is envisaged that there would be at least one health centre at every administrative sector (*Umurenge*) which was achieved in 2015.<sup>231</sup>

The improvements reported by Rwanda can be applied to the prison sector. The problem of inaccessible health facilities or the inability to travel to such facilities must also be considered in respect of prisoners. States ought to embark on initiatives to ensure that prisoners have equal access to hospitals and other health facilities as free persons. The health care of prisoners is after all a responsibility of the State.

#### **2.9.3.4 Special Rapporteur on Prisons and Conditions of Detention in Africa**

The African Commission established the position of Special Rapporteur on Prisons and Conditions of Detention in Africa (SRP) in terms of Article 45 of the Charter.<sup>232</sup> In 1995 the

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<sup>231</sup> Periodic Report of the Republic of Rwanda 2009-2016 93.

<sup>232</sup> The African Commission on Human and Peoples' Rights 2013 available at <http://www.achpr.org/sessions/54th/resolutions/244/> (accessed 1 June 2014). Viljoen F, International Human Rights Law in Africa 2012 (2ed) 192.

African Commission adopted the Resolution on Prisons in Africa. This Resolution extended the rights in the African Charter to prisoners and detainees.<sup>233</sup> Arguably the position of inmates had not been considered as deserving of explicit protection during the drafting of the Charter. The position of the SRP is as a result a major milestone in the advancement of inmates' rights in Africa. However, the SRP is a part-time members of the African Commission and has Commission duties additional to their prison mandate.<sup>234</sup>

The SRP is empowered to examine the situation of detainees within the territories of States Parties to the African Charter.<sup>235</sup> States are required to consent to country visits and to give the SRP unfettered access to all detention facilities. This presents a limitation as States from which allegations of maltreatment of detainees come might not be agreeable to such visits.<sup>236</sup> The SRP appears to have a complex task of balancing a confrontational approach with a constructive dialogue with some States.<sup>237</sup>

In 2004 the SRP visited ten correctional centres in South Africa. It was found that with the exception of one correctional centre, all the others lacked adequate health staff and facilities.<sup>238</sup> At the time HIV/AIDS was a serious health burden for the correctional system.<sup>239</sup> The South African government was encouraged to increase budget allocations to prisons and to employ more personnel in the health sectors in prisons.<sup>240</sup> The 2004 mission report is invaluable in contextualising health care in the South African correctional setting.

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<sup>233</sup> African Commission on Human and Peoples' Rights (2012)3.

<sup>234</sup> Report of Special Rapporteur on Prisons and Conditions of Detention in Africa 19.

<sup>235</sup> Viljoen (2005) 126.

<sup>236</sup> Viljoen (2005) 394.

<sup>237</sup> Viljoen (2012) 396.

<sup>238</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa Mission to the Republic of South Africa (2004) 48.

<sup>239</sup> At 56.

<sup>240</sup> At 64.

Viljoen notes that there had been a noticeable decline in country visits after 2004.<sup>241</sup> This gives rise to serious concern as African prisons have a myriad of problems which impact negatively on the human rights of prisoners. Although Reports vary from country to country, the SRP's Reports 'have overwhelmingly called for additional resources to be dedicated to prisons'.<sup>242</sup> Though prison populations have increased over the years investments in prison systems do not match the prisoner numbers.<sup>243</sup> Systematic underfunding has therefore contributed to overcrowding in most prisons and in turn to the deterioration of conditions and treatment of prisoners. The SRP notes that this state of affairs has directly resulted in violations of prisoners' rights.<sup>244</sup> Prisoners also suffer from serious illnesses.<sup>245</sup>

In March 2001 the SRP visited prisons in Uganda.<sup>246</sup> It was reported that there are medical services in the prisons under the Ministry of Justice, but not in prisons that are managed by local government. Prisoners who are sick are therefore transported to the nearest public health centre. It was also reported that infirmaries receive monthly health supplies based on the statistics provided for the previous month. Such statistics are provided by the Health Department. The Report notes further that during the SRP visit it was noticed that some prisons that were situated very far from Kampala did not regularly collect medication. The SRP was informed that owing to high transport costs it was not always possible to collect the medication. The transport costs in fact often exceeded the costs of the medication.

The SRP furthermore reported that three-quarters of the medical staff in prisons are seconded by the Ministry of Health and that they are therefore not part of the prison administration

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<sup>241</sup> Viljoen (2005) 395.

<sup>242</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa 2012.

<sup>243</sup> See the Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa 2012.

<sup>244</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa *South Africa* 2012.

<sup>245</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa 2012.

<sup>246</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa Mission to Uganda (2001) 20.

staff. Due to poor working conditions many of them return to their department of origin. This issue arguably represent a major challenge to the provision of health care in prisons. The plight of prisoners in Uganda appeared to be even more serious when it is considered that there were no means of transport for sick prisoners in any of the prison health centres.<sup>247</sup> It is also of concern that most prison infirmaries, with the exception of model prisons, did not have adequate consulting rooms or lacked space for quarantine rooms in cases where a prisoner suffered from a contagious disease. In the light of a study on the causes of death in Ugandan prisons which found that between 1985 to 1995 tuberculosis was the main cause of death in prisons, the lack of quarantine rooms has proven to be fatal.<sup>248</sup>

The SRP reported that at the time of the visit HIV tests were no longer free of charge to prisoners. The cost of about US\$1 is still out of reach of most detainees. The SRP states that this explains why some people with AIDS are never tested. It is possible to conclude thus that many of these prisoners became terminally ill, that there was a lack of awareness of their health care needs, and that they had not received any treatment to palliate some of the symptoms. Considering also that medical officials acknowledge that 90 per cent of deaths that occur in prison are of remand detainees, and that 50 per cent of these occur within the first year following admission it is possible that most of these prisoners had not even received basic health assessments.

The problems with regard to health care in Ugandan prisons appear to be significant. Inadequate medical staff, and lack of infrastructure, supplies and medication are further exacerbated by problems with appropriate nutrition for persons who require it. In the absence

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<sup>247</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa Mission to Uganda (2001) 21.

<sup>248</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa Mission to Uganda (2001) 21.

of regular, free health assessments and HIV tests, the suffering of prisoners and particularly those who are terminally ill, will continue. The SRP therefore made the following recommendations: prisons health budgets should be increased; an effective distribution strategy should be developed to ensure prisoners receive their medication; infirmaries should be refurbished and adequate medical equipment should be acquired; more staff should be employed; AIDS education programmes should be strengthened; and necessary resources must be available to deal with medical emergencies.<sup>249</sup>

The SRP visited and inspected nine prisons, two prison farms and two police stations in five regions of Ethiopia.<sup>250</sup> The report indicates that Article 27 of Proclamation No. 365 of 2003 provides that the government is responsible for the welfare and health of the prisoners. The Report also indicates that all the prisons have clinics that offer first aid treatment to prisoners and that more serious medical problems that cannot be dealt with by the clinics are referred to nearby hospitals. In the Addis Ababa Prison, there is a clinic in each of the six zones of the prison and another bigger clinic for more serious problems. Apart from the Addis Ababa Prison, all the other prisons have very few medical facilities. There are also limited medicines in the dispensaries and none has a resident doctor or even a visiting doctor.

In the Arba Minch Prison, for example, there is a quota of eight inmates that can be sent to hospital each day. This quota cannot be exceeded as it is imposed by the hospital authorities. This is necessitated by the fact that there is also a quota on the number of patients each doctor can attend to, and furthermore the government does not provide the hospital with a separate

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<sup>249</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa Mission to Uganda (2001) 40-41.

<sup>250</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa Mission to the Federal Republic of Ethiopia (2004) 28.



budget for the treatment of prisoners. The most common diseases in prisons are TB and HIV/AIDS.

Given the problems outlined above the SRP recommended that the prison budget be increased to ensure that prisoners are given basic necessities. The SRP also encouraged oversight of prison conditions. Government officials, non-governmental organisations and human rights institutions should visit the prisons regularly. The problem of overcrowding in prisons should also be addressed.<sup>251</sup>

#### 2.9.3.5 Recommendation of the SRP: Support networks and the right to health care

The SRP has recommended that States Parties should pay special attention to vulnerable prisoners and that non-governmental organisations should be supported in their work with these prisoners.<sup>252</sup> Despite the fact that many organisations do support prisoners, there are widespread reports that such organisations are frequently confronted with unreasonable restrictions on access to prisoners and the services they may offer to them.<sup>253</sup> Such restrictions may have a profound impact on terminally ill prisoners as human contact and care can be very important for upholding their dignity.

#### 2.9.3.6 Selected Resolutions on health in Africa

The devastating impact of diseases like malaria, tuberculosis and HIV/AIDS and the obligation on governments to protect the rights of citizens have spurred the adoption of a number of health related Resolutions in Africa. Below only a selected few of these Resolutions are discussed. These Resolutions focus mainly on serious diseases.

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<sup>251</sup> At 47.

<sup>252</sup> Report of the Special Rapporteur on Prisons and Conditions of Detention in Africa 2012: 23.

<sup>253</sup> Tapscott (2008) 80.

The Heads of States and Governments of Africa adopted the 2000 and 2001 Abuja Declarations and Action Frameworks which obligate African Union Member States to eradicate and mitigate the progression of diseases in Africa.<sup>254</sup> In 2006, the ‘Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa’ renewed commitment to effectively implement the Abuja Declarations and Action Frameworks. In short a monitoring and reporting mechanism was developed for the purpose of tracking progress in each country.<sup>255</sup>

Despite progress with regards to *inter alia* preventing and treating HIV and AIDS, tuberculosis treatment and the reduction of malaria-related deaths, few African countries have increased health budgets to the 15 per cent recommended threshold by the Abuja Declaration.<sup>256</sup> Consequently, only 45 per cent of persons eligible for antiretroviral treatment have access to it in Africa. Moreover, compliance with requests to report on country progress is very low and poses a real risk to the strengthening of health systems.<sup>257</sup>

The Resolution on Access to Health and Needed Medicines in Africa<sup>258</sup> states that essential medicines were only available in 38 per cent of all health facilities in Africa between 2001 and 2007.<sup>259</sup> As access to medicines is an important part of the right to health, it is imaginable that many people on the continent have probably not had their basic health needs met.

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<sup>254</sup> Tuberculosis and Malaria Services Progress Report 2013. In 2001 at the time of the Abuja Declaration, African governments undertook to allocate at least 15 per cent of their annual budgetary allocations to their health sector. African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases 2001.

<sup>255</sup> Tuberculosis and Malaria Services Progress Report 2013 Executive Summary.

<sup>256</sup> Tuberculosis and Malaria Services Progress Report 2013 Executive Summary.

<sup>257</sup> Tuberculosis and Malaria Services Progress Report 2013 Executive Summary.

<sup>258</sup> ACHPR/Res 141 (XXXXVIII) 08.

<sup>259</sup> According to Durojaye, E and Mirugi-Mukundi G ‘States’ obligations in relation to access to medicines: Revisiting Kenyan High Court Decision in P.A.O and Others v Attorney-General and Another’ (2013) 13 *Law, Democracy and Development* 25, a great percentage of those in need of medicines are not receiving them.

## 2.10 'SOFT LAW' AIMED AT THE PROTECTION OF PRISONERS' RIGHT TO HEALTH CARE

### 2.10.1 Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules)

In December 2015 the United Nations General Assembly adopted the revised Nelson Mandela Rules.<sup>260</sup> These Rules had originally been adopted in 1957. Rules 24, 25 and 27 if properly implemented will arguably have a positive impact on the plight of terminally ill prisoners.<sup>261</sup> Rule 24 states that the health care of prisoners is a State responsibility and that such care must be of the same standard as in communities. It is further provided that access to necessary health-care services must be offered free of charge without discrimination on the grounds of legal status.

Rule 24(2) addresses the problem(s) associated with the transient nature of imprisonment and their impact on health in communities. It aptly provides that health-care services should be organised in close association with the general public health administration to ensure continuity of treatment and care. Furthermore, Rule 25 requires that every prison should have in place a health care service to evaluate, promote, protect and improve the physical and mental health of prisoners. Particular attention should be paid to special health care needs. This Rule may ensure that many of the hurdles to terminally ill prisoners' health care are uncovered and addressed.

Rule 25(1) states that health care services in prisons should consist of an interdisciplinary team with sufficient qualified personnel acting with full clinical independence. This is important as terminally ill prisoners may require an array of health services to ensure that their dignity is upheld. Rule 27 requires that prisons shall ensure prompt access to medical

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<sup>260</sup> See Mandela Rules adopted for prisoners, 25 May 2015 available at <http://www.southafrica.info/news/mandela-rules-250515.htm#.VXhW3TCqHw#ixzz3cfoDI4Xe> (accessed 12 June 2015).

<sup>261</sup> Commission on Crime Prevention and Criminal Justice 2015.

attention in urgent cases. Additionally, prisoners who require specialised treatment or surgery should be transferred to institutions or civil hospitals. Prisons with health care facilities must be adequately staffed and equipped to ensure that prisoners receive appropriate treatment and care. Rule 127(2) stipulates that clinical decisions may only be taken by the responsible health care professionals and may not be overruled or ignored by non-medical prison staff. These rules are to the benefit of all prisoners. Terminally ill prisoners in particular ought to benefit substantially if States implement these rules.

#### 2.10.2 United Nations Rules for the Treatment of Women Prisoners and the Non-custodial Measures for Women Offenders (Bangkok Rules)

Rule 6 of the Bangkok Rules<sup>262</sup> requires that health screening should be comprehensive to determine the primary health care needs of prisoners. Rule 14 provides that in developing HIV prevention, treatment, care and support services, penal institutions shall be responsive to the specific needs of women. Apparently these rules may be relied upon to uphold women prisoners's right to health care if they are terminally ill.

#### 2.11 CONCLUSION

This Chapter demonstrates that international instruments that are binding do not deal with the issue of terminal illnesses in relation to prisoners. Despite this, there appears to be global awareness that such illnesses affect certain groups such as the elderly. This is evidenced by examples, such as, the Vienna Plan of Action on Ageing; the Recommendation 1418 of 1999 of the Parliamentary Assembly of the Council of Europe, entitled Protection of Human Rights and Dignity Terminally Ill and the Dying; and more recently, the adoption of the World Health Assembly Resolution on Strengthening Palliative Care. In the face of this vacuum insofar as prisoners are concerned, cognisance ought to be taken of the principles that

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<sup>262</sup> UN General Assembly, *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules): note / by the Secretariat*, 6 October 2010, A/C.3/65/L.5, available at <http://www.refworld.org/docid/4dcbb0ae2.html> (accessed 22 January 2014).

prisoners ought not to be subjected to hardships and constraints beyond those which result from their detention and that respect for their dignity must be guaranteed under the same conditions as those of free persons. These principles were upheld by the European Court of Human Rights in *Dybeku* and the HRC in its General Recommendations. Additionally, the African Commission in *International Pen and Others (on behalf of Saro-Wiwa) v Nigeria* held that prisoners depend on the state for their well-being.

Importantly, it appears from most of the country Reports discussed in this Chapter that there is an acceptance that the state is responsible for the provision of health care services to prisoners. Where such services are not available in the prison system, prisoners should be afforded access to the same health facilities as free persons. This may arguably give effect to their dignity and may assist in reintegrating them into society as law-abiding citizens. In the African countries discussed, prisoners often experience that they cannot access public health facilities due to understaffing in the prison system and lack of transport. Though these problems may not be solved instantly, efforts must be made to improve prisoners' access to outside health facilities as recommended by the SRP.

The abovementioned principles can be bolstered by the CRPD's finding in 2014, discussed earlier, that States Parties have a duty to ensure that prison authorities make adjustments in prisons to accommodate prisoners with disabilities on an equitable basis with others. This finding makes it reasonable to infer that terminally ill prisoners should also be suitably accommodated. Furthermore, the cases of persons on death row, for example, *Henry and Douglas v Jamaica*, demonstrate that the physical conditions of prisons must be conducive to prisoners' needs. In *Pinto v Trinidad and Tobago* and *Leslie v Jamaica*, too, it was held that even prisoners on death row must be afforded adequate health care. On the basis of these

cases it cannot be easily refuted that constant efforts must be made by States to ensure that prisoners have equal access to health care as other citizens and that prison conditions give effect to prisoners' right to dignity. Any contention that the foreseeability of a prisoner's death in the near future renders him ineligible for reasonable health care measures can therefore not be accepted.

Based on international jurisprudence it may be reasonably argued that appropriate health care must be provided when required by a prisoner. Examples of such jurisprudence include the CRPD's finding, discussed in this Chapter, which required that a prisoner be afforded suitable and timely health care consistent with his actual health status. The African Commission in *Media Rights Agenda and Others* also confirmed that detainees should be granted access to health care when they need it. Further, the HRC has urged States Parties to take urgent measures to protect prisoners' right to health. The European Committee of Social Rights has similarly held that access to treatment must not be unnecessarily delayed and that criteria for access must be transparent. A patient's quality of life should also be considered in this regard. Arguably the application of these principles may assist in addressing the plight of terminally ill prisoners whose physical condition may necessitate urgent access to health care to enhance their quality of life and address their symptoms. Furthermore, States Parties ought to adopt laws and measures to protect the right to health of vulnerable persons. This principle, upheld in *Alban-Cornejo et al*, may greatly assist the plight of terminally ill prisoners.

Apart from access to public health facilities where prisons do not offer appropriate health care, and avoiding delays in accessing such facilities, prison authorities should ensure that prisoners are given appropriate nutrition consistent with their health needs. This may

contribute to better health care. Furthermore, prisoners must be afforded quality medications. As seen in relation to mothers with children in prison, special provision can be made for vulnerable persons in the prison system.

In the *Andrea Mortlock v United States of America* as well as in *D v The United Kingdom*, the fact that the deportation of the detainee would have exposed him to an inferior health system in his country of origin, was accepted as a powerful humanitarian ground to avoid such deportation. These cases demonstrate the extent of the measures that may be employed to protect the right to health of terminally ill prisoners. Arguably such measures may even include the earlier release of prisoners where reasonable health care cannot be afforded within the prison health care system.

In conclusion, the principles outlined above may to some extent serve as the basis for addressing the plight of terminally prisoners. However, awareness of the existence of terminally ill prisoners in correctional environments is crucial to highlight their common challenges and uphold their right to health care. Moreover prison issues, such as the meaning of terminally ill prisoners' right to health care, should feature more prominently on the agendas of the international and regional enforcement bodies.

## CHAPTER 3

### THE MEANING OF THE RIGHT TO HEALTH IN SOUTH AFRICA

‘My notion of democracy is that under it the weakest should have the same opportunity as the strongest.’ -Mahatma Gandhi (1869-1948)<sup>1</sup>

#### 3.1 INTRODUCTION

The right to health care in international law does not guarantee the realisation of the same health entitlements for everyone everywhere. The domestic legal framework and available resources of a State significantly affect an individual’s enjoyment of the right. The question of what the right to health care means for terminally ill inmates in South Africa thus necessitates a discussion of the right to health in terms of the constitutional and statutory framework. Furthermore, legal principles which apply to terminally ill inmates are highlighted. Logically, though, it is necessary to briefly trace the historical landscape against which the current South African health system came into existence.

#### 3.2 THE ROOTS OF THE MODERN SOUTH AFRICAN HEALTH CARE SYSTEM

It is not possible to provide an in-depth or exhaustive account of the development of the South African health care system here. Only some of the main events and developments are therefore highlighted.

At the outset it may be mentioned that the South African health system was historically characterised by fragmentation<sup>2</sup>, inequality and responses to various health pandemics. Fortunately, more than two decades after the democratisation of South Africa, laws from the

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<sup>1</sup> See <http://www.parliamentarystrengthening.org/humanrightsmodule/2/2a.html> (accessed 15 June 2014).

<sup>2</sup> Ngwena, C ‘Equity and the development of the South African Health Care System: From the Public Health Act of 1919 to the Present Day *Fundamina* 2003 (9) 127.



eras of colonialism, segregation (1910 – 1948) and the Apartheid regime (1948 to 1994) no longer exist. These different eras will be discussed below to highlight some of the significant contributions to the current South African health care system.

### 3.2.1 Colonialism in South Africa

The first health care legislation reportedly came into force in 1807, when the Supreme Medical Committee was established to oversee health matters.<sup>3</sup> In 1830, Ordinance 82 which allowed for the regulation of all health practices in the Cape Colony was passed and replicated by the other three colonies.<sup>4</sup> In 1883 the Public Health Act came into force as a response to the smallpox epidemic, and in 1897 the Public Health Amendment Act was introduced to separate curative and preventative care.<sup>5</sup> By the mid-1800s there were hospitals in most major centres of South Africa, but missionaries were mainly responsible for the provision of health care to Black South Africans.

### 3.2.2 Segregation before 1948

In 1910 the South Africa Act of 1909 created the Union of South Africa. Unification ‘merely effected a transfer of colonial powers and duties to provincial authorities’ and the ‘provision of health care remained fragmented, with no central authority to formulate and co-ordinate policy’.<sup>6</sup> Furthermore, health care remained mainly the responsibilities of individuals and families.<sup>7</sup> The 1918 influenza epidemic which resulted in approximately 142 000 deaths

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<sup>3</sup> Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre ‘The health and health system of South Africa: historical roots of current public health challenges’ (2009) 374 *The Lancet* 820.

<sup>4</sup> Coovadia H *et al* (2009) 820.

<sup>5</sup> Coovadia H *et al* (2009) 820.

<sup>6</sup> Ngwena C (2003) 127.

<sup>7</sup> Ngwena C (2003) 128

highlighted the need for the State to assume primary responsibility for the provision of health care services.<sup>8</sup>

The Public Health Act of 1919 was passed with the intention to replace colonial legislation.<sup>9</sup> This enactment created a tripartite system which sanctioned discrimination in the provision of health care along racial lines and marked the beginning of the modern health care system in South Africa.<sup>10</sup> Between 1942 and 1944 the Gluckman Commission advocated for a unitary national health service. Thus, when Gluckman became Minister of Health in 1945 several community health centres were set up. These centres were the precursors of community-based primary health care.<sup>11</sup>

### 3.2.3 Apartheid (1948 – 1993)

In 1948, the Apartheid policy consolidated the injustices of the preceding 300 years.<sup>12</sup> All South Africans were subjected to racial classification and an individual's specific classification as either White, Indian, Coloured or Black dictated the resources allocated to their health care. Under Apartheid, Bantustans, which operated independently from one another, were created. There were 14 separate health departments in South Africa at the end of Apartheid.<sup>13</sup> Moreover, overcrowded informal settlements, poverty, and the migrant labour system which disrupted family structures and exposed workers to a myriad of health risks and inadequate health services prevailed for the majority of Black South Africans. These conditions were conducive to the spread of tuberculosis and sexually transmitted diseases.<sup>14</sup>

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<sup>8</sup> Ngwena C(2003) 128.

<sup>9</sup> Ngwena C (2003) 127.

<sup>10</sup> Ngwena C (2003) 127.

<sup>11</sup> Coovadia H *et al* (2009) 825.

<sup>12</sup> Coovadia H *et al* (2009) 817.

<sup>13</sup> Coovadia H *et al* (2009) 825.

<sup>14</sup> Abdool Karim S, Churchyard G, Abdool Karim Q, Lawn S 'HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response' (2009) 374 *The Lancet* 921.

Homosexual men were the first persons diagnosed with AIDS, but the Apartheid government did not address the impact of the disease on the affected individuals.<sup>15</sup> Contrarily, when in the early 1980s approximately 100 patients with hemophilia were diagnosed with HIV and presumably had been infected by contaminated blood, the government set up a fund to compensate the 'innocent victims'.<sup>16</sup> The moral judgement as to who can be categorised as innocent victims and who had received their just deserts for their immoral behaviour affected the Apartheid government's subsequent approaches to the disease.<sup>17</sup> In 1986 there were only three out of 29 312 mine workers who had been identified as HIV-positive.<sup>18</sup> They were not South African and were forcibly repatriated. Later, the Apartheid government introduced a policy to prohibit HIV-positive migrant workers from entering South Africa. Despite these measures there was an exponential increase in the prevalence of HIV between 1990 and 1994.<sup>19</sup>

Nurses played an important role in offering health services to communities. However, from the 1950s, there emerged widespread reports of abusive behaviour by nurses towards their patients.<sup>20</sup> As a result the challenge to improve relationships between nurses and patients remains even during the era of constitutionalism.<sup>21</sup> Some argue that the negative image of nurses may be attributed to their training which had been regarded as a socialisation process in terms of which they had been 'groomed as middleclass elite' tasked to 'moralise and save the sick and not simply nurse them'.<sup>22</sup>

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<sup>15</sup> Abdool Karim S *et al* (2009) 921.

<sup>16</sup> Abdool Karim S *et al* (2009) 921.

<sup>17</sup> Abdool Karim S *et al* (2009) 921.

<sup>18</sup> Abdool Karim S *et al* (2009) 921.

<sup>19</sup> Abdool Karim S *et al* (2009) 921.

<sup>20</sup> See Health Systems Trust 'South African Health Review 2017' 20(ed) 4.

<sup>21</sup> Coovadia H *et al* (2009) 829.

<sup>22</sup> Coovadia H *et al* (2009) 829.

After 1994, the maldistribution of staff, poor skills and the staffing crises<sup>23</sup> impacted on the delivery of important health programmes.<sup>24</sup> While a considerable portion of the health budget had been allocated to human resources the effects of inadequate staffing was felt at the district level.<sup>25</sup> Policy decisions which allowed public sector staff to take voluntary severance packages also resulted in many highly skilled health professional staff moving out of the public sector to pursue opportunities in the private sector or with international agencies.<sup>26</sup>

After 1994 the new government created a single national health department and nine provincial health departments, all health facilities were desegregated and health policy provided that primary health care would be delivered by a district health system. Primary health care became available free of cost to users. New laws were passed to *inter alia* make the health professional councils more representative of the South African population, and to create a new medicines regulatory body.<sup>27</sup>

The above discussion serves only to briefly contextualise the current health system. This is important as prisoners should be afforded access to the public health system as will be evident below.

### 3.3 THE RIGHT TO HEALTH IN THE SOUTH AFRICAN CONSTITUTION

The South African Constitution confers a right to have access to health care services to ‘everyone’ (section 27(1)(a)) and a right to medical services at State expense to detained

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<sup>23</sup> Mokoka, E, Oosthuizen, V, Ehlers V 'Retaining professional nurses in South Africa: Nurse managers' perspective' *Journal of Interdisciplinary Health Sciences* 2010 (15) <http://www.hsag.co.za/index.php/HSAG/article/view/484/531>(accessed 8 November 2017)..

<sup>24</sup> Coovadia H *et al* (2009) 829.

<sup>25</sup> Coovadia *et al* (2009) 829.

<sup>26</sup> Ogilvie L, Mill J, Astle B, Fanning A and Opare, M ‘ The exodus of health professionals from sub-Saharan Africa: balancing human rights and societal needs in the twenty-first century *Nursing Inquiry* 2007 14(2)114-124. See also Bateman, C, ‘Legislating for nurse/patient ratios ‘clumsy and costly’ – experts’ (2009) 99 *South African Medical Journal* 566 – 568.

<sup>27</sup> Abdool Karim S *et al* (2009) 921

persons and sentenced inmates (section 35(2)(e)). These sections of the Constitution will be discussed respectively below.

### 3.3.1 The right to health care of ‘everyone’: Section 27 of the Constitution

In South Africa, the State has both a negative and positive obligation to protect the right to health care. The negative obligation entails that the right may not be subjected to ‘deliberate retrogressive measures,’ such as, denying individuals their existing access to resources or preventing them from utilising resources at their disposal to satisfy their health needs.<sup>28</sup> Currie and De Waal state that a law prohibiting the purchase of anti-retroviral drugs by HIV-positive people is an example of the direct negative infringement of the right to health care.<sup>29</sup> The positive obligation to fulfil socio-economic rights is made subject to progressive realisation. This is evident from section 27(2) of the Constitution which provides that the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. The progressive realisation of the right to health will be discussed later in this Chapter.

Before section 27 is discussed it is necessary to consider that the section applies to everyone regardless of whether or not they are terminally ill persons who are free or imprisoned. The thesis may therefore evoke the question why there should be a specific focus on terminally ill prisoners. This question is answered in part below as it must be understood that terminal illnesses *per se* affect the South African society and that the protection of individuals’ right to health is essential. In the Chapters 4,5 and 6 it becomes clearer why the position of terminally ill prisoners warrants a concerted focus.

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<sup>28</sup> Currie I & De Waal J *The Bill of Rights Handbook* (2013) 6ed 568.

<sup>29</sup> Currie I & De Waal J (2013) 568.

### 3.3.1.1 Why the focus on the constitutional right to health care of persons who are terminally ill?

Most people are not able to foretell the conditions that will precede their demise. Discussions about terminal illnesses are therefore not a popular subject amongst the public. Despite the daunting and sensitive nature of contemplating the issues relevant to terminal illness, it is important to realise that if human beings are to

‘retain the self-consciousness and self-respect that is the greatest achievement of our species, [we] will let neither science nor nature simply take its course, but will struggle to express, in the laws [we] make as citizens and the choices [we] make as people, the best understanding [we] can reach of why human life is sacred, and of the proper place of freedom in its dominion.’<sup>30</sup>

Arguably the rationale for the inclusion of an unqualified right to life and dignity in the Constitution may be substantially attributable to the recognition of the sanctity of human life. It furthermore impels the State to take cognisance of, and to address, issues affecting the quality of citizens’ lives. In doing so, the State ought not to overlook the legal position of terminally ill persons who require support to maintain their dignity. This can arguably be achieved by defining the care, services and support that they are entitled to (or not) by virtue of their right to health. The starting point, however, is to gain insight into the extent to which the phenomenon of terminal illness affects South African society.

It is estimated that of the 58 million people who die every year, 35 million will experience a prolonged, advanced illness.<sup>31</sup> Unfortunately South Africa is not exempt from this reality. The impact of the HIV/AIDS pandemic and predictions by the Cancer Association of South Africa that ‘. . . within half a century, the number of annual cancer diagnoses in South Africa

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<sup>30</sup> Dworkin R *Taking rights seriously* (1978) 2ed 241.

<sup>31</sup> Stjernsward, J Foley, K, Frank D, Ferris, M ‘The Public Health Strategy for Palliative Care’ (2007) *Journal of Pain and Symptom Management* 487.

could soar from approximately 100 000 to half a million<sup>32</sup> cannot be overlooked by the State. Moreover, the WHO estimated that South Africa had 500 000 cases of active tuberculosis in 2011 and has stated that this is worldwide the third highest number of tuberculosis cases after India and China.<sup>33</sup> Additionally, of the 500 000 tuberculosis cases, WHO estimates that 330 000 (66 per cent) are also HIV-positive.<sup>34</sup> Tuberculosis thus ‘continues to be the leading cause of death in South Africa’ with an estimated 25 000 deaths from tuberculosis in 2011.<sup>35</sup> This figure excludes persons who had both tuberculosis and HIV when they died as such persons are internationally considered to have died of HIV.<sup>36</sup> In 2015, tuberculosis caused the death of more than 33 000 people in South Africa, according to Statistics South Africa.<sup>37</sup>

Illnesses like cancer, tuberculosis and HIV infection are not necessarily conditions that render patients terminally ill. Though HIV is currently incurable, the illnesses such as some types of tuberculosis for example, which may develop as a result of such HIV infection may be preventable and curable. Some may thus contend that the state should focus resources on the curing and prevention of these illnesses. While it is not objectionable that resources should be used to cure and prevent illnesses where possible, it cannot be overlooked that such conditions can become incurable even in cases where curative and preventative health services had been provided to patients. The potential for terminal illnesses to develop is therefore real. Health care services should thus not be solely targeted at recovery and

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<sup>32</sup> Caring the hospice way available at [http://www.health24.com/medical/Condition\\_centres/777-792-4394-4395,42398.asp](http://www.health24.com/medical/Condition_centres/777-792-4394-4395,42398.asp) (accessed 7 August 2012).

<sup>33</sup> TB Statistics for South Africa available at [www.tbfacts.org/tb-statistics-south-africa.html](http://www.tbfacts.org/tb-statistics-south-africa.html) (accessed 1 August 2013).

<sup>34</sup> TB Statistics for South Africa available at [www.tbfacts.org/tb-statistics-south-africa.html](http://www.tbfacts.org/tb-statistics-south-africa.html) (accessed 1 August 2013).

<sup>35</sup> TB Statistics for South Africa available at [www.tbfacts.org/tb-statistics-south-africa.html](http://www.tbfacts.org/tb-statistics-south-africa.html) (accessed 1 August 2013).

<sup>36</sup> TB Statistics for South Africa available at [www.tbfacts.org/tb-statistics-south-africa.html](http://www.tbfacts.org/tb-statistics-south-africa.html) (accessed 1 August 2013).

<sup>37</sup> ‘Tuberculosis still the leading cause of death, says Stats SA’ *The Citizen* 28 February 2017 available at <https://www.google.co.za/amp/amp.citizen.co.za/news/south-africa/1442581/tuberculosis-still-leading-cause-death-says-statssa> (accessed 1 March 2017). See also Health Systems Trust (2017) 160 where it is stated that prisoners are at high risk of drug-resistant tuberculosis.

prevention, but must also afford care and treatment that are palliative in nature. (Palliative care as an aspect of the right to health care will be discussed in Chapter 6).

In summary the sanctity of human life finds expression in and commands concretisation of the absolute rights to life and dignity in the South African Constitution. This entails that laws must give effect to the enhancement of the quality of citizens' lives. Those who are terminally ill cannot be excluded in this regard. Their right to life and dignity of necessity demands that their *right* to health care be given legal meaning.

### 3.3.1.2 The progressive realisation of section 27: The relevant domestic jurisprudence

In *Soobramoney v Minister of Health (KwaZulu-Natal)* the Constitutional Court had the opportunity to define the right to health care of terminally ill persons. A terminally ill patient in the final stages of renal failure claimed that he was legally entitled to access a renal dialysis programme at a public hospital.<sup>38</sup> The applicant's claim was based on *inter alia* the right to life (section 11) and the right to emergency medical treatment (section 27(3)) of the Constitution. Based on the hospital's guidelines, he did not qualify for treatment because he was not a suitable candidate for a kidney transplant.

The Court dismissed the argument that the right to emergency medical treatment together with the right to life entitles everyone to life-saving treatment at State expense where a patient is unable to afford private treatment.<sup>39</sup> It was held that such an interpretation would result in the prioritisation of tertiary health care treatment of terminal illnesses over

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<sup>38</sup> *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).

<sup>39</sup> Moellendorf D 'Reasoning about resources: *Soobramoney and the future of socio-economic rights claims*' (1998) 14 *SAJHR* 327, observed that a right to life includes a duty not to interfere and a claim against those who do interfere or would interfere with life, but not a duty to provide 'the sustenance of life'.



preventative health care and treatment of non-life-threatening conditions.<sup>40</sup> The Court held that section 27(3) does not extend to those with chronic illnesses and who therefore require continuous treatment aimed at prolonging life.

Whilst the Court's interpretation of section 27(3) cannot be criticised in its entirety, it appears to have created a hierarchical approach to health care in South Africa. Preventative health care and treatment of non-life-threatening illness appears to be far more important than treatment for life-threatening conditions. Such an approach seems discriminatory in that it suggests that the needs of those who are healthy or capable of attaining a reasonable standard of health are more important than those of persons who are terminally ill. The judgment impacts negatively upon the dignity of persons who cannot benefit optimally from preventative care or non-life-threatening treatment.

The Court indicated that the applicant's claim had to be determined in terms of sections 27(1) and (2) which affords everyone a limited right to health care services.<sup>41</sup> The Court thus considered whether the State's plan for the provision of renal dialysis treatment was reasonable within the available resources. It was held that sections 27(1) and (2) entitle everyone to have access to health care services provided by the State within its available resources.<sup>42</sup> The Court ultimately found that the State's plan was reasonable given the limited resources available and that granting the applicant and persons in a similar position access to it would disrupt the State's carefully crafted plan.

Liebenberg correctly notes that the Court in *Soobramoney* paid negligible attention to defining the substantive content of the right of everyone to have access to health care

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<sup>40</sup> *Soobramoney* para 19.

<sup>41</sup> *Soobramooney* para 22.

<sup>42</sup> *Soobramooney* para 22.

services.<sup>43</sup> She also refers with approval to the observation that the ‘ . . . implication of confining the scope of the right solely to budgetary allocations is that government’s budgetary decisions will be allowed to determine the content of rights, instead of our constitutional commitment to human rights norms and values guiding economic policy’.<sup>44</sup>

Moellendorf emphasises that section 27(2) of the Constitution limits the ‘reasonable pursuit’ of socio-economic rights by requiring that measures to realise such rights be taken within the State’s available resources.<sup>45</sup> There are, however, two possible constructions of ‘available resources’. A narrow interpretation refers to the resources allocated to a department and which the department has budgeted for the protection of the right. A broader interpretation may mean ‘any resources that the State can marshal to protect the right’.<sup>46</sup> Moellendorf is of the view that the Court in *Soobramoney* had adopted a narrow interpretation of the concept ‘available resources’.<sup>47</sup>

The narrow interpretation of ‘available resources’ is contrary to the Court’s finding in the *Certification* case where it was confirmed that the recognition of socio-economic rights may result in courts making orders with budgetary implications.<sup>48</sup> It was held that even if a court makes orders to enforce civil and political rights, such orders may still have budgetary implications for the State.<sup>49</sup> The Court gave the example of a court order that State benefits be extended to a class of persons who did not previously enjoy such benefits.<sup>50</sup> There thus

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<sup>43</sup> Liebenberg S *Socio-Economic Rights: Adjudication under a transformative constitution* (2010) 139.

<sup>44</sup> See Liebenberg S (2010)140 fn 6. See also Moellendorf (1998) 332.

<sup>45</sup> Moellendorf (1998) 330.

<sup>46</sup> Moellendorf (1998) 330.

<sup>47</sup> Moellendorf (1998) 331.

<sup>48</sup> Moellendorf (1998) 331.

<sup>49</sup> *In re: Certification of the Constitution of the Republic of South Africa, 1996* 1996 (4) SA 744 (CC) para 77.

