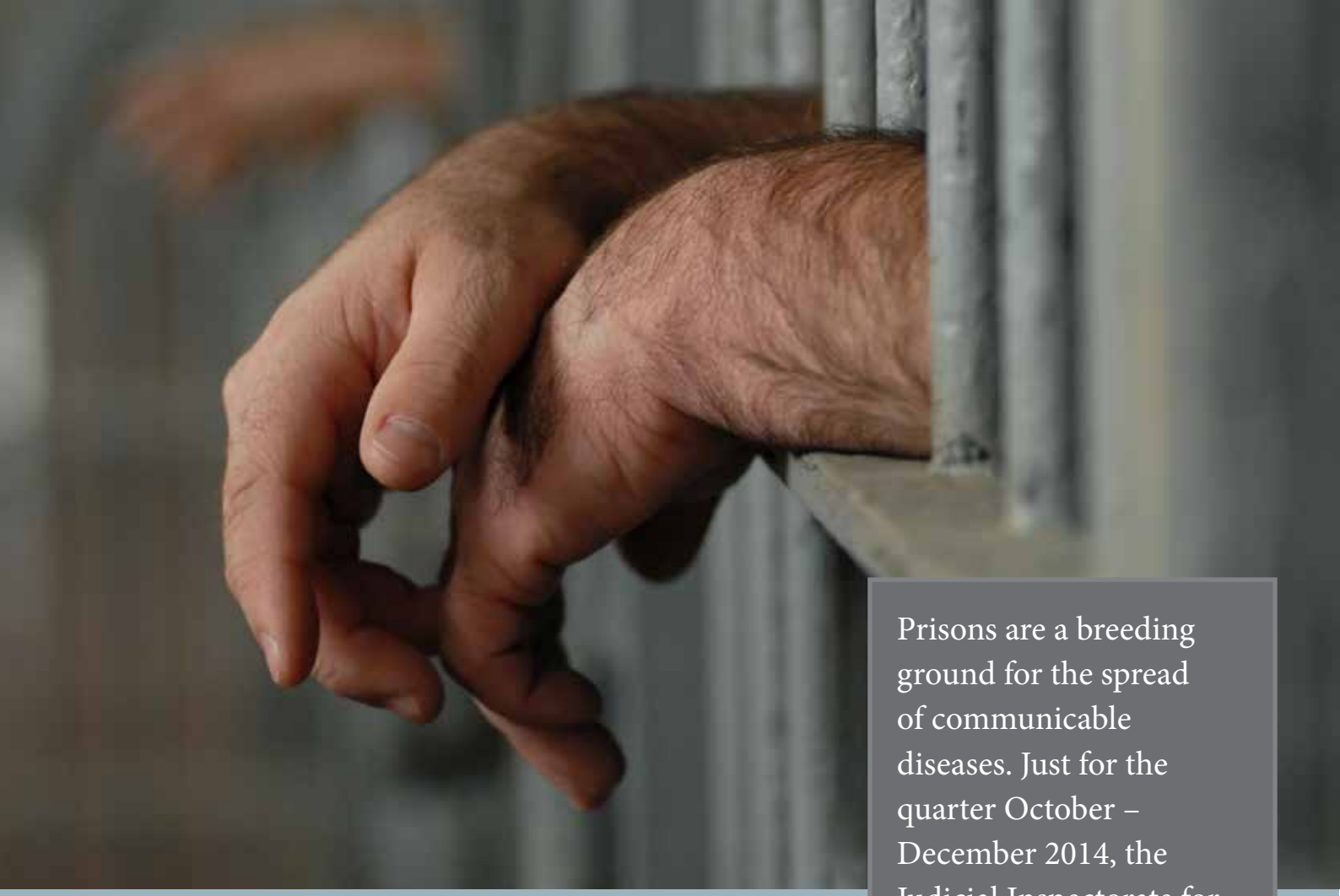

TUBERCULOSIS (TB) in South African prisons

Prisons are a breeding ground for the spread of communicable diseases. Just for the quarter October – December 2014, the Judicial Inspectorate for Correctional Services (JICS) received 11 reports of natural deaths caused by TB,[4] a preventable and treatable disease.