<sup>50</sup> *In re: Certification of the Constitution of the Republic of South Africa* para 77.

seems to have been an acknowledgement that the judiciary will at times have to grant orders which may impact on the State's fiscal priorities.

Moellendorf's contention that the Court's approach in the *Certification* case is more preferable than the finding in the *Soobramoney* judgment can be supported. The approach in the former case is appropriate if socio-economic rights are to have the same status as civil and political rights.<sup>51</sup>

It is evident from the discussion above that substantial emphasis was placed on the availability of resources in interpreting the right to have access to health care services. Admittedly, dialyses treatment for all persons in the applicant's position might have had significant budgetary implications for the State. However, in accordance with the Court's duty to uphold the dignity of the applicant and all similarly placed persons, it could have offered a more balanced approach to interpreting the right to health than dismissing the claim mainly due to an interpretation of the right to health which hinged almost exclusively on resource limitations.

Arguably, an approach which acknowledged that resource limitations would have an impact on giving effect to terminally ill person's right to health, but that nevertheless proceeded to define the right in terms that fully recognised the values of dignity and equality, would have sufficed. This is not to say that there should be no limitations on the right to health. The Court should at least have given meaningful expression to what the limitations of the right are; instead the judgment suggests that persons who are terminally ill cannot receive expensive treatment at State expense where such treatment is aimed at prolonging a patient's life.

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<sup>51</sup> Moellendorf (1998) 331.

The Court could have avoided this message by cautioning that though the claim of the applicant could not be upheld, his dignity can be upheld by a formal plan to ensure suitable and affordable treatment. The Court needed not to have been prescriptive about what such plan should entail, but guidance that made it clear that terminally ill patients do have a right to health care and that their dignity must be respected despite resource constraints would have made the judgment more valuable.

The right to access health care entitles persons to much more than conventional medical treatment. It guarantees access to the underlying determinants of health.<sup>52</sup> Moreover persons who are terminally ill may require medication to palliate and/or prevent various symptoms including pain and discomfort. The *Soobramoney* judgment could have been valuable if it had made it clear that the right to health care services includes the right of access to medicines that are affordable and that the State has an obligation to promote access to medicines that are affordable. Due to the Court's omission these principles were only confirmed almost a decade later in *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others*.<sup>53</sup>

The *Government of the Republic of South Africa and Others v Grootboom and Others*<sup>54</sup> was heard after the *Soobramoney* judgment. The *Grootboom* case did not involve the right to have access to health care. The claimants relied on section 26(1) of the Constitution which affords everyone the right to have access to housing. Like section 27(1), section 26(1) also gives rise to a limited right. Furthermore, section 26(2), like section 27(2), provides that the State must fulfil its obligation by taking 'reasonable legislative and other measures, within its available resources, to achieve the progressive realisation' of the right.

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<sup>52</sup> The underlying determinants of health include food, nutrition, housing, access to safe and potable water and adequate sanitation, safe and health working conditions, and a health environment. See CESCR General Comment No 14 2000 para 4.

<sup>53</sup> 2006 (2) SA 311 para 514.

<sup>54</sup> 2001 (1) SA 46 (CC).

In *Grootboom* the Constitutional Court found that the State's housing programme was unreasonable. It violated the right to have access to housing, because it did not address the plight of those who were desperate and destitute. The Court confirmed that the State is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing.<sup>55</sup> The Court's approach to the interpretation of socio-economic rights in *Grootboom* seems vastly different to, and more progressive than, that in the *Soobramoney* case. In the latter case the Court made no comment about a reasonable plan to give effect to the rights of the most desperate, such as terminally ill persons.

The *Minister of Health and Others v Treatment Action Campaign (TAC) and Others (No2)*<sup>56</sup> was heard two years after the *Grootboom* judgment. It was argued on behalf of the TAC that the State unreasonably prohibited the administration of Nevirapine, an antiretroviral drug, which reduces *intrapartum* mother-to-child transmission of HIV. Nevirapine was only administered at two pilot sites per province.<sup>57</sup> It was also argued that the State failed to create and implement a comprehensive national programme for the prevention of mother-to-child HIV transmission and that this constituted a violation of the right of everyone to have access to health care services.<sup>58</sup> The Court made a declaratory and mandatory order against the Government. The Court indicated that the applicant's claim had to be determined in terms of section 27(1).

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<sup>55</sup> *Grootboom* para 24.

<sup>56</sup> 2002 (5) SA 721 (CC).

<sup>57</sup> *Treatment Action Campaign (No2)* para 10 and 11.

<sup>58</sup> In the section on the history of the South Africa health system it was mentioned that the Apartheid State adopted a judgemental approach towards the first persons diagnosed with AIDS. It appears that the democratic government's initial approach towards HIV-positive pregnant women was not dissimilar to that taken by the Apartheid government. It seems that only infants and not their mothers were viewed as 'innocent victims'. See Abdool Karim *et al* (2009) 922.

It was argued on behalf of the TAC that section 27(1) has a minimum core to which every person in need is entitled.<sup>59</sup> The ‘minimum core’ concept was developed by the ESCR Committee. The Court, however, held that the socio-economic rights in the Constitution do not entitle everyone to demand that a minimum core be provided to them.<sup>60</sup> Furthermore the Court held that it is impossible to give everyone access to a core service immediately. The public can only expect that the State acts reasonably to provide them access to their socio-economic rights.<sup>61</sup>

The Court in the *TAC (No2)* case referred to *Soobramoney* where it had been held that at times the State must take a holistic approach to the ‘larger needs of society rather than to focus on the specific needs of particular individuals’.<sup>62</sup> Against this it may be contended that the applicant in the *Soobramoney* case’s claim may have seemed individualistic on the face of it, but that the Court had not taken a holistic view. Though the courts must only deal with the facts presented by the parties, the nature of the applicant’s claim had implications for a defined sector of society. The Court in *Soobramoney* should thus have considered the extent to which society is affected by terminal illnesses and that the judgment would impact on the right to health of that sector. In the *TAC (No2)* case the Court held correctly that a programme for the realisation of socio-economic rights must ‘be balanced and flexible and make appropriate provision for attention to crises and to short, medium and long term needs. A programme that excludes a significant segment of society cannot be said to be reasonable’.<sup>63</sup>

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<sup>59</sup> *Treatment Action Campaign (No2)* para 26.

<sup>60</sup> *Treatment Action Campaign (No2)* para 34.

<sup>61</sup> *Treatment Action Campaign (No2)* para 34.

<sup>62</sup> *Treatment Action Campaign (No2)* para 37.

<sup>63</sup> *Treatment Action Campaign (No2)* para 68.

To determine whether the State has given effect to the positive duties in terms of section 27 of the Constitution it must be asked whether the State's chosen means (it could be a policy or statutory measure, for example,) is reasonably capable of facilitating the realisation of the right.<sup>64</sup> In both the *Grootboom* and the *TAC (No2)* cases, the Constitutional Court began to develop 'a more substantive set of criteria for assessing the reasonableness of the State's acts or omissions'.<sup>65</sup> Liebenberg contends that a reasonable government programme aimed at fulfilling a socio-economic right will have the following features:

- It must be capable of facilitating the realisation of the right;
- It must be comprehensive, coherent and co-ordinated;
- Appropriate financial and human resources must be available for the programme;
- It must be balanced and flexible and make provision for short-, medium- and long-term needs;
- It must be reasonably conceived and implemented;
- It must be transparent, and its content must be made known effectively to the public;
- It must make short-term provision for those whose needs are urgent and who are living in intolerable conditions.<sup>66</sup>

Significantly, '[i]f the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the [reasonableness] test'.<sup>67</sup> Moreover, human dignity is the 'animating value of the reasonableness standard' in the context of socio-economic rights'.<sup>68</sup> Given the desperation of terminally ill persons, the State's health programmes should address their needs too.

In *Khosa and Others v Minister of Social Development and Others; Mahlaule and Others v Minister of Social Development and Others*<sup>69</sup> the Constitutional Court held that in dealing with the issue of reasonableness in the context of socio-economic rights, context is all-

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<sup>64</sup> Liebenberg (2010)151.

<sup>65</sup> Liebenberg (2010) 152.

<sup>66</sup> Liebenberg (2010) 152.

<sup>67</sup> *Grootboom* para 44.

<sup>68</sup> Liebenberg (2010) 153.

<sup>69</sup> 2004 (6) SA 505 (CC) 56.

important. In sketching the health care context it must be borne in mind that in South Africa the private health care system covers less than 15 per cent of the population<sup>70</sup> and that it comprises general practitioners and private hospitals funded mainly by private medical schemes.<sup>71</sup> ‘A further 21 [per cent] of the population relies on the private sector, mainly for primary health care on an out-of-pocket basis [whilst the] remaining 64[per cent] of the population depend on the public sector for all health care services.’<sup>72</sup> It is also relevant to note that almost half of the country’s health care expenditure go to private medical scheme, and that public health users have been ‘radically under resourced’. What is more, the sector of the populace that is most reliant on the public health system has a ‘low socio-economic status’ and its disease profile indicates as common illnesses: HIV/AIDS; tuberculosis; maternal; infant and child mortality; non-communicable diseases; and the effects of injury and violence.<sup>73</sup> Based on the aforesaid, it is arguable that poor health, and consequently life-limiting illness, may be more prevalent amongst indigent communities. It is likely thus that many terminally ill South Africans depend on the public health system.

### 3.3.1.3 The legislative framework of the right to health care

According to Sen, legislation which promotes good health is important, but the right to health goes beyond this.<sup>74</sup> This is true in the light of the impact that terminal illnesses can have on society. It is therefore relevant to note that legislation should also address the health care of those who are affected by serious and terminal illnesses.

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<sup>70</sup> Young & Lemaitre (2013)199.

<sup>71</sup> Section 1 of the South African Medical Schemes Act 131 of 1998 defines the business of a medical scheme as ‘the business of undertaking liability in return for a premium or contribution’.

<sup>72</sup> Young & Lemaitre (2013) 199.

<sup>73</sup> Young and Lemaitre (2013)199.

<sup>74</sup> Sen A ‘Why and how is health a human right?’ *The Lancet* (2008) 372 (9655) *The Lancet* 2010. Also available at <http://nrsharvard.edu/urn-3:HUL.InstRepos:3124128> (accessed 8 July 2013).



In South Africa an array of legislation is aimed at giving effect to section 27 of the Constitution. An exhaustive account of the legislation relevant to the realisation of the right to health is beyond the scope of this Chapter. Reference to only some of the main statutes on health care is made here. The National Health Act<sup>75</sup> establishes the foundation of the health care system and does so along with other laws and policies.<sup>76</sup> Section 3(1)(a) of the National Health Act provides that the Minister of Health must within the limits of available resources ‘endeavour to protect, promote, improve and maintain the health of the population’. The Minister of Health is also further obliged in terms of section 3(1)(d) to ensure the provision of such ‘essential health services, which must at least include primary health care services . . . as may be prescribed after consultation with the National Health Council’. The Minister must therefore determine the content of primary health care services as well as essential services.<sup>77</sup>

In 2010, the Minister of Health, Dr Aaron Motsoaledi, indicated that greater emphasis will be placed on Primary Health Care (PHC) so as to reduce the heavy burden of disease which the country faces. He stated that ‘[w]e just have to go back to the basics of primary healthcare. We have to prevent diseases before they occur’.<sup>78</sup> While his contention cannot be criticised and it must be noted that in 2017 a national policy framework and strategy were introduced, it is still reasonable to question how the State will ensure that all persons, particularly terminally ill prisoners, who are already affected by poor health and diseases will have equal enjoyment of the right to access health care.

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<sup>75</sup> 61 of 2003.

<sup>76</sup> Berger J, Hassim A, Heywood M, Honermann B, Krynauw M and Rugege U, *The National Health Act – A Guide* (2013) 2ed xviii.

<sup>77</sup> Berger *et al* (2013) 36. See ‘Health Minister calls for emphasis on Primary Health Care’ 7 July 2010 <http://www.doh.gov.za/show.php?id=1947> (accessed 1 November 2013). The Department of Health has furthermore indicated that there is a need to change health service delivery from a curative model to one that promotes cost-effective primary healthcare as close to the community and households as possible. The Department envisaged the development and implementation of a model for delivering primary health care services that gives incentives for health promotion and disease prevention.

<sup>78</sup> ‘Health Minister calls for emphasis on Primary Health Care’ 7 July 2010 available at <http://www.gov.za/health-minister-calls-emphasis-primary-healthcare> (accessed 2 June 2013).

In Chapter 6 the National Policy Framework on Palliative Care is discussed in detail. At this juncture, however, it may be submitted that this policy does not adequately address the needs of all persons who are terminally ill. Tentatively it may be stated that the Policy Framework makes only fleeting references to prisoners. The reasons for this contention are evident from the analysis in Chapter 6.

It is widely known that South Africa is profoundly affected by diseases like HIV/AIDS and tuberculosis that can be deemed chronic and even life-threatening. In this regard, the Department of Health has indicated that HIV, AIDS and tuberculosis services will be completely integrated with PHC services.<sup>79</sup> Terminally ill person's or prisoners' access to these services are, however, not addressed by the Department of Health.

Section 4 of the National Health Act deals with eligibility for free health services in public health establishments. It provides that the Minister of Health must, in consultation with the Minister of Finance, prescribe conditions subject to which categories of persons are eligible for free health services at public health establishments. Section 4(2) provides that in prescribing conditions regarding eligibility for free health services the Minister must have regard to:

‘(a) the range of free health services currently available; (b) the categories of persons already receiving free health services; (c) the impact of any such condition on access to health services; and (d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities’.

The needs of terminally ill persons and particularly terminally ill inmates should arguably also be considered as they too are vulnerable.

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<sup>79</sup> See the Department of Health website available at <http://www.doh.gov.za/list.php?type=HIV%20and%20AIDS> (accessed 15 August 2015)

Some of the most important legislation relevant to health in South Africa include the: Choice on Termination of Pregnancy Act<sup>80</sup>; Health Professions Act<sup>81</sup>; Medicines and Related Substances Act<sup>82</sup>; Medical Schemes Act<sup>83</sup>; Nursing Act<sup>84</sup>; National Health Laboratory Service Act<sup>85</sup>; Pharmacy Act<sup>86</sup>; and Traditional Health Practitioners Act.<sup>87</sup> Some of these statutes are discussed in greater detail below with a view to determining the extent that terminal illnesses are contemplated by the law.

Section 56 of the Health Professions Act 50 of 1974 refers to the classification of the death of a person undergoing a procedure that is therapeutic, diagnostic or palliative nature. As mentioned earlier, palliative care is deemed to be an appropriate health care approach for terminally ill persons. Hence it may be contended that the type of care which terminally ill persons require is acknowledged, albeit not directly, in the legislation.

The Medical Schemes Act does not make any specific reference to terminally ill persons. Interestingly though, section 29(n) which deals with rules for medical schemes provides that no medical scheme may be registered and allowed to carry on business unless the terms and conditions applicable to the admission of a person as a member provides for the determination of contributions on the basis of income or the number of dependents or both the income and the number of dependents. Moreover the section specifies that the terms and conditions for membership shall not provide for any other grounds, including the age, sex,

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<sup>80</sup> Act 92 of 1996.

<sup>81</sup> Act 56 of 1974.

<sup>82</sup> Act 101 of 1965.

<sup>83</sup> Act 131 of 1998.

<sup>84</sup> Act 33 of 2005.

<sup>85</sup> Act 37 of 2000.

<sup>86</sup> Act 53 of 1974.

<sup>87</sup> Act 22 of 2007.

past or present state of health of the applicant or one or more of the applicant's dependents, frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependents other than for the provisions as prescribed. Section 29(n) appears to cover the eventuality of terminal illness. This seems plausible if one considers that membership of a medical scheme may not be made subject to considerations, such as, age and past and present state of health.

Section 29(s) of the Medical Schemes Act provides that rules should also be made with regards to the continuation, subject to the prescribed conditions, of the membership of a member, who retires from the service of his or her employer or whose employment is terminated by his or her employer on account of age, ill health or other disability and his or her dependents. This section leaves open the possibility that a member of a scheme who becomes terminally ill or whose dependents become terminally ill may still benefit from the scheme.

Section 1 of the Nursing Act 33 of 2005 defines 'nursing' as a 'caring profession practised by a person registered under section 31 of the Act, which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives in comfort and with dignity until death'. This definition denotes an inclusive approach to health care in South Africa. It takes cognisance of the important role of nurses with regards to preventative, curative and palliative care. The definition also alludes to an acceptance that health can be fallible, but that human beings require appropriate health care throughout their lifetime.

Section 47(1)(m) of the Traditional Health Practitioners Act 22 of 2007 provides that the Minister of Health may after consultation with the Interim Traditional Health Practitioners Council of South Africa, make regulations relating to any disease contemplated in section 49(1)(g) to be terminal. Section 49(1)(g) provides that a person who is not registered as a traditional health practitioner or as a student in terms of the Act is guilty of an offence if he or she: diagnoses, treats or offers to treat, or prescribes treatment or any cure for cancer, HIV and AIDS or any other prescribed terminal disease<sup>88</sup>; holds himself or herself out to be able to treat or cure cancer, HIV and AIDS or any other prescribed terminal disease or to prescribe treatment therefore;<sup>89</sup> holds out that any article, compound, traditional medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, HIV and Aids or any other prescribed terminal disease.<sup>90</sup>

The abovementioned provisions explicitly recognise the reality that terminal illnesses may be prevalent in South Africa and that it renders people vulnerable to the extent that they require protection against persons who may exploit their desperation or unintentionally cause them harm. It must be stated, however, that these provisions are criticised as they only criminalise the actions of unregistered traditional healers and therefore registered healers who undertake the same harmful actions will on the face of it not be prosecuted.<sup>91</sup> Whilst this may have been an unintentional oversight by the drafters of the Act, it arguably denotes that the plight of terminally ill persons has not yet gained the attention that it deserves. Furthermore, it may be mentioned that terminally ill inmates who require or desire traditional healing methods are not contemplated in the Act.

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<sup>88</sup> Section 49(1)(g)(i).

<sup>89</sup> Section 49(1)(g)(ii).

<sup>90</sup> Section 49(1)(g)(iii).

<sup>91</sup> 'Traditional and alternative health care' in *Health and Democracy* 213 available at <http://www.section27.org.za/wp-content/uploads/2010/04/Chapter7.pdf> (accessed 3 October 2015).

The Older Persons Act 13 of 2006 does not refer to persons who are terminally ill, but appears to afford protection to the health care of frail older persons by prohibiting unfair discrimination on the ground of their health status.<sup>92</sup> Home-based care programmes provided in the community and directed at frail older persons may also afford free health care to older persons as determined by the Minister of Health.<sup>93</sup> These provisions can arguably protect the right to health care of older persons who are terminally ill and not imprisoned.

The Social Assistance Act 13 of 2004 makes it possible for persons who are affected by a physical or mental disability to the extent that they are unable to sustain themselves financially to apply for a disability grant.<sup>94</sup> Persons who have reached the age of 60 years may also apply for an older persons grant.<sup>95</sup> Importantly, a person who receives a social grant may qualify for an additional grant referred to as a grant-in-aid if they are in such physical or mental State that they require regular attendance by another person.<sup>96</sup> Arguably a terminally ill person who is not in the care of a State institution may, depending on his age, receive a social grant to cover his daily expenses, such as, food and accommodation, and a grant to ensure that he receives regular care from another person. Such a person may furthermore also have access to available public health benefits and facilities.

The HIV/AIDS and tuberculosis epidemics resulted in the introduction of several types of community carers in South Africa.<sup>97</sup> Such carers include, *inter alia*, lay counsellors and home-based carers. There are also many community health worker programmes that are run by non-governmental organisations and funded by various donors.<sup>98</sup> Whilst there are many

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<sup>92</sup> Section 5(2)(d).

<sup>93</sup> Section 11(3)(f).

<sup>94</sup> See section 9.

<sup>95</sup> See section 10.

<sup>96</sup> Section 12.

<sup>97</sup> Coovadia *et al* (2009) 830.

<sup>98</sup> Coovadia *et al* (2009) 830.

challenges to overcome with regards to the aforementioned sector,<sup>99</sup> significant numbers of South Africans affected by terminal illnesses do benefit from such programmes.<sup>100</sup>

In South Africa, the right to health care of terminally ill persons must be legally defined. *Soobramoney* adopted a hierarchical approach to health care to the detriment of terminally ill persons' right to dignity. The subsequent jurisprudence of the courts, however, confirms that a reasonable approach to health care should be holistic and inclusive of the most vulnerable members of society. The legislative framework within which the right to health care must be fulfilled does not address the needs of terminally ill persons comprehensively and explicitly, but does lend itself to the protection of such persons to some extent. In practice, initiatives, such as, the community-based and home care programmes, operationalised largely by non-governmental organisations, have shouldered some of the responsibility to care for terminally ill persons. Many terminally ill persons therefore do receive care and support in their homes. The protection and support afforded to terminally ill persons who are free are not duplicated in the correctional environment. Below prisoners' right to health is discussed in greater detail with a view to delineating the legal protection of terminally ill prisoners' right to health care.

#### 3.4 DETAINEES' RIGHT TO MEDICAL SERVICES AT STATE EXPENSE: SECTION 35(2)(e) OF THE CONSTITUTION

Section 35(2)(e) of the South African Constitution specifically states that everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at State expense of adequate accommodation, nutrition, reading material and medical treatment. The qualified

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<sup>99</sup> See Coovadia *et al* (2009) 830.

<sup>100</sup> Caring the hospice way 19 February 2013 available at <http://www.health24.com/Medical/Palliative-care/About-palliative-care/Caring-the-hospice-way-20120721> (accessed 1 October 2015).

(or limited) right to health care for everyone in section 27 and a seemingly unqualified right (unlimited) to medical care at State expense for inmates in section 35(2)(e) have triggered debate in South Africa. This will become more apparent below.

The most evident difference between sections 27 and 35(2)(e) of the Constitution is arguably that the latter provision has not been made subject to resource constraints. Liebenberg states that the strong constitutional protection afforded to the socio-economic rights of inmates is appropriate given that inmates are totally dependent on the State for all their basic needs.<sup>101</sup> This contention can be supported by the fact that conditions in many South African correctional centres have been described as inhumane,<sup>102</sup> appalling and as a threat to health.<sup>103</sup> Inmates in South African correctional centres face greater risks to their health than ordinary citizens do. Unlike citizens who are free, the limitation of inmates' freedom further diminishes their opportunities to gain access to available health services outside of correctional centres.

#### 3.4.1 The protection of inmates' rights

Legally the purpose of imprisonment is not to punish inmates. The purpose of imprisonment is to rehabilitate and reintegrate prisoners into society as law-abiding citizens, but in practice this principle is often not recognised or complied with and many inmates therefore experience violations of their rights. Laws that explicitly require the protection of inmates'

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<sup>101</sup> Liebenberg (2010) 257.

<sup>102</sup> 'Krejeir wins prison conditions appeal' 7 October 2017 available at <https://www.security.co.za/news/35397> (accessed 7 October 2017).

<sup>103</sup> See for example Cameron E 'Report: Pollsmoor Correctional centre - Remand Centre and Women's Centre' available at [www.constitutionalcourt.org.za/site/PrisonVisits/Cameron/Pollsmoor-Prison-Report-23-April-2015-Justice-Edwin-Cameron-FINAL-for-web.pdf](http://www.constitutionalcourt.org.za/site/PrisonVisits/Cameron/Pollsmoor-Prison-Report-23-April-2015-Justice-Edwin-Cameron-FINAL-for-web.pdf) (accessed 2 October 2015).



rights in South African correctional centres are consequently necessary. The need for such protection had been recognised as early as 1979 in the *Goldberg* case,<sup>104</sup> where it was held:

‘[A] ... prisoner retains all the basic rights and liberties ... of an ordinary citizen except those taken away from him by law ... or those necessarily inconsistent with the circumstances in which he, as a prisoner, is placed ... [T]here is a substantial residuum of basic rights which he cannot be denied.’<sup>105</sup>

In *August v Electoral Commission* in 1999, the Constitutional Court upheld inmates' right to vote in the elections and confirmed that the common law residuum principle had been 'reinforced and entrenched' by the Constitution.<sup>106</sup> Singh and Maseko also correctly contend that prisoners enjoy those rights that are specifically provided to them by the Constitution as well as those enjoyed by ordinary people.<sup>107</sup> This is with the exception of the right to freedom of movement.

Arguably the protection of inmates' right to health care does not mean that the drafters of the Constitution valued inmates more than they did citizens who are not incarcerated. The history of outright abuse and malign treatment of inmates in South African correctional centres (as discussed in Chapter 1) arguably signalled the need for measures to protect inmates' rights in the era of constitutionalism. Human dignity and equality, which are foundational values in South Africa's constitutional democracy, furthermore provide the justification for the unequivocal expression of inmates' rights.

Indications of the failure to give effect to inmates' most basic rights demonstrate the profound vulnerability of inmates compared to persons who are not incarcerated. Much still has to be done to ensure that the protection of inmates' rights in the Constitution is mirrored

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<sup>104</sup> *Goldberg v Minister of Prisons* 1979 (1) SA 14 (A).

<sup>105</sup> At 39D-F.

<sup>106</sup> *August v Electoral Commission* 1999 (3) SA 1 (CC) paras 18-19.

<sup>107</sup> Singh A and TW Maseko 'The protection of prisoners' rights to health care services in the South African law: Is it adequate?' (2006) 31 *Journal for Juridical Science* 81.

in practice. Probably the drafters of the Constitution foresaw that substantial and unambiguous constitutional guarantees of inmates' rights were needed to ensure that society recognises them in the new constitutional dispensation.

### 3.4.2 The meaning of 'adequate medical care' at State expense: South African jurisprudence

Below, the meaning of section 35(2)(e) of the Constitution insofar as it pertains to inmates' right to health will be discussed. It will become evident that there is 'some discord' with regards to how the provision should be interpreted.<sup>108</sup>

In *Van Biljon and Others v Minister of Correctional Services and Others*<sup>109</sup> the Court ordered that HIV-positive inmates should be provided with access to antiretroviral treatment. It held that 'once it is established that anything less than a particular form of medical treatment would not be adequate, the prisoner has a constitutional right to that treatment'.<sup>110</sup> The Court read the resource qualification<sup>111</sup> into the ambit of the right by adding that adequate medical treatment must be considered within the scope of what the State can afford. Singh and Maseko contend that the standard of adequacy in section 35(2)(e) should not have been made subject to the availability of resources.<sup>112</sup>

Singh and Maseko contend that the 'accepted basic standards of medical treatment for prisoners in international and comparative law'<sup>113</sup> should have been considered. Furthermore, the Court should have considered that inmates must be treated with humanity and that their

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<sup>108</sup> Pieterse M 'The potential of socio-economic rights litigation for the achievement of social justice: Considering the example of access to medical care in South African prisons' (2006) 50 *Journal of African Law* 125.

<sup>109</sup> 1997 (6) BCLR 789 (C).

<sup>110</sup> 1997 (4) SA 441 (C) para 49.

<sup>111</sup> Barnes J 'Not too "Great Expectations": Considering the right to health care in prisons and its constitutional implementation' (2009) 1 *SACJ* 44.

<sup>112</sup> Singh & Maseko (2006) 90.

<sup>113</sup> Singh & Maseko (2006) 90.

dignity must be respected. They emphasise the Human Rights Committee's decision in *Mukong v Cameroon*<sup>114</sup> where it was held that the fulfilment of prisoners' right to health care, as a requirement in terms of the Standard Minimum Rules for the Treatment of Prisoners, does not depend on the availability of resources. It means that the availability or lack of resources should determine the nature of the actions to be taken by a State. If the fulfilment of a right thus requires substantial resources which the State does not have at its disposal, the State must still take steps in pursuance of the right. The initial steps may involve actions which require limited resources.

With regards to unqualified rights, like those of section 35(2)(e), resource limitations should not be applied to the ambit of the entitlement, but rather to the enforcement of the right.<sup>115</sup> A limitation will then have to be justified in terms of section 36 of the Constitution.<sup>116</sup> Liebenberg correctly states that the words 'at least' in section 35(2)(e) denote the minimum goods and services which inmates should be afforded.<sup>117</sup> Inmates may claim 'whatever [is] necessary to ensure conditions of detention consistent with human dignity'.<sup>118</sup> This interpretation has been borne out by a number of cases subsequent to *Van Biljon*.

In *Strydom*<sup>119</sup> the Court held that the prison authority's decision to remove access to electrical sockets in the prison cells was a violation of the inmates' human dignity.<sup>120</sup> The Court ordered that inmates be given access to electricity in their cells. In *EN*,<sup>121</sup> 15 HIV/AIDS positive inmates sought an order compelling the State to, *inter alia*, give them access to anti-

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<sup>114</sup> No.458/1991 (August 10, 1994) U.N. Doc.CCPR/C/51/D/458/1991.

<sup>115</sup> Pieterse (2006) 125. See also Liebenberg (2010) 258.

<sup>116</sup> Pieterse (2006) 125.

<sup>117</sup> See Liebenberg (2010) 257. *Huang v Head of Grootvlei Prison (ZAFSHC)* unreported case no 992/2003 ( 15 May 2003) at para 30.

<sup>118</sup> Liebenberg (2010) 257.

<sup>119</sup> *Strydom v Minister of Correctional Services* 1999 (3) BCLR 342 (W).

<sup>120</sup> At para 15.

<sup>121</sup> *EN and Others v Government of the RSA and Others* [2007] 1 All SA 74 (D).

retroviral treatment in accordance with the government Operational Plan for Comprehensive HIV and AIDS Care (Operational Plan). The Court held that it was ‘regrettable that prisoners, being a class, very vulnerable to infection, were not given special consideration in the Operational Plan ...’.<sup>122</sup> It was ordered that inmates be granted access to the programme. A reasonable State programme must therefore include vulnerable groups like inmates.

In *Ehrlich* the Court held that the prison authority’s decision to prohibit the applicant’s access to the prison gymnasium where their karate development programme had been running for the previous two years violated the inmates’ right to dignity.<sup>123</sup> The Court ordered that access to the gymnasium be allowed.

These cases demonstrate that the State’s obligation may involve enabling access to the resources in the correctional centres as well as resources provided to the public. The State may follow this approach in giving effect to terminally ill inmates’ rights.

In 2012 the Constitutional Court handed down its judgment in *Dudley Lee v Minister of Correctional Services*.<sup>124</sup> The judgment will be discussed in greater detail in Chapter 4 with regard to the issue of equality. The Court found in favour of the applicant that the DCS had failed in its duty to protect inmates’ right to health care. Significantly, the Court took cognisance of the overcrowded and unhygienic conditions of the correctional centre. It confirmed that such correctional centres are incubators of disease. The Court furthermore considered that inmates are highly dependent on the correctional authorities and that the breaking down of the health systems of the correctional centre deepens inmates’ vulnerability

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<sup>122</sup> At para 29.

<sup>123</sup> *Ehrlich v Minister of Correctional Services and Another* 2009 (2) SA 373 (E) para 43.

<sup>124</sup> 2013 (2) SA 144 (CC).

to diseases. In 2015 the Western Cape High Court ordered the DCS to reduce overcrowding in Pollsmoor Correctional Centre, thus indicating that conditions of imprisonment were unacceptable and that judicial intervention is sometimes required.<sup>125</sup>

In summation, it ought to become evident that inmates' right to health require express protection as they are highly dependent on the State for almost all their basic needs. Furthermore, though it is widely known amongst legal scholars that the purpose of imprisonment is not to punish an inmate, this principle is often not adhered to in practice. Many inmates face threats to their health which they would in all likelihood not be exposed to outside of correctional centres. These threats are made real by the physical conditions in correctional centres as well as by the lack of adequate health systems in some centres. Against this background, the need for law which unambiguously and specifically provides for inmates' right to health care ought to be self-evident.

### 3.4.3 The legislative framework for the fulfilment of section 35(2)(e)

'The rise and rapid spread of HIV infection, the resurgence of other serious communicable diseases such as tuberculosis and hepatitis . . . have thrust prison health high on the public health agenda [and] WHO has [therefore] emphasized [that] any national health strategy must include prison policies that address these serious health problems.'<sup>126</sup>

#### 3.4.3.1 Correctional Services Act 111 of 1998

In South Africa section 6(5) of the Correctional Services Act 111 of 1998 requires that every prisoner must undergo a health status examination, which must include testing for contagious and communicable diseases as soon as possible after admission. Section 38(1)(b) similarly requires that the health needs of a sentenced inmate must be established as soon as possible

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<sup>125</sup> *Sonke Gender Justice v Government of the Republic of South Africa and Head of Centre Pollsmoor Remand Detention Facility* Case number: 24087/15 22 December 2016 (C).

<sup>126</sup> United Nations Office on Drugs and Crime *Women's health in prison: Correcting the gender inequity in prison health* (2009) World Health Organization v. available at [http://www.euro.who.int/\\_data/assets/pdf\\_file/0004/76513/E92347.pdf](http://www.euro.who.int/_data/assets/pdf_file/0004/76513/E92347.pdf) (accessed 24 June 2014).

after admission. These provisions are important as many inmates engage in lifestyles that expose them to health risks. They may have engaged in gang violence, alcohol and illegal substance abuse, poor diets and may not be aware that their health has been compromised. Given that the majority of prisoners have to share cells and other amenities, health screening is imperative for the purpose of limiting the spread of contagious diseases.

Section 7(1) of the Correctional Services Act provides that prisoners must be held in cells which meet the requirements prescribed by regulation in respect of floor space, cubic capacity, lighting, ventilation, sanitary installations and general health conditions. These requirements must be adequate for detention under conditions of human dignity. It is widely known that prison cells in South African correctional centres are often overcrowded and not conducive to humane detention. The fact that the law clearly prescribes detention under conditions of human dignity thus affords a basis for insisting on the improvement of prison accommodation. As alluded to already, the law in itself may not result in instant and automatic improvements, but it can provide the foundation for positive changes in the long term.

Section 7(2)(d) of the Correctional Services Act stipulates that prisoners of specific ages, health categories or security risk categories must be kept separate. Section 7(3) allows departures from the provisions on accommodating different categories of prisoners separately if approved by the Head of Prison and effected under supervision of a correctional official for the purpose of providing development or support services or medical treatment to prisoners. It is clear, however, that under no circumstances may there be departures in respect of sleeping accommodation. These provisions appear to align with the sentiment that the physical environment can have an impact on a person's health and well-being. Section 7(3)

seems to indicate that the correctional authorities may deviate from ordinary practice to ensure that prisoners are afforded appropriate health care including that a prisoner may be moved to a place where such health care is available. This may be necessary in the case of terminally ill prisoners. However, in transferring a prisoner to a facility where appropriate health care may be provided, it is imperative that his next-of-kin be informed of such transfer.

Section 8(1) of the Correctional Services Act provides that each prisoner must be provided with an adequate diet to promote good health. Provision is also made for categories of prisoners whose physical condition requires a special diet.<sup>127</sup> Presumably this means that a terminally ill inmate should be afforded the diet suitable for his condition. Additionally, a medical officer may order a variation in the prescribed diet for a prisoner and the intervals at which the food is served, when such variation is required for medical reasons.<sup>128</sup>

Section 11 of the Correctional Services Act affords prisoners the right to exercise in order to remain healthy. Though it may seem irrelevant or inappropriate to contemplate exercise for terminally ill prisoners, there may be inmates whose condition requires appropriate exercise to sustain or improve their condition. This section should thus not be regarded as inapplicable to terminally ill prisoners.

Section 12 of the Correctional Services Act deals with the health care of inmates. It provides that the DCS must provide, within its available resources, adequate health care services, based on the principles of primary health care to allow every inmate to lead a healthy life. This Act subjects inmates' right to health care to resource constraints. This is on the face of it inconsistent with section 35(2)(e) of the Constitution. However, this does not mean that

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<sup>127</sup> Section 8(2).

<sup>128</sup> Section 8(4).

terminally ill inmates' health needs can be overlooked as section (2)(a) guarantees that every prisoner has the right to adequate medical treatment.

Section 2(b) of the Correctional Services Act provides that medical treatment must be provided by a medical officer, medical practitioners or a specialist or health care institution or person or institution identified by such medical officer. This denotes that qualified persons must attend to the medical needs of a prisoner and thus protects prisoners against harmful medical practices. Section 12(3) states that every prisoner may be visited and examined by a medical practitioner of his or her choice and, subject to the permission of the Head of Prison, may be treated by such practitioner. The prisoner is, however, personally liable for the costs of any such treatment. It is not clear whether this section contemplates traditional health practitioners or a student registered in terms of the Traditional Health Practitioners Act. Arguably the services of a registered traditional health practitioner or student should be allowed if requested by a terminally ill prisoner who is prepared to pay for such services.

It is arguable that there may be instances where the State must at its own expense, within its available resources, allow for the reasonable provision of services by a traditional healer or student to terminally ill prisoners. This may be in instances where conventional medical treatment proves futile or yields negligible results and there is agreement between the prison medical staff and the prisoner that the services of a traditional healer are likely to improve or palliate the prisoner's condition. The overriding considerations in such circumstances ought to be that the right to health care which always gives rise to entitlements (albeit negligible in some instances) and the State's duty to give effect to inmates' right to dignity.



Section 12(4)(a) of the Correctional Services Act provides that every prisoner should be encouraged to undergo medical treatment necessary for the maintenance or recovery of his or her health. It is contended that this section applies to all inmates regardless of their health status. Reasonable goals may therefore be set for the maintenance of terminally ill prisoners' health. Such goals may include, for example, the prevention of further conditions or the delaying or relieving of certain unpreventable symptoms. Section 12(4)(b) protects the autonomy of prisoners in that they may not be compelled to undergo any medical examination, intervention or treatment without informed consent, unless failure to submit to such medical intervention will pose a threat to the health of other persons.