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Dudley Lee spent four and a half years as an awaiting trial detainee at Pollsmoor maximum security prison from November 1999 until September 2004 on charges of fraud and money laundering. After over 70 court appearances, he was acquitted of all charges and released in September 2004.[1] However, during those years of incarceration, he was subjected to prison conditions that have been dubbed as 'inhumane'[2] and led to his contracting tuberculosis (TB). After a drawn-out court battle that ended in the Constitutional Court, Lee was awarded R270, 000 in damages which he received in November 2013, just a few months before he died in May 2014.[3]

With Lee's court victory, South African civil society expected a legal precedent in liability for TB transmission to be set. But the State is now backtracking on its promise to settle cases of Zaid Seedat (Lee's co-accused who was also hospitalised in Pollsmoor with him) and Glen Spencer, inmates who contracted TB in similar circumstances as Lee. Jonathan Cohen, lawyer of Lee and the two inmates, explains:

> The State attorney's office requested that the cases of Seedat and Spencer be held in abeyance ...as it was agreed that we would first await the outcome of the Dudley Lee matter, and on receipt of that outcome, the Seedat and Spencer matters may well settle. Despite that agreement, the State has persisted with its defence of both the Seedat and Spencer matters.

According to Cohen, the State's refusal to accept accountability for causing harm to its citizens, despite the fact that such harm can be prevented through reasonable measures, is a challenge. Cohen is currently in the process of 'taking steps to bring these two matters to trial' and since his success with Lee's case; he has been approached by other inmates with similar cases, illustrating the critically high rate of TB in South African prisons.

Relationship between the Human Immunodeficiency Virus (HIV) and TB

Prisons are a breeding ground for the spread of communicable diseases. Just for the quarter October – December 2014, the Judicial Inspectorate for Correctional Services (JICS) received 11 reports of natural deaths caused by TB,[4] a preventable and treatable disease. Worldwide, the prevalence of TB is alarmingly high in prisons compared to the general population.[5] The link between HIV and TB further exacerbates the spread of TB in South Africa prisons, where the burden of HIV is already high. According to Emily Keehn from Sonke Gender Justice, as of March 2014, 27 980 inmates were on record as being HIV positive in South African prisons. Globally, TB is the number one cause of illness and death in people living with HIV, including those on antiretroviral treatment (ART).[6]

It should be noted that the prevalence and spread of communicable diseases in prisons is not only a concern for inmates and correctional services staff, but has implications for society at large because those detained will eventually be released back into their communities.[7-8] During the 2012/13 financial year, a total of 65 931 inmates were released back into the community.[9]

Overcrowding

Overcrowding, poor ventilation, late case detection, debilitated prison infrastructure, limited access to health care, weak preventative interventions for HIV, inadequate funding and constant movement of inmates to and from the community have been cited among the factors propelling the spread of TB in prisons.[7, 8, 10] Lee was diagnosed with TB three years after his incarceration. When he arrived at the prison in 1999, he was reasonably healthy and did not have TB: 'Apart from some trouble with his heart and prostate he was healthy and he had never been ill with TB prior to his incarceration.'[1] However, the Supreme Court of Appeal (SCA) ruled that Lee could not prove that he would not have contracted TB had conditions at Pollsmoor been different. Lee appealed to the Constitutional Court and finally won in December 2012. The Constitutional Court's decision to overturn the decision by the SCA reiterates the point that negligence by the department to improve poor conditions at Pollsmoor caused Lee to become infected with TB. After his diagnosis in June 2003, Lee was returned back into his cell, where he was confined for up to 23hours per day, with at least one other inmate, with limited sunlight and poor ventilation,[11] creating an optimum environment for TB-causing bacteria to thrive. TB-causing bacterium stays airborne for a long time in dark, confined, and poorly ventilated spaces.[12]

In addition to perpetuating the spread of TB, high levels of overcrowding infringe on the rights of inmates enshrined in the Constitution. Section 35(2) (e) 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.[13]

(See information boxes for responsibilities of health care workers (HCWs) working with inmates and basic human rights of inmates).

Awaiting Trial Detainees

Awaiting trial detainees[1] are by law "presumed innocent" and more than half will be released back into society on acquittal or their case being struck off the roll.[14] What are they doing in detention for extended periods of time where they are exposed to inhumane conditions? In *Lee v Minister of Correctional Services*, conditions in awaiting trial centres were put in the spotlight. The judge stated that:

Pollsmoor is notoriously congested and inmates are confined to close contact for as much as 23 hours every day – thus providing ideal conditions for transmission; on occasion, the lock-up total was as much as 3052 inmates

WHY FOCUS ON PRISONERS?