Section 13 of the Correctional Services Act deals with contact between prisoners and the community. It provides that the prison authorities should give prisoners the opportunity, under such supervision as may be necessary, of communicating with and being visited by at least their spouses or partners, next of kin, chosen religious counsellors and chosen medical practitioners. A minimum of one hour must be allowed for visits each month. The right to have access to a medical practitioner of the prisoner's choice is reiterated in section 13. Furthermore, though contact between any inmate and his community is essential, such contact may become crucial to the well-being of prisoners who are faced with a terminal illness. Arguably, the minimum of one-hour visits per month should be extended to reasonably meet the needs of terminally ill prisoners.

#### 3.4.3.2 The Correctional Matters Amendment Act 5 of 2011

The Correctional Matters Amendment Act<sup>129</sup> amended, *inter alia*, several definitions in the old legislation, introduced a new medical parole system, and provided for the management of

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<sup>129</sup> Act 5 of 2011.

remand detainees (awaiting-trial-prisoners). Section 49B deals with remand detainees with disabilities. It provides that if the National Commissioner deems it necessary, having regard to a remand detainees' disability, such prisoner may be detained separately in a single or communal cell, depending on the availability of accommodation specifically designed for persons with disabilities. Section 49B(2) further provides that the State must provide, within its available resources, additional health care services, based on the principles of primary health care, in order to allow the remand detainee to lead a healthy life. Section 49C(3) obligates the State to provide, within its available resources, additional psychological services, if recommended by a medical practitioner.

Section 49C(1) provides that the National Commissioner may detain remand detainees over the age of 65 years in single or communal cells, depending on the availability of accommodation. Section 49(2) stipulates that a registered medical practitioner may order a variation in the prescribed diet for an aged remand detainee and the intervals at which the food is served, when such a variation is required for medical reasons and is within the available resources of the Department of Correctional Services.

The provisions relevant to disabled and aged remand detainees appear to be premised on the understanding that the general health system in correctional centres may be inadequate or unsuitable to meet the health care needs of such inmates. Though it makes the right to health subject to available resources, it is a positive step that the unique needs of such inmates are formally recognised. It also indicates that the fulfilment of the right to health for different persons has varying requirements depending on the actual needs and vulnerabilities of such persons.

Section 49E of the Criminal Procedure Amendment Act provides that the head of a remand or correctional centre may apply to a court for the release of a terminally ill remand detainee provided certain requirements are met. This provision is analysed in Chapter 5 of this thesis.

#### 3.4.3.3 South African policies on prisoners' right to health care

The *White Paper on Corrections 2005* provides the policy framework for the health care of sentenced inmates, while the *White Paper on Remand Detention Management 2013* places certain obligations on remand institutions with regard to the health of detainees. These two national policies will be discussed respectively below.

The preamble to the *White Paper on Corrections* provides that it is underpinned *inter alia* by values and rights enshrined in the Constitution and the core values of the DCS which include the rights to human dignity and equality, underlying the humane treatment of every detainee, to health care services, and other associated rights. The *White Paper on Corrections 2005* also provides that it has replaced the *1994 White Paper* because the latter was not aligned with key government policies and a broader range of other public service regulations, including those pertaining to health.<sup>130</sup> It would therefore appear that health in correctional centres was an important area for improvement when the *2005 White Paper* was introduced.

The *White Paper on Corrections 2005* states that provision must be made for health care services to inmates that are consistent with services provided by the State to other citizens.<sup>131</sup> In Chapter 4 it will become clearer that this does not occur in practice as conditions in many prisons are detrimental to inmates' health and they do not always have access to the same services as members of the public. The *White Paper* furthermore identifies the following key

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<sup>130</sup> *White Paper on Corrections 2005*: Executive Summary.

<sup>131</sup> *White Paper on Corrections 2005*: Executive Summary.

service delivery areas which are related to inmates' health: 'Security' which refers to all services aimed at ensuring safe and healthy conditions consistent with the human dignity of inmates; and 'Care' which refers to needs-based services aimed at the maintenance of the well-being of inmates, providing for their physical well-being in the form of nutrition and health care, the maintenance and establishment of social links with families and society, their spiritual and moral well-being as well as their psychological well-being.<sup>132</sup>

The *White Paper on Corrections* provides that as soon as possible after admission a sentenced offender must be assessed to determine, *inter alia*, his or her health needs.<sup>133</sup> The *White Paper on Corrections* acknowledges that incarceration can have a damaging effect on both the physical and mental well-being of inmates and that the DCS is therefore obliged to provide for the 'special health needs' of inmates in its institutions.<sup>134</sup> The *White Paper* further requires that those providing health care to inmates be trained in the specific health needs and health problems encountered in a correctional centre environment. It also stipulates that inmates must have the ability to seek health care solutions that are appropriate and attainable in a correctional centre environment.<sup>135</sup> The responsibility of the Department is not just to provide health care, but also to provide conditions that promote the well-being of inmates and correctional officials.<sup>136</sup>

The abovementioned provisions arguably recognise that the conditions in prisons are detrimental to the health of inmates and that inmates should therefore be afforded special health care due to their vulnerable position in prisons. The requirement that 'special' health care be provided by health personnel specifically trained to offer medical assistance in the

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<sup>132</sup> At para 9.6.2.

<sup>133</sup> At para 9.6.3.

<sup>134</sup> At para 10.5.3.

<sup>135</sup> At para 10.5.3.

<sup>136</sup> At para 10.5.3.

prison environment suggests that conditions in prisons are generally not conducive to healthy lifestyles, that the health of prisoners is expectedly poorer than that of free persons and that the conventional and/or ordinary treatments afforded to free persons might not suffice for prisoners. The special health needs of terminally ill prisoners should be addressed from this perspective.

The *White Paper* recognises the right of individuals to access private health care facilities at their own expense, which in the case of inmates can also be limited by security constraints. It should be clear, however, that on placement on parole or if serving a sentence of correctional supervision in the community, health care is accessed through the State health care system and not through the DCS.<sup>137</sup> If a prisoner or parolee is permitted to access the same health system as free persons it may assist in preparing him to reintegrate into society. To afford a prisoner access to the same facilities and services as free persons denotes respect for his right to health and dignity.

The *White Paper on Corrections 2005* does not expressly refer to terminally ill inmates. It provides:

HIV/AIDS and other communicable diseases such as TB and sexually transmitted infections will be addressed as integral to provision of comprehensive health care services and health care education to inmates. The department should focus on programmes to reduce the impact of HIV/AIDS and other communicable diseases to allow people under correction to leave the system as healthy as possible'.<sup>138</sup>

The goal expressed in this policy, as mentioned in Chapter 1 of this thesis seems patently geared towards the introduction of curative and preventative initiatives to assist those affected by serious illnesses. The intention to introduce such initiatives cannot be criticised.

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<sup>137</sup> At para 10.7.2.

<sup>138</sup> At 5.

However, policymakers framed these goals in a manner that suggests an obliviousness to the reality that there are prisoners for whom curative and preventative health measures are not viable options. For many terminally ill prisoners the goal of ‘[leaving] the system as healthy as possible’ is simply unattainable. It may as a result be inferred that the unintended consequence of attending to the systemic problems of prisons has been that the challenges experienced by the most marginalised and vulnerable groups, such as the terminally ill, are often overlooked.

The *White Paper on Remand Detention Management 2013* provides that the issue of uninterrupted medical care throughout the criminal justice system custody chain must be dealt with.<sup>139</sup> In Chapter 4 of this thesis it will become clearer that there are many junctures in the custodial chain where inmates’ health is subjected to risks and that such risks often exist under the radar. Like the prison legislation and the *White Paper on Corrections 2005*, the *White Paper on Remand Detention Management* provides that every remand detainee must undergo a health status examination, which must include testing for contagious and communicable diseases. Remand detention institutions must also ensure that policies that address the health of detainees are in place.<sup>140</sup> It may therefore be inferred that every correctional centre or remand facility should have a policy in place on the management of terminally ill remand detainees who cannot be released immediately.

The *White Paper on Remand Detention Management* refers to section 63A of the Criminal Procedure Act 51 of 1977 which allows the Head of a correctional centre or remand detention facility to approach a court if he/she is satisfied that the population is reaching such proportions that it constitutes a material and imminent threat to the human dignity, physical

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<sup>139</sup> *White Paper on Remand Detention Management 2013*: Executive Summary.

<sup>140</sup> At 13.

health or safety of an accused who has been granted bail but remains in custody.<sup>141</sup> This provision, which is dealt with in greater detail in Chapter 5 of this thesis, allows prison authorities to deal with overcrowding. In practice, however, it seems that the provision is not applied frequently as many correctional facilities are severely overcrowded and faced with health crises as a result.

The *White Paper on Remand Detention Management* refers to section 49E of the Correctional Matters Amendment Act. It expressly classifies terminally ill remand detainees as persons with special needs and calls for integrated training for new recruits to meet the needs of such special detainees.<sup>142</sup> This is a unique feature of the *White Paper* as other pieces legislation and policies do not directly refer to terminally ill inmates as a special category of prisoners with special needs that require specific care. The *White Paper* furthermore mentions that in terms of section 49E, application may be made to court for the placement of terminally ill remand detainees outside of the correctional environment while they are awaiting trial.<sup>143</sup> This statement is important as it indicates that a diagnosis of a terminal illness does not exempt an accused from standing trial. Moreover, a diagnosis of a terminal illness does not guarantee the instant release of an inmate. Terminally ill inmates, as mentioned in Chapter 1 and 2 of this thesis, do inhabit prisons. Whether an inmate will be released on medical parole or not (as will be seen in Chapter 6 of this thesis) does not negate the need to define what the right to health means for terminally ill inmates.

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<sup>141</sup> At 23.

<sup>142</sup> At 38.

<sup>143</sup> At 50.

### 3.5 CONCLUSION

In South Africa, like most places in the world, citizens do not have an absolute right to health care. History, legislation, policies and available resources inform the nature of the health care system and the realisation of the right to health care. This means that everyone has a right to health care, but not that they have a right to be granted everything they desire or believe they need. The *Soobramoney* case, for example, demonstrated this reality. Unfortunately the case did not take into consideration the implications of adopting what appears to be a hierarchical approach to health care, with the resultant exclusion and further marginalisation of some of the most vulnerable persons in society.

Despite the negligible attention accorded to defining the substantive content of the right in the *Soobramoney* case, subsequent cases at least clarify that the State should have a reasonable plan in place to give effect to the right to health care. Such a plan must of necessity include the most vulnerable and desperate persons in our society, otherwise it will be deemed unreasonable. On this basis, terminally ill inmates should not be excluded from the State's health care plans. Furthermore, the courts have confirmed that the right to health care includes the right of access to affordable medicines. This is crucial to the plight of terminally ill persons as many of them do experience severe pain and suffering and may require medicines to manage or prevent the onset of other illnesses and/or symptoms.

Courts have made it plain that a reasonable plan will take into consideration the context in which it must operate. In South Africa the health plan must operate in a context where significant numbers of people are terminally ill and indigent. It is regrettable though that none of these judgments considered the right to health of terminally ill inmates while they are detained. As seen earlier in this Chapter, the legislative framework, though not ideal, can be



relied upon to afford protection of terminally ill free persons' right to health care. The same cannot be said of terminally ill prisoners. It appears that terminally ill prisoners' right to health care has not been addressed explicitly and adequately. At best the removal or release of such inmates from correctional centres is considered without any indication as to what should happen to them between the time that they diagnosed with a terminal illness and the time when (or if) they are released or die. South African prison policies acknowledge the hazardous nature of the correctional environment and the health risks it poses to inmates, yet there are no concrete provisions on the health care of such inmates.

## CHAPTER 4

### PRISON HEALTH CARE EQUAL TO PUBLIC HEALTH CARE

#### 4.1 INTRODUCTION

While the preceding Chapters of this thesis were aimed at establishing the bases of terminally ill prisoners' right to health, this Chapter focuses on sketching the unequal position of such prisoners with terminally ill free persons. By showing the significant differences in their contexts, it becomes arguable that greater protection of terminally ill prisoners' right to health is required. Such protection will be afforded by adopting a substantive equality approach with regards to the fulfilment of terminally ill prisoners' right to health. While this contention will be bolstered throughout this Chapter, it may be asserted here that health care provided to the public differs from health care in correctional centres.

Many prisons are incubators of disease. The provision of health care in the prison environment is likely to be affected by this reality. Additionally there are indications that more than a third of prisoners are not medically examined within the first 24 hours of admission to prison.<sup>1</sup> Furthermore 54 per cent of inmates reportedly are not given medical treatment when they need it.<sup>2</sup> Studies by civil society organisations also show that 'understaffing, overcrowding and inconsistent treatment of disease' in prison remain serious causes for concern.<sup>3</sup> While health care to the public is also affected by many issues,<sup>4</sup> the public has better access to health facilities than prisoners. For example, the WHO indicates

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<sup>1</sup> Rademeyer J & Van Wyk A 'Public versus prison healthcare: What are the facts?' *Africa Check* 18 December 2014 available at <http://mg.co.za/article/2014-12-18-do-prisoners-have-access-to-better-medical-facilities-than-the-public> (accessed 24 November 2015).

<sup>2</sup> Rademeyer & Van Wyk 2014.

<sup>3</sup> Rademeyer & Van Wyk 2014.

<sup>4</sup> See *Health Systems Trust* (2017) 6 where it is mentioned that the health system is affected by the overall maldistribution between the private and public sectors; overall under-resourcing of the public sector; maldistribution of spending between geographical areas with relatively affluent (urban) areas receiving a greater proportion than poorer areas (rural, ex-homeland); and maldistribution between levels of care.

that access to HIV/AIDS treatment has reportedly expanded significantly and access to health services in general has improved for poorer South Africans.<sup>5</sup>

It is imperative to consider the differences between the position of terminally ill persons who are free and that of those who are incarcerated as they may inform the meaning and protection afforded to, the right to health. This is particularly important in South Africa where the sentiment that inmates are afforded more or greater protection of their rights than law-abiding citizens is often expressed.<sup>6</sup> Consequently, this Chapter is aimed at discussing and comparing the position of terminally ill inmates with that of terminally ill persons outside of prison.

The jurisprudence and legislation relevant to terminally ill inmates dealt primarily with the question of medical parole or inmates' access to antiretroviral medication for those living with HIV/AIDS, as is evident in Chapter 3 of this thesis. Some may interpret such precedents and domestic law as having answered the question posed here. However, it is contended that there is no legal authority or precedent which substantially and directly expounds the legal position of terminally ill inmates insofar as their right to health care is concerned. The question must therefore be approached from a legal perspective and in the light of the unique impact that imprisonment has on persons.

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<sup>5</sup> Bulletin of the WHO 'Bridging the gap in South Africa' available at <http://www.who.int/bulletin/volumes/88/11/10-021110/en/> (accessed 17 October 2017); See also *Twenty Year Review: South Africa 1994 - 2014*.

<sup>6</sup> Shange N 'Cop killing: Criminals have more rights than cops – aunt' *News24* 1 April 2015 available at <http://www.news24.com/SouthAfrica/News/Cop-Killing-Criminals-have-more-rights-than-cops-aunt-20150401> (accessed 15 May 2017); Motala N & McQuoid-Mason D 'Do prisoners in South Africa have a constitutional right to a holistic approach to antiretroviral treatment?' *The South African Journal of Bioethics and Law* (2013) 6(2) 44; Do prisoners have access to better medical facilities than the public? 18 December 2014 available at <https://africacheck.org/reports/do-prisoners-have-access-to-better-medical-facilities-than-the-public/> (accessed 17 May 2017).

## 4.2 SHOULD ALL TERMINALLY ILL PERSONS BE REGARDED AS ‘LIKES’?

In a constitutional democracy based on freedom, equality and dignity, this question is justified. Though the question must be pursued within the framework of the law, it is generally known that prisoners are not regarded or treated like law-abiding citizens by the public and the State. Prisoners’ humanity is often knowingly or unknowingly judged according to their criminal deeds. This affects the recognition and fulfilment of their rights.

Dread of contamination and sometimes even physical fear of someone, not because he is, in fact, dirty, or diseased, or dangerous, but simply because he is a convicted criminal, is quite a common reaction . . . This fear of contamination by the criminal goes back a long time, and has deep, psychological roots . . . And today . . . under the surface there is still the same irrational dread of pollution as well as the old desire to make the offender suffer.’<sup>7</sup>

Despite the societal reservations about prisoners’ rights, whether or not we choose to acknowledge them, the instinctive legalistic response to the question of treating terminally ill prisoners like all other persons insofar as the recognition and fulfilment of their right to health is concerned may be answered in the affirmative by some. A more considered approach to the question, however, requires that cognisance be taken of their actual position and how it impacts on their right to health in the prison system. The reality for many terminally ill inmates may be the following:

‘Prison continues [on them] a work begun elsewhere, which the whole society pursues on each individual through innumerable mechanisms of discipline. By means of a carceral continuum, the authority that sentences infiltrates all those other authorities that supervise, transform, correct, improve . . . But, in its function, the power to punish is not essentially different from that of curing or educating.’<sup>8</sup>

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<sup>7</sup> Klare H *Anatomy of Prison* (1962) 13.

<sup>8</sup> Foucault M *Discipline and Punishment: The birth of the prison in Why Punish? How much?* Tonry M (ed) 2011 428.

Albeit that this view had been expressed many decades ago, it is contended here that it still holds true for many prisoners in South African.<sup>9</sup> This makes it reasonable to assert that terminally ill prisoners are profoundly vulnerable. They are made vulnerable by their background, social origin, illness, and many other factors which they may share with some free people. Additionally, however, their imprisonment and the discrimination and marginalisation which ensue deepen their vulnerability. Tentatively, this may cast some doubt on whether they should be treated like other persons who are terminally ill and not incarcerated. At this stage, however, the concept of ‘vulnerability’ within this thesis will be briefly unpacked to support the argument that terminally ill prisoners are in a significantly different and less favourable position than most terminally ill free persons.

‘Vulnerability’ is a ‘notoriously vague’ term for which there is no single definition; It is used in different contexts and is ascribed different meanings.<sup>10</sup> The purpose to which it is put will determine its meaning.<sup>11</sup> Such purpose may include to designate a person who is in need of special attention or a group that is entitled to protection.<sup>12</sup> Prisoners diagnosed with terminal illness can therefore be designated as vulnerable given that they require special attention in that they are fatally ill and require services by the State, and that they are also entitled to protection of their fundamental rights, such as, the right to dignity and the right to health as they are frequently not acknowledged and treated as bearers of these rights. It must be emphasised, however, that the concept is not intended to be used in an ‘oppressive, controlling and exclusive manner’ in this thesis.<sup>13</sup> It is recognised here that every prisoner diagnosed with a terminal illness is the bearer of the right to dignity and physical integrity.

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<sup>9</sup> See Albertus C ‘Offender reintegration in South Africa: A complementary crime prevention measure’ Criminal Justice Initiative Occasional Paper Series Paper 7 *Open Society Foundation for South Africa* (2010) 13.

<sup>10</sup> Herring J *Vulnerable adults and the law* 2016 5-6.

<sup>11</sup> Herring (2016) 6.

<sup>12</sup> Herring (2016) 6.

<sup>13</sup> Herring (2016) 267.

They remain autonomous despite their physical limitations and socio-economic conditions. Insofar as they are physically able to express their views, those views ought to be afforded due consideration.

Herring contends that academic literature presents two major schools of thought on the definition of vulnerability.<sup>14</sup> The first emphasises the universal vulnerability of everyone. Vulnerability is seen as an essential part of our humanity. The second states that there are some people or groups of people who should be seen as vulnerable. Herring states that these schools of thought are often presented as competing. He, however, proffers that there is no contradiction between them if it is recognised that the second definition seeks to identify a category of people who are vulnerable in a way above and beyond the way we all are vulnerable.<sup>15</sup> The vulnerability of all free persons, including terminally ill free persons is therefore not denied here. However, terminally ill prisoners' experiences within the correctional environment add to their vulnerability.

Herring's view resonates with this thesis. It is recognised that we are all vulnerable because we are dependent on others for our physical and psychological well-being.<sup>16</sup> However, it is also recognised that we tend to highlight the accommodations made for groups such as prisoners more than we do the adjustments made for ourselves in society. Lindemann demonstrates this assertion effectively by contrasting adjustments made for persons with disabilities to minimise the impact of disability with accommodations made for working people.<sup>17</sup> She explains that adult employees are unconscious of the numerous

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<sup>14</sup> Herring (2016) 7.

<sup>15</sup> Herring (2016) 7.

<sup>16</sup> Herring (2016) 7. See also Albertson Fineman M 'Equality, Anatomy, and the Vulnerable Subject in Law and Politics' in Albertson Fineman M and Grear A (eds) *Vulnerability: Reflections on a new ethical foundation for law and politics* 2013 20-21.

<sup>17</sup> Lindemann K 'The ethics of receiving' (2003) 24 *Theoretical Medicine and Bioethics* 501.

accommodations that society provides to make their work and lifestyle possible. She mentions the existence of automated money machines, extended hours at banks and medical offices, the fast food industry, delivery services, child care centres, cleaning services, and a myriad of other services which make it possible for people to hold full-time jobs. Thus, even if we see everyone as vulnerable it is still possible to recognise that we are positioned differently as our economic and social conditions may impact differently on our vulnerabilities.<sup>18</sup> Insofar as terminally ill prisoners are concerned, we should appreciate that socially and economically they are not in the same position as others. Their position exposes them to a myriad of risks in the prison system, many of which may prove to worsen their struggles and may even be fatal to their existence. They do face what other prisoners also have to endure: violence or the constant threat thereof; the trauma of being separated from family and friends as well as witnessing violence; lack of resources and basic amenities; limited or no access to family; and no or inadequate health care. Unlike other prisoners, they also have to contend with pain, and limitations on, or the lack of the ability to care for themselves, thus having to accept the indignity of relying on others for basic care. Above and beyond this, they have to cope with the knowledge that they may die alone away from their loved ones if they do have people who support them from the outside.

Furthermore Reichter aptly opines:

‘[D]espite the importance of viewing human rights within a universal context and not simply as something for the disadvantaged, instances arise when particular groups often require more attention to ensure human rights of those groups. This does not mean that these groups are being elevated above others. The term *vulnerable* refers to the harsh reality that these groups are more likely to encounter discrimination or other human rights violations than others.’<sup>19</sup>

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<sup>18</sup> Herring (2016) 17.

<sup>19</sup> Reichter E *Understanding Human Rights: An Exercise Book* (2006) 77-78.

Terminally ill prisoners fall into the category of persons who are likely to experience discrimination and violations, especially of their right to health. This is evidenced by the fact that even the families of some inmates may reject them or be reluctant to care for them. In Chapter 3 reference was made to cases where inmates on death row were denied health care because correctional staff were of the view that the inmates would die soon and that resources should not be wasted on them. The discriminatory attitude towards those whose death is a reasonably foreseeable event in the near future has existed for a long time. This is evident if one considers the poignant quote from Wiesel's account of his father's last days before dying in Auschwitz, the Nazi concentration camp: 'They didn't give us anything . . . They said that we were sick, that we would die soon, and that it would be a waste of food.'<sup>20</sup> Human rights principles consequently suggest that if one group seems disadvantaged compared to other groups, and is subjected to discrimination and at risk of violations of its rights, it should be afforded additional protection.<sup>21</sup>

It is acknowledged that in practice not all terminally ill inmates will encounter the same experiences as some may have support networks, such as, family, friends, and communities, or they may be detained in better equipped prisons with dedicated staff. Clark contends that it is important to acknowledge that the 'fixed, essentialist categorical ideals of "vulnerables" do not reflect the more complex reality of dynamic vulnerability in shifting relationships and contexts.'<sup>22</sup> Better responses to the needs of vulnerable persons may be provided if their vulnerability is understood within the parameters of their actual circumstances. This is why in Chapter 3 of this thesis it is argued that States must be aware of terminally ill inmates' presence in prisons and the factors which contribute to poor health in order to address their needs appropriately, and that prison authorities should continuously conduct comprehensive

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<sup>20</sup> Wiesel E *Night* (2006) 107.

<sup>21</sup> Reichter (2006) 81.

<sup>22</sup> Clark CR 'Understanding vulnerability: From categories to experiences of Congolese young people in Uganda' *Children and Society* 2007 (21)1.



health screenings. States should also be aware of the grounds on which persons are discriminated against, as also argued in Chapter 3.

The fact that terminally ill inmates' vulnerability is not explicitly recognised also impacts negatively on their position. In South Africa 'vulnerable' groups are frequently referred to in government policy documents and case law. Such groups have invariably been categorised along lines of gender, race, sexual orientation, economic status, and disability.<sup>23</sup> The Department of Justice has defined 'vulnerability' as 'exposure to risk and stress and the lack of ability to cope with the consequences of risk'.<sup>24</sup> Vulnerability is furthermore determined by the presence of factors, such as, poverty, lack of empowerment, underdevelopment, economic insecurity, lack of education, social exclusion, illiteracy, discrimination, and lack of information and commodities to protect against abuse.<sup>25</sup> Though the aforementioned factors have been cited in relation to Persons Living With HIV/AIDS (PLWHA), they are equally relevant to terminally ill prisoners, yet few public documents and policies specifically refer to terminally ill prisoners as a vulnerable group within South Africa, despite the fact that the HIV/AIDS rate of infection in South African prisons is high. It must be cautioned, however, that not all terminally ill inmates live with HIV/AIDS and not all inmates living with HIV are terminally ill.

It is relevant to consider that the Department of Justice has recognised that vulnerability exists where there is a lack of legal protection and where there is social exclusion of

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<sup>23</sup> Department of Justice and Constitutional Development Draft Discussion Paper: HIV/AIDS, Human Rights and Access to Justice 2009 14.

<sup>24</sup> Department of Justice and Constitutional Development HIV/AIDS, Human Rights and Access to Justice (2009)14-15.

<sup>25</sup> Department of Justice and Constitutional Development HIV/AIDS, Human Rights and Access to Justice (2009) 15.

persons.<sup>26</sup> The WHO Exclusion Knowledge Network has defined ‘social exclusion’ as follows:

‘[It consisting] of dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions – economic, political, social and cultural – and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities.’<sup>27</sup>

Based on this definition terminally ill inmates can be regarded as socially excluded persons. They are for the most part not included at all or adequately in law, policies (as is evident in Chapter 6) and even academic legal literature. Though discussed in greater detail in Chapter 5, the failure to properly consider the rights of all terminally ill prisoners is evidenced by laws on medical parole and remand detention and State actions in this regard. A case in point may be found in the context of HIV/AIDS, where the Department of Justice recognised incarcerated persons as a vulnerable group.<sup>28</sup> Despite such formal recognition and that prisoners are generally recognised as vulnerable in government policies and some legal texts, terminally ill prisoners *per se* are not widely acknowledged nor formerly accepted as one of the most vulnerable groups in society in general or in prison environments for that matter. Arguably it is the social exclusion of terminally ill inmates coupled with the lack of legal protection in practice that makes them one of the most vulnerable groups insofar as the fulfilment of the right to health is concerned. The discussion below is therefore aimed at illuminating some of the general experiences which reasonably affirm that the groups are not ‘likes’ and that they should therefore not be treated alike.

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<sup>26</sup> Department of Justice and Constitutional Development HIV/AIDS, Human Rights and Access to Justice (2009) 16.

<sup>27</sup> Popay J, Escorel S, Hernández M, Johnston H, Mathieson J and Rispel L ‘Understanding and Tackling Social Exclusion’ 2008 World Health Organisation Exclusion Knowledge Network 2.

<sup>28</sup> Department of Justice and Constitutional Development HIV/AIDS, Human Rights and Access to Justice (2009) 16.

### 4.3 BEING FREE, BUT TERMINALLY ILL: THE SOCIAL CONTEXT IN GENERAL

The history of racial and economic inequality in South Africa and/or other personal factors may shape an individual's daily life. A discussion of all these factors is beyond the ambit of this Chapter. Below, some of the general features which indicate that the positions of free persons and inmates who are terminally ill are vastly different will be briefly discussed.

#### 4.3.1 Income inequality

It is conceivable that the contention that terminally ill inmates are vulnerable may evoke responses that there are terminally ill free persons who are also vulnerable. This is not disputed, but it is maintained that those who are imprisoned constitute a more vulnerable category of persons. This will become clearer later in this Chapter. It is necessary though to discuss the fact that free persons who are terminally ill can be affected by indigence, but that their position is not comparable to that of inmates.

The availability of personal resources can have a major influence on the fulfilment of free persons' right to health care. It is therefore important to understand whether free persons have the means to access health care services and treatment. To this end, it must be highlighted that in South Africa it is colloquially said that we are one of the most unequal societies in the world as there is a major disparity between the income of the indigent and that of the wealthy. Such statements are unfortunately not social rhetoric. According to the Human Science Research Council, South Africa is ranked the fourth most unequal society in the world, and the World Bank has data on the income equality of 130 countries.<sup>29</sup> The Gini coefficient or index is a measure of income inequality. It uses a scale from 0 to 1 to indicate

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<sup>29</sup> Chitiga, M, Sekyere, E, and Tsoanamatsie, N, 'Income inequality and limitations of the gini index: the case of South Africa' available at <http://www.hsrc.ac.za/en/review/hsrc-review-november-2014/limitations-of-gini-index> (accessed 10 October 2015).

income inequality. A Gini index of 0 indicates perfect income equality, while an index of 1 represents complete income inequality. The World Bank, the main organisation that provides Gini index data, has indicated that South Africa has a Gini index of 0.63.

The significant economic inequality mentioned above means that there may be terminally ill persons who have access to substantial health resources and care whilst others do not have access to any or only limited resources and this may impact on the fulfilment of their right to health care. Whether their indigence makes them as vulnerable as terminally ill inmates depends on several factors. One such factor is whether they have access to the State's social grant system, mentioned in Chapter 3 of this thesis. The South African Social Security Agency (SASSA) indicates that as at 28 February 2015, 3 075 520 persons were in receipt of old aged grants, 1 117 653 received disability grants, and 109 729 received grants-in-aid to ensure the care of those who require daily assistance.<sup>30</sup> In 2017, 3,295,710 persons were in receipt of grants for the aged, 1 067 402 received disability grants, and 161 989 received grants-in aid. .<sup>31</sup> These figures indicate that many people do benefit from State grants and it may be inferred that it is likely that terminally ill persons do constitute a certain percentage of the recipients.

Some may correctly argue that the actual social grant amounts afforded to recipients do not allow for comprehensive and appropriate care of a terminally ill person. Whilst such a contention is not disputed, social grant recipients or carers on their behalf may decide how to utilise their grants. This provides free persons with a greater sense of dignity than having no say in how they are cared for, which may be the case for some terminally ill prisoners.

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<sup>30</sup> Factsheet No2 2015 available at [www.sassa.gov.za](http://www.sassa.gov.za) (accessed 11 October 2015).

<sup>31</sup> Ferreira, L *Factsheet: Social grants in South Africa – separating myth from reality* available at <https://africacheck.org/factsheets/separating-myth-from-reality-a-guide-to-social-grants-south-africa/> (accessed 25 May 2017).

According to Moodley, an element of choice is important in terms of the care provided to terminally ill persons.<sup>32</sup> Furthermore, the Court in *Grootboom* held that if under section 27 of the Constitution the State has in place programmes to provide adequate social assistance to those who are otherwise unable to support themselves, that would be relevant to the State's obligations in respect of other socio-economic rights.<sup>33</sup>

A further possible contention related to the above is that the poorest of the South African poor do not have access to water, food and sanitation, for example, and may therefore be in a more dire position than prisoners. After the *Van Biljon* case (discussed in Chapter 3), Ngwena criticised the decision by arguing that the Court had afforded preferential treatment to the applicant prisoners.<sup>34</sup> He states that the *Van Biljon* judgment favours prisoners over the indigent and overlooks the State's constitutional duty to provide food, water and housing to the very poor.<sup>35</sup> This view cannot be supported. The judgment cannot be said to have had a direct impact on the rights of indigent free persons. The Court had to respond to the facts presented by the parties. It had to consider that very sick prisoners were being detained in extremely hazardous conditions and had no access to much needed life-saving treatment. To not uphold their constitutional right to health and dignity would have been to reinforce the oppressive environment in which prisoners' rights are continuously limited.

It is perhaps not wise to compare very poor free persons with terminally ill inmates insofar as the fulfilment of the right to health care is concerned. Both groups are very vulnerable due to their health status and circumstances. By choosing one, the dignity of the other is negated.

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<sup>32</sup> Moodley A 'A study into palliative care services for offenders with aids at Westville prison' Masters' thesis in Social Work 2006 University of KwaZulu-Natal 75.

<sup>33</sup> *Grootboom* para 36

<sup>34</sup> Ngwena C 'Substantive equality in South African health care: The limits of law' *Medical Law International*, 2000 (4) 119.

<sup>35</sup> Ngwena (2000)119.

Moreover the State has a constitutional obligation in respect of both groups. It is also arguable that most prisoners come from poor communities before incarceration and if they are released they go back to those communities.<sup>36</sup> Denying appropriate health care to a terminally ill inmate may even result in a heavier burden on a very poor family.

#### 4.3.2 Family and community care

Byock states that terminally ill inmates may fear spending their last hours alone in prison, away from family and friends.<sup>37</sup> According to Twycross and Lichter much of the support that a dying person needs can only be given by the family. Unfortunately many families are not willing or able to care for their family member who is terminally ill when he is released.<sup>38</sup>

Though section 13 of the Correctional Services Act 111 of 1998 requires that correctional authorities should encourage contact between inmates and their family and community, the provision does not adequately address a terminally ill person's need to be close to family and friends. In most correctional centres inmates are afforded a limited number of visits per month which are usually only for an hour or less at a time.<sup>39</sup> There are also restrictions on the material goods such as food, toiletries, medicines and clothing with which an inmate's family members may provide them.<sup>40</sup> Terminally ill persons who are free do not experience these limitations and may benefit from charitable gestures of their family and community. They are more likely to have the choice of being cared for and dying at home with family and community in support.

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<sup>36</sup> Fourie E 'Thinking about incarceration in South Africa: The Inside-out Outside-in interest group' (2015) *Psychology in Society* 81.

<sup>37</sup> Byock, I 'Dying well in corrections: Why should we care', 2002 *Journal of Correctional Health* 1.

<sup>38</sup> 'Traditional and alternative health care' in *Health and Democracy* 213 available at <http://www.section27.org.za/wp-content/uploads/2010/04/Chapter7.pdf> 294 (accessed 3 October 2015).

<sup>39</sup> See The Department of Correctional Services website in this regard <http://www.dcs.gov.za/VisitingOffenders/Visitinghours.aspx> (accessed 17 May 2017).

<sup>40</sup> No offender may bring any item into the correctional centre immediately after a visit. See <http://www.dcs.gov.za/VisitingOffenders/VisitationProcess.aspx> (accessed 17 May 2017).

### 4.3.3 Religious needs

The prospect of dying in prison, away from family and friends, can have a very harmful impact on patients' mental well-being. It can exacerbate suffering.

'Unless provided with adequate human contact and psycho-spiritual support, a dying prisoner is likely to suffer from a myriad of mental problems associated with feelings of isolation, and the prospects of dying in prison, in addition to physical pain.'<sup>41</sup>

In their home environment terminally ill persons who are free are more likely to have their religious needs fulfilled. According to Puchalski, terminally ill people are often comforted by the presence of spiritual leaders during chronic illness even if they were not actively involved in religious activities before their illness.<sup>42</sup> Though section 13 of the Correctional Services Act provides for inmates' access to their religious leaders, it is common knowledge that such access is not without restrictions; one-on-one counselling and privacy may prove difficult; and access to a prisoner when the prisoner requires the presence of a religious leader may often be affected by timing issues. In the home environment, there would be much greater access to religious leaders, groups and their support than in the correctional environment. There would also be a greater degree of privacy which may be an important need for a person who is terminally ill.

### 4.2.4 Cultural needs

Some terminally ill persons may experience needs such as treatment or advice from a traditional healer. It has been recognised that traditional medicine is an important element of the treatment and care model for terminally ill persons.<sup>43</sup> Fortunately, this need may be met in the home environment of a terminally ill person who is free. In Chapter 3 of this thesis,

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<sup>41</sup> United Nations Office on Drugs and Crime *Handbook on Prisoners with Special Needs* (2009) 146 available at <http://www.refworld.org/docid/4aB969d42.html> (accessed 15 February 2016).

<sup>42</sup> Puchalski, C M & Sandoval, C *Spiritual Care* (2003) 2ed 290.

<sup>43</sup> NPFSPC (2017) 25.

however, it was mentioned that the Traditional Health Practitioners Act does not contemplate terminally ill inmates' need for traditional medicines and treatment. The Correctional Service Act and regulations do not provide for this either.

#### 4.3.5 Access to public health facilities

Free persons have greater liberty to access public health services whereas internal prison security regulations may delay or make impossible access to such services by inmates.<sup>44</sup> Continuity of services and treatment and compliance with medical practitioners' orders and advice may also be easier in the home environment than in prisons.<sup>45</sup> The proximity of terminally ill free persons' family and friends affords a much more privileged position than that of inmates as they may assist their terminally ill relative or friend in accessing health care. It needs also to be considered that the DCS<sup>46</sup> and not the Department of Health is responsible for health care in prisons. It has therefore been argued that prisoners do not have access to the same standard of health care as is available in the public sector.<sup>47</sup>

#### 4.3.6 Community-based and/or home care

The availability of community-based and/or home care in some communities may furthermore place terminally ill free persons in a more advantageous position than inmates. The Department of Health estimates that there are between 60 000 – 70 000 home-based carers who are mostly volunteers managed by non-profit organisations.<sup>48</sup> The Hospice Palliative Care Association member organisations provide palliative care services to

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<sup>44</sup> Moodley A (2006) 75.

<sup>45</sup> Moodley A (2006)75.

<sup>46</sup> Section 12(1) of the Correctional Services Act 111 of 1998 provides that the DCS must, within its available resources, provide adequate health care services based on the principles of primary health care to inmates.

<sup>47</sup> The right to health of vulnerable groups to health care in *Health and Democracy* 295 available at <http://www.section27.org.za/wp-content/uploads/2010/04/Chapter7.pdf> (accessed 3 October 2015).

<sup>48</sup> NACOSA Recognition for Home-Based Carers *Position Paper* July 2013.



approximately 50 000 patients and their families per month.<sup>49</sup> Whilst not all terminally ill free persons have access to home-based care programmes, the aforementioned figures indicate that substantial numbers do enjoy access.

Home-based carers offer ‘a package of care’ to terminally ill persons.<sup>50</sup> The package includes: conducting community, household and individual health assessments and identifying potential or actual health needs, and helping families or individuals to access appropriate health services; promoting the health of the households and the individuals within these households; referring people for further assessment and testing after performing basic screening tests; providing limited health interventions in a household, such as basic first aid, oral rehydration and other interventions that they are trained to provide; and providing psycho-social support and managing interventions, such as, treatment defaulter tracing and adherence support.<sup>51</sup>

Arguably few prisons (this will be discussed in greater detail in Chapter 5) in South Africa have programmes in place which provide comprehensive and adequate care to terminally ill inmates which is comparable to home-based care offered to free persons. This inference is reasonable given the general access constraints faced by non-governmental organisations that wish to work in prisons. Furthermore, prison medical staff or volunteers may fear that some terminally ill inmates pose a risk to their safety and this places a limitation on the care that such inmates receive. Additionally, in prisons where care programmes for terminally ill prisoners have been implemented, there is also the reasonable concern that other prisoners who are volunteers or trainee carers may exploit their access to commodities, such as, food,

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<sup>49</sup> See <http://www.ngopulse.org/organisation/hospice-palliative-care-association-south-africa> (accessed 12 October 2015).

<sup>50</sup> NACOSA (2013).

<sup>51</sup> NACOSA (2013).

medication, clothing and other goods.<sup>52</sup> The increased freedom of movement of the prison trainees and volunteers in the prison and terminally ill inmates' dependence on the volunteer or trainee inmate carer may even create the potential for abuse and power dynamics in the prison system.

In summary it is reasonable to contend that the position of free persons who are terminally ill generally differs from that of inmates who are also terminally ill. It appears that free persons with limited material resources, though their suffering may not be underestimated, are in a better position than inmates insofar as the recognition of their right to dignity and health is concerned. Despite this, it is contended that the position of terminally ill prisoners and very poor persons should not be compared for the purpose of improving either group's protection of the right to health care. This may be better understood from the next section of this chapter.

#### 4.4 BEING TERMINALLY ILL AND IMPRISONED

It may be thought that '...death is the great equalizer' amongst human beings and that some of its 'cousins: illness, dementia, physical debility, and advanced age'<sup>53</sup> can ensure a journey marked by severe pain and suffering before we reach our fate. However, for the terminally ill inmate there may be additional suffering which does not stem from the illness itself, but can succeed in exacerbating it. To explain this phenomenon to some extent one may take into consideration how inmates' rights to health and dignity are generally violated. To this end the case of *Lee v Minister of Correctional Services*<sup>54</sup> will be discussed to demonstrate how the criminal justice system contributes to poor health in contemporary times. The impact of

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<sup>52</sup> Moodley (2006) 93.

<sup>53</sup> Byock (2002) 108.

<sup>54</sup> *Lee v Minister of Correctional Services* 2013 (2) BCLR 129 (CC).

the architectural design of prisons on prisoners and of imprisonment on the individual will be considered.

#### 4.4.1 The *Lee* case: A depiction of the health pitfalls in the criminal justice system

The applicant in this case was in prison awaiting trial. During this time he attended court approximately 70 times.<sup>55</sup> Every time he was transported to court ‘[inmates] were stuffed into vans like sardines [and] [a]t court they were placed into cells which were jam-packed’.<sup>56</sup>

Mr Lee shared a cell, which was meant to accommodate one person, with two other inmates.<sup>57</sup> For a short period of time he shared a communal cell with approximately 25 other inmates. Three years after his admission to Pollsmoor,<sup>58</sup> he was diagnosed with tuberculosis. During the two-week period after his diagnosis he was detained in a cell with another inmate. He might still have been contagious at that time.<sup>59</sup> These facts demonstrate that there may be cases where the DCS does not consider the health of prisoners when allocating cells and that health may therefore be at risk on a continuous basis.

Mr Lee did not have tuberculosis when he was admitted to Pollsmoor. Pollsmoor is known to be overcrowded and inmates generally spend up to 23 hours a day in a cell and in close contact with each other.<sup>60</sup> Factors, such as, poor ventilation in cells, inadequate nutrition and a breakdown in the health care system due to insufficient staff, pose a risk to health in general. Given that tuberculosis is an ‘airborne communicable disease which spreads easily especially in confined, poorly ventilated and overcrowded environments’<sup>61</sup>, the conditions in Pollsmoor were ideal for the spread of the disease. Brief synopses of the judgments of the

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<sup>55</sup> *Lee v Minister of Correctional Services* para 6.

<sup>56</sup> *Lee v Minister of Correctional Services* para 6.

<sup>57</sup> In 2015 a remand detainee was released after eleven years. He is said to hold the South African record for having spent the longest time awaiting trial. See *Legal Brief* 18 June 2015 available at [www.legalbrief.co.za/story/man-freed-after-11-years-awaiting-trial/](http://www.legalbrief.co.za/story/man-freed-after-11-years-awaiting-trial/) (accessed 18 June 2015).

<sup>58</sup> Pollsmoor Maximum Security Prison is situated in Tokai, a suburb of Cape Town, South Africa.

<sup>59</sup> *Lee v Minister of Correctional Services* para 10.

<sup>60</sup> *Lee v Minister of Correctional Services* para 8.

<sup>61</sup> *Lee v Minister of Correctional Services*.

Western Cape High Court, Supreme Court of Appeal and Constitutional Court in this matter are given below.

#### 4.4.1.1 The High Court and Supreme Court of Appeal judgments

Mr Lee instituted action against the DCS. He claimed that he had been infected as a result of the negligent conduct of the DCS. The Western Cape High Court held that the uncontrollable spread of tuberculosis at Pollsmoor constituted a negligent breach of the correctional authorities's duty to protect inmates.<sup>62</sup> The High Court found that the DCS was liable for causing Mr Lee's infection with tuberculosis. This decision was later overturned by the Supreme Court of Appeal (SCA). It was held that evidence that reasonable precautions had not been taken by the DCS to avoid foreseeable harm, and the fact that the harm indeed occurred, 'does not establish that the [omission] caused the [harm]'.<sup>63</sup>

Furthermore, the SCA held that it must be asked what the DCS ought to have done to prevent the spread of tuberculosis and whether this would have prevented Mr Lee from contracting the disease. At Pollsmoor the authorities relied on self-reporting. Self-reporting entailed that inmates should report symptoms to prison authorities, as a means of detecting and preventing the spread of tuberculosis. The Court found that in an overcrowded correctional centre like Pollsmoor 'self-reporting' by inmates will 'necessarily be the only means for its detection in many cases'.<sup>64</sup> Importantly, Mr Lee could not provide evidence to prove the exact source of his infection. The Court held that had he been able to prove a causal link between his infection and the specific negligent act of the DCS he might have succeeded in his claim. Mr Lee's claim failed because he could not prove that a reasonably effective health system would have totally eliminated the risk of him becoming infected.

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<sup>62</sup> *Lee v Minister of Correctional Services* para 14.

<sup>63</sup> *Minister of Correctional Services v Lee* 2012 (1) SACR 592 (SCA) para 55.

<sup>64</sup> *Minister of Correctional Services v Lee* para 61

#### 4.4.1.2 The Constitutional Court judgment

Mr Lee appealed to the Constitutional Court. The majority of the Court held that the South African common law of delict (law on tort) was sufficiently flexible to dispose of the case. The Court adopted an ‘empirical or common-sense view of causation’.<sup>65</sup> It rejected the SCA’s finding that Mr Lee failed to prove that ‘reasonable systemic adequacy would have altogether eliminated the risk of contagion, that he does not know the source of his infection and that had he known the source it is possible that he might have been able to establish a causal link between his infection and the specific negligent conduct on the part of the responsible authorities.’<sup>66</sup>

The Constitutional Court confirmed the correctness of the High Court’s finding that it had to be questioned whether the factual conditions of Mr Lee’s incarceration were a more probable cause of his tuberculosis, than would have been the case had he not been detained in those conditions. Nkabinde J held ‘[i]t would be enough, I think, to satisfy probable factual causation where the evidence establishes that the plaintiff found himself in the kind of situation where the risk of contagion would have been reduced by proper systemic measures’.<sup>67</sup> Mr Lee’s claim for damages was accordingly upheld.

The fact that a prisoner had to embark on the legal journey outlined above to assert his right to health speaks volumes for the DCS’ commitment to the health care of prisoners. The DCS’s defence of the matter also alludes to an attitude that health care is not a priority in prisons. On the whole the judgment leaves without question that a correctional system which continues to allow the *status quo* runs the risk of facing legal sanctions. Subsequent to the

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<sup>65</sup> *Lee v Minister of Correctional Services* para 46.

<sup>66</sup> *Lee v Minister of Correctional Services* para 42.

<sup>67</sup> *Lee v Minister of Correctional Services* para 60.

Constitutional Court judgment it was reported that the DCS had begun to engage with the Department of Health, some non-governmental organizations as well as the National Health Laboratory Service to formulate guidelines on how to manage tuberculosis in correctional centres.<sup>68</sup> Further efforts to stem the spread of tuberculosis have also been reported in 2013.<sup>69</sup> Whether these measures will contribute to reasonable health systems in correctional centres may only become evident in the future.

To date Constitutional Court Justice Cameron has released a Report on his visit to Pollsmoor in 2015. The finding in the Report is of immense concern. Justice Cameron reported that conditions in Pollsmoor were not in accordance with the statutory and constitutional requirements for detention.<sup>70</sup> He found that the prison was generally overcrowded with the remand section overcrowded at over 300 per cent capacity and the female section housing double the number of women it is supposed to accommodate.<sup>71</sup> The Report also notes that there was a shortage of essential supplies and medicines, that there are delays as long as two weeks with furnishing of medications (including chronic medication), and that there was a shortage of medical staff.<sup>72</sup> As pointed out in Chapter 3, in 2016 Sonke Gender Justice, a non-governmental organisation, successfully applied for a court order compelling Pollmoor

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<sup>68</sup> See Harry Hausler, 'Opinion: TB cannot be kept behind bars' *Mail & Guardian* available at <http://mg.co.za/print/2013-03-22-00-opinion-tb-cannot-be-kept-behind-bars> (accessed 15 May 2013).

<sup>69</sup> Harry Hausler, "Opinion: TB cannot be kept behind bars" *Mail & Guardian* available at <http://mg.co.za/print/2013-03-22-00-opinion-tb-cannot-be-kept-behind-bars> (accessed 15 May 2013). Some of the measures reportedly include the installation of a 'GeneXpert tuberculosis diagnostic instrument' at Pollsmoor. This machine can allegedly diagnose tuberculosis and detect resistance to Rifampicin, an important anti-tuberculosis drug, within two hours. The traditional methods of diagnosis took up to two days and to identify drug resistant tuberculosis would take up to six weeks. With this machine it is possible for inmates to commence treatment the same day as they are diagnosed. Other measures are: making available (at Pollsmoor) ten lay counsellors to provide HIV counselling and testing with tuberculosis screening; a laboratory technician to operate the GeneXpert machine; and a professional nurse to help prison staff to diagnose tuberculosis. The DCS has also established a Remand Detention Branch, but at the time of writing the conditions in remand facilities are still very poor.

<sup>70</sup> Cameron (2015) 4.

<sup>71</sup> Cameron (2015) 5.

<sup>72</sup> Cameron (2015) 1-13.

Correctional Centre to reduce overcrowding, one of the major causes of health problems in prisons.

The prevailing conditions in South African prisons can result in terminal illnesses and/or aggravate them. Though it is absolutely imperative that conditions should be improved to prevent health problems in the first place, it appears to be unlikely that the correctional system will be completely transformed in the near future to reflect South African constitutional values. The reality must be accommodated. The State must make provision for the health care needs of all inmates including those who are terminally ill when they are admitted to prison or who will become terminally ill due to *inter alia* the health hazards in prison or pre-existing health issues.

Furthermore, though the applicant in the *Lee* case was not terminally ill, the case indirectly draws our attention to other issues that affect the whole criminal justice system and which can impact negatively on detainees' rights, with terminally ill inmates suffering the worst violations. Historically widespread poverty, inequality and high rates of unemployment have arguably affected how detainees experience the criminal justice system. Though these factors existed prior to the inception of democracy, the introduction of new social and economic policies has not resulted in considerable improvements. It is thus still the case that many detainees are poor, unemployed, lack adequate education and thus do not have the financial resources to appoint lawyers, access relevant information to divert their cases from the formal justice system or to pay bail in order to be released. In Chapter 6 it will also be demonstrated that these factors may affect inmates' potential to be released on medical parole. Had the applicant in *Lee* had the resources to appoint top lawyers in the first place, his experience of the criminal justice system may in all likelihood have been less challenging.

#### 4.4.2 Prison buildings

The major problems in Pollsmoor cited in the *Lee* case closely resemble the conditions of detention prior to the advent of constitutional democracy. One of the possible explanations for the similarity in conditions during Apartheid and in the new era of democracy may be that most prisons that were designed and built by the former regime are still utilised today. These facilities had not been constructed with humane detention in mind and therefore require substantial upgrades to meet contemporary human rights standards

There appears to be no doubt that the structure and layout of a prison building influences the prevailing atmosphere and the morale of prisoners and staff.<sup>73</sup> Hence a prison must be designed to ensure the safety, control and development of prisoners.<sup>74</sup> As mentioned above most prisons in South Africa were not built for this purpose. Originally prisons were designed to punish offenders and what happened to them behind prison walls did not really concern the public.<sup>75</sup> Many prisoners continue to be accommodated in communal cells which are rarely supervised and as such provide opportunities for violence and crime.<sup>76</sup> Communal cells also present significant health risks as was demonstrated in the *Lee* case. They present challenges for access to health care too.<sup>77</sup> These prisons with their architectural designs which date back to the 19<sup>th</sup> and 20<sup>th</sup> centuries present major management challenges to prison authorities that have to operate within a constitutional dispensation.<sup>78</sup>

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<sup>73</sup> Klare (1962) 19.

<sup>74</sup> Luyt W, Jonker J & Bruyns H *Unit Management and legal principles in prisons* 2010 27.

<sup>75</sup> Luyt *et al* (2010) 29.

<sup>76</sup> Luyt *et al* (2010) 29. Muntingh L 'Reducing prison violence: implications from the literature for South Africa' *Civil Society Prison Reform Initiative Research Paper 17* 2009 Community Law Centre 2009 14.

<sup>77</sup> During an informal interview with a former prisoner in Durban in November 2016, he recalled an incident where a fellow prisoner experienced what he believed could have been an epileptic seizure during the night. He claimed that since prison officials do not guard the cells at night, fellow prisoners attempted to assist the prisoner. A prison official only arrived almost an hour after other prisoners had started to bang objects against the walls and prison bars to draw the officials' attention. Incidents of this nature alludes to the problem of physical accessibility to health care in prisons. Other former inmates also relayed incidents of similar medical emergencies.

<sup>78</sup> Muntingh (2009) 14.



Furthermore, the steel doors, barred windows and dreary walls as well as overcrowding and noise levels can impact negatively upon human health and behaviour.<sup>79</sup> Privacy and the need for quiet space, which may be required by a terminally ill inmate, remain unmet in the typical prison setting. These factors which may all impact negatively on a person's health may be less prevalent in a home environment. While the overcrowding and poorly designed prison cells may be problems that can only be effectively addressed in the long-term, they negate the fundamental right especially of terminally ill prisoners. The State is under an obligation to ensure reasonable accommodation for such prisoners. Solutions may include moving terminally ill persons to the hospital section of a prison, accommodating them in single cells if available. While a prisoner's security classification may be considered, it cannot be the overriding consideration if the inmate is terminally ill. This should be considered particularly in cases where medical parole had been denied or an inmate does not have support outside of the correctional environment. Reasonable measures must be employed to ensure humane detention.

#### 4.4.3 The impact of imprisonment on the individual

Foucault opines:

‘In this panoptic society of which incarceration is the omnipresent armature; the delinquent is not outside the law; he is, from the very outset, in the law, at the very heart of the law, or at the least at the midst of those mechanisms that transfer the individual imperceptibly from discipline to the law, from deviation to offence . . . The delinquent is an institutional product.’<sup>80</sup>

Though Foucault's view on incarceration was expressed many decades ago, it appears to reflect to some extent the position of prisoners in South Africa. In 1979 in *Goldberg v Minister of Prisons* it was held:

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<sup>79</sup> Luyt *et al* (2010) 41.

<sup>80</sup> Foucault (2011) 427.

‘The inroads which incarceration necessarily make upon a prisoner’s personal rights and liberties ... are very considerable. He no longer has freedom of movement and has no choice in the place of his imprisonment. His contact with the outside world is limited and regulated. He must submit to the discipline of prison life and to the rules and regulations which prescribe how he must conduct himself and how he is to be treated while in prison’.<sup>81</sup>

In 1995 the Jali Commission found that prisoners were subjected to torture, assault, and abuse and made to perform duties that infringed upon their dignity. It appeared to the Commission that DCS officials believed that prisoners were in prison ‘for punishment’ and not ‘as punishment’.<sup>82</sup> Twenty years later, complaints of an abusive prison system characterised by gang violence, corrupt officials and hazardous prison conditions still exist with dire consequences for the physical and mental health of prisoners.<sup>83</sup>

The impact of imprisonment on the individual can be better understood when it is taken into account what ‘prison’ as an institution objectively entails. According to Steinberg, an inmate’s experience is essentially one of infantilisation.<sup>84</sup> He explains that if adult life is made meaningful by the exercise of one’s agency, then this is exactly what the inmate is denied in the correctional environment. ‘Agency’ includes even the simplest things we do by ourselves like washing, using a telephone, deciding when to eat and when to rest. Inmates are deprived of the very basics of being an adult. For a terminally ill prisoner who may, for example, need to bathe more often than others, special diets, regular contact with friends and family and more rest, the restrictions may result in severe suffering. This is also likely to

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<sup>81</sup> 1979(1) SA 14(A) 39 C–E.

<sup>82</sup> Van der Berg Summary of the Final Report of the Judicial Commission of Inquiry into Allegations of Corruption, Maladministration and Violence in the Department of Correctional Services – ‘The Jali Commission’ *CSPRI Research Report* 13 of (2007) 27.

<sup>83</sup> See for example Broughton T ‘Payouts for prison horror’ *The Mercury* 27 October 2016,1 which reports on two remand detainees who had been imprisoned for two months and were awarded R1 million for their exposure to the ‘horrors of prison’. Their account indicates the extreme violence which prevails in some South African prisons.

<sup>84</sup> Steinberg J ‘Nongoloza’s Children: Western Cape Prison Gangs During and After Apartheid’ *Monograph for the Centre for the Study of Violence and Reconciliation* (2004) 18.

affect an inmate's sense of self-worth.<sup>85</sup> A terminally ill inmate in particular may feel demoralised as they arguably require an environment that is emphatic to their condition.

From the discussion above it should be evident that imprisonment generally has an incapacitating and demoralising impact on inmates. Inmates who are further debilitated by the ravages of terminal illnesses may experience a complete negation of their right to dignity and the right to health. As a result of the severe limitations on their rights, it is imperative that the State should take reasonable steps to ameliorate their experience of the prison environment. In contemporary times there is evidence that such steps are often not taken and that the State in fact exposes those who are in conflict with the law to health risks. This is demonstrated by the *Lee* case discussed above.

#### 4.5 EQUALITY FOR TERMINALLY ILL INMATES

From the preceding discussions it may be evident that terminally ill prisoners are in a very precarious position insofar as the realisation of their right to health care is concerned. The Correctional Services Act does not deal specifically with their right to health care. Legislative provisions on health care in prisons are aimed at addressing the health of prisoners in general. Though the legislation does refer to the 'special needs' of prisoners with chronic health conditions, for example (discussed in Chapter 3 of this thesis), such provisions do not adequately protect terminally ill prisoners' right to health care. At best legislation only refers to terminally ill inmates' health when an application for medical parole (discussed in chapter VI of this thesis) is made. It is therefore arguable that by essentially treating

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<sup>85</sup> Albertus (2010) 14.

terminally ill inmates' health care needs in the same manner as other inmates' needs, the law overlooks them (terminally ill inmates).<sup>86</sup>

In Chapter 5 of this thesis the right to palliative care is discussed more fully. Tentatively it must be noted that most persons diagnosed with a terminal illness will require the holistic care provided in terms of palliative care approaches. It is contended that the absence of adequate provisions in national law and/or policy which deal with palliative care and other health related needs of terminally ill prisoners places them at a disadvantage.<sup>87</sup> The law and government policies appear to prioritise curative and preventative health services. Whilst such services are warranted, the omission of, or limited focus on, palliative services and particularly in the prison environment is cause for concern. It appears to create the impression that the right to health applies only to those who are healthy or capable of attaining improved health.

#### 4.5.1. Sameness of treatment

Some may argue that terminally ill prisoners have equal access to the same health services as other persons and that the former are thus not discriminated against. It must be recognised though that 'sameness' of treatment does not ensure true (or substantive) equality.<sup>88</sup> As

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<sup>86</sup> At the time of writing the Strategic Plan for 2015/2016 – 2019/2020 16 indicated that the DCS continues to identify gaps in policy issues relating to priorities. A few policies, including a Policy on the Provision of Palliative Care in the Department of Correctional Services were identified. The purpose of the policy is to provide guidelines on the provision of palliative care in the DCS by the external and internal stakeholders. The Strategic Plan, however, provides no significant detail about such policy. It is contended that while the intention to develop and introduce such a policy may be necessary, the health care of those diagnosed with a terminal disease or condition should extend beyond palliative care. This contention is discussed in greater detail in Chapter 7.

<sup>87</sup> The Health Care Act 61 of 2003 does not make any reference to the specific provision of palliative care. It has also been noted that the National Health Insurance has a strong focus on 'health promotion and prevention services'. Palliative care seems not to be a priority. See Matsoso M & Fryatt R 'National Health Insurance: The first 18 months' *South African Medical Journal* 103 (3) 1.

<sup>88</sup> Dworkin (1978) 209.

Dworkin puts it, ‘we must take care not to use [the constitutional equality clause] to cheat ourselves of equality’.<sup>89</sup> Thus

‘. . . realising equal access to health care for disadvantaged groups in society requires that health care institutions must take into consideration the peculiar circumstances of these groups. In essence a substantive equality approach in health care services is imperative to meeting the special needs of vulnerable and marginalised groups<sup>90</sup> [like terminally ill prisoners]’.

‘Equality or lack of it affects the capacity of one to enjoy many other rights [including the right to health].’<sup>91</sup> Similarly, the Committee on Economic, Social and Cultural Rights (ICESCR) has held that the enjoyment of the right to health is dependent on other rights, such as, rights to life, privacy, dignity and non-discrimination.<sup>92</sup> The ICESCR has also expressed the view that the International Covenant on Economic, Social and Cultural Rights prohibits discrimination<sup>93</sup> in accessing health care and the underlying determinants of health on grounds of, *inter alia*, health status. It seems that the aforementioned principle regarding equality in accessing health care has been endorsed in South Africa. This can be inferred from the Constitutional Court’s judgment in *Minister of Health v Treatment Action Campaign and Others* where it was held that a government policy which fails to address the needs of those who were in dire need of antiretroviral therapy was unreasonable and gave rise to government being in breach of its duty to realise the right to health of its citizens.<sup>94</sup> The same principle should also be applied to persons diagnosed with terminal diseases and particularly terminally ill inmates. If government continues to neglect the duty to provide appropriate health care for them, then such omission is unreasonable.

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<sup>89</sup> Dworkin (1978) 209.

<sup>90</sup> Durojaye E ‘Realising Equality in access to HIV treatment for vulnerable and marginalised groups in Africa’ (2012) 15 *Potchefstroom Electronic Law Journal* 218.

<sup>91</sup> See *Legal Resource Foundation v Zambia* 2001 AHRLP 84 (ACHPR).

<sup>92</sup> Committee on ESCR *General Comment 14* para 12.

<sup>93</sup> Committee on ESCR *General Comment 14* para 18.

<sup>94</sup> 2002 10 BCLR 1033 (CC).

#### 4.5.2 Substantive equality in health care for terminally ill inmates

It ought to be accepted that a ‘. . . substantive equality approach in health care services is imperative to meeting the special needs of vulnerable and marginalised groups’.<sup>95</sup> The same State action or support may therefore not be effective in upholding the right to health care of all terminally ill free persons and inmates. The discussion below is therefore aimed at illuminating some of the general experiences which reasonably affirm that the groups are not ‘likes’ and that they should therefore not be treated alike.

Health care in prisons is not the same as health care provided to the public. Historically South African prisons were used as institutions of oppression. Though the era of constitutionalism has introduced rehabilitation as the primary aim of correctional centres, much of the physical infrastructure which housed inmates in the past is still utilised to detain inmates. Correctional centres are also still widely known as ‘universities of crime’ and breeding grounds for disease. This must be considered, as these factors contribute to the stigmatisation of, and discrimination against inmates while they are incarcerated and even after they are released. It is also important to take into account the differences in the positions of inmates and free persons who are terminally ill. In the *Grootboom* case the Court noted the difference between those who could not afford any form of housing and those who could afford basic adequate housing.<sup>96</sup> The Court explicitly held that those who are poor and particularly vulnerable must be afforded ‘special attention’.<sup>97</sup> Arguably, inmates who are terminally ill are therefore entitled to special attention in order to unlock the system of quality health care that is available to the public.<sup>98</sup>

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<sup>95</sup> Durojaye (2012) 218.

<sup>96</sup> *Grootboom* para 36.

<sup>97</sup> *Grootboom* para 36

<sup>98</sup> *Grootboom* para 36.

To simply expand health care measures to the general inmate population without focusing on the most vulnerable and marginalised encroaches upon the right to equality and health. It is important to acknowledge and act upon the characteristics of those, such as terminally ill inmates, who are likely to be affected by health-related decisions, policies and programmes.<sup>99</sup> The Department of Justice and Constitutional Development itself indicated that a human rights based approach entails that matters which had formerly been regarded as discretionary may become ‘legal entitlements’.<sup>100</sup> In the context of terminally ill inmates, it may arguably mean that they become entitled to *inter alia* full-time palliative care (which will be discussed in greater detail in Chapter 6) and the support ordinarily afforded to persons cared for in a familial and/or community setting.

#### 4.6 CONCLUSION

Though it is well-known that health care in the public sphere differs from the quality of health care provided in correctional centres in South Africa, the impact of the inequality is not always fully comprehended. From a legal perspective some may argue that everyone has an equal right to access health care and that this includes inmates who are terminally ill. Some may also concede that while such inmates are vulnerable their position is not very different from that of free persons who are indigent and terminally ill. Against this it must be noted that in reality the South African criminal justice system exposes detainees to health risks on an almost continuous basis and that the deterioration of pre-existing health conditions is a reality for many inmates who may come from indigent communities and families. Detainees are also often denied access to the holistic care and support they require and that would be more readily accessible in a community setting. The position of terminally ill inmates is unique and renders them exceptionally vulnerable. They therefore require

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<sup>99</sup> Durojaye (2012) 221.

<sup>100</sup> Department of Justice and Constitutional Development HIV/AIDS, Human Rights and Access to Justice (2009) 16.

special attention. They must be acknowledged in health-related decisions, policies and programmes. The communities of origin, particularly their indigence and lack of access to health care, in the first place, and the health pitfalls of the criminal justice system, must be considered in sketching the health entitlements of terminally ill inmates. The State's failure to adequately address the plight of terminally ill inmates affirms that 'in penal justice, the prison transformed the punitive procedure into a penitentiary technique; the carceral archipelago transported this technique from the penal institution to the entire social body'<sup>101</sup>

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<sup>101</sup> Foucault (2011) 425.



## CHAPTER 5

### EARLY RELEASE OF ELIGIBLE TERMINALLY ILL INMATES AND REMAND DETAINEES

#### 5.1 INTRODUCTION

In the context of a correctional system widely berated for its appalling conditions, it seems that release from prison may be the most humane option for many terminally ill inmates and remand detainees. At the same time, however, it must be understood that the early release of an inmate or remand detainee 'is not a right, but a concession by society for either reasons of compassion or pragmatism'.<sup>1</sup> Furthermore, it cannot be gainsaid that the early release of an inmate or remand detainee on medical grounds is often accompanied by controversies and challenges (as will become more apparent later in this Chapter).<sup>2</sup> Despite these difficulties and consonant with the right to health care and the right to dignity, this Chapter will discuss the law which regulates the release of inmates on medical parole<sup>3</sup> as well as the release of remand detainees on medical grounds. The challenges presented by these systems will also be considered. Furthermore it will be contended that in addition to a reasonable health care system in the correctional setting (as argued for throughout this thesis), an effective and fair medical parole or release system is required to uphold the right to health and dignity of all terminally ill persons who are detained. Put plainly, an effective medical parole system does not preclude the need for appropriate health care (palliative care) and *vice versa*.

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<sup>1</sup> Editorial: Parole must be even-handed *Business Day Live* 22 February 2015 available at <http://www.bdlive.co.za/opinion/editorial/2015/02/02/editorial-parole-must-be-even-handed> (accessed 2 December 2016).

<sup>2</sup> See for example Curlewis L 'Understanding imprisonment –an in-depth discussion' (2016) July *De Rebus* 34. 'Shabir Shaik still 'terminally ill' after 8 years – but can work and attend sports' *Timeslive* 27 July 2017 available at <https://www.timeslive.co.za/news/south-africa/2017-07-27-shabir-shaik-still-terminally-ill-after-8-years-but-can-work-and-attend-sports/> (accessed 7 August 2017) and Furlough A 'Prisoner fights in court for fellow inmate with brain cancer' 9 May 2017 available at <http://www.groundup.org.za/article/prisoner-fight-court-fellow-inmate-brain-cancer/> (accessed 7 August 2017) which highlight some of the controversies and challenges which may be encountered.

<sup>3</sup> 'Parole' is '... a continuation of a sentence outside of the correctional facility.' Mujuzi J 'Unpacking the law and practice relating to parole in South Africa' (2011) 14 *PER* 2011 (14) 205. 'Medical parole' is, in short, granted to an inmate who is too ill to continue serving his or her sentence in the correctional facility. In other words, an inmate can be released on humanitarian grounds.

A coherent discussion of the early release of detained persons for medical reasons must commence with the recognition that in South Africa different laws apply to remand detainees and sentenced inmates who are terminally ill. For this reason the Chapter will deal with remand detainees and sentenced inmates separately.

## 5.2 REMAND DETAINEES

Before the laws which may impact on the early release of remand detainees can be discussed, it is necessary to sketch a rudimentary picture of the plight of remand detainees who are terminally ill. This will be followed by an analysis of legislative provisions which may contribute to their early release. The discussion is important as it ultimately determines whether or not there are effective legal mechanisms in place to protect the dignity of terminally ill remand detainees who cannot be appropriately cared for whilst they are incarcerated. To this end, section 49E of the Correctional Services Act which deals with the release of remand detainees on medical grounds will be analysed. Additionally, section 49G of the Correctional Services Act and section 63 of the Criminal Procedure Act will be discussed with a view to determining whether these provisions may be of assistance to such detainees. They, respectively, provide for certain limitations on the period of detention of remand detainees, and their release where prison conditions may be detrimental to the health of inmates in general.

### 5.2.1 The picture of remand detention

Section 1 of the Correctional Services Act defines a ‘remand detainee’ as a

- (a) person detained in a remand detention facility awaiting the finalisation of his or her trial, whether by acquittal or sentence, if such person has not commenced serving a sentence or is not already serving a prior sentence; and
- (b) (b) includes a person contemplated in section 9 of the Extradition Act 67 of 1962 detained for the purposes of extradition.

Remand detention in South Africa cannot be properly understood without briefly having regard to its constitutional bases. The Constitution permits<sup>4</sup> such detention which limits *inter alia* an individual's right to freedom. This may be inferred from section 35(1) and (2) of the Constitution as these provisions explicitly refer to 'arrested' and 'detained' persons and furthermore confers a host of rights which apply to such individuals.<sup>5</sup> In short these rights prescribe procedures that must be followed after arrest and the required treatment of detainees during detention. Legal protection of an accused person's rights is further cemented by section 35(3)(h) of the Constitution which provides that every accused person has a right to a fair trial, which includes the right to be presumed innocent.<sup>6</sup> A person charged with an offence is therefore to be deemed innocent until proven guilty in a court of law. Based on section 12 of the Constitution, the detention of an accused person may therefore constitute an unjustifiable encroachment upon his rights, if such detention is arbitrary and/or without good cause or inconsistent with the mentioned constitutional imperatives.

Notwithstanding the unequivocal constitutional protection of the rights of persons in conflict with the law, the image of remand detention in South Africa in general is of serious concern. Moreover, it will arguably become evident later that the current conditions of detention heighten the plight of those who are terminally ill and that legal protection is therefore vital. At the outset it may also be contended that the constitutional guarantee in section 35(2)(e) of the Constitution of conditions of detention that are consistent with human dignity, including

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<sup>4</sup> The Constitution explicitly provides for arrested and detained persons' rights in section 35(1) and (2) for example. It may therefore be inferred that persons not yet convicted and/or sentenced may be detained.

<sup>5</sup> Sections 35(1)(d)- (f) stipulates the time-frames for the accused's first appearance in court, determines what ought to happen at the first court appearance and that he should be released if the interests of justice permits.

<sup>6</sup> See *White Paper on Remand Detention Management in South Africa* 2014,10 where it is stated that the *White Paper* is based on the constitutional right that a person charged with a crime is presumed innocent until proven guilty and should be treated as such.

at least exercise and the provision, at State expense, of adequate accommodation, nutrition, reading material and medical treatment, often appears to ring hollow in practice.

The Judicial Inspectorate for Correctional Services, an oversight body for correctional centres<sup>7</sup>, reports annually on the work of the Department Correctional Services. The information published by the Judicial Inspectorate is invaluable in gauging the treatment of inmates and remand detainees. Below, some of the facts and statistics released by the Judicial Inspectorate will be considered to contextualise some of the realities of remand detention in South Africa.

In the 2013/2014 Judicial Inspectorate's Annual Report it is indicated that 588 inmates had died of natural causes.<sup>8</sup> Unlike in subsequent years, the Annual Report distinguished between sentenced and remand detainees. The Annual Report stated that of those who had died of natural causes, 425 were sentenced inmates and 163 remand detainees.<sup>9</sup> Statistically this may seem insignificant given the large inmate population. Against such a view, one may, however, contend that each death may represent an infringement of an array of fundamental constitutional rights. It may also be plausible to assert that remand detainees who had died during this period may have been denied reasonable health services. During the same period (2013/2014), Independent Correctional Centre Visitors<sup>10</sup> dealt with 52647 health care complaints and requests. This is further bolstered by reports that there had been 15 medical releases in process for sentenced inmates and only one for remand detainees.<sup>11</sup>

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<sup>7</sup> Established in terms of s 85 of the Correctional Services Act 111 of 1998.

<sup>8</sup> Judicial Inspectorate for Correctional Services Annual Reports 2013/2014 69.

<sup>9</sup> At 2013/2014 69 .

<sup>10</sup> These are independent persons from communities who are appointed to visit correctional centres and to observe conditions as well as to communicate with inmates who may lodge any complaints with them (Independent Correctional Visitors).

<sup>11</sup> Judicial Inspectorate for Correctional Services Annual Reports 2013/2014 71.

During the financial year 2014/2015 the Judicial Inspectorate reported that there had been 32 applications for medical releases in process during this period.<sup>12</sup> The Judicial Inspectorate further indicated that there had been 128 complaints about medical releases in the same year.<sup>13</sup> The statement that most deaths in correctional centres are due to natural causes and that there had been 583 natural deaths during that financial year is arguably an indication of the dire position of some detainees.<sup>14</sup> It is reasonably possible that at least some of the inmates who had died were terminally ill.

In 2015/2016 the Judicial Inspectorate reported that five correctional regional offices dealt with 27 complaints regarding medical releases.<sup>15</sup> During the same period, a total of 7574 complaints about health care were made to the DCS.<sup>16</sup> Many of the complaints involved claims that professional services had not been rendered as needed by detainees or that such services had not been rendered on a regular basis.<sup>17</sup> Considering the amount of complaints about health care, it is perhaps not surprising that 511 detainees had died of natural causes.<sup>18</sup> Though the complaints regarding health care and medical releases and the number of natural deaths may be inclusive of both remand detainees and sentenced inmates, it cannot be assumed that the former are less affected than the latter. Both categories of detainees are in need of better and regular health services and do, as will be clearer later<sup>19</sup>, experience challenges in accessing and navigating the relevant medical release systems.

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<sup>12</sup> At 75.

<sup>13</sup> At 75.

<sup>14</sup> At 86.

<sup>15</sup> At 82.

<sup>16</sup> At 82.

<sup>17</sup> At 83.

<sup>18</sup>Section (2) of the Correctional Services Act 111 of 1998 provides that all deaths in detention must be reported to the office of the Judicial Inspectorate which may carry out or instruct the National Commissioner of Correctional Services to conduct an inquiry.

<sup>19</sup> In sections 5.2.2 and 5.3 of this Chapter.

The DCS's Annual Report 2014/2015 indicates that at least one-third of South Africa's correctional population are remand detainees. Furthermore approximately 41 717 persons occupied remand facilities or awaiting trial sections of correctional centres during the financial year 2014/2015. The 2015/2016 Annual Report of the DCS indicated that there are 45 257 remand detainees in South African correctional centres. Correctional centres therefore accommodate a rather large remand detainee population. The size of the remand detainee population also suggests that the State is custodian to many individuals with vast and diverse health care needs.

Based on the discussion above, it may be inferred that remand detention in South Africa often does not occur in compliance with constitutional imperatives. It is also possible therefore that remand detainees who are terminally ill may experience serious challenges which may be exacerbated by the conditions of their imprisonment. While it is contended in this thesis that every detainee should receive reasonable and appropriate health care, the need for a legal framework which provides reasonable recourse for such detainees' early release is also important. Below an attempt is made to trace the contours of the existing framework and to determine whether it affords adequate protection to remand detainees.

### [5.2.2 Release of remand detainees: Section 49E of the Correctional Matters Amendment Act 5 of 2011](#)

Despite the laws which guarantee remand detainees the right to adequate health care in practice many are afforded limited or no access to such care. Though there are many cogent arguments for the improvement of the health care of all inmates, it is equally important that there are reasonable mechanisms in place for the release of terminally ill detainees in appropriate cases. Below, the legislative provisions which may allow for such release will be discussed.

Section 2 of the Correctional Services Act sets out the purpose of the correctional system. It provides that the purpose of the correctional system is to contribute to a just, peaceful and safe society by, *inter alia*, detaining all inmates in safe custody whilst ensuring their human dignity.<sup>20</sup> This section evidently applies to all inmates and it may therefore be assumed that if the correctional system cannot detain an inmate in humane conditions due to resource constraints, for example, the law should provide other mechanisms to give effect to the rights of such an inmate. Insofar as offenders with terminal diseases or conditions are concerned the Legislature has introduced sections 49E and 79 of the Correctional Matters Amendment Act 5 of 2011. The former applies to remand detainees and the latter to sentenced inmates. Section 49E will therefore be discussed next.

Section 49E is entitled ‘Referral of terminally ill or severely incapacitated remand detainee to court’. Arguably the title of the provision in itself denotes a potentially taxing and time intensive process for applicants. This is further evidenced by the content of the provision which reads as follows:

- ‘If the Head of a remand detention facility or correctional centre, as the case may be, is of the opinion that—
- (1) (a) a remand detainee is, based on the written advice of the medical practitioner treating that person, suffering from a terminal disease or condition or if such detainee is rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care;
  - (b) the remand detention facility or correctional centre in question cannot provide adequate care for such detainee; and
  - (c) there are appropriate arrangements for the remand detainee’s supervision, care and treatment within the community to which the inmate is to be released, that Head may apply to the court concerned, in the manner set out in this section, for the release of such detainee.
- (2) (a) An application contemplated in subsection (1) must be lodged in writing with the clerk of the court, and must—

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<sup>20</sup> Section 2(b) of the Correctional Services Act 111 of 1998.

- (i) contain a sworn Statement or affirmation by the Head of the remand detention facility or correctional centre concerned to the effect that he or she is satisfied that the conditions stipulated in subsection (1) have been met; and
  - (ii) contain a written certificate by the Director of Public Prosecutions concerned, or a prosecutor authorised thereto by him or her in writing whether the prosecuting authority opposes the application or not.
- (b) The remand detainee and his or her legal representative, if any, must be notified of an application referred to in subsection (1).
- (3) The National Commissioner may, in consultation with the National Director of Public Prosecutions, issue directives regarding the procedure to be followed by a Head of a remand detention facility or correctional centre, as the case may be, and a Director of Public Prosecutions whenever it is necessary to bring an application contemplated in subsection (1).’

For convenience and coherence, section 49E will be analysed under different subheadings.

#### 5.2.2.1 Written advice by a medical practitioner

The section is triggered only when a medical practitioner who treats a remand detainee advises in writing that the detainee is suffering from a terminal disease or that he is rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care. The rationale for this section seems to be that only detainees whose physical condition is of such a nature that their continued detention poses a risk to their rights to life and to dignity will be released. On the face of it, this strict requirement appears to serve the objective of ensuring that most remand detainees will stand trial as well, as the greater goal of attaining justice. In reality, however, this requirement may pose severe challenges to remand detainees as their access to a medical practitioner may be limited by a variety of obstacles. The remand sections of most correctional centres are notoriously overcrowded, understaffed with insufficient numbers of medical personnel and/or other correctional staff, and a lack of transport to other health facilities may be limited.<sup>21</sup> To be diagnosed without undue delay by a medical practitioner is therefore the first and perhaps one of the most serious potential hurdles faced by remand detainees.

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<sup>21</sup> Rademeyer & Van Wyk (2014).



A further impediment that remand detainees may face is that a medical practitioner's written advice that he suffers from a terminal disease or is severely incapacitated does not automatically result in release. The head of a facility must be convinced by the medical practitioner's advice. This creates room for dissent and arguably too great a discretion is afforded the head of remand facilities. Presumably, if the head of a correctional facility does not agree with the medical practitioner's report, an application will not be made to a court.

#### 5.2.2.2 The requirement of being physically incapacitated

A further, yet equally important, issue is the requirement that the remand detainee must be rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care. This requirement is duplicated in section 79 of the Correctional Services Act 111 of 1998 which deals with medical parole in respect of sentenced inmates (and will be dealt with later in this Chapter). It is contended that such a requirement threatens the dignity of inmates. In the *Stanfield* judgment<sup>22</sup>, which concerned the constitutionality of the predecessor to the current section 79, the Court held that 'medical parole is a mechanism to protect the dignity of the offender and any other concerns are subservient to this.'<sup>23</sup> The Court furthermore held that to detain an inmate until such time as he is no longer physically capable of committing further crimes is inhumane.<sup>24</sup> It may be contended that to wait until an offender is incapable of self-care, violates the right to dignity. The inmate's right to dignity must be balanced against the public's right to safety and the State may have to employ innovative measures to ensure both.

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<sup>22</sup> *Stanfield v Minister of Correctional Services and Others* [2003] 4 All SA 282 (C).

<sup>23</sup> Muntingh L and Ballard C 'Correctional Matters Amendment Bill (41 of 2010)' *CSPRI Newsletter* 38 of 2011.

<sup>24</sup> *Stanfield* para 90.

The case of Mr George Louka<sup>25</sup> illustrates that the principles upheld in *Stanfield* above are still not applied at times despite amendments to the law. During his trial, Mr Louka, accused, *inter alia*, of murder, had been diagnosed with stage four lung cancer. The media depicted Mr Louka as in a visibly frail state, confined to a wheelchair and with an oxygen mask and tank during court proceedings.<sup>26</sup> He was in remand detention when the DCS applied in terms of section 49E of the Correctional Services Act 111 of 1998 to the court for his release so as to afford him an opportunity to receive treatment privately. The presiding officer noted that at the time there had been no precedent of section 49E applications.<sup>27</sup> The case was therefore significant in establishing guidance for future courts when dealing with such applications.

The State opposed the application for release. Mr Louka, who had been extradited to stand trial, had after all shown his reluctance to stand trial in South Africa. Arguably the complexities of this case presented the South Gauteng High Court with an opportunity to demonstrate not only compliance with the legislation, but also conformance to the foundational values of a constitutional democracy. The Court rejected the application for release, because it was believed that Mr Louka would not stand trial if his health improved whilst on the outside.<sup>28</sup> Mr Louka subsequently died before the conclusion of the trial.

The presiding officer had expressed her personal empathy for Mr Louka's suffering, but could find no legal reason to support his release in terms of section 49E.<sup>29</sup> The criticism here is not against the Court's rejection of an application to release a dying man from prison *per*

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<sup>25</sup> Mr Louka, originally from Cyprus, had been extradited to stand trial on a number of criminal charges in South Africa.

<sup>26</sup> Evans J 'Louka to stay in prison in SA' *News24* 22 April 2015 available at <http://www.news24.com/SouthAfrica/News/Louka-to-stay-in-prison-in-SA-20150422> (accessed 23 April 2015).

<sup>27</sup> Evans (2015).

<sup>28</sup> Evans (2015).

<sup>29</sup> Evans (2015).

*se*, but rather of the Court's display of rigidity in the application of the law. The outcome of the case makes it evident that despite meeting what may be perceived to be the majority of the paramount requirements in order to be released on medical grounds, courts may still order the continued detention of a remand detainee. In this case it seems that the State's opposition to the application appeared to have weighed heavier than the accused's rights to health care and dignity. Though the accused had been charged with serious offences and previous conduct indicated an unwillingness to stand trial, the denial of the application for release suggests a 'justice at all cost' approach with no apparent concerted attempt to find a balance between the fundamental rights of the accused and the interests of justice.

#### 5.2.2.3 Adequate care not available

In terms of section 49E(1)(b) of the Correctional Services Act 111 of 1998, the head of a remand facility must be of the opinion that the remand detainee cannot be adequately cared for within the facility. The consideration of whether an inmate can be adequately cared for during his incarceration is in principle a fair and necessary consideration, but the provision is problematic. The head of the facility's opinion regarding the detainee's condition must be informed by the advice of the treating medical practitioner, but he does not have to consult with the medical practitioner with regards to whether the detainee can adequately be cared for in the remand facility. This is not a clear legislative requirement. It appears that how a remand detainee will be cared for depends solely on the opinion of the head of the facility who may in all likelihood not have medical expertise. This contention is further bolstered by the fact that the head does not have to follow the advice of the medical practitioner as the provision states that he 'may' and (not must) apply to court for the release of the detainee.

It is estimated that there is only one professional nurse for every 195 inmates and one doctor for every 14 545 prisoners.<sup>30</sup> The WHO states that correctional institutions require more health professionals than the public does as inmates are sicker than persons who are free.<sup>31</sup> Apart from the shortage of health professionals, there are also general staff shortages.<sup>32</sup> Remand detainees who require full-time care may therefore find themselves in a seriously precarious position.

Persons who are diagnosed with terminal illnesses ought to be provided with palliative care.<sup>33</sup> The need for palliative care will be fully discussed in Chapter 6. At this juncture it suffices to argue that in some correctional facilities inmates and correctional staff are not familiar with this approach to caring for terminally ill persons.<sup>34</sup> This may be an indication that such care is perhaps not widely available or easily accessible in correctional settings. This assertion may be further supported by the fact that Westville Correctional Centre in KwaZulu-Natal has a palliative care facility which was started in 2011<sup>35</sup> and to which remand detainees cannot be admitted as it is meant for sentenced inmates.<sup>36</sup>

Furthermore, Westville Prison's palliative care facility reportedly provides care to more than 900 inmates who had been diagnosed with life-threatening illnesses.<sup>37</sup> Although Westville has been lauded for the palliative care services rendered to inmates, the correctional centre

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<sup>30</sup> Skosana I 'Prisoners' health rights routinely violated in SA jails' 23 April 2015 *M&G Centre for Health Journalism, Bhekisisa*.

<sup>31</sup> Skosana (2015).

<sup>32</sup> Skosana (2015).

<sup>33</sup> This will be discussed in greater detail in the next Chapter.

<sup>34</sup> During interviews with former inmates and former DCS staff no one was familiar with the concept 'palliative care' and after they had been provided with an explanation of what it entails, all participants admitted that such care was not offered in the centres where they had worked or served time. Interviews were conducted in November 2016.

<sup>35</sup> Mtshali S Minister praises prison palliative care efforts available at <http://www.iol.co.za/dialynews/news/minister-praises-prison-palliative-care-efforts-2074452> (accessed 29 September 2016).

<sup>36</sup> Mtshali (2016).

<sup>37</sup> Mtshali (2016).

still experiences challenges, such as, overcrowding, staff shortage, and problems in accessing medication.<sup>38</sup>

Because limited or no access to palliative care is available to them the vast majority of remand detainees diagnosed with a terminal illness should at least be considered for release. However, their release depends on the opinion of the head of a correctional centre, whether or not the prosecutor opposes the release and whether or not the court which must ultimately consider the decision believes that adequate care is available. In this regard it may have been more acceptable that less reliance is placed on the head of prison. The Legislature should perhaps have allowed for more independent and expert advice to inform the court's decision as to whether a facility can offer appropriate care to a remand detainee who is terminally ill.

#### 5.2.2.4 Cared for in the community

In terms of section 49E(1)(c) of the Correctional Services Act, appropriate arrangements must be made for a remand detainee's supervision, care and treatment in order to be released. The need for appropriate care in the community is important. The requirement can therefore not be easily criticised. However, many remand detainees may not have access to such care. It must be borne in mind that many of them are detained because they cannot afford bail; hence they may be indigent.<sup>39</sup> The current provisions do not specify how a remand detainee will be cared for if appropriate care is not available inside prison and within the detainee's community. This omission may result in infringements of the rights of such detainees as they are more than likely to be detained for extended periods in conditions that may have a detrimental impact on their health and could prove to be fatal.

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<sup>38</sup> Mtshali S (2016).

<sup>39</sup> Morris M 'Prisoners of Poverty' *Weekend Argus* 12 March 2016 available at <https://www.iol.co.za/weekend-argus/prisoners-of-poverty-in-overcrowded-jails-1996929> (accessed 2 April 2016).

#### 5.2.2.5 The application procedure

From section 49E of the Correctional Services Act it appears that the application for the release of a remand detainee is not a straightforward process which can be completed promptly. It commences with a written application lodged with the clerk of the court. The head of a remand facility or correctional centre must affirm that he or she is satisfied that the requirements as discussed above have been met. The Director of Public Prosecutions must also issue a written certificate to indicate whether or not the State is opposed or not to the release of the remand detainee. The remand detainee and his or her legal representative, if any, must then be notified of the application.

These requirements appear to be fair and appropriate. Some may argue that if the Legislature had provided for a much simpler procedure, it would open the floodgates for applications. Against this it must be considered that remand detainees, although they are the subjects of the applications, do not have a voice in the process. They do not initiate the process. Despite being presumed innocent, their fate lies first in the hands of the head of the correctional facility where they are detained and, secondly, with the State who can oppose the application. The further reality is that the State may oppose applications for release for a myriad of reasons. Apart from their uncertainty with regards to the grounds upon which objections may be made against their release, remand detainees are not in a position to predict how long the finalisation of an application may take. This may be important to individuals faced with terminal illnesses. The Legislature unfortunately did not provide any indication in this regard. This may have serious implications for persons with a limited lifespan.

Notwithstanding that the law does not provide explicit guidance as to the time-frames for the finalisation of an application to release terminally ill or severely incapacitated remand

detainees, section 49G of the Correctional Services Act 111 of 1998 may offer some relief to them. This section will be discussed below.

### 5.2.3 Section 49G: Limitations on the period of incarceration of remand detainees

The position of remand detainees who are terminally ill or severely incapacitated is exacerbated when it is considered that many remand detainees have historically often been detained for lengthy periods. To ameliorate the conditions of remand detainees and to ensure that they are not detained for too lengthy periods, the Legislature introduced what is termed ‘maximum incarceration periods’ in 2013.<sup>40</sup> These maximum periods will be discussed below with a view to determining whether the limitations on the incarceration periods may improve remand detainees plight. Put plainly, the discussion which follows is aimed at determining whether remand detainees who are terminally ill may find relief from the general application of section 49G.

Section 49G of the Correctional Services Act 111 of 1998 reads as follows:

‘(1) The period of incarceration of a remand detainee must not exceed two years from the initial date of admission into the remand detention facility, without such matter having been brought to the attention of the court concerned in the manner set out in this section: Provided that no remand detainee shall be brought before a court in terms of this section if such remand detainee had appeared before a court three months immediately prior to the expiry of such two year period and the court during that appearance considered the continued detention of such detainee.

(2) The Head of the remand detention facility must report to the relevant Director of Public Prosecutions at six-monthly intervals the cases of remand detainees in his or her facility that are being detained for a successive six-month period.

(3) Any remand detainee whose detention will exceed the period stipulated in subsection (1) must be referred to the relevant court by the Head of the remand detention facility or correctional centre, as the case may be, to determine the further detention of such person or release under conditions appropriate to the case.

(4) If, subsequent to the referral of the remand detainee to court as contemplated in subsection (3), the finalisation of his or her case is further delayed, the Head of the remand facility or correctional centre, as the case may be, must refer the matter back to the court on a yearly basis to determine

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<sup>40</sup> Section 49G of the Correctional Services Act 111 of 1998.

the remand detainee's further detention or release under conditions appropriate to the case.

(5) The National Commissioner may, in consultation with the National Director of Public Prosecutions, issue directives regarding the procedure to be followed by a Head of a remand detention facility or correctional centre, as the case may be, and a Director of Public Prosecutions whenever it is necessary to bring an application contemplated in subsection (3) or (4).<sup>7</sup>

In terms of section 49G(1)(a) no remand detainee may be detained for longer than two years.

Whilst this limitation may mark a major improvement for most remand detainees, it may be of insignificant or no assistance to those who are terminally ill and with poor prognoses in terms of lifespan. Put differently, a remand detainee who has a short period (a few months or weeks) left to live will not benefit from this provision. Furthermore, a closer reading of the section indicates that the two year period is not an absolute maximum period for detention. If a detainee had appeared before a court three months before the expiry of the two year period and the court deemed his continued incarceration to be necessary, such an inmate's further detention in terms of the court's order will be legitimate.<sup>41</sup>

Notwithstanding the limitation of section 49G(1) as mentioned above, the provision has the potential to positively impact upon remand detention in general. The proper application of the section may result in the reduction of overcrowding, which may in turn directly allow for better conditions in remand facilities. Unfortunately, this may not improve the position of terminally ill remand detainees who may have unique needs in terms of their overall health and well-being.

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<sup>41</sup> Further criticism of this provision includes that the period of two years is too long given that there are no continuous and formal reviews of a remand detainee's detention and that courts are not compelled to take any specific action where the period of detention exceeds two years. See, Thematic Report on Criminal Justice and Human Rights in South Africa: A Submission to the UN Human Rights Committee in Response to the Initial Report by South Africa under the International Covenant on Civil and Political Rights at the 116th session of the Human Rights Committee (Geneva March 2016) 11.



Section 49G(2) stipulates that the head of the remand facility must report to the Director of Public Prosecutions on a six-monthly basis on all remand detainees who are detained for a successive six months. This may be of great benefit to the general remand detainee population. The section does not specify that the head of the remand facility must report on the health and well-being of the inmates concerned, however. It seems that the purpose of reporting to the Director of Public Prosecutions is solely to keep an account of detainees' period of detention so as to comply with the maximum incarceration periods. As a result it cannot be concluded that this section offers any significant measure of protection to terminally ill or severely incapacitated remand detainees in particular.

Section 49G(3) arguably offers a semblance of hope as it obligates the head of a correctional centre to refer a remand detainee to court if his period of detention will exceed two years. The court should then determine whether or not to release the remand detainee. Presumably this could be an opportunity for a court to become aware of the health status of a remand detainee and may result in the release of such detainee or other forms of intervention to address the plight of the detainee. Unfortunately, this potential benefit of section 49G will only be of assistance to a terminally ill remand detainee who has already served almost two years of imprisonment. Section 49G(4) further stipulates that if the court decides that the remand detainee should be further detained and there are further delays relating to the case, the head of the remand facility must refer the remand detainee back to the court on an annual basis to determine whether he should be released or further detained.

In summation, it is evident that although section 49G could offer a margin of respite to some remand detainees, it cannot address the plight of those who are terminally ill and in desperate and urgent need of suitable health care. The maximum periods of detention may assist to some extent in the alleviation of the harrowing conditions of detention, but they do not guarantee the humane detention and health care of persons who are terminally ill or severely

incapacitated due to injuries. In practice conditions in remand sections of prisons are often worse than in the section for sentenced inmates, and remand detainees do not have access to the same services as sentenced inmates.<sup>42</sup> Moreover section 49G does not compel a court to do anything if a remand detainee's health is failing or he is detained in dire conditions. This is arguably a major lost opportunity to strengthen the possibilities of compliance with constitutional values.

#### 5.2.4. Section 63A of the Criminal Procedure Act 51 of 1977

Earlier it was mentioned that South African correctional centres are generally overcrowded and that the remand detainee population contributes to this problem. It is also common knowledge that the remand detainee population comprises *inter alia* some persons who had been granted bail, but could not afford to pay such bail. 'These people were never really meant to be in prison pending the outcome of their trial.'<sup>43</sup> Notwithstanding that they were not intended to be incarcerated while they await trial, they still do contribute to endemic problems, such as, the threat to the dignity, physical health and safety of inmates in the correctional system. Evidently the Legislature has taken cognisance of this issue and therefore introduced section 63A into the Criminal Procedure Act 51 of 1977.<sup>44</sup> Below, section 63A is discussed with a view to ascertaining whether its application may be of benefit to remand detainees who are terminally ill.

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<sup>42</sup> Arends M 'Remanded and forgotten: The fate of South Africa's prisoners who have not been tried' *Daily Maverick* 26 September 2016 available at <https://www.dailymaverick.co.za/article/2016-09-26-remanded-and-forgotten-the-fate-of-south-africas-prisoners-who-have-not-yet-been-tried/> (accessed 26 September 2016). It is stated that remand detainees do not have access to psychosocial services, support and development programmes. See also, Thematic Report on Criminal Justice and Human Rights in South Africa: A Submission to the UN Human Rights Committee in response to the Initial Report by South Africa under the International Covenant on Civil and Political Rights at the 116th session of the Human Rights Committee (Geneva March 2016) 29 in this regard.

<sup>43</sup> Joubert JJ (ed) *Criminal Procedure Handbook 2017* Juta: Claremont, 221.

<sup>44</sup> Section 62A was introduced into the Criminal Procedure Act 51 of 1977 by s 6 of the Judicial Matters Amendment Act 42 of 2001.

Section 63A reads as follows:

‘Release or amendment of bail conditions of accused on account of prison conditions

(1) If a Head of Prison contemplated in the Correctional Services Act, 1998 (Act 111 of 1998), is satisfied that the prison population of a particular prison is reaching such

proportions that it constitutes a material and imminent threat to the human dignity, physical health or safety of an accused-

(a) who is charged with an offence falling within the category of offences-

(i) for which a police official may grant bail in terms of section 59; or

(ii) referred to in Schedule 7;

(b) who has been granted bail by any lower court in respect of that offence, but is unable to pay the amount of bail concerned; and

(c) who is not also in detention in respect of any other offence falling outside

the category of offences referred to in paragraph (a), that Head of Prison may apply to the said court for the-

(aa) release of the accused on warning in lieu of bail; or

(bb) amendment of the bail conditions imposed by that court on the accused.

(2) (a) An application contemplated in subsection (1) must be lodged in writing with the clerk of the court, and must-

(i) contain an affidavit or affirmation by the Head of Prison to the effect that he or she is satisfied that the prison population of the prison concerned is reaching such proportions that it constitutes a material and imminent threat to the human dignity, physical health or safety of the accused concerned; and

(ii) contain a written certificate by the Director of Public Prosecutions concerned, or a prosecutor authorised thereto by him or her in writing, to the effect that the prosecuting authority does not oppose the application.

(b) The accused and his or her legal representative, if any, must be notified of an application referred to in subsection (1).

(c) The clerk of the court must, without delay, cause the application to be placed before any magistrate or regional magistrate, as the case may be, who may consider the application in chambers.

(d) The application may be considered in the presence of the accused if the magistrate or regional magistrate deems it necessary.

(3) (a) If the magistrate or regional magistrate is satisfied that the application complies with the requirements set out in subsection (2) (a), he or she may-

- (i) order the release of the accused from custody and, if the accused is present, warn him or her to appear before a specified court at a specified time on a specified date in connection with such offence or, as the case may be, to remain in attendance at the proceedings relating to the offence in question, and the court may, at the time of such order or at any time thereafter, impose any condition referred to in section 62 in connection with such release; or
- (ii) reduce the amount of bail determined under section 60 and, if deemed appropriate, amend or supplement any condition imposed under section 60 or 62.'

A cursory reading of the above section denotes that it offers an avenue for release to certain remand detainees. The application process in terms of section 63A must, however, be initiated by the head of a correctional centre who is of the view that the overcrowding in a correctional centre poses a material and imminent threat to the dignity, physical health and safety of an accused. Such an accused must also have been granted either police or prosecutorial bail and must not have been granted bail for an offence other than one for which either police or prosecutorial bail would be granted. The accused should also lack the financial means to pay bail. In other words, his detention should be attributable to his inability to pay bail.

At first glance it may seem that section 63A applies mainly to indigent remand detainees who committed minor offences as police bail is only granted in respect of trivial offences. Closer perusal of schedule 7 offences, for which prosecutorial bail may be granted, however reveals that section 63A may also apply to remand detainees who have been charged with serious offences. This notwithstanding, it has been recommended that a head of prison who contemplates an application in terms of section 63A(1) should as a general guideline focus on

offenders for whom police bail could have been granted.<sup>45</sup> The scope for release from remand detention therefore appears to be limited from the outset.

In spite of the limitations inherent in, or sometimes imposed upon, section 63A, the provision may offer a measure of relief to remand detainees who are terminally ill. Arguably, though the prerequisites for release in terms of the section eliminate those who committed serious offences not included under schedule 7, terminally ill remand detainees who have been charged with minor or schedule 7 offences should presumably be in a better position to be released than their healthier counterparts who may also be indigent and facing charges for minor offences. This ought to be possible as section 63A patently stipulates that the head of a correctional centre should be of the opinion that the overcrowded conditions pose an imminent and material threat to the dignity, physical health and safety of the remand detainee. Possibly it may be easier for a head of a correctional centre to form this opinion in respect of a detainee who is known to be terminally ill or severely incapacitated.

Though it appears that section 63A has the potential to alleviate the plight of indigent remand detainees charged with minor offences and who are terminally ill, it also seems possible that the provision is not invoked on a frequent basis or at all. This appears to be the case as correctional centres remain overcrowded and the remand detention population contributes to their dire state.

The parlous conditions which affect inmates, and particularly remand detainees, have attracted widespread attention in recent years.<sup>46</sup> A case in point was when Justice Cameron<sup>47</sup>

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<sup>45</sup> Du Toit E, De Jager F, Paizes A, Skeen A & Van der Merwe S *Commentary on the Criminal Procedure Act* Juta (Service 57, 2016) 9-94.

visited *inter alia* the remand section of Pollsmoor Correctional Centre in April 2015.<sup>48</sup> The Report of this visit noted that Justice Cameron found that there was a major disparity between the conditions of that correctional centre and the South African constitutional and legislative standards for places of detention.<sup>49</sup>

The remand facility within Pollsmoor was established in 2012 and is the largest of the five sections of that correctional centre.<sup>50</sup> At the time of the visit the remand section was overcrowded to over 300 percent capacity, making it the most overcrowded section in Pollsmoor. Some of the reasons cited as contributing to the overcrowding in the remand section included: delays in investigations; finalisation of trials; and as mentioned earlier, the inability to pay bail due to indigence and that this was often the case for detainees charged with petty offences.<sup>51</sup>

The facts mentioned above therefore confirm that section 63A is not utilised as frequently as appears to be possible. This reality is of immense concern when one considers that as early as 2015, when the visit by Justice Cameron had been undertaken, it was noted with comprehensible outrage that the conditions in Pollsmoor were untenable. Specifically relevant to the discussion at hand was the fact that the Justice remarked on the obvious levels

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<sup>46</sup> See, Thematic Report on Criminal Justice and Human Rights in South Africa: A Submission to the UN Human Rights Committee in response to the Initial Report by South Africa under the International Covenant on Civil and Political Rights at the 116th session of the Human Rights Committee (Geneva March 2016) 4, where it is stated that overcrowding, understaffing and lack of services contribute to the poor health of remand detainees.

<sup>47</sup> Section 99(2) of the Correctional Services Act 111 of 1998 authorises a judge anywhere in South Africa, and a magistrate within his or her area of jurisdiction, to visit all areas of a correctional centre, as well as to access the centre's documentary records. A judge or magistrate may interview any prisoner while visiting the facility.

<sup>48</sup> Cameron (2015).

<sup>49</sup> Cameron (2015) para 8.

<sup>50</sup> Cameron (2015) para 10.

<sup>51</sup> Cameron (2015) para 16.

of disease and ‘the emaciated physical appearance of detainees’.<sup>52</sup> It begged the question why section 63A had not been invoked.

Less than one year after the report by Justice Cameron was released, a non-governmental organisation, Sonke Gender Justice, successfully obtained a court order confirming that the conditions at Pollsmoor were contrary to the South African constitutional and legislative requirements.<sup>53</sup> The State was also ordered to reduce overcrowding and improve the conditions in the remand section of Pollsmoor. Though this is commendable, it cannot be overlooked that the recommendations by Justice Cameron subsequent to his visit to the correctional centre, had not been followed. Additionally, the fact that a non-governmental organisation had to approach the court for an order compelling the State to improve conditions arguably indicates a lack of will on the part of the DCS to utilise legal mechanisms, such as section 63A, to alleviate the conditions of detention. By neglecting to do so all detainees will suffer. Arguably, however, terminally ill inmates may suffer even more.

### 5.3 MEDICAL PAROLE FOR SENTENCED INMATES

The discussion of remand detainees leaves little doubt that the release of a detainee on account of medical grounds is not an unfettered process. There are clearly inherent limitations in the laws and the application thereof can at times be marred by challenges. Below, however, the position of sentenced inmates who are terminally ill will be discussed. In this regard the amended section 79 of the Correctional Services Act 111 of 1998 will be

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<sup>52</sup> Cameron (2015) para 17.

<sup>53</sup> *The Sonke Gender Justice v Government of the Republic of South Africa and the Head of Pollsmoor Remand Centre Detention Facility* Case number: 24087/15 22 December 2016 (C).

considered as it specifically deals with the question of medical parole in respect of sentenced offenders. The discussion will commence with a brief look at the predecessor to section 79. Given the challenges posed by the old section 79, an attempt will be made to establish whether the current version has yielded sufficient improvements for the position of affected inmates.

### 5.3.1 Section 79 before 2012

Before the current version of section 79 of the Correctional Services Act 111 of 1998, the old section provided as follows:

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

‘It doesn’t mean that if you are HIV positive and the CD4 count is low therefore you would be granted medical parole. It’s about sick people, very sick people.’<sup>54</sup> This statement made by the former Minister of Correctional Services, NN Mapisa-Nqakula, arguably captured the essence of the State’s approach to medical parole at the time. Before 1 March 2012, the early release of inmates on medical grounds was a highly contentious issue in South Africa. The erstwhile law, section 79 of the Correctional Services Act 111 of 1998, did not specify who may initiate applications for medical parole. It had been assumed that only the DCS medical personnel could start the process of applying for medical parole.<sup>55</sup> Unfortunately, the DCS

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<sup>54</sup> Lindeque M *New Medical Parole Advisory Board won’t “open floodgates”* ‘ available at <http://www.jacarandafm.com/kagiso/content/en/jacaranda/jacaranda-news?oid=1542187&sn=Detail&New-Medical-Parole-Advisory-Board-won> (accessed 23 February 2014).

<sup>55</sup> See for example the speech by the Hon NN Mapisa-Nqakula at the Parole Board Working Session held at the Pretoria Management Area on 26 March 2012 available at <http://www.dcs.gov.za/UploadedFiles/Parole%20Board%20Work%20Session%20Speech.pdf> (accessed 25 April 2012); Minister announces the Medical Parole Advisory Board available at <http://www.dcs.gov.za/UploadedFiles/medical%20paroleboard.pdf> (accessed 25 April 2012).



often failed to initiate applications in worthy cases.<sup>56</sup> Furthermore, section 79 only permitted the release of inmates who were in the ‘final phase of a terminal illness’. Inmates, suffering from life threatening illnesses, but who were not bedridden or noticeably terminally ill, were considered ineligible for early release on medical grounds. The resultant inroads on inmates’ dignity attracted heavy criticism from the courts.<sup>57</sup>

On 1 March 2012 a new section 79 came into operation; the old section 79 had been amended by section 14 of the Correctional Matters Amendment Act 5 of 2011. The amendment of the law was motivated by several factors. One of the main factors which prompted the amendment was that the courts had, in a number of cases, ordered the release of terminally ill inmates whose initial applications had failed because they had not complied with the ‘final phase of a terminal illness’ requirement.<sup>58</sup> Prior to the introduction of the new section 79 it was also of concern that the proportion of inmates who had been released on medical grounds over the years had been extremely low compared to the number of inmates who had died of natural causes in prison.<sup>59</sup> Moreover, the release of Shabir Shaik, former financial adviser to President Zuma, on medical grounds after serving less than three years of his 15-year sentence, triggered public debate and ‘put the issue of medical parole under the spotlight’.<sup>60</sup>

In 2009, in response to the continuous controversy surrounding medical parole, Correctional Services Minister, NN Mapisa-Nqakula, ordered a review of the medical parole policy in South Africa. The National Council on Correctional Services, led by Judge Desai, undertook

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<sup>56</sup> Judicial Inspectorate of Prisons Annual Report 2008/2009 25.

<sup>57</sup> *Stanfield* para 124.

<sup>58</sup> See for example *Mazibuko v Minister of Correctional Services and Another* [2007] JOL 18957 (T); *Du Plooy v Minister of Correctional Services and Others* [2004] JOL 12850 (T); *Stanfield*.

<sup>59</sup> Mujuzi, J ‘Releasing terminally ill prisoners on medical parole in South Africa’ (2009) 2 *South African Journal of Bioethics and Law* 60.

<sup>60</sup> Mujuzi (2009) 59.

the review (which was finalised in January 2010). The review aimed to address all the shortcomings of the medical parole system.

While the old medical parole system had many flaws some of its major inadequacies related to the ‘final phase of a terminal illness’ requirement. As a result of this requirement, medical doctors were reluctant to recommend inmates for release on medical grounds as it is ‘difficult to certify’ that an inmate is in the final phase of a terminal illness.<sup>61</sup> The fact that 60 per cent of prisoners released on medical parole did not die after placement on parole also highlighted the need to review the law.<sup>62</sup> Seriously ill and/or severely incapacitated inmates were detained in correctional centres despite the fact that the DCS did not have the financial and human resources to provide them with proper care.<sup>63</sup> The reluctance of medical practitioners to recommend inmates for medical parole also contributed to the high number of deaths due to natural causes in the correctional centres.<sup>64</sup> It may therefore be inferred that the sole objective of the old section 79, to allow a terminally ill inmate to ‘die a consolatory and dignified death’, had largely not been attained.

In South Africa, a constitutional democracy based on the values of human dignity, equality and freedom,<sup>65</sup> it is mandatory that the fundamental rights enshrined by the Bill of Rights are respected, protected and promoted.<sup>66</sup> Section 39(2) of the Constitution specifically provides that when interpreting legislation, the spirit, purport and objects of the Bill of Rights must be

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<sup>61</sup> ‘Reviewing medical parole: Brief notes on the proposed amendments to section 79 of Correctional Services Act 1998’ available at <http://www.pmg.org.za/report/20101110-department-correctional-services-matters-related-enhanced-parole-syst> (accessed 27 May 2014).

<sup>62</sup> ‘Reviewing medical parole: Brief notes on the proposed amendments to section 79 of Correctional Services Act 1998’.

<sup>63</sup> ‘Reviewing medical parole: Brief notes on the proposed amendments to section 79 of Correctional Services Act 1998’.

<sup>64</sup> ‘Reviewing medical parole: Brief notes on the proposed amendments to section 79 of Correctional Services Act 1998’.

<sup>65</sup> Section 7(1) of the Constitution.

<sup>66</sup> Section 7(2) of the Constitution.

promoted. The legislative framework within which the South African medical parole system operates ought therefore to be understood in the light of the Bill of Rights. Consequently cognisance must be taken of section 10 of the Constitution which provides that everyone has inherent dignity and the right to have their dignity respected and protected. Prisoners are not precluded from the enjoyment of this non-derogable right. The Constitution furthermore provides that all prisoners have a right to be detained in conditions that are consistent with human dignity.<sup>67</sup> This right is supported by section 2 of the Correctional Services Act 111 of 1998 which sets out the purpose of the correctional system, stating that the purpose of the correctional system is to contribute to a just, peaceful and safe society by, *inter alia*, detaining all inmates in safe custody whilst ensuring their human dignity.<sup>68</sup>

Whilst prison conditions in South Africa have historically not been described as consistent with prisoners' human dignity, our courts have as early as 1912 pronounced that, with the exception of the right to freedom of movement, prisoners are generally entitled to all their other rights.<sup>69</sup> Innes J held in *Whittaker and Morant v Roos and Bateman* that '[inmates] were entitled to all the personal rights and personal dignity not temporarily taken away by law, or necessarily inconsistent with the circumstances in which they had been placed'.<sup>70</sup> Nearly 70 years later Corbett JA, in a minority judgment, confirmed this dictum, which became known as the residuum principle, in *Goldberg and Others v Minister of Prisons and Others*.<sup>71</sup> In *Minister of Justice v Hofmeyr*, reported in 1993, Hoexter JA held:

‘The Innes dictum serves to negate the parsimonious and misconceived notion that upon admission to gaol a prisoner is stripped, as it were, of all his personal rights. . . The Innes dictum is a salutary reminder that in truth the prisoner retains all his personal

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<sup>67</sup> Section 35(2)(e) of the Constitution, 1996.

<sup>68</sup> Section 2(b).

<sup>69</sup> *Whittaker and Morant v Roos and Bateman* 1912 AD 122–123.

<sup>70</sup> At 122–123.

<sup>71</sup> 1979(1) SA 14(A) 39 C–E.

rights save those abridged or proscribed by law. The root meaning of the Innes dictum is that the extent and the content of prisoner's rights are to be determined by reference not only to the relevant legislation but also to his inviolable common-law rights.<sup>72</sup>

In 2008, in *Ehrlich v Minister of Correctional Services and Another*, Plasket J held that 'now in the era of democratic constitutionalism ... the residuum principle has stronger protection than before. There can be no doubt that it is in harmony with the Constitution's values'.<sup>73</sup>

In the context of medical parole, Van Zyl J in *Stanfield* also confirmed the residuum principle.<sup>74</sup> Additionally, the Court articulated how medical parole relates to prisoners' right to human dignity. The Court held that '[t]o insist that [a terminally ill inmate] remain incarcerated until he has become visibly debilitated and bedridden can by no stretch of the imagination be regarded as humane treatment in accordance with his inherent dignity'.<sup>75</sup> Similarly, the Court held that the continued imprisonment of a terminally ill inmate in circumstances where the necessary medical facilities to palliate his condition are lacking, infringes upon his right to dignity.<sup>76</sup> Also, if considerations, such as, the crime committed by the inmate or the actual time served by him, are relied upon to preclude his release on medical parole, then his dignity is violated.<sup>77</sup> As already mentioned under paragraph 5.2.2.3 of this chapter, the Court had held that to detain an inmate until such time as he is no longer physically capable of committing further crimes is inhumane.<sup>78</sup> The *Stanfield* judgment demonstrates that 'medical parole is a mechanism to protect the dignity of the offender and any other concerns . . . are subservient to this'.<sup>79</sup>

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<sup>72</sup> Also referred to in Chapter 3 of this thesis 1993(3) SA 131(A) 141 C–E.

<sup>73</sup> Also mentioned in Chapter 3 of this thesis 2009(2) SA 373 (E) para 7.

<sup>74</sup> *Stanfield* para 90.

<sup>75</sup> *Stanfield* para 124.

<sup>76</sup> *Stanfield* para 125.

<sup>77</sup> *Stanfield* para 125.

<sup>78</sup> *Stanfield* 126.

<sup>79</sup> Muntingh L and Ballard C (2011).

The old section 79 was criticised for its infringement on inmates' dignity. According to the former Correctional Services Minister, NN Mapisa-Nqakula, however, the amended section 79 creates a medical parole system which beckons 'a complete departure from the previous system'; effect is given to inmates' right to dignity and due consideration is afforded to public safety.<sup>80</sup> Whether the new medical parole system truly achieves these goals or not, is not self-evident. There is a need to critically analyse the current section 79. To this end an attempt is made to determine the positive aspects of section 79 as well as to gauge the possible challenges that the law may present to inmates and the public. Additionally, reference is made to some of the cases in which medical parole applications had been considered by the courts or reported in the media. Such cases may arguably assist in highlighting challenges which may not necessarily have been anticipated by the Legislature.

### 5.3.2 The amended section 79

The amended version of section 79 reads as follows:

‘Medical parole

79. (1) Any sentenced offender may be considered for placement on medical parole, by the National Commissioner, the Correctional Supervision and Parole Board or the Minister, as the case may be, if—

(a) such offender is suffering from a terminal disease or condition or if such offender is rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care;

(b) the risk of re-offending is low; and

(c) there are appropriate arrangements for the inmate's supervision, care and treatment within the community to which the inmate is to be released.

(2) (a) An application for medical parole shall be lodged in the prescribed manner, by—

(i) a medical practitioner; or

(ii) a sentenced offender or a person acting on his or her behalf.

(b) An application lodged, by a sentenced offender or a person acting on his or her behalf, in accordance with paragraph (a)(ii), shall not be considered by the

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<sup>80</sup> Speech by the Hon NN Mapisa-Nqakula at the Parole Board Working Session held at the Pretoria Management area on 26 March 2012 available at <http://www.dcs.gov.za/UploadedFiles/Parole%20Board%20Work%20Session%20Speech.pdf> 11 (accessed 25 April 2012).

National Commissioner, the Correctional Supervision and Parole Board or the Minister, as the case may be, if such application is not supported by a written medical report recommending placement on medical parole.

(c) The written medical report must include, amongst others, the provision of—

(i) a complete medical diagnosis and prognosis of the terminal illness or physical incapacity from which the sentenced offender suffers;

(ii) a Statement by the medical practitioner indicating whether the offender is so physically incapacitated as to limit daily activity or inmate self-care; and

(iii) reasons as to why the placement on medical parole should be considered.

(3) (a) The Minister must establish a medical advisory board to provide an independent medical report to the National Commissioner, Correctional Supervision and Parole Board or the Minister, as the case may be, in addition to the medical report referred to in subsection (2)(c).

(b) Nothing in this section prohibits a medical practitioner or medical advisory board from obtaining a written medical report from a specialist medical practitioner.

(4) (a) The placement of a sentenced offender on medical parole must take place in accordance with the provisions of Chapter VI and is subject to—

(i) the provision of informed consent by such offender to allow the disclosure of his or her medical information, to the extent necessary, in order to process an application for medical parole; and

(ii) the agreement by such offender to subject himself or herself to such monitoring conditions as set by the Correctional Supervision and Parole Board in terms of section 52, with an understanding that such conditions may be amended and or supplemented depending on the improved medical condition of such offender.

(b) An offender placed on medical parole may be requested to undergo periodical medical examinations by a medical practitioner in the employ of the Department.

(5) When making a determination as contemplated in subsection (1)(b), the following factors, amongst others, may be considered:

(a) Whether, at the time of sentencing, the presiding officer was aware of the medical condition for which medical parole is sought in terms of this section;

(b) any sentencing remarks of the trial judge or magistrate;

(c) the type of offence and the length of the sentence outstanding;

(d) the previous criminal record of such offender; or

(e) any of the factors listed in section 42(2)(d).

(6) Nothing in this section prohibits a complainant or relative from making representations in accordance with section 75(4).

(7) A decision to cancel medical parole must be dealt with in terms of section 75(2) and (3): Provided that no placement on medical parole may be cancelled merely on account of the improved medical condition of an offender.'

From the wording of section 79 it is clear that the Legislature had intended to deal with some of the challenges occasioned by the previous medical parole system. The positive (and in some instances seemingly positive) features of section 79 are therefore highlighted here and analysed with a view to gauging their impact on inmates. Put plainly, several questions are

discussed below to determine whether section 79, as amended, adequately protects the dignity of terminally ill inmates.

### 5.3.2.1 Can inmates be assured that their applications will be given due and objective consideration?

In the light of the challenges presented by the old section 79, it is important that the current medical parole application process itself allows for fair decision-making. To answer the question posed here, this section will commence with a brief description of the medical parole application process. The description is followed by a discussion of some of the challenges presented by the process.

Regulation 29(A)(3) (in terms of the Correctional Services Act) provides that any head of a correctional centre must refer all applications for medical parole to a correctional medical practitioner for evaluation in terms of section 79. The correctional medical practitioner should make a written recommendation to Medical Parole Advisory Board (MPAB) as to whether or not the criteria prescribed by section 79 are present.<sup>81</sup> The primary role of the MPAB, which comprises ten medical doctors,<sup>82</sup> is to provide an ‘independent medical report to National Commissioner, Correctional Supervision and Parole Board or the Minister, as the case may be’.<sup>83</sup>

In specific, the MPAB must assess whether an inmate suffers from one of the conditions listed in regulation 29A (5)(a) and (b) or any other condition not listed in these regulations provided it complies with the principles of section 79. From the

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<sup>81</sup> Section 79(3)(a) introduced the establishment of the MPAB.

<sup>82</sup> ‘Minister announces new Medical Parole Advisory Board’ 23 February 2012 available at <http://www.info.gov.za/speech/DynamicAction?pageid=461&sid=25537&tid=58789> (accessed 13 March 2012).

<sup>83</sup> Section 13 of the Correctional Matters Amendment Act 5 of 2011 provides that the Correctional Supervision and Parole Boards may place sentenced offenders on medical parole and make recommendations to the court on the granting of medical parole to inmates who had been declared dangerous criminals in terms of s286A of the Criminal Procedure Act 51 of 1977. The Boards may also make recommendations to the Minister in respect of the granting of medical parole to inmates sentenced to life imprisonment. Section 13(7)(a) empowers the National Commissioner to grant medical parole to a prisoner serving a sentence of 24 months or less

regulations it appears that the written recommendation of the correctional medical practitioner will be the subject of the assessment. Arguably, at this stage too much reliance is placed on the opinion of a single medical practitioner who may even be overburdened given the levels of understaffing of medical personnel in the DCS.<sup>84</sup>

In terms of Regulation 29B(8)(a), a member of the MPAB may also examine any sentenced offender applying for medical parole.<sup>85</sup> Presumably the examination referred to is a physical examination of the prisoner; the Regulation itself does not expressly state the nature of the examination. The circumstances in which such an examination may occur are not stipulated in the Regulations. It is also not clear why MPAB members may as ‘far as possible’ only examine inmates ‘within the region wherein they are appointed’.<sup>86</sup> Moreover, it seems curious that these Regulations appear under the heading ‘Appointment and composition of the Medical Parole Advisory Board’. At this juncture it must be noted that these Regulations are confusing and that their purpose is not clear. Finally, Regulation 29A(7) provides that if the MPAB’s recommendation is positive, the National Commissioner, Correctional Supervision and Parole Board or the Minister, must consider whether the inmate indeed poses a low risk of reoffending and whether appropriate arrangements for his supervision, care and treatment had been made.

There are two obstacles which may compromise inmates’ and the public’s confidence in the MPAB’s recommendations. The first obstacle is that the MPAB’s recommendations will largely be based on the assessment of the written recommendations of a correctional medical practitioner. Not all inmates will be

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<sup>84</sup> Skosana (2015).

<sup>85</sup> Regulation 29B(8)(a).

<sup>86</sup> Regulation 29B(8)(c).



examined by all MPAB members. This does not create the mechanism necessary to eradicate subjectivity or error in the medical parole system. Mistakes or inaccuracies (whether made intentionally or not) by a correctional medical practitioner may thus contribute to, or lay the basis for, the MPAB's recommendation to the final decision-makers in respect of an application.

The second obstacle arises due to the composition of the MPAB when reviewing applications and the limitation with regards to the examination of inmates. It is required that the chairperson, deputy chairperson and at least three other MPAB members must be present when reviewing an application.<sup>87</sup> The latter may examine an inmate whose medical parole application is under consideration.<sup>88</sup> However, MPAB members should 'as far as possible' examine only inmates from the region for which he/she (the board member) had been appointed. Practically this means that if none of the board members present during the review process had been appointed for the region within which an inmate finds himself then, the inmate will not necessarily be examined. The assurance that fairness and objectivity will prevail is thus diminished.

In brief, the MPAB has the potential to instil confidence in the new medical parole system. Within the parameters of the new section 79 that potential remains untapped, however. This is due to the limitation on the MPAB with regards to the examination of inmates and because the MPAB will generally be restricted to the written reports of correctional medical practitioners. It is of concern that the new legislation does not

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<sup>87</sup> Regulation 29B(5).

<sup>88</sup> Regulation 29B(8).

make it clear whether the report of a treating physician will be considered by the MPAB.

Apart from the inherent challenges presented by the new law, there are also practical considerations which may negatively impact on the goals of ensuring a medical parole system characterised by objectivity and efficiency. For example it may be considered that in 2009/2010 some 900 prisoners died due to natural causes.<sup>89</sup> From earlier Reports by the Judicial Inspectorate for Correctional Services it is clear that 85 per cent were receiving medical treatment and thus potential cases for medical parole – thus 765 cases in a year. This means that the MPB will need to deal with 64 cases per meeting if they meet once per month. Even if they spend only half an hour per case, their meeting will nonetheless last 32 hours or four working days per month.<sup>90</sup> That is assuming that all the information is available. At such a work rate it will be little more than a rubber stamping process.

While the practical challenges alluded to above may probably be attributed to some extent to resource constraints, there are also issues of a polemic nature that affect the system of medical parole in South Africa.<sup>91</sup> The cases of Shabir Shaik, on the one hand, and Clive Derby-Lewis, on the other, may reasonably explain the phenomenon. As already mentioned, Mr Shaik's release on medical parole in all likelihood prompted the amendment of section 79 with a view to broadening its scope of application. Almost a decade after his release on medical parole, numerous reports of

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<sup>89</sup> Judicial Inspectorate for Correctional Services Annual Report 2010/2011 25.

<sup>90</sup> Albertus C 'Palliative care for terminally ill inmates: Does the State have a legal obligation?' (2012) 7.

<sup>91</sup> The DCS itself has on occasion acknowledged that there is a public perception that medical parole is discriminatory. 'Correctional Services dismisses perception on medical parole' 5 March 2014 available at <http://www.sabc.co.za/news/a/22246880432809d29be69b45a23ba143/Correctional-Services-dismisses-perception-on-medical-paroles-20140503> (accessed 5 December 2014).

his conduct in public and further applications to relax his parole conditions so as to allow him to work and attend sports events,<sup>92</sup> hint at a system susceptible to abuse and mismanagement. Juxtaposed with the application for medical parole of Derby-Lewis, the political malleability of the medical parole system becomes even clearer.

Mr Derby-Lewis had been sentenced to life imprisonment for the murder of South African Communist Party leader, Chris Hani, in 1993. In 2011, 2013 and January 2015 he applied for medical parole as he had been diagnosed with a host of serious ailments, including gangrene and lung cancer, and had spent months in hospital. These applications were unsuccessful. In May 2015, however, he applied for medical parole again and the MPAB recommended his release on medical parole. He had served 21 years and six months of his life sentence and was 79 years old.

Despite the abovementioned factors, the Minister of Justice and Correctional Services refused to release Mr Derby-Lewis on medical parole.<sup>93</sup> The main reason for the refusal was that Mr Derby-Lewis had been diagnosed with Stage IIIB Carcinoma of the lung and that he therefore did not meet the requirement in terms of Regulation 29A(5)(i) that an applicant must be diagnosed with stage IV cancer.<sup>94</sup> Another vital consideration taken into account by the DCS was that Mr Derby-Lewis had allegedly not shown any remorse for the crimes he had committed.<sup>95</sup> Presumably this was taken into consideration in relation to the requirement that the offender must pose a low risk

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<sup>92</sup> Timeslive 'Shabir Shaik still 'terminally ill' after 8 years – but can work and attend sports' 27 July 2017 <https://www.timeslive.co.za/news/south-africa/2017-07-27-shabir-shaik-still-terminally-ill-after-8-years-but-can-work-and-attend-sports/> (accessed 7 August 2017).

<sup>93</sup> *Derby-Lewis v Minister of Correctional Services* 2015 SACR 412 (GP) para 2.

<sup>94</sup> *Derby-Lewis* para 18.

<sup>95</sup> *Derby-Lewis* para 29.

of re-offending. An application to the North Gauteng High Court was consequently made to set aside the Minister's decision and to release Mr Derby-Lewis.

*In casu* Baqwa J held that the facts of the case pertain to a matter of 'life and death, the latter having been forecast as a possibility in the not too distant future'.<sup>96</sup> The judge further held that section 79 ought not to be applied rigidly or read like a 'mathematical equation'.<sup>97</sup> Two independent specialists had confirmed that Mr Derby-Lewis was terminally ill and had only six months to live.<sup>98</sup> Legislation should be interpreted in a manner that upholds human dignity.<sup>99</sup> The Court ordered that Mr Derby-Lewis be placed on medical parole. Mr Derby-Lewis was released on medical parole in June 2015. He died in November 2016.<sup>100</sup>

The struggle for Mr Derby-Lewis' release on medical parole appears ironic. The underlying purpose of the amended section 79 is theoretically no longer limited to allowing a bedridden, terminally ill inmate a 'conciliatory and dignified death', but also to ensure that effect is given to the inmate's right to health care, dignity and life. Yet the new section 79, seems to be an instrument that can be used to achieve the opposite. That this is possible even when ten medical practitioners (on the MPAB) and two specialists concur on the medical status of an applicant suggest a system at risk of maladministration. Moreover it weakens and causes the regression of the achievements of democracy.

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<sup>96</sup> *Derby-Lewis* para 48.

<sup>97</sup> *Derby-Lewis* para 58.

<sup>98</sup> *Derby-Lewis* para 54.

<sup>99</sup> *Derby-Lewis* para 55.

<sup>100</sup> 'Breaking: Clive Derby-Lewis dies' *News24* 3 November 2016 available at <http://www.news24.com/SouthAfrica/News/breaking-clive-derby-lewis-dies-20161103> (accessed 5 November 2017).

### 5.3.2.2 How far beyond the old section 79 criterion of ‘in the final phase of a terminal illness’ does the new section 79 really extend?

As indicated earlier, section 79(1)(a) provides that an inmate may be considered for placement on medical parole if he is ‘ . . . suffering from a terminal disease or condition or if [he] is rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care’. On the face of it section 79(1)(a) extends the possibility of being considered for medical parole beyond inmates who are terminally ill and bedridden. Presumably the law permits inmates to apply for medical parole before they reach the stage where they are awaiting their death. Put differently, it may thus seem that the new law is a major improvement on the old law as it is no longer required that an inmate’s death should be imminent.<sup>101</sup>

The omission of the phrase ‘in the final stage of a terminal condition’ from the new section 79 definitely broadened the range of who may apply for medical parole. It, however, also raises the question of whether any prisoner diagnosed with a terminal condition may be granted medical parole regardless of his physical state. Some may argue that the diagnosis of a terminal medical condition in itself should not make a prisoner eligible for medical parole as it may ‘open the floodgates to . . . applications’.<sup>102</sup> The question should, however, be answered with reference to the genuine purpose of medical parole, i.e. to protect the dignity of terminally ill prisoners.<sup>103</sup> The perennial question in every application should thus be whether the terminally ill prisoner’s dignity will be best served inside or outside the walls of prison.

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<sup>101</sup> Mujuzi (2009) 59.

<sup>102</sup> Bauer N ‘Correctional Services widens the criteria for medical parole’ *Mail and Guardian* 23 February 2012 available at <http://mg.co.za/article/2012-02-23-correctional-services-widens-criteria-for-medical-parole> (accessed 23 March 2014).

<sup>103</sup> Bauer N (2012).

Section 79(2)(b) requires that every application for medical parole be accompanied by a written medical report recommending placement on medical parole. Section 79(2)(c) stipulates that the medical report ‘must include’ the following:

- ‘(i) a complete diagnosis and prognosis of the terminal illness or physical incapacity from which the prisoner suffers;
- (i) a Statement by the medical practitioner indicating whether the offender is so physically incapacitated as to limit daily activity or inmate self-care; and
- (ii) reasons as to why the placement on medical parole should be considered.’

On closer scrutiny of the provision it seems that in addition to the prognosis and diagnosis of the terminal illness or physical incapacity, a medical practitioner must state in writing that the prisoner is incapacitated to the extent that his daily activities or self-care are limited. It furthermore seems that an application for medical parole will not be considered unless the latter statement is included in the medical practitioner’s written report. If this reading of section 79(2)(c) is accurate, then the new section 79, like its predecessor, makes a grave inroad into inmates’ right to dignity. It also renders the phrase ‘terminally ill’ redundant. It may also then limit applications for medical parole to inmates who are already suffering the indignity of being dependent on others for their daily self-care. To avoid the latter interpretation the legislature should have made it more explicit that section 79(2)(b)(ii) is not a requirement which applies to all applicants for medical parole and that it specifically applies to applicants who wish to be released due to their physical incapacitation.

Recent anecdotal reports in the media point to some of the challenges mentioned above. Notable accounts include that of an inmate who had been diagnosed with a brain tumour in 2015 and had become partially paralysed. Fellow inmates had to ‘bathe him, take him to the

toilet, wash his clothes, dress him and fetch his food'.<sup>104</sup> In June 2016 one of these inmates therefore made an application for medical parole on behalf of the sick inmate. However, it reportedly took four months for the inmate to be seen by a medical practitioner who could prepare a report for the parole application. Almost nine months after the application had been made, fellow inmates still had to take care of the sick inmate. A fellow inmate consequently made an application to the High Court, probably in the hope that the process would be hastened. The application was heard on 18 April 2017. The Court ordered that the inmate be considered for medical parole within 30 days and that he be informed of the outcome within 24 hours of the decision being taken.

Though the case discussed above may be criticised as denoting a single incident only and not reflective of the medical parole application process in general, it arguably signifies possible problems which may be anticipated in the future. First, it seems that applications are not dealt with as a matter of urgency. Much time may lapse between the date of an inmate's diagnosis and when an application is finalised. In 2014, for example, it was reported that the DCS had reported to the Committee on Correctional Services in Parliament, that in the previous year 23 inmates had died in correctional centres whilst they awaited the outcome of their applications for medical parole.<sup>105</sup> Secondly, it is clear that an applicant who is dissatisfied with the arduous process may have to seek relief from the courts. Finally, the inmate's actual state of health and ability to navigate the system appear to be of little consequence. Put plainly, in the case discussed above the inmate would have languished without the assistance of his fellow inmates who had assumed responsibility for his care and his application for medical parole.

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<sup>104</sup> Furlogh (2017).

<sup>105</sup> 'Correctional Services dismisses perception on medical parole' (2014).

In respect of another case reported on in the media it was stated that an inmate in his 50s had been diagnosed with a disease which left him with ‘less than liveable heart functionality’.<sup>106</sup> A cardiologist initiated his medical parole application. His ‘battle for medical parole’ lasted for a year and was finally rejected. He had, however, not been given written reasons for his unsuccessful application and could therefore not appeal the matter. This case, like the previous one, suggests that the finalisation of the application process may be prolonged regardless of the extent of an inmate’s illness. The case also reveals a further challenge for dissatisfied applicants; if they are not afforded the official reasons for the rejection of their application they may not be in a position to appeal against such decision. These cases appear to suggest that there is a need to attach timelines to applications and to prioritise cases in which an inmate’s prognosis is very poor. Inmates should also be given concrete, written reasons in cases where their applications are not successful to enable them to appeal if they wish to do so.

### 5.3.2.3 Does section 79 reasonably ensure that inmates will lead a dignified life after their release?

If it is accepted that the purpose of section 79 is to protect the dignity of inmates, it would be pointless to release them unless adequate provision for their care and necessary medical treatment had been made. Section 79(1)(c) appears to address this need. It requires that ‘appropriate arrangements for the inmate's supervision, care and treatment within the community to which the inmate is to be released’ be made in order for an application for medical parole to be considered. This requirement is laudable, but the CSA itself does not provide any guidance as to what constitutes ‘appropriate arrangements’. The new Regulations which amend the 2004 Correctional Services Regulations are also silent on this

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<sup>106</sup> Mawson N ‘Dying for right to medical parole’ *Sunday Independent* 30 August 2015 available at <https://www.iol.co.za/sundayindependent/dying-for-right-to-medical-parole-1907688> (accessed 16 August 2017).



issue.<sup>107</sup> They do not provide details on who ought to make the arrangements or what constitutes ‘appropriate arrangements’. In terms of section 79(1), the National Commissioner<sup>108</sup>, the Correctional Supervision and Parole Board<sup>109</sup> or the Minister of Correctional Services,<sup>110</sup> are the final decision-makers in a parole application.<sup>111</sup> Arguably one of the latter will have the final say as to the appropriateness of the arrangements. This, however, does not assist persons who wish to prepare applications for medical parole. They will have to learn what is deemed appropriate through trial and error.

Furthermore, the question of what should happen to inmates who do not have any family or other support networks outside of the correctional environment cannot be overlooked. If sufficient State or private care institutions are not available to accommodate such inmates outside of the prison environment they will not meet the requirement of section 79(1)(c). Medical parole can then not be granted. This may be a violation of the right to be equal before the law.

It should be borne in mind though that the State’s primary duty is to the protection and promotion of inmates’ dignity and well-being. The question should therefore always be: How may an inmate’s dignity best be given effect to? If an inmate’s dignity can best be served in prison (whether in a prison hospital or other health care facility) then the prisoner ought not to be released. The prisoner should then be afforded the benefit of available resources in the correctional environment.

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<sup>107</sup> Amendment of Correctional Services Regulations 2004 GN 143 GG 35032 of 27 February 2012.

<sup>108</sup> In respect of prisoners sentenced to imprisonment 24 months or less.

<sup>109</sup> In respect of prisoner serving a definite sentence of imprisonment of more than 24 months.

<sup>110</sup> In respect of prisoners sentenced to life imprisonment.

<sup>111</sup> A court must decide whether or not to release prisoners who had been declared dangerous criminals in terms of s 286A of the Criminal Procedure Act 51 of 1977. See s 13 of the Correctional Matters Amendment Act 5 of 2011.

#### 5.3.2.4 Is the new medical parole system ‘accessible’ to all inmates?

Sections 79(2)(a)(i) and (ii) respectively provide that an application for medical parole may be lodged by ‘a medical practitioner’ or ‘a sentenced offender or a person acting on his or her behalf’. This is a major improvement on the old system as anyone can now lodge an application for medical parole. It affords an avenue for possible relief to inmates who are capable of navigating the medical parole application process or who have friends and/or family who are willing to lodge applications on their behalf. However, there are inmates who are not literate and are thus incapable of lodging an application. Additionally, many inmates can also not rely on friends and family to apply for medical parole on their behalf because they may have lost contact with them.

Although it cannot be reasonably expected that section 79 should make provision for all eventualities, it would have been prudent if the law had created a mechanism to ensure that inmates who are illiterate and/or who have no support outside of the correctional centres are not precluded from the possibility of applying for medical parole. A possible mechanism to ensure that inmates are not unfairly prevented from accessing the medical parole system may be to expressly confer a primary duty on the DCS, as custodian of all prisoners, to initiate applications for medical parole. At the same time prisoners or anyone acting on their behalf should not be prevented from initiating applications.

Regulation 29A(1)<sup>112</sup> provides that if during a health status examination it is discovered that an inmate is suffering from a condition listed in regulation 29A(5), which states the conditions which may make an inmate eligible for medical parole, ‘such facts must be recorded in the prescribed register’. The register could have been useful in holding the DCS accountable for informing inmates about their possible eligibility for medical parole and for

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<sup>112</sup> Amendment of Correctional Services Regulations 2004 (27 February 2012).

the initiation of medical parole applications on prisoners' behalf. Unfortunately, the new section 79 does not confer these obligations on the DCS.

#### 5.4 DOES THE AMENDED SECTION 79 ADEQUATELY PROTECT THE PUBLIC AGAINST REPEAT OFFENDING BY INMATES WHO ARE RELEASED?

It appears that much of the disinclination regarding the release of inmates on medical parole may be attributed to the public's fear that such offenders may commit further crimes once released. This is understandable. In South Africa many offenders commit crimes during their incarceration and after they are released from prison.<sup>113</sup> The need to lessen the impact of repeat offending on public safety is consequently evident. Section 79 arguably includes at least two safeguards aimed at preventing re-offending. The first is the requirement that an inmate must pose a 'low risk' of re-offending, and the second safeguard lies in the possibility that medical parole can be revoked in certain circumstances. These two safeguards are discussed below.

##### 5.4.1 How effective is the 'low risk of re-offending' requirement in preventing the commission of a crime by a medical parolee?

The notion that it is 'not inconceivable that [terminally ill inmates] would be even less inhibited from committing further crimes should they be released prematurely',<sup>114</sup> although rejected in *Stanfield*, appears to underlie the section 79 'low risk of re-offending' criterion. This may be due to the estimated high rate of repeat offending in South Africa, but it should be added immediately that there exists no reliable and scientific findings exist in this regard. The question that looms, however, is whether it is possible to establish, with reasonable certainty, whether an inmate poses a 'low risk' of re-offending.

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<sup>113</sup> Makoni M 'Repeat offenders fill up jails' *Free State Times* 2 August 2013 available at <http://fstimes.co.za/?p=1105> (accessed 18 October 2017).

<sup>114</sup> *Stanfield* para 34.

Medical parole decision-makers may choose to rely on section 79(5) as it contains factors which *may* be considered when determining an inmate's risk of re-offending. These factors include: (a) whether at the time of sentencing, the court was aware of the inmate's medical condition for which he is seeking medical parole; (b) a presiding officer's sentencing remarks; (c) the type of offence for which the inmate had been convicted and the length of the sentence still to be served; (d) the previous criminal record of the inmate; or any of the factors listed in section 42(2)(d). Section 42(2)(d) permits medical parole decision makers to consider the crime for which an inmate had been convicted, the length of his sentence, and the remarks of the sentencing judge. Furthermore, an inmate's previous criminal record, conduct, disciplinary record, training, aptitude, physical and mental state, as well as the likelihood of a relapse into crime, the risk posed to the community, and the manner in which this risk can be reduced may be considered.

In 2014 the Justice and Correctional Services Minister, Mr Michael Masutha, indicated the possibility of the introduction of 'agreed-upon, standard questions' to be used by parole boards when determining whether a parole applicant is likely to re-offend in the future.<sup>115</sup> At the time of writing (August 2017) the author's efforts to establish whether such standard questions are in fact utilised by parole boards, yielded no results. Notwithstanding this, it may be inferred that the Minister's Statement that such standard questions will possibly be introduced, suggests that that the DCS recognises the inadequacy of section 79(5). Additionally, the Minister expressed concern about the 'unavailability of police reports and sentencing remarks [and] outdated reports from the professionals dealing with offenders'

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<sup>115</sup> 'Parole system, community supervision under scrutiny' *Legalbrief Today* 27 November 2014 available at <http://www.legalbrief.co.za/article.php?story=20141127052343347> (accessed 27 November 2014).

when determining offenders' risk of re-offending. This too affirms that there are major challenges to determining the risk of re-offending.

The factors in section 42(2)(d) are in many respects the same as those in section 79(5). Both provisions, however, fail to offer guidance that will significantly assist in making reasonably accurate risk assessments. To determine an inmate's risk of re-offending arguably calls for the skills and experience of experts. Currently ' . . . there is very little South African based sociological and psychological research documenting the predictive factors associated with re-offenders'.<sup>116</sup> In the absence of relevant expertise, the consideration of the factors listed in sections 79(5) and 42(2)(d) may give rise to speculation regarding an inmate's risk of committing further crimes. It may therefore be arbitrary, biased, subjective and ultimately unconstitutional.

#### 5.4.2 Cancellation of medical parole

Section 79(7) permits the cancellation of medical parole. Inmates who contravene their parole conditions or who commit further crimes while on parole can therefore be compelled to serve the balance of their prison sentence in a correctional centre. This arguably inhibits the commission of further crime by parolees and thus contributes to public safety. Section 79(7) has been criticised as it expressly precludes the cancellation of medical parole on account of the improved health of an inmate.<sup>117</sup> This aspect of section 79(7) may indeed appear to be peculiar as it justifies medical parole in circumstances where the primary condition, viz severe illness and incapacity, for such parole ceases to exist. Perhaps this is aimed at preventing the DCS from transferring its responsibilities to the inmate or his family.

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<sup>116</sup> See Muntingh & Ballard (2011).

<sup>117</sup> Bateman C 'Tighter medical parole – Shaik, rattle and roll' *South African Medical Journal* (2012) 210 -212.

As parole is generally the objective of most inmates,<sup>118</sup> some may argue that attempts to manipulate their (inmates') health condition in an effort to be granted medical parole may not be too far-fetched. The knowledge that their freedom is guaranteed even if they recover after release may serve as further motivation to meet the initial requirements for medical parole.

It may further be contended that while the “. . . commission of further crimes would be the last thing on the mind of any prisoner released on parole for medical reasons . . .”,<sup>119</sup> a prisoner who has recovered may be less inclined to desist from committing crimes. Public safety is consequently compromised by the absence of mechanisms to send medical parolees back to prison if they recover. Against this argument it may be asserted that the possibility of revoking medical parole will always exist in circumstances where a parolee violates parole conditions. What is more, the *White Paper on Corrections* itself states that ‘[b]y its very nature, incarceration can have a damaging effect on both the physical and mental well-being of inmates.’<sup>120</sup> Release may therefore of itself be beneficial to the sick prisoner.

## 5.5 CONCLUSION

The discussion of the early release on medical grounds of remand detainees and sentenced inmates denotes the possibility of many hurdles for affected persons. In short, a speedy and flawless process to ensure the release of a terminally ill offender, whether on remand or serving a sentence, appears to be an unrealistic expectation under the current correctional regime.

From the preceding discussion it may be clear that the position of a person who is terminally ill and in remand detention can be disproportionately precarious in South Africa. Palliative

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<sup>118</sup> Moses J ‘Is it a right or a privilege?’ (2003) 19 *SAJR* 264.

<sup>119</sup> *Stanfield* para110.

<sup>120</sup> *White Paper on Corrections 2005* para 10.5.3.

care, the very type of health approach that such detainees require as soon as possible after diagnosis, is not available, or easily accessible, to them. The criminal justice trajectory may therefore even be fatal for some. What is more, it is not only the conditions of detention that may contribute to the violation of a remand detainee's rights, but also the extant laws that fall short of affording effective protection to them. Section 49E, though specifically crafted to address the realities of terminally ill remand detainees, is by no means a panacea for the untenable challenges experienced by remand detainees. It is in fact flawed and burdensome to the extent that its application may be impractical and simply unjust at times. It affords heads of correctional centres too broad a discretion; Arguably this is irrational in a context, where most heads of correctional centres do not have the expertise to determine a detainee's actual state of health or health care needs. Section 49G too, although it holds the promise of preventing unreasonably long stays in prison and the reduction of overcrowding, does not offer any concrete reprieve to terminally ill remand detainees. Section 63A similarly, appears to be aimed at rescuing those who are not too morally reprehensible to society and is not applied as rigorously as it seems possible to do.

The plight of terminally ill remand detainees, though seemingly to be addressed by the legislative provisions indicated above, seems to be neglected in effect. The voice of the remand detainee is subtly silenced as a result of the laws which appear to afford them protection. This indicates a need for an intense overhaul of the legislative framework which deals with remand detainees. An improved system should include at least that heads of correctional centres are afforded limited discretion in deciding the state of health and health needs of remand detainees, and that the views of such detainees or their suitable representatives be heard.

In respect of terminally ill inmates, it is also clear that the new medical parole system does not operate without challenges. Some of the recurring questions with regards to the early

release of inmates on medical grounds have not been effectively addressed by the new section 79. For example, though our courts have rejected the requirement that inmates must be bedridden and severely debilitated in order to be granted medical parole, it seems that in effect section 79 has not moved away from this completely. The very requirements aimed at reasonably ensuring that inmates who are released are assured of a dignified life, may have a discriminatory effect on vulnerable and indigent inmates. Inmates, without the resources, support or skills to attempt an application on their own, may be precluded from accessing the medical parole system. Additionally, the MPAB is constrained by the largely ‘deskbound’ nature of its tasks. Inmates and the public alike should be assured that the MPAB’s role will not be confined to reviewing correctional medical practitioners’ written recommendations and the occasional request to examine an inmate.

Furthermore, though public safety is not the primary concern when considering an application for medical parole, due consideration should be given to it. The ‘low risk of re-offending’ requirement, in the absence of sociological and psychological expertise, amounts to mere speculation regarding an inmate’s future criminality. This does not reasonably contribute to public safety and may violate prisoners’ right to dignity. It may ultimately be concluded that more is needed to inspire confidence in the system. Finally and crucially, it is contended that appropriate health care such as palliative care (discussed in the next Chapter) should be available in the correctional setting in addition to an effective medical parole and/ release system.



## CHAPTER 6

### THE RIGHT TO PALLIATIVE CARE OF TERMINALLY ILL INMATES IN SOUTH AFRICA

‘We ought to give those who are to leave life ... the terminally ill ... the same care and attention that we give those who enter life – the new-born.’<sup>121</sup>

#### 6.1 INTRODUCTION

‘While they waited for the [medical parole] application to be processed they had no access to medication and so they died within the prison premises.’<sup>122</sup> Based on this comment, the image of an emaciated inmate confined to a prison cell can no longer be relegated to urban legend. Inmates do become ill. Some, unfortunately, even become terminally ill. The existence of a medical parole system and correctional health system in South Africa, regardless of its inadequacies mentioned in earlier chapters, attest to the recognition of the maladies affecting inmates. However, the constitutional guarantee that the life and dignity of all including inmates, deserve protection, heralds a need for more than what is actually offered to terminally ill inmates by the current systems. This thesis proposes that to truly comply with the mentioned constitutional imperatives, all inmates diagnosed with a terminal condition ought to have access to quality palliative care as they have a right to such care. Furthermore, it is argued that terminally ill inmates’ right to palliative care should be made explicit in national legislation to ensure its permanency, expansion and development beyond the introduction of recent policies.

This chapter will commence with a description of the concept ‘palliative care’. It will furthermore be argued that the State has a duty to provide palliative care to all inmates diagnosed with a terminal illness. The bases for claiming it as a right which accrues to all terminally ill inmates will be unpacked.

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<sup>121</sup> Doyle D, Hanks G, Cherny N, Calman K *Oxford Textbook of Palliative Medicine* 3ed (2004) 1199.

<sup>122</sup> Comment of a former inmate interviewed in the Eastern Cape in October 2016.

## 6.2 PALLIATIVE CARE

In the 21st century we have begun to recognise that our physical and mental well-being is fundamental to a dignified life. The endorsement of the right to health thus finds widespread support since a failure to give effect to it impairs the right to dignity. In South Africa efforts to fulfil the constitutional right to access health care services include *inter alia* free health care services for pregnant women and children under the age of seven years and the provision of Nevirapine to HIV-positive mothers and their new-born babies to prevent HIV transmission to babies.<sup>123</sup> However, the plight of inmates who are terminally ill and denied release on medical parole appears to have not featured prominently on the State's health care agenda to date. They, like other terminally ill persons, need palliative care. Though there has been recent movement insofar as policy with regards to palliative care in general is concerned, the position of terminally ill inmates and remand detainees remains largely unchanged. Consequently, it is important to contextualise the claim for palliative care to terminally ill inmates and to establish the basis for their right to such care. First, however, a description of palliative care is provided below. To some extent the description of the concept arguably assists in illuminating the basis for claiming an entitlement to such care.

### 6.2.1 The description

Palliative care includes total care: physical; psychosocial; and spiritual.<sup>124</sup> '[T]he essence of palliative care is the relief of pain.'<sup>125</sup> Palliative care aims to: (a) recognise the importance of life, but regards dying as a normal process; (b) provide relief from pain and other distressing symptoms; (c) integrate the psychological and spiritual aspects of patient care; (d) help patients live as actively as possible until death; (e) to assist the family to cope during the

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<sup>123</sup> McQuoid-Mason & Dada (2011) 6. See also *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC).

<sup>124</sup> *Legal Aspects of Palliative Care* available at <http://www.osf.org.za/Publications/default.asp?PubCatID=34> (accessed 8 August 2014).

<sup>125</sup> *Legal Aspects of Palliative Care* (2014).

patient's illness and their subsequent bereavement when the patient dies;<sup>126</sup> (f) neither hasten nor postpone death; and (g) use a team approach to address the needs of patients and their families.<sup>127</sup> The WHO adds to this that palliative care is applicable early in the course of the illness, 'in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiotherapy, and includes those investigations needed to better understand and manage distressing clinical complications'.<sup>128</sup> This form of care takes cognisance of the fact that 'dying is more than a set of medical problems to be solved. Dying is personal; it is experiential. Caring for people who are dying involves helping them to say and do the things that matter most *to them*'.<sup>129</sup>

National policy assumes all the main elements of the abovementioned description and defines 'palliative care' as the 'holistic multi-disciplinary care of a patient and family affected by a life limiting or life threatening illness and is applicable from the time of diagnosis for all adults and children across the life span and includes bereavement care for the family'.<sup>130</sup> The provision of such care should thus start from the time of diagnoses until the death of a patient.<sup>131</sup> Though this seems ideal, the application of this principle may prove challenging in the correctional environment where the basic required health assessments upon admission to a correctional centre is sometimes not complied with.

### 6.2.2 The rationale for palliative care

Palliative care, as may be gleaned from the above description is a humane response to persons who may be facing final traumas, heightened grief, and even misgivings about their

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<sup>126</sup> McQuoid-Mason & Dada (2011) 312.

<sup>127</sup> WHO Definition of Palliative Care available at <http://www.who.int/cancer/palliative/definition/en/> (accessed on 8 August 2014).

<sup>128</sup> WHO (2014).

<sup>129</sup> Byock (2002) 110.

<sup>130</sup> NPFSPC 2017-2022 9.

<sup>131</sup> NPFSPC 2017-2022 10.

own existence. In a constitutional democracy like South Africa, palliative care should naturally have been embraced as crucial to upholding the rights to life, dignity and health of the terminally ill. In the absence of such a logical acceptance of palliative care, it becomes necessary to briefly sketch the rationale for the claim.

The claim for palliative care cannot be completely detached from the historical attitudes which inhibited such care as a stage to the right to health care. Put plainly, these (often unspoken) attitudes regarding care for the terminally ill have over the years contributed to palliative care being on an unequal footing with the rights to curative and preventative health care. This imbalance between the different layers of health care may be inferred from the fact that an estimated 50 per cent of all people who die in South Africa ‘could have benefitted from palliative care’.<sup>132</sup> By referring to some of these attitudinal barriers, the rationale for inmates’ access to palliative care may become less opaque.

Palliative care is not only about dying, but also about living a quality life (as may be evident from the definition provided above). Despite this more tolerable understanding of palliative care it cannot be easily gainsaid that most people choose not to think or talk about such care. The issues that affect human beings during the period of life called dying, which is possibly the most vulnerable time in human existence, have thus always been almost unmentionable socially and side-lined in legal discourse. The limited discussions on end-of-life issues arguably exacerbate the vulnerability of those who are affected by terminal illnesses. This is unfortunate and particularly of concern in the South African context where there are indications that thousands of people are not enjoying good health and are in fact facing life-

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<sup>132</sup> NPFSPC 2017-2022 10.

threatening or potentially life-threatening medical diagnoses. Furthermore health problems are heightened in correctional settings.<sup>133</sup>

The lack of or inadequate engagement with end-of-life issues may be morally comprehensible as death and the issues related to it are not pleasant or popular subjects of discussion for many individuals. However, cognisance must be taken of the implications of not broaching and dealing with, some of these issues. The rights of terminally ill persons and those affected by their illness are at risk of violations. Such risks may have been prevented or mitigated through palliative care approaches.

### 6.3 WHY TERMINALLY ILL INMATES?

Apart from the challenges inherent in the South African medical parole system and the large number of reported natural deaths in correctional centres discussed in Chapter 5, there are other reasons why all terminally ill inmates should be afforded access to quality palliative care. Some of these less obvious justifications for the provision of palliative care in correctional centres will be considered below.

At present terminally ill persons who are free appear to have access to more resources, whether State or private, than their counterparts who are imprisoned. As seen in Chapter 4, for example, domestic legislation makes it possible for free persons to access State grants for themselves and their carers. There are also some non-governmental as well as governmental initiatives that can be relied upon by free persons. More recently, a National Policy Framework on Palliative Care 2017-2022 (NPFSPC) (to discussed in greater detail later) which aims to deal with palliative care provision for all including inmates, adopted a more

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<sup>133</sup> Motala & McQuoid-Mason (2013) 1.

favourable approach to terminally ill persons who are free. The position of inmates is thus still much different from that of free persons.

Though State funded palliative treatment is at present not readily available, terminally ill persons who are not imprisoned may, with assistance from their family and support networks, gain access to *some* State services. They may also depend on their support networks where the State's assistance is lacking. The plight of inmates is worse. They cannot freely access services available to the public due to security measures in correctional centres, a lack of transport and staff capacity, and the absence of family or other support networks. They are thus a marginalised group in the absence of State assistance. Remand detainees, in particular, as discussed in Chapter 5, are in a precarious position as they do not have access to available services.

There are at least two categories of terminally ill inmates who require care. The first includes those who are not eligible for medical parole as they do not meet all the requirements of the medical parole provisions. The second category consists of those who have no support outside of the correctional environment and for whom the DCS cannot find alternative care in hospice institutions, for example.

#### 6.4 DOES THE STATE HAVE A LEGAL OBLIGATION TO PROVIDE PALLIATIVE CARE TO TERMINALLY ILL INMATES?

In Chapter 2 and 3, the international and domestic law relevant to the right to health care and inmates was discussed. The foundations of terminally ill inmates' right to palliative care as contended for do not readily emerge from the prior discussion, however. In other words, it is likely that at this juncture terminally ill inmates' need for palliative care may be more evident than the obligation on the State to fulfil it. It is therefore important to understand whether in addition to the justifications referred to earlier, there is any legal basis for a claim to specific

support by terminally ill inmates. Below arguments that an international human right to palliative care is emerging and that South Africa should endorse the right to palliative care as part of the right to health care are also made. This necessitates that international and domestic law as already discussed in Chapters 2 and 3 should be considered to form the basis for the right to palliative care. Inevitably there will be some repetition. To avoid superfluous repetition, reference will therefore be made to the relevant parts of Chapters 2 and 3 as appropriate.

#### 6.4.1 A constitutionally entrenched residuum of basic rights

In Chapter 3 of this thesis, it is contended that inmates retain all their constitutional rights with the exception of the limitation on their freedom of movement. It is also accepted that inmates acquire dual rights as ordinary citizens and as a result of their status as persons who are detained. Based on the aforesaid, the claim for palliative care may thus be premised on the constitutional right to health care services guaranteed in sections 27 and 35(2)(e) of the Constitution, which were discussed in Chapter 3 and are only briefly considered here for the sake of constructing a comprehensive argument.

In discussing section 27(1)(a) of the Constitution in Chapter 3 of this thesis the judgment in *Soobramoney*, where the applicant had sought expensive renal dialysis treatment from a State hospital to prolong his life, was considered. The Court held that ‘if everyone in the same position as the appellant was to be admitted, the [State’s] carefully tailored programme would collapse and no one would benefit from that’.<sup>134</sup> There will be times when the State cannot focus on the specific needs of an individual and must adopt a holistic approach to the needs of the populace.<sup>135</sup> As mentioned earlier, the appellant’s claim was dismissed.

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<sup>134</sup> *Soobramoney* para 26.

<sup>135</sup> *Soobramoney* para 31.

At this stage it is important to note that the claim for palliative care is distinguishable from that in *Soobramoney*. A claim for palliative care does not necessarily involve expensive treatment. The financial burden on the State will not be extended beyond the ‘natural span’ of a terminally ill person’s life. Palliative care is aimed at upholding the dignity of a terminally ill person. The State indeed has a duty in this regard even if the contention here is not that state-of-the-art treatment should be provided instantly, but that there should be a plan to address basic needs of terminally ill persons, and which sets out how comprehensive care will be afforded in the long-term. Some may argue that the newly introduced National Policy Framework and Strategy on Palliative Care 2017-2022 (to be analysed later in this chapter) serves this purpose. Tentatively though, it is contended that the Policy offers negligible support to inmates as there are no more than a few passing references to palliative care in correctional centres, thus making the State’s plan unreasonable to the extent that it does not properly include the most desperate subjects, as held in the *Grootboom* case.

In addition to section 27, section 35(2)(e) of the Constitution, which confers on detainees the right to appropriate conditions of detention including medical treatment consistent with the right to dignity (also analysed in Chapter 3), also supports inmates’ right to palliative care. To briefly recapture the discussion in Chapter 3. Section 35(2)(e) is not subject to resource limitations and affords a robust constitutional protection to the right to health care of all inmates. Currently there may still be some dissonance between the courts’ findings and legal scholars’ view with regards to the standards of adequacy insofar as resource allocation to inmates<sup>136</sup> in compliance with section 35(2)(e) is concerned. Notwithstanding these debates, it cannot be easily refuted that palliative care constitutes the reasonable (health) care consistent with the human dignity of terminally ill inmates. Whilst palliative care does not

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<sup>136</sup> See Chapter 3 of this thesis at section 3.2.2.



exclude the provision of curative and preventative care and may even be offered in tandem with other forms of health care approaches, it arguably also fulfils the ‘minimum goods’ requirement of section 35(2)(e), as suggested by Liebenberg (and mentioned in Chapter 3).

In summation, the South African Constitution evidently assists in laying the foundations for the conferral of a right to palliative care to all terminally ill inmates. This, however, does not suffice as will be explained in the final chapter of this thesis. National legislation which specifically expounds the legal position of terminally ill remand detainees and sentenced inmates, is necessary due to their extreme vulnerability in an already oppressive correctional milieu. The marginalisation of terminally ill inmates will persist during and beyond the current NPFSPC. The reasons for this aforementioned assertion may become clearer in the next discussion.

#### 6.4.2 National Policy Framework and Strategy on Palliative Care 2017-2022

During the Department of Health Budget Vote Speech 2017, the Deputy Minister of Health, Dr Phaahla, announced that South Africa had adopted a National Policy Framework and Strategy on Palliative Care 2017-2022 (NPFSPC).<sup>137</sup> In doing so, South Africa had become one of only a few countries in the world with a policy on palliative care which is based on World Health Assembly Resolution 69.17 :‘Strengthening of palliative care as a component of comprehensive care throughout the life course’.<sup>138</sup> It is possible that the introduction of this Policy Framework is a major step towards the formal legal recognition of palliative care as a right for terminally ill persons. Whether such recognition will materialise and put palliative care on an equal footing with curative and preventative care for terminally ill free persons will become clearer over time. Currently, however, the NPFSPC signifies that the

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<sup>137</sup> Deputy Minister of Health: Budget Vote Speech (2017)2.

<sup>138</sup> Deputy Minister of Health: Budget Vote Speech (2017) 2.

State accepts that for a five-year period (the duration of the policy framework) that it has a duty to introduce palliative care as appropriate care for terminally ill persons.

A preliminary analysis of the NPFSPC unfortunately raises concern regarding the State's recognition of, and duty to fulfil, the right to palliative care of terminally ill inmates. In short, a cursory reading of the Policy Framework suggests that, overall, great effort and resources may be invested to implement and expand palliative care to public hospitals, local clinics and the homes of terminally ill persons. Though it is stated a number of times in the Policy Framework that all terminally ill persons including inmates have a right to palliative care, it is unclear how the State will fulfil its duty to them. It also appears that the Department of Health does not envisage a direct role for itself in making palliative care accessible to inmates.

Apart from what may be described as no more than a few fleeting and superficial references to the provision of palliative care in correctional centres, there are no detailed and concrete discussions on the issue in the NPFSPC. While it may be contended that the DCS is responsible for health care in correctional centres, it must be borne in mind that the Department of Health is the lead department in all matters concerning health. Moreover, section 27 of the Constitution confers upon inmates the same health care entitlements as other persons. The deepened vulnerability of terminally ill inmates also gives rise to a need for specific emphasis on their right to ensure that they are not overlooked with regards to the fulfilment of their rights. To demonstrate the inadequacy of the NPFSPC to the extent that it deals with palliative care in correctional centres, various aspects of the Policy Framework will be discussed next.

#### 6.4.2.1 The impact of disease in correctional settings

It is positive that the NPFSPC acknowledges at the outset that it has become crucial for palliative care to be integrated into health care service delivery given the already heavy burden of disease.<sup>139</sup> Though it is well known that in correctional settings this burden is even more pronounced than in many other communities, a statement to this effect is absent from the Policy. Due consideration of the full extent of disease and its impact in correctional centres does not emerge from this Policy Framework. This is further demonstrated by the fact that in expressing the need to expand access to palliative care to all, the NPFSPC provides that ‘[w]e can only achieve this access if we focus on strengthening services at a primary health care level which includes our clinics as well as care within our communities and in the homes of patients’.<sup>140</sup> The impact of disease on free communities is thus recognised, but no mention is made of the effects in the correctional system. Admittedly, it may be difficult to anticipate how the Department of Health may expand access to palliative care to inmates, but such difficulty does not justify an avoidance of the issue, especially in a national policy framework. If creating equitable access to palliative care for all including vulnerable inmates is to be achieved, the extent to which the inmate population is affected by disease should at least have been presented and acknowledged in the NPFSPC so as to put the issue on the State’s agenda.

#### 6.4.2.2 The stated purpose of the NPFSPC

A less obvious, yet serious, concern is that the most significant purpose of the NPFSPC, as stated in this Policy Framework itself, is to change how palliative care is viewed.<sup>141</sup> The Policy seeks to instil the view that ‘palliative care includes but does not equate to end of life care.’<sup>142</sup> Changing perceptions on palliative care is not objectionable; it is in fact necessary in the South African context. However, public acknowledgement of the need for palliative

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<sup>139</sup> NPFSPC 2017-2022 2.

<sup>140</sup> NPFSPC 2017-2022 2.

<sup>141</sup> NPFSPC 2017-2022 4.

<sup>142</sup> NPFSPC 2017-2022 4.

care and education about what such care entails is not tantamount (nor sufficient) to recognising the fundamental right to such care, and does not automatically indicate the State's duty to provide such care. The most significant purpose of the Policy Framework should therefore have been to engender an understanding that the State has a legal duty to fulfil towards all bearers of this right. Changing the perception of palliative care as envisaged in the NPFSPC may improve the plight of some terminally ill persons in that a more charitable view may be adopted to creating access to such care for them. A more direct and forceful expression of palliative care as a right of all terminally ill persons as well as the State's duty to fulfil the right is needed, however. Education and awareness strategies to change perceptions should then be aligned to such expressed right so as to avoid misconceptions of palliative care provision as a State obligation.

#### 6.4.2.3 Fostering partnerships

It is positive that the NPFSPC affirms that palliative care is currently mainly offered by the non-governmental sector, but that it (the NPFSPC) aims to facilitate the State's responsibility to strengthen health systems in order to extend integrated care, including palliative care for life-threatening or life-limiting illnesses.<sup>143</sup> Based on the aforesaid a reasonably concrete plan for (introducing and) aligning standards of palliative care within correctional centres with palliative care offered in the public domain is therefore a basic expectation. This expectation is further cemented by the NPFSPC's description of various models of palliative care which ought to allow for the provision of palliative care in different settings and according to the needs of a specific community.<sup>144</sup> Additionally, the NPFSPC provides assessment tools to measure the patients' need for palliative care which would arguably ensure that resources are utilised appropriately.<sup>145</sup>

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<sup>143</sup> NPFSPC 2017-2022 4.

<sup>144</sup> NPFSPC 2017-2022 13.

<sup>145</sup> NPFSPC 2017-2022 13-15.

Furthermore, the NPFSPC indicates that it aims to make palliative care accessible to everyone including those who are vulnerable. Terminally ill inmates are included as a vulnerable group. The NPFSPC refers to certain barriers to palliative care in correctional centres. It indicates that palliative care in prisons is challenging because of the ‘hostile’ environment in which access to family is limited and there are not enough carers for terminally ill inmates.<sup>146</sup> In most correctional centres nurses are only available during the day, thus making opioid administration impossible at night. It is also mentioned that there is a need for the development of a strategy to establish a multi-disciplinary team specialising in palliative care to be consulted with regards to issues regarding medical parole and comprehensive care.<sup>147</sup>

The NPFSPC may be commended, as it offers various models for palliative care in different settings, provides assessment tools to determine patients’ need for such care, and identifies some of the problems which impede access to palliative care in correctional centres. Unfortunately though, it fails to lay the foundation for partnership with the DCS. This may be implied from the fact that the NPFSPC mentions some of the challenges to palliative care in correctional centres, but does not grapple with them or provide broad guidelines for addressing such issues.

At best the NPFSPC sets the following goals: Goal 1: Strengthen palliative care services across all levels of the health system, from the tertiary hospital to the patient at home, to provide integrated and equitable care; Goal 2: Ensure an adequate number of appropriately qualified health care providers to deliver palliative care at all levels of the health service; Goal 3: Establish and maintain systems for the monitoring and evaluation of South Africa’s palliative care program; Goal 4: Ensure appropriate allocation of financial resources to

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<sup>146</sup> NPFSPC 2017-2022 18.

<sup>147</sup> NPFSPC 2017-2022 18-19.

strengthen and sustain South Africa's palliative care program; and Goal 5: Strengthen governance and leadership to support implementation of the policy.<sup>148</sup> It is only with regard to Goal 5 that the NPFSPC appears to take cognisance of the need to engage the DCS. In pursuit of this goal an inter-government forum to strengthen delivery of palliative care by other sectors, including correctional services, will be established. The ultimate target in terms of this goal is that by 2022 all social cluster policies should be supportive of palliative care service delivery.<sup>149</sup>

The achievement of the goals of the NPFSPC may greatly assist to finesse, and perhaps even entrench the State's duty to provide palliative care to terminally ill persons in the long-term. However, there may be major discrepancies between standards of palliative care in communities and such care in correctional centres as different policies will have been developed by the different departments with the continuing aim to align such policies, but without any guarantee to achieve it. Although the State generally has a duty to provide palliative care to all terminally ill persons, inmates and free persons may not have access to the same treatment as a result of the parallel creation of separate policies. Resources would therefore have to be spent on aligning policies as opposed to effectively implementing policies conceived and framed with an ethos of upholding equality between inmates and free persons.

In summary, the NPFSPC is undeniably a positive step towards acknowledging and fulfilling the right to palliative care of all free persons. To the extent that it deals with inmates, however, it may widen the gap in terms of fulfilling the State's duty to provide palliative care to both free persons and inmates. Due to terminally ill inmates' profound vulnerability, the

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<sup>148</sup> NPFSPC 2017-2022 56.

<sup>149</sup> NPFSPC 2017-2022 65.

State's duty to fulfil their right to palliative care ought not to be dealt with as a secondary matter that may be deferred.

Apart from the constitutional right to health care of terminally ill inmates in South African correctional centres and the newly introduced NPFSPC, there is a growing recognition of an international human right to palliative care.<sup>150</sup> Though the NPFSPC refers to access to palliative care as an internationally recognised basic human right, it is important to give substance to this assertion to bolster the submission that the State has a legal duty to provide palliative care to terminally ill inmates.

## 6.5 AN EMERGING INTERNATIONAL HUMAN RIGHT TO PALLIATIVE CARE

Growing recognition that an international human right to palliative care exists further bolsters the contention that the State has a duty to provide palliative care to terminally ill persons. To substantiate this argument it may be considered at the outset that the definitions of the 'right to health' (as mentioned in Chapter 1) and 'palliative care' (above) are not inconsistent with a claim that terminally ill persons may have a legal entitlement to such care from the State. To elucidate this assertion, it may be recalled that in Chapter 1 it was mentioned that Mubangizi and Twinomugisha state that the right to health care can be defined as 'the prevention, treatment and management of illness and the preservation of mental and physical well-being through services by the . . . health professions'.<sup>151</sup> Based on this understanding of the right to health it emerges that there is an acceptance that human beings require an array of services and care insofar as their health is concerned.

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<sup>150</sup> See the Cape Town Declaration (2002), the Korea Declaration (2007) and the Budapest Commitment (2007).

<sup>151</sup> See Mubangizi & Twinomugisha (2010) 109.

Inevitably the degree and type of care required differ from one individual to another and may also change over time for an individual, as one's health is neither certain nor infallible or unchangeable. Importantly, it seems that a person's actual health status is not an obstacle to his position as a bearer of the right to health. It may therefore be inferred that the right to health literally applies to everyone, including terminally ill persons. Logically thus it may be argued that the right to health must include 'palliative care' given its definition as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. Given that palliative care entails more than medical care it must also be emphasised that other rights, such as, the to social security, food, accommodation and, importantly, to dignity, indirectly support the claim for palliative care.<sup>152</sup>

To further assist in cementing the contention that the State has a duty to provide palliative care to all terminally ill persons including inmates, the right to health in international law will be discussed next. This is necessary as there appears to be an increasing recognition of such an international human right.<sup>153</sup> Brennan, for example, contends that the 'right to palliative care' can be implied from the overall human right to health.<sup>154</sup> Indications of the possible existence of such a right are thus highlighted below.

### 6.5.1 The World Health Organization (WHO)

One of the possible indications of the existence of an international human right to palliative care may be traced to the right to the highest attainable standard of health as articulated in the Constitution of the WHO in 1946.<sup>155</sup> As pointed out earlier, the right to health does not obligate States to guarantee every citizen's good health, as such an obligation may prove to

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<sup>152</sup> Albertus (2012) 78.

<sup>153</sup> See the Cape Town Declaration (2002), The Korean Declaration (2005) and the Budapest Commitment (2007).

<sup>154</sup> Brennan F 'Palliative Care as an International Human Right' (2007) 33 *Journal of Pain and Symptom Management* 495.

<sup>155</sup> See Riedel (2009) 21.



be impossible to fulfil, particularly in respect of individuals who suffer from life-threatening diseases. Despite this, a suggestion that this right does not apply to terminally ill persons cannot be accepted. A more reasonable understanding of the right may be that every person is entitled to support that would ensure his or her optimum health taking into consideration his actual physical and/or biological conditions. Put plainly, in respect of a terminally ill person the State should consider, taking into consideration the actual medical prognosis of the individual, how that person can be assisted to ensure that suffering is minimised and optimal comfort enjoyed. Advocates of palliative care would argue that palliative measures are often the best way of ensuring such comfort to the patient.

More pertinent to the existence of a right to palliative care is the fact that at least 14 palliative care medications are on the WHO Essential Drug List.<sup>156</sup> Significantly, as will be explained later, access to these drugs has been described as part of the core minimum content of the right to health. This strengthens the assertion of an emerging right to palliative care and therefore a State's duty to fulfil the right. If access to the very drugs which often form a primary part of palliative care is to be deemed part of the right to health itself, then it is reasonable to assume that at least the basis for the emergence of a right to palliative care has begun to unfold. It may also be asserted that, in the absence of any concrete indications that inmates are to be excluded from access to such medications, the State must ensure that inmates like other persons should be afforded access to the appropriate medications in order to protect them against or to alleviate pain and suffering in order to uphold their dignity.

### 6.5.2. The Universal Declaration of Human Rights

In addition to the WHO's definition of health and the WHO Essential Drug List which contains palliative care medications, the Universal Declaration of Human Rights (UDHR)

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<sup>156</sup> Gwyther L and Cohen J *Legal Aspects of Palliative Care* (2009) *Hospice Palliative Care Association of South Africa* 9.

may also be relied upon to support the claim of a right to palliative care. The UDHR in Article 25(1) provides that '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services'. Arguably this formulation promotes the comprehensive approach which palliative care affords patients.<sup>157</sup> There appears to be an appreciation that for many 'health and well-being' are closely linked to the living and health conditions of the individual and his or her family. Furthermore, it is relevant to consider Article 5 of the UDHR which prohibits cruel, inhuman and degrading treatment. This right may also be indicative of the existence of a right to palliative care as the withholding of such care, particularly in cases where terminally ill persons suffer from severe physical pain, could potentially be regarded as a violation of Article 5. This Article is arguably of particular relevance to terminally ill inmates given the general occurrence of abuse and neglect in correctional settings.

### 6.5.3 International Covenant on Civil and Political Rights (1966)

Though this instrument does not contain a right to health it may be relevant to consider what the Human Rights Committee, which monitors the implementation of the International Covenant on Civil and Political Rights, has held with regard to Article 7 which prohibits cruel, inhuman and degrading treatment. The Human Rights Committee has held that the conditions of detention and treatment of inmates may in certain circumstances violate Article 7.<sup>158</sup> Consequently, States Parties 'regardless of their development' are under an obligation, to comply with certain minimum standards regarding the conditions of detention. These include *inter alia* adequate sanitary facilities, clothing, and food of nutritional value, adequate for health and strength.<sup>159</sup> The minimum standards must be complied with even under

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<sup>157</sup> Albertus (2012) 78.

<sup>158</sup> Liebenberg (2010) 259.

<sup>159</sup> *Allen Womah v Cameroon*, Comm No 458/1991, Report on Human Rights Committee, Vol II, General Assembly Official Records, 49th Sess Suppl No 40 (A/49/40) para 9.4.

conditions of budgetary constraints.<sup>160</sup> The Covenant in Article 10 places a positive duty on the States Parties to ensure that inmates are treated with respect and human dignity. The fulfilment of the rights protected in Articles 7 and 10 may arguably include the provision of palliative care to terminally ill inmates.

#### 6.5.4 International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights, ratified by South Africa on 18 January 2015, provides that '[t]he State Parties [must fulfil] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.<sup>161</sup> The CESCR has interpreted the right to health as 'an inclusive right extending ... to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information ...'.<sup>162</sup> This interpretation of the right may also be relied upon to support the claim for State-funded palliative care to terminally ill persons. In particular it may assist in constructing the basis for reasonable health care to terminally ill inmates.

The CESCR recognises that rights may not be immediately attainable due to resource constraints. States Parties are thus committed to progressive realisation of the right to health. The CESCR recognises that the right is dependent upon a number of social, economic and cultural rights, and that while this raises challenges of how to prioritise an entire population's socio-economic needs, it must be accepted that rights are interdependent.<sup>163</sup> The CESCR has confirmed that access to essential drugs, as defined by the World Health Organisation Action

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<sup>160</sup> *Allen Womah v Cameroon* para 9.4.

<sup>161</sup> Article 12.1.

<sup>162</sup> The Right to the Highest Attainable Standard of Health, UN Committee on Economic Social and Cultural Rights General Comment No 14, UN Doc E/C/12/2000/4 para 38.

<sup>163</sup> In *Grootboom* para 23 the Court held that all rights in the Bill of Rights are inter-related and mutually supportive.

Programme on Drugs, is part of the minimum core content of the right to health. As already mentioned, at least 14 palliative care medications are on the World Health Organisation Essential Drug List.<sup>164</sup> The CESCR has observed that a State Party ‘... cannot ... justify its non-compliance with the core obligations ... which are non-derogable’.<sup>165</sup> In General Comment No 14 the CESCR asserted that States Parties must respect the right to health by refraining from denying or limiting equal access for all persons, including prisoners to preventative, curative and palliative health services. It is significant that palliative care is recognised as a health service alongside curative and preventative care. It denotes that these health services are all of equal importance.

General Comment No. 14 also outlines the different dimensions of the right to health. This is important for envisaging how a right to palliative care may be applied in practice. It distinguishes between ‘freedom’ and an ‘entitlement’ dimensions. The former relates to the right to have control over one’s own health and body. It includes the right to be free from torture and not to be subjected to non-consensual medical experimentation or treatment. ‘Entitlement’ includes the right to a system of health protection which provides equal opportunity for people to enjoy the highest attainable level of health. It covers *inter alia* the right to emergency medical services, and the right to the underlying determinants of health, such as, adequate sanitation, safe and potable water, adequate food and shelter and a healthy environment. These underlying health determinants must be met since without them the right cannot be properly protected.<sup>166</sup>

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<sup>164</sup> Gwyther & Cohen (2009) 9.

<sup>165</sup> Lohman D, Schleifer R, Amon J ‘Access to pain treatment as a human right’ (2010) 8 *BCM Medicine* 6.

<sup>166</sup> CESCR *General Comment No 14 on the right to the highest attainable standard of health*, 11 August 2000, UN Do. E/C.12/2000/4 para 8.

To further support the existence of a right to palliative care the CESCR's interpretation of the right to health may be considered. According to the CESCR the right to health contains four essential and interrelated elements, namely, availability, accessibility, acceptability and quality (The AAAQs).<sup>167</sup> It is argued here that if all these elements are present the provision of palliative care can be accommodated by States. These elements will be discussed below.

### 1. *Availability*

For the right to health to be fulfilled States Parties must ensure that adequate health facilities, goods and services are available. The nature of the facilities, goods, services and programmes will depend on *inter alia* the State Party's level of development. The underlying determinants of health must be included, however. 'Availability' can also be defined as the 'measurement of the degree to which the health provider can meet the patient's need with resources such as personnel and technology'.<sup>168</sup> In South Africa, terminally ill persons will not have their needs met unless sufficient facilities, trained care-givers and appropriate medication are made available to provide palliative care to them. Though South Africa's newly adopted National Policy Framework aims to achieve all of the aforesaid, the materialisation of these goals will naturally only become evident over time, and since many of the targets are aimed at free persons, fulfilment of inmates' right predictably may be poor.

### 2. *Accessibility*

Health facilities, goods and services must be accessible to everyone within the jurisdiction of the State Party without discrimination. This is particularly problematic in respect of inmates. Though South Africa's National Policy Framework mentions that access to palliative care in

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<sup>167</sup> CESCR *General Comment No 14 on the right to the highest attainable standard of health*, 11 August 2000, UN Do. E/C.12/2000/4 para 12 a-d. See also Office of the United Nations Commissioner for Human Rights, World Health Organization 'The Right to Health' *Fact Sheet No. 31*, 3-4.

<sup>168</sup> Butler, M, Plaks, 'Access to public healthcare in South Africa' 2012 *South African Actuarial Journal* 131.

correctional settings is challenging, it does not set out any noticeable goals to overcome these challenges.

The ‘accessibility’ element of the right to health has four overlapping elements. These elements are:

- a) **Non-discrimination:** Health facilities, goods and services must be accessible to all without discrimination. The most vulnerable and marginalised persons, in law and fact, must not be discriminated against. This is arguably important when it comes to persons who are terminally ill and imprisoned. In practice they may be treated differently or deemed ineligible to benefit from certain resources due to the fact that they have life threatening conditions and had been found guilty or suspected of committing crimes.
- b) **Physical accessibility:** Health facilities, goods and services must be within safe reach of everyone including minorities and the most vulnerable groups in society. Both medical services and the underlying determinants of health must be accessible to everyone. Persons with disabilities must, for example, have access to buildings. Transport time to health facilities and the time spent waiting for such transport are also relevant to the question of accessibility.<sup>169</sup> In South Africa it has been found that the distance to health care facilities has a significant impact on health outcomes: ‘Geographic accessibility to health care facilities is likely to be a crucial determinant in the take-up of and adherence to anti-retroviral drugs for HIV therapy’.<sup>170</sup> Indications are that where the travel time to a health facility exceeds one hour the

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<sup>169</sup> Butler & Plaks (2012) 130.

<sup>170</sup> Butler & Plaks (2012) 134.

utilisation of such facility tends to decline rapidly.<sup>171</sup> At the time of writing there are no standards or guidelines for the distance to health care facilities in South Africa. Arguably, vulnerable groups, such as persons who are terminally ill and imprisoned, may be gravely affected by excessive geographical distances and transport limitations between where they are and health facilities.

- c) Economic accessibility (affordability): Health facilities, goods and services must be affordable to everyone including socially disadvantaged groups. 'Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households'.<sup>172</sup> This principle should also be applied to inmates who have no, or negligible, income and are therefore heavily dependent on the State.
- d) Information accessibility: This includes the right to seek, receive and impart information and ideas about health. However, personal health data should be treated confidentially.

### 3. *Acceptability*

Health facilities, goods and services must be respectful of medical ethics and sensitive to cultural diversity as well as to gender and life cycle requirements. 'Acceptability' also relates to whether the patient is content with certain features of the health provider, such as, the provider's race, gender, age and culture.<sup>173</sup> In turn, the service provider must also be 'comfortable with such characteristics of the patient as well as with the patient's method of payment'.<sup>174</sup> Thus service providers should be sensitised to the plight of terminally ill

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<sup>171</sup> Butler & Plaks (2012) 134.

<sup>172</sup> Butler & Plaks (2012) 134.

<sup>173</sup> Butler & Plaks (2012) 131.

<sup>174</sup> Butler & Plaks (2012) 131.

inmates and the quality of the care afforded to them ought not to be negatively affected by the fact that they are not personally able to pay for such services.

#### 4. *Quality*

Health facilities, and services must be medically and scientifically appropriate and of good quality.<sup>175</sup> This requires *inter alia* that health care professionals should be properly trained, that adequate facilities are used, and that scientifically acceptable methods are employed in treating patients.<sup>176</sup> States must therefore ensure that the health care services that are available contribute ‘in a real and effective way’ to the realisation of the highest attainable standard of health.<sup>177</sup> In respect of terminally ill prisoners that means that the services afforded to them should contribute to pain relief and enhancing the comfort of the patient as far as reasonably possible.

#### 6.5.5 United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment reported that the *de facto* denial of access to pain relief, ‘if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment’.<sup>178</sup> He recommended that ‘all measures should be taken to ensure full access and to overcome regulatory, educational and attitudinal obstacles to ensure full access to palliative care’.<sup>179</sup> Based on this recommendation, as well as the earlier discussions on access to palliative care medication, it seems that a claim for palliative care medication cannot be easily rejected even if arguments for the existence of a right to palliative care are initially not fully supported.

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<sup>175</sup> Tobin (2013) 173.

<sup>176</sup> Tobin (2013) 173.

<sup>177</sup> Tobin (2013) 173.

<sup>178</sup> Nowak (2009) para 72.

<sup>179</sup> Nowak (2009) para 74.



### 6.5.6 International instruments pertaining to inmates

A detailed discussion of the international instruments that apply to inmates' health rights in South Africa is beyond the scope of this Chapter. Instruments providing for inmates' right to health care services include: The Revised Standard Minimum Rules for the Treatment of Prisoners (2015); the Basic Principles for the Treatment of Prisoners (1990); the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988), and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990).

The African Commission's Robben Island Guidelines<sup>180</sup> are also important as they prohibit torture, cruel, inhuman and degrading treatment. They provide that States must ensure that detainees are treated in conformity with the international standards guided by the United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules).<sup>181</sup> The latter instrument contains standards for the nature of medical services to be provided to prisoners, as well as the conditions of their detention, including facilities, food, sanitation and exercise. They also provide that inmates who require specialised treatment should be transferred to facilities where their needs can be met.<sup>182</sup> This strengthens the claim of terminally ill inmates.

The notion of palliative care as an international human right enjoys increasing support, yet at least one alternative to framing the right in this way has been proposed. Kirk argues that the claim is not sufficiently developed philosophically.<sup>183</sup> He suggests that the right to palliative

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<sup>180</sup> Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa.

<sup>181</sup> Article 3.

<sup>182</sup> See Rules 22 and 23 of the instrument. See also Liebenberg (2010) 258.

<sup>183</sup> Kirk (2011) 84.

care can be reasonably grounded in the ‘sanctity of individual liberty’.<sup>184</sup> ‘Pain ... [is] an incursion on liberty ...’.<sup>185</sup> He argues that States must introduce national palliative care strategies that maximise opportunities for effective care that minimises pain and provides individual liberty. Additionally, Kirk argues that human rights are perceived as individually held rights, while palliative care is aimed at palliating the suffering of terminally ill patients and their relatives. He advises that palliative care ought to be framed as a collective right.<sup>186</sup>

Kirk’s argument *can* give impetus to the promotion of palliative care services. It must be stated, however, that to frame palliative care as a human right is not ineffective as he suggests. Though couched as an individual human right in many international instruments, the right to health when given effect to has a positive impact on the well-being of both the individual and his/her intimates. Arguably, care provided to the patient not only consoles those close to him/her, but also affirms to them that their rights will be given effect to. Colombo and Ziegler appropriately state that ‘... what most of us fear the most of death, is not so much the fact that we will not be around anymore, but rather the possibility of becoming, before dying, an intolerable burden, for ourselves and for others’.<sup>187</sup>

The human rights approach to palliative care speaks to the concerns of the individual and the collective. It is contended that there is an unspoken acceptance that satisfying the individual rights of a terminally ill patient eases the suffering of those around the patient. There is thus a collective benefit flowing from the fulfilment of an individual’s human right. Moreover, it strengthens the claims of others in similar positions.

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<sup>184</sup> Kirk (2011) 87.

<sup>185</sup> Kirk (2011) 87.

<sup>186</sup> Kirk (2011) 89.

<sup>187</sup> Colombo S and Ziegler R ‘End-of-life and the good society: Affirming a legal right to palliative care – A model for Israel’ (2001) 2 *European Journal of Comparative Law* 295–296.

### 6.5.7 WHA Resolution 67.19: ‘Strengthening of palliative care as a component of comprehensive care throughout the life course.’

Though the right to palliative care had not been formally articulated in the early binding international law instruments the World Health Assembly adopted Resolution 67.19 in 2014. The Resolution is a major milestone as it was the first time that Member States had discussed palliative care.<sup>188</sup> Significantly, South Africa was one of the co-sponsors of the resolution which was adopted by all 194 Member States.<sup>189</sup> Despite the unanimous support for this Resolution the World Health Assembly indicated on 1 August 2017 that globally less than 14 per cent of people who require palliative care receive such care.<sup>190</sup> Notwithstanding the seemingly stagnant attitude to implementing the Resolution it is still worth considering how it may assist the plight of terminally ill persons, particularly those who also happen to be inmates.

The Resolution has nine points which are aimed at guiding Member States in their implementation. The nine points are as follows<sup>191</sup>:

‘1) [T]o develop and implement palliative care policies; 2) to ensure adequate domestic funding and allocation of human resources for palliative care initiatives; 3) to provide basic support to families, community volunteers and other individuals acting as caregivers, under the supervision of trained professionals; 4) to aim to include palliative care as an integral component of the ongoing education and training offered to care providers, in accordance with their roles and responsibilities; 5) to assess domestic palliative care needs, including pain management medication requirements, to ensure adequate supply of essential medicines in palliative care; 6) to review and revise national and local legislation and policies for controlled medicines; 7) to update, as appropriate, national essential medicines lists; 8) to foster partnerships between governments and civil society, including patients’ organisations, to support the provision of services for patients requiring palliative care; and 9) to implement and monitor palliative care actions included in WHO’s global action plan for the prevention and control of non-communicable diseases 2013–2020.’

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<sup>188</sup> NPFSPC 2017-2022 28.

<sup>189</sup> NPFSPC 2017-2022 28

<sup>190</sup> WHA Fact File 2017.

<sup>191</sup> NPFSPC 2017-2022 28

The guidelines provided by the Resolution appear to be broad, yet appropriate for Member States to form approaches that may accommodate their unique situations domestically. The fact that the Resolution itself does not offer detailed guidance on how to extend palliative care to vulnerable groups, such as inmates, is therefore not a cause for serious criticism. The need to accommodate vulnerable groups ought to be self-evident to States in their compliance with guiding principle 5 above which calls on Member States to assess domestic palliative care needs. South Africa's failure to do so adequately may therefore not be attributed to any inadequacy of this Resolution. Furthermore, it is submitted that South Africa (as already alluded to in the discussion of the NPFSPC) has also not dealt satisfactorily with guiding point 8 which calls for the fostering of partnerships.

Guiding principle 5 is also an issue of concern in South Africa. The NPFSPC notes that there is a relative shortage of doctors in the country (0.77 per 1000 population) and that this makes it necessary to shift certain tasks in the provision of palliative care to nurses.<sup>192</sup> One such shift ought to be that nurses be allowed to prescribe opioids which are important for pain and symptom management. The NPFSPC acknowledges that the new Policy allows nurses to prescribe medication from the primary health care Standard Treatment Guidelines and Essential Medicines List, but the NPFSPC itself notes that it is unclear if they may also prescribe opioids.

The preceding discussion demonstrates that the acceptance and recognition of the right to health in international law creates an awareness and obligation for States to meet citizens' health needs. Though there is no express right to palliative care in an internationally binding instrument, there appears to be a realisation that people's health needs are diverse and that actual needs ought to be given consideration in designing responses aimed at fulfilling health rights. To some extent cognisance has been taken of the plight of those who are terminally ill. However, more needs to be done to effectively uphold their rights to health and dignity. The explicit acceptance of a right to palliative care in binding sources of law can improve the experience of everyone affected by terminal illnesses.

In South Africa the adoption of the Resolution and the later introduction of the NPFSPC denote that the State recognises the need for palliative care and that it has a duty to fulfil this need. While these are positive steps, it must be noted that after the adoption of the Resolution

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<sup>192</sup> NPFSPC 2017: 25.

it took South Africa three years to introduce the NPFSPC,<sup>193</sup> which in its current form does not sufficiently protect terminally ill inmates' right to palliative care, nor does it introduce reasonable and workable plans to improve their access to such care as may become clearer below.

#### 6.5.8 United Nations Office on Drugs and Crime

The United Nations Office on Drugs and Crime's Handbook on Prisoners with Special Needs provides that in many countries tuberculosis and HIV are the primary causes of death in correctional centres.<sup>194</sup> Yet the focus of the Handbook is not on the treatment and control of these diseases, and readers are directed to other literature which deals with these diseases. Although it is not stated in the text, an important lesson emerges from this method, namely, that cognisance must be taken of the most prevalent diseases that give rise to the terminal condition of inmates, but it ought not to limit, or distract from the focus of palliative care approaches being on all terminally ill persons regardless of their type of afflictions.

The Handbook cautions that the suffering inherent in a sentence is exacerbated by the diagnosis of a terminal illness.<sup>195</sup> Some may realise this truth, but it also needs to be imbedded in the conscience of the correctional authorities. Express provisions within policies and laws may assist in this regard and may inform practices in correctional centres. In addition the Handbook stipulates that policies on palliative care must be made accessible.<sup>196</sup> This is definitely a lesson yet to be learned in South Africa as the DCS' policies on palliative care are not easily accessible to members of the public and inmates.

The issue of access to justice is highlighted in the Handbook. Though it is self-evident that terminally ill persons may require access to a legal representative to, for example, assist with

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<sup>193</sup> The Resolution was adopted in 2014 and South Africa introduced the NPFSPC in 2017. NPFSPC 2017: 2.

<sup>194</sup> United Nations Office on Drugs and Crime (2009) 148.

<sup>195</sup> United Nations Office on Drugs and Crime (2009) 148.

<sup>196</sup> United Nations Office on Drugs and Crime (2009) 148

matters, such as, the drafting of a will and the appointment of legal guardians for minor children, it may be less obvious that terminally ill inmates also have a need to legal representation. The Handbook recognises that such inmates may need the support of lawyers to access appropriate health care while they are imprisoned. This is particularly true for remand detainees. It is equally important though that inmates have legal representation during medical parole applications. This guideline in the Handbook resonates with the view of some.<sup>197</sup>

Access to palliative care medications is a serious concern in many correctional systems in the world, according to the Handbook.<sup>198</sup> Understandably, the problem of drug abuse in prisons cannot be underestimated. South Africa should therefore have strict regulations in place to ensure that inmates who genuinely need such medications are not deprived thereof. The Guidelines on Palliative Care discussed below do contain detailed directions on how pain medications should be dealt with in prisons.<sup>199</sup> Such Guidelines should, however, be consolidated and perhaps included in legislation which would be binding on the DCS.

## 6.7 Guidelines on palliative care for the DCS by the HPCA

‘You must forget about it. You’ll never get such things. If you are dying, you are dying.’<sup>200</sup>

This poignant comment by a former inmate who had witnessed the death of fellow inmates may suggest that there is not a consistent approach to palliative care in all correctional centres. Some, like the aforementioned former inmate, unfortunately find themselves in a hostile environment where basic care is denied even to the terminally ill. Though guidelines

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<sup>197</sup> During interviews with former inmates the majority of them commented that they believed an inmate’s prospects of being released may be improved if they were legally represented.

<sup>198</sup> United Nations Office on Drugs and Crime (2009) 146.

<sup>199</sup> See Hospice Palliative Care Association of South Africa ‘Guidelines for Palliative Care in Correctional Settings’ <https://www.hpca.co.za/category/resources.html> (accessed 20 September 2017).

<sup>200</sup> Comment about palliative care by interviewee from the Eastern Cape October 2016.

are not binding, they may assist in harmonising standards across different correctional centres. The fact that in 2013 the HPCA assisted the DCS in the drafting of guidelines for palliative care in correctional settings was therefore positive despite the lack of implementation. Some of the guidelines will be briefly discussed next.

The Guidelines for Palliative Care in Correctional Settings (Guidelines)<sup>201</sup> are arguably all important. The unique nature of the correctional environment requires special consideration in the formulation of guidelines. Though conditions may vary amongst correctional centres, these Guidelines are arguably more pliable than guidelines that had been drafted for palliative care in the home environment.

As there is no specific law or regulations on palliative care in correctional centres the Guidelines provide a list of legislation and policies, 22 items in total, which should be complied with in the provision of palliative care.<sup>202</sup> While it is helpful for correctional authorities to be aware of the laws and policies which they should uphold, they also require explanations as to the exact relevance of these laws and how compliance may be ensured. Despite these considerations, the Guidelines ought to be introduced in correctional settings as they would caution staff and inmates that the law requires that palliative care be provided and that there are specific standards that must be followed. In the long-term, however, efforts ought to be made to consolidate laws specifically relevant to palliative care in correctional centres as this may result in greater awareness of the law and perhaps even easier compliance with such law.

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<sup>201</sup> Hospice and Palliative Care Association of South Africa ( HPCA) ‘Guidelines for Palliative Care in Correctional Settings’ available at <https://www.hpca.co.za/category/resources.html> (accessed 20 September 2017).

<sup>202</sup> Hospice Palliative Care Association of South Africa ‘Guidelines for Palliative Care in Correctional Settings’: 3.

The Guidelines provide that an inmate has the right to be involved in any decision relevant to his care, treatment and service.<sup>203</sup> Whilst this is legally correct and applies to everyone it is all the more important for it to be emphasised in respect of inmates. They should also be afforded professional support to assist them in making decisions, and be permitted to confer with their next-of-kin if they wish to do so. It is unfortunate that the Guidelines do not express the aforementioned detail, yet this does not render them ineffective as long as there is a basic understanding that inmates should have a say in how they are cared for.

The Guidelines provide that plans for palliative care ought to be based on a needs assessment of the inmate population, characteristics of the physical institution, medical-care capabilities, and other resources.<sup>204</sup> These are realistic considerations. If the Guidelines are followed correctional authorities will have to address the question of how quality palliative care may be provided in an oppressive, overcrowded environment, where there is also a lack of reasonable medical resources, as these factors do exist in many prisons. Admittedly, it may be very difficult to address the issues mentioned here, but these are the exact impediments to palliative care which ought to be addressed by the State.

The Guidelines affirm that inmates may have no familial support due to their incarceration and consequent separation from their biological family. The Guidelines therefore introduced the concept of a ‘family of choice’ which is defined as ‘biological family members, significant others from the community and/ or inmates or individuals named as family by the

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<sup>203</sup> Hospice and Palliative Care Association of South Africa ‘Guidelines for Palliative Care in Correctional Settings 4.

<sup>204</sup> Hospice and Palliative Care Association of South Africa ‘Guidelines for Palliative Care in Correctional Settings 4.



inmate patient.<sup>205</sup> The family of choice is, as would be the case in a community setting, the focus of care and support. This is excellent as some inmates serve long sentences and do form emotional bonds with their peers. If not this Guideline, the importance of affording support to the family of choice may probably not occur to all correctional health staff.

The Guidelines also include the following: In providing services, staff and management should be sensitive to the culturally and spiritually diverse needs of the correctional community it serves; palliative care should be offered as part of comprehensive care according to the need of each inmate; care must be fully coordinated to ensure continuity from admission to release/parole of the inmate patient and for the family; and a written care plan must be developed for each inmate patient. Such plan must take into account the special needs of the family and the services provided to the family, at the inmate patient's discretion. An interdisciplinary team must identify and incorporate specialised professionals, and must meet the specific needs of inmate patients and their families as identified in the plan of care. They should provide quality, coordinated care as defined by current professional guidelines that relate to the team member's practice specialties and to the principles of interdisciplinary team practice.<sup>206</sup>

The abovementioned Guidelines, if properly implemented would ensure that the individual needs of each inmate diagnosed with a terminal disease will be identified and documented. The interdisciplinary team will furthermore ensure that holistic care is provided to the inmate and that the needs of his family of choice are also attended to.

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<sup>205</sup> Hospice and Palliative Care Association of South Africa 'Guidelines for Palliative Care in Correctional Settings' 4.

<sup>206</sup> Hospice and Palliative Care Association of South Africa 'Guidelines for Palliative Care in Correctional Settings' 10.

The Guidelines also provide for spiritual care services.<sup>207</sup> Such services should be based on an initial and ongoing documented assessment of the inmate patient's and family's spiritual needs by a chaplain or spiritual worker, utilising required resources as needed. The provision of these services may be of paramount importance to inmates who may be in extreme physical and emotional pain. This is also true for those who may be facing death in the near future. Spiritual guidance may provide them with comfort.

The Guidelines provide that the caregiver services in a correctional centre may include volunteer inmate caregivers, specially trained in the care of the inmate patients who are terminally ill.<sup>208</sup> This Guideline may be beneficial to both terminally ill inmates as well as the volunteer inmates. The former may be comforted by the fact that someone familiar with their struggles and experiences is caring for them, while the latter may acquire new skills which may assist them in finding employment once released.

Further Guidelines include that: Throughout all phases of care, patient needs must be matched with appropriate resources within and, when necessary, outside the correctional centre; all patients cared for by the correctional centre should have their holistic needs identified through an established assessment process; and when an opportunity to improve or to correct a problem in the quality of care or services is identified, action must be taken to improve the care or to correct the problem.<sup>209</sup>

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<sup>207</sup> Hospice and Palliative Care Association of South Africa 'Guidelines for Palliative Care in Correctional Settings' 6.

<sup>208</sup> Hospice and Palliative Care Association of South Africa 'Guidelines for Palliative Care in Correctional Settings' 8.

<sup>209</sup> Hospice Palliative Care Association of South Africa 'Guidelines for Palliative Care in Correctional Settings': 9.

The abovementioned Guidelines are important. If implemented they will ensure that the correctional authorities are always aware of the actual needs of as well as the problems experienced by, terminally ill inmates. These Guidelines also indicate that the State should make resources available to ensure the care of terminally ill inmates, and where their needs cannot be met within the correctional setting, services which are available to the public must be accessed.

Importantly, the Guidelines provide that patient accommodation should be adequate to allow for the safety, privacy and comfort of patients.<sup>210</sup> Further, patient and family educational needs must be assessed and written in the records. The correctional centre must design and carry out processes to provide continuity of patient care when the patient is transferred to another organisation; all terminally ill inmates referred for medical placement must have access to the services and support of a palliative care interdisciplinary team.

The above Guidelines indicate that terminally ill inmates should not be accommodated in overcrowded cells where they have no privacy, where safety is compromised and their symptoms may be exacerbated. Creating a comfortable environment conducive to the needs of the terminally ill inmate appears to be vital to ensuring proper care for them. Apparently, an understanding of the needs of the inmate and what palliative care involves is important, hence the educational needs of the family must be assessed and recorded.

Unsurprisingly the Guidelines provide that the pharmaceutical needs of inmate patients must be met, consistent with all applicable regulations and acceptable standards of practice; Inmate patients must receive coordinated and accurate communication, information, instruction and

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<sup>210</sup> Hospice Palliative Care Association of South Africa 'Guidelines for Palliative Care in Correctional Settings': 9.

education about their medication, medication profile and results of medication monitoring. The correctional centre must decide which medicines and pharmaceutical supplies will be made available for prescribing and ordering. This decision is based on patient needs and the types of services provided.<sup>211</sup>

If all the Guidelines discussed above were to be followed in all correctional centres it may lay the foundations for a human rights orientated approach to palliative care. A lesson learnt from these Guidelines which were drafted almost five years ago is that, though the content is appropriate for correctional centres, a firm undertaking from DCS is needed for actual implementation. There can be little doubt that these Guidelines are not followed in all correctional centres. This may be attributed to conditions in correctional centres, but it cannot be gainsaid that the non-binding nature of this instrument also contributes to the failure to observe the Guidelines.

## 6.8 ARE THERE ANY LESSONS FOR SOUTH AFRICA?

### 6.8.1 Uganda

Uganda is regarded as an African leader in palliative care as the country has been successful in the development of palliative care approaches.<sup>212</sup> Uganda was ranked 35th overall on the 2015 Quality of Death Index, developed by the Intelligence Unit of *The Economist* newspaper to rank 80 countries in terms of the quality and availability of palliative care services for adult populations.<sup>213</sup> Uganda had been ranked the highest of all African countries and its palliative care development had been considered across five areas, namely: education and training of health care providers in palliative care; access to opioid

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<sup>211</sup> Hospice Palliative Care Association of South Africa ‘Guidelines for Palliative Care in Correctional Settings’ 13.

<sup>212</sup> Fraser *et al* (2017) 1.

<sup>213</sup> Fraser *et al* (2017)1.

medications; professional and public attitudes toward palliative care; integration of palliative care into national health care systems; and palliative care research.<sup>214</sup> South Africa may therefore gain valuable insights from Uganda's policies and practices on palliative care. To this end only some of the salient features which contribute to Uganda's status as an African leader in palliative care will be briefly highlighted below.

In 1993 a non-governmental organisation, Hospice Africa Ugandan (HAU), introduced palliative care into Uganda.<sup>215</sup> Five years later, the Ugandan government and the WHO agreed that national palliative care policies must be developed, and that training in palliative care and access to drugs will be increased.<sup>216</sup> Subsequently, Uganda became the first nation in Africa to declare palliative care an essential clinical service for all citizens.<sup>217</sup> Additionally, HAU has: trained more than 8000 nurses and physicians in palliative care; and extended education programmes to medical officers, community volunteer workers, spiritual caregivers, traditional healers, and allied health professionals. Furthermore, HUA has in collaboration with Makerere University, has created a training programme for nurses and clinical officers to provide the necessary skills to prescribe opioids for pain management.

South Africa may learn from the above that partnerships amongst government departments and with non-governmental organisations are vital to integrating palliative care programmes successfully into the health care system. Furthermore though South Africa now has a Policy Framework on palliative care, capacity to make such care available should be enhanced by providing training for health professionals, volunteer workers, spiritual leaders and traditional healers. Fortunately this is provided for in the National Policy Framework, however, it must

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<sup>214</sup> Fraser *et al* (2017)1.

<sup>215</sup> Fraser *et al* (2017)1.

<sup>216</sup> Lohman (2010) 7.

<sup>217</sup> Lohman (2010) 7.

be emphasised that by embedding palliative care as a prominent aspect of training in the curricula of health professionals and even volunteer workers it may become a permanent and known form of health care for everyone who is affected by life-limiting illnesses. Specialisation in palliative care in institutional settings, such as prisons, should also be considered as an important area for training.

In Uganda there are stigmas attached to death and dying. In South Africa this may be equally true. However, the employment of volunteers who are trained to work in communities and to destigmatise death and dying whilst also advocating for palliative care are yielding results in Uganda.<sup>218</sup> In Uganda the media and monthly newsletters are also employed to raise awareness of palliative care.<sup>219</sup> Such initiatives may be equally valuable in South Africa and may even assist in increasing the uptake of palliative care both in communities and institutions like prisons.

Uganda's efforts should be a motivation for South Africa. The Ugandan Constitution does not contain a substantive right to health care, but under its national objectives of national policies it requires that the State 'take all practical measures to ensure the provision of basic medical services to the population'.<sup>220</sup> Mubangizi and Twinomugisha explain that Uganda is State Party to many international and regional human rights instruments that spell out the right to health care; and, further, that the Ugandan Constitution provides that the rights and freedoms specifically mentioned in the Bill of Rights do not exclude other rights not mentioned.<sup>221</sup> The right to health must thus be given effect to. To this end the introduction of policies set the 'level of health care guaranteed'. Though Uganda still has much to do to meet the full extent

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<sup>218</sup> Fraser *et al* (2017) 4.

<sup>219</sup> Fraser *et al* (2017) 5.

<sup>220</sup> Mubangizi and Twinomugisha (2010) 105.

<sup>221</sup> Mubangizi & Twinomugisha (2010) 122.

of its obligation, the country is moving in the right direction.<sup>222</sup> South Africa ought to draw lessons from this example.

### 6.8.2 Pilot projects: The need for a lasting ethos

‘It was terrible . . . It showed how prisoners were trying to help other inmates who were dying in pain.’<sup>223</sup> This was the response of Ms Zodwa Sithole, advocacy manager of Hospice Palliative Care Association (HPCA), to a 2008 documentary about correctional centres in South Africa. Arguably, the documentary and the subsequent work of HPCA and other non-governmental organisations assisted immensely in drawing the State’s attention to the issue of terminally ill inmates and their need for palliative care. In 2012, for example, the national Department of Correctional Services signed a Memorandum of Understanding with HPCA for the implementation of a pilot project in Westville Correctional Centre in KwaZulu Natal (KZN) and the project was also rolled out to certain correctional centres in Western Cape, Eastern Cape and Gauteng.<sup>224</sup>

The purpose of the project was to provide training and mentorship to DCS health staff to equip them to provide palliative care to terminally ill inmates. At the time the DCS had no formal plan or policy on palliative care in place.<sup>225</sup> There had also been challenges to providing care to affected inmates. As mentioned in chapter 5 these challenges included problems such as lack of access to remand detainees, security limitations which prevented

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<sup>222</sup> Bwambale T & Nabaranzi V ‘Only 10 % Ugandans have access to palliative care’ *New Vision* 1 September 2011, available at <http://www.newvision.co.ug/newvision/news/1005966/-ugandans-access-palliative-care> (accessed on 3 September 2017).

<sup>223</sup> Carlisle D ‘Care without prejudice: a nurse is introducing palliative care in South Africa's prisons, where AIDS-related deaths are common’ available at <http://go.galegroup.com/ps/anonymous?p=AONE&sw=w&iissn=00296570&v=2.1&it=r&id=GALE%7CA293811709&sid=googleScholar&linkaccess=fulltext&authCount=1&isAnonymousEntry=true> (accessed 20 September 2017).

<sup>224</sup> Sithole Z ‘Palliative Care in Correctional Services Facilities’ 22 October 2012 available at <http://www.ehospice.com/articlepreview/tabid/790/articleid/1364/language/en-GB/Default.aspx> (accessed 20 September 2017).

<sup>225</sup> Sithole (2012).

trainers from accessing trainee staff and inmates, lack of appropriate medication, overcrowding and staff shortages. ‘Palliative care is not a priority in prisons and so trainings etc, may be cancelled at short notice due to competing demands.’<sup>226</sup> In 2017 the NPFSPC highlighted the same problems (as mentioned above) thus indicating that there had either been no or ineffective efforts employed to overcome these challenges previous five years.

Notwithstanding the challenges, there had reportedly also been many successes. Such successes included that the DCS had been in the process of drafting policies and procedures for palliative care in prisons.<sup>227</sup> The Palliative care guidelines within prisons had also been compiled. It is unfortunate, however, that since the pilot project’s completion there had been no further reported action by the State with regards to introducing and implementing national policies on palliative care in prisons. It may be fair to conclude that palliative care is not provided to the majority of inmates who require such care.<sup>228</sup> Though it is not refuted here that the DCS currently has a plan or policy on palliative care, it is submitted that no national policy or plan has been made accessible to the public.<sup>229</sup> Reports on the implementation of such a policy have also not been published or made otherwise accessible. Arguments against the need for reporting on the implementation of palliative care in correctional centres are tantamount to denying that the DCS should be held accountable to ensure that effect is given to inmates’ rights.

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<sup>226</sup> Palliative care for prisoners in South Africa 17 August 2015 available at <https://www.ehospice.com/southafrica/ArticleView/tabid/10689/Artic...>( accessed 12 August 2016).

<sup>227</sup> Sithole (2012).

<sup>228</sup> A cursory survey of the following DCS Annual Reports and Plans revealed that palliative care had never been reported on in official public documents: DCS Annual Report 2012-13; DCS Annual Report 2014-2015; DCS Annual Report 2015-2016; DCS Strategic Plan for 2013/2014-2016/2017; DCS Strategic Plan 2015/2016-2019/2020; DCS Annual Performance Plan for 2015/2016; Annual Performance Plan for 2016/2017; and Annual Performance Plan for 2017/2018.

<sup>229</sup> During informal interviews with former DCS staff and former inmates some claimed that there are policies which deal with the health care of terminally ill inmates, but had no knowledge of what palliative care entails. One former inmate remarked, ‘There are policies within prisons, but most people are not aware of them. Its just a written document which is not accessible to prisoners.’ Verbatim response of former inmate from the Eastern Cape in October 2016.



Some of the lessons that may be learned from this is that policies on palliative care in correctional centres ought to be accessible to all; During informal interviews with ex-inmates and former correctional officials it emerged that none of them had ever heard about palliative care being offered to inmates.<sup>230</sup> If there were greater awareness of, and access to, a policy, more inmates may be in a position to assert their rights. Furthermore, it is evident that sustainable, long-term partnerships between the DCS, non-governmental organisations and, not least, the Department of Health are necessary to revive the urgency and importance of implementing (existing) and/ refining policies on palliative care. There is also a profound need for accountability. It is submitted that there is a need for national legislation which specifically obligates the DCS to ensure that palliative care is provided to terminally ill inmates.

## 6.9 CONCLUSION

The time is ripe to recognise that not all terminally ill inmates are released from correctional centres. In the past some inmates were denied release on medical parole even in instances where they had been diagnosed with a terminal illness. The case law as well as the statistics on medical parole and natural deaths of inmates provided by the Judicial Inspectorate attest to this reality. Additionally, the DCS has confirmed that it has in its custody terminally inmates who do not have any support network outside of prison and who can thus not be released. The problem of terminally ill inmates who require palliative care thus establishes an urgent need for State action. Moreover the State must recognise that it has a legal obligation to provide

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<sup>230</sup> Individual interviews were conducted with four former inmates and three former officials from the Eastern Cape, the same number of former inmates and DCS officials from KwaZulu-Natal and the Western Cape. The interviewees respectively had served time or been employed at different correctional centres in their respective province. In the case of the former inmates, none of them were on parole at the time of the interviews (October-November 2016). They had all served their sentences. Not more than two years had passed between their dates of release and the interview and at least one had been released a week before he had been interviewed. Each of the former offenders had served a minimum of one year's imprisonment. The former inmate who had served the longest sentence had served 18 years. The former officials included persons of different ranks within the DCS. None of them had been dismissed by the DCS. Their reasons for leaving the employ of the DCS included having reached retirement age or finding other jobs.

terminally ill inmates with palliative care. The State's duty arises from inmates' constitutional right to health care services in terms of both section 27 and section 35(2)(e) of the Constitution. Section 35(2)(e) in particular affords inmates the right to claim medical treatment and other services that will at least give effect to their human dignity. A successful claim for palliative care on this basis is highly possible. It is also bolstered by the growing recognition of an international human right to palliative care which applies to everyone including inmates, and there is also the new NPFSPC.

It must be realised that '[i]nitiatives to improve the health of a country's citizens are ineffective if they do not reach those in greatest need . . .'.<sup>231</sup> Though great strides have been made in South Africa to give effect to health needs that can be addressed through curative and preventative measures, a substantial number of citizens require palliative care. The fact that States already have an obligation in terms of international law to ensure that there is access to palliative care drugs, and that there are concrete indications of the emergence of the right to palliative care, provide the basis and motivation for such care to be given greater priority by South Africa. Policy-makers and legislators must also address barriers to access to the health system as increased expenditure by itself does not necessarily enhance access.<sup>232</sup> It ought also to be remembered that '[a]t the end of life, we are far more alike than different from one another [and] that [h]ow we care for others may well determine how we are cared for ourselves'.<sup>233</sup> Though infirmity and death are some of the least popular subjects, it is the reality for thousands of people.

The NPFSPC reference to affirmations that palliative care is a basic human right does not suffice in engraining such right in the South African legal system. Admittedly the NPFSPC is a commendable achievement for advocates of palliative care. As a policy document with a finite duration, it may be the impetus for service delivery until the year 2022. The laudable commitment of the Steering Committee may make this reasonably achievable. After the five-year period the Steering Committee may dissolve, and the officials and focus of the Ministry of Health may also change. The current momentum for creating equitable access to palliative care may consequently decline and support for a right to palliative care, although buttressed by other laws, may have to be summoned and recalled afresh. This may be especially true for

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<sup>231</sup> Butler & Plaks (2012) 130.

<sup>232</sup> Butler & Plaks (2012) 130.

<sup>233</sup> Byock (2002) 110.

terminally ill inmates for whom the right to health care, even though it is constitutionally guaranteed, is often a point of contention. An explicit conferral of a right to palliative care within the framework of an Act of Parliament would guarantee the permanence and further development of palliative care in South Africa.

## CHAPTER 7

### CONCLUSION AND RECOMMENDATIONS

#### 7.1 ACKNOWLEDGING TERMINALLY ILL INMATES' PLIGHT AND RIGHTS

If it is true that '[h]uman suffering anywhere concerns men and women everywhere',<sup>234</sup> then much of the world is engulfed by an imperilling obliviousness to the connection between terminally ill prisoners and society. Their plight has much to do with society. If the South African State adequately acknowledges and protects their rights, then the State's character as a constitutional democracy based on dignity, equality and freedom will become less questionable. The State may then also influence society's view and treatment of such prisoners. Therefore it is essential that the State recognises in its laws, policies and practices the dual vulnerability of terminally ill prisoners (they are marginalised because they are offenders and due to their illness). Terminally ill prisoners should not be mentioned in passing only in the laws and policies. Detailed attention should be given to declaring and protecting their right to health and to dignity. The inequalities between health care afforded to free persons and to prisoners must be acknowledged and addressed. The context in which health plans must operate should also be considered to ensure the reasonableness of such plans.

Policies on palliative care must be made accessible to the public. The criteria for treatment should also be made public and undue delays or hurdles to accessing such treatment should

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<sup>234</sup> Wiesel (2006)119.

be eliminated. The State's health systems cannot be deemed to be reasonable unless due consideration is given to terminally ill prisoners who are vulnerable. Adequate resources must be invested in their health care. Furthermore, efforts to create equal access to health care should be tangible and measurable.

As shown in Chapters 2 and 3 of this thesis, international law and domestic law do not mention terminally ill prisoners. This is the case even with regards to instruments which specifically apply to prisoners. Similarly, though the introduction of the NPFSPC is a positive step towards giving effect to the right of terminally ill persons to health care, it does not hold the same promise for those who are inmates as they are only mentioned in passing. The vulnerability of terminally ill prisoners ought to be properly expounded and more concrete plans for the implementation of palliative care programmes must be designed and presented specifically for prisons.

Further, the current description of the model for palliative care in correctional centres is superficial and offers no meaningful guidance with regards to the unique challenges posed by the correctional setting. It provides merely that palliative care may be offered within correctional centres by health professionals or by visiting health professionals.<sup>235</sup> In time legislation which expressly grants the right to palliative care to prisoners must be introduced to ensure that they are given greater protection of their right to health care. Terminally ill prisoners will then know what they may legally claim and what they cannot insist upon in terms of the law. It will also ensure the permanency, expansion and development of palliative care beyond the introduction of recent policies. South Africa ought to embrace the standard of the best interest of terminally ill inmates in every decision that affects their well-

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<sup>235</sup> NPFSPC 2017-2022:20.

being.<sup>236</sup> It must be emphasised that by embedding palliative care as a prominent aspect of training in the curricula of health professionals and even of volunteer workers it may become a permanent and known form of health care for everyone who is affected by life-limiting illnesses. Specialisation of palliative care in institutional settings such as prisons should also be considered as an important area for training.

## 7.2 AWARENESS AND OVERSIGHT

Awareness of terminally ill prisoners is necessary to highlight their challenges and uphold their right to health care. Attention to what causes and exacerbates the symptoms of terminal illnesses in prisons is also vital. Additionally, prisoners' communities of origin, their indigence and lack of health care in the first instance, as well as the health pitfalls of the criminal justice system must be considered in sketching the health rights of terminally ill prisoners.

The perception that terminal illnesses are only associated with elderly persons should be corrected as such illnesses affect everyone. Special oversight of health care in prisons which explicitly also focuses on terminally ill prisoners is necessary as such prisoners often constitute a small minority and are in need of special measures to protect their rights. Perhaps such oversight may be more effective if a structure comprising representatives from government departments, such as, the Department of Health, and the Department of Social Development, as well as from civil society and prisoners' next-of-kin should be established to ensure that prisoners' plight is understood and attended to.

Active engagement and participation by civil society and community members is essential to ensure that services are available to all, culturally appropriate, relevant, understood, and

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<sup>236</sup> African Palliative Care Association (2011) 68.

utilised. Communities and community-based organisations should be encouraged to provide input and feedback into the development and delivery of services.

### 7.3 UPHOLDING DIGNITY AT ALL COSTS

While security classifications and regulations are important in the correctional environment, they should never trump terminally ill inmates' right to dignity. The purpose of imprisonment is to reintegrate all prisoners into society as law-abiding citizens. Although some terminally ill prisoners will never return to society, the goal of restoring their dignity must still not be lost sight of. This may necessitate that security regulations be relaxed to accommodate their health needs. More regular contact with family and community, access to traditional medicines, desired foods, literature and the like (all that may provide for the greater comfort of the inmate) should be reasonably considered by the prison authorities. Provision should also be made for emergency situations where an inmate is dying and requests the support of a religious leader. Efforts to embed palliative care as an integral part of the health regime in correctional centres may therefore have to include addressing the endemic problems, such as, overcrowding and discriminatory practices.

Prisoners must be provided with proper diagnoses, and be informed of health care options (if any) and available resources. They should also be afforded professional support to assist them in making decisions, and be permitted to confer with their next-of-kin if they wish to do so. Though this may require the investment of resources, such investments resonate with the words of the founder of modern palliative care, Dame Cicely Saunders: 'You matter because you are you, and you matter to the last moment of your life.'<sup>237</sup>

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<sup>237</sup> See <https://www.africanpalliativecare.org/awareness/the-history-of-palliative-care/> (accessed 6 October 2017).

## 7.4 UNDERSTANDING TERMINALLY ILL INMATES' RIGHT TO HEALTH FULLY

While terminally ill inmates' right to health entitles them to palliative care as argued for in this thesis, this does not mean that preventative and curative health care are precluded. Where reasonably possible they should still be afforded such care. Terminally ill inmates' right to health care also includes access to an effective release system. This is not to say that they must be released. They are, however, entitled to a fair and effective medical parole system if they are sentenced prisoners, or a fair and effective early release system if they are remand detainees. Currently prisoners may need the support of lawyers to access appropriate health care while they are imprisoned. This is particularly true for remand detainees. It seems that it is equally important though, that inmates have legal representation during medical parole applications. The following poignant remark by a former prisoner alludes to this need:

‘The one thing I want, my sister, is at least if one says that they are sick and they really look like they are sick then they must be released. I says this because others they are battling until death. Truthfully I have seen very sick people who had not been released. They had diseases that other people don't have and they end up dying right before us.’<sup>238</sup>

One of the perennial questions posed is whether or not DCS officials should always be allowed to override medical doctors' advice. Furthermore, it should be recognised that access to effective palliative care must be afforded from the moment that a prisoner is diagnosed, hence his eligibility or not for release should not affect the provision of palliative care.

## 7.5 CONCLUSION

In conclusion South Africa may achieve the goal of granting effective palliative care to all terminally ill persons including those who are inmates, provided that the plight of terminally

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<sup>238</sup> Verbatim response of interviewee November 2016, Durban.

ill prisoners is adequately recognised and that their right to palliative care is formally declared and protected in national legislation. Greater effect may be given to their right if there are competent oversight mechanisms to monitor the implementation of health plans. Finally, the unequivocal acceptance of prisoners' right to dignity may ignite much needed change.

## ANNEXURE A

### INTERVIEW SCHEDULE

#### **The meaning of the right to health of terminally ill inmates in South Africa**

For the purpose of this study 'terminal illness' means that the inmate was diagnosed with an illness or condition that will inevitably result in his death.<sup>1</sup> At least two medical practitioners must agree that the inmate is terminally ill. The illness must be incurable. Such a disease or condition must also cause severe physical pain, discomfort and suffering and/or negate a person's prospects of leading a meaningful life. Some patients may be imminently and irreversibly terminally ill. This means that they will die within a relatively brief period of time.<sup>2</sup> Others are regarded as distantly terminally ill because they may have been faced with imminent death at an earlier period but were medically rescued, and are medically sustained for an indefinite period of time.<sup>3</sup>

Currently the law provides that all inmates have a right to health care and that such care should be the same as for persons who are not detained. Additionally, inmates with special health needs or serious health conditions are entitled to appropriate health care. Despite this, there is no concrete law pertaining specifically to the health care of inmates who are diagnosed with a terminal condition or disease.

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<sup>1</sup> McQuoid-Mason D & Dada M (2011) 414.

<sup>2</sup> Fleck L (2011) 156-171.

<sup>3</sup> Fleck L (2011) 156-175.



The questions will thus be directed to different role players in the correctional system to ascertain whether there are challenges to providing appropriate and adequate health care such as palliative care, to terminally ill inmates.

1. Are you or have you ever been aware of an inmate who was diagnosed with a terminal condition or disease while he or she was detained?
2. Were they released on medical parole?
3. What were the longest and shortest periods an inmate had to wait between being diagnosed and being released on medical parole?
4. Are you aware of policies in place which specify what ought to happen with regards to health care once an inmate has been diagnosed with a terminal condition?
5. If your answer to question 4 is “yes” are such policies appropriate and adequate in addressing the needs of inmates? Can you explain why you hold this view?
6. If your answer to question 4 is “no”, do you believe that such policies or regulations are necessary?
7. What are the most important issues addressed (or to be addressed) by such policies?
8. Do you know what palliative care is?
9. If your answer to question 8 is “yes” , can you explain what it entails and whether it is provided to inmates?
10. When is an inmate eligible to receive such care?
11. Is there anything in the correctional system which negatively affects how an inmate diagnosed with a terminal illness is cared for?

## ANNEXURE B

### The meaning of the right to health of terminally ill inmates in South Africa

#### Consent form – Individuals

Individual interviews: Participant to sign the original document, which remains with the researcher; researcher to sign a copy and hand same to the participant

#### Introduction

The study is aimed at assisting the researcher with the completion of her doctoral thesis which deals with the question of what the right to health means for inmates who are terminally ill. The study seeks to determine what such inmates can and cannot legally insist upon in terms of health care in the correctional system. Desktop research has already been done. The data gathered during the interviews will therefore be used to supplement the desktop research. Such data may also assist the researcher in better understanding some of the extant problems pertaining to health care for terminally ill inmates.

Interviewees who agree to participate in the study will therefore mostly be asked questions related to conditions and services pertaining to health care and the treatment of terminally ill inmates in correctional centres. An interview schedule will be used. Interviewees may choose not to answer all the questions.

1. The researcher has explained to me that the purpose of the interviews is to gather information about the challenges to giving effect to terminally ill inmates' right to health care.
2. I understand that I do not necessarily have to speak about any personal experiences.
3. I understand the overall aims of the research.
4. I understand that I may refuse to participate in the interview and may also refuse to answer certain questions without providing specific reasons for my refusal.
5. The researcher has explained that the information given will be confidential and that my anonymity will be preserved.

6. I understand how the information I give during the interview will be used.
7. The researcher has explained the purpose of recording the discussion .i.e. to ensure accuracy, and also what will happen to the recording i.e. it will be destroyed immediately after it has been transcribed and the research data will be stored on-line in a password protected google-drive. I agree to the recording under these conditions.
8. I have received an Information Sheet with contact details of the researcher in case I would like further information about the research.

**I hereby consent to participate in the interview**

.....

**Interviewee**

**Date:**

**Researcher: Chesne Albertus**

**021-9593298/0723791911**

**[calbertus@uwc.ac.za](mailto:calbertus@uwc.ac.za)**

**Supervisor: Prof Jamil Mujuzi**

**[jdmujuzi@uwc.ac.za](mailto:jdmujuzi@uwc.ac.za)**

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**Interviewer**

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