1. Upon imprisonment, inmates still retain all their other basic human rights, including access to health care
2. When the state deprives a person of his/her liberty, it assumes responsibility to provide appropriate care.
3. Ineffective TB/HIV prevention inside prisons contributes to the TB and HIV burden in the general community because most inmates will be released into their respective communities.

RESPONSIBILITIES OF A HEALTH CARE WORKER (HCW) WORKING WITH INMATES

HCWs have a role of acting, within the legal framework, as advocates for access to health care, & not to restrict or ration care. This may mean that HCWs may be faced with conflicting loyalties to the authorities and to their patients. In that case, HCWs may need to seek support from their representative associations.

Furthermore, HCWs should advocate for adequate medical and support staffing to meet the health needs of inmates.

No motive, whether personal, collective or political, shall prevail against HCWs' obligation to alleviate distress to their patients.

and single cells regularly housed three inmates; communal cells were filled with double and sometimes triple bunks ... [para 8][11]

According to JICS 2013/2014 annual report, the inmate population in South Africa is one of the highest per capita in the world, with sometimes inmates doubling or tripling the cell capacity.[15]

Professor Robin Wood, Director of the Desmond Tutu HIV Centre at the University of Cape Town, and colleagues used data from court evidence and judicial reports to mathematically calculate the likelihood that an inmate held in the awaiting trial section at Pollsmoor would contract TB. They found that a person incarcerated in Pollsmoor for one year had a 90% chance of contracting TB. Furthermore, if Pollsmoor implemented the cell occupancy standards required by South African prison regulations, transmission probability would be reduced by 30%. They concluded that "current conditions of detention for awaiting trial prisoners are highly conducive for spread of drug-sensitive and drug-resistant TB".[10]

Although the legal framework (see Chapter 3 of the Correctional Services Act 11 of 1998)[16] stipulates that conditions where inmates are accommodated must be consistent with human dignity, current conditions in many South African prisons are indicative of the gap between theory and practice.

Current situation and moving forward

On March 24 2015– World TB Day – a fixed high-tech digital X-ray machine was installed at Pollsmoor prison. The machine, according to Professor Harry Hausler, CEO of the TB/HIV Care Association, will reduce the time between diagnosis and initiation of treatment. Inmates whose x-rays show abnormalities will be separated and their sputum collected for GeneXpert testing, thus reducing the likelihood of transmission. The fixed machine came a few months after *TB/HIV Care* started providing mobile x-ray services on December 18 2014 and two years after the launch of a GeneXpert machine, on March 24 2013, at Pollsmoor. Over a period of just three months (December 2014 – February 2015), the mobile x-ray service diagnosed 31 new TB cases that were started on treatment. Since the launch of the GeneXpert machine, the time from sputum collection to initiation of treatment has decreased from almost a week (6.5 days) to less than two days (1.9 days).

Moving forward, one short term solution cited by Prof Hausler to address the issue of TB transmission in prisons would be to rapidly train and mentor Department of Correctional Services (DCS) nurses in TB diagnosis and treatment. In the long-term, he stated the necessity to: (1) continue partnership between civil society and government; (2) increase the number of facilities with decentralised HIV services which enable DCS nurses to prescribe and dispense ART; and (3) focus on systemic change that can positively affect the criminal justice system as a whole – for instance, look into restorative justice for minor offences. According to Professor Hausler, decriminalizing of petty offences and release of offenders into community care will reduce overcrowding, which he cited as one of the leading challenges in the fight against the scourge of TB in South African prisons.

Globally, overcrowding in prisons is exacerbated by excessive use of remand detention.[2] Correct application of bail laws could help alleviate overcrowding: awaiting trial detainees are in remand detention because they have either not been granted bail or granted a bail amount they cannot afford.[17] The poor, even if accused of petty offences, will likely be in remand for prolonged periods, susceptible to the spread of communicable diseases, where 'conditions are even worse than those for convicted prisoners'.[18] According to DCS statistics, as of April 20 2015, occupancy of Pollsmoor remand detention facility (RDF) was at 295%. In contrast, occupancy at medium B and C (both housing sentenced offenders) was at 236.8%, and 144.8%, respectively.[2] Justice is often delayed and freedom denied for the poor who are unable to pay even the smallest amounts of bail.

> In addition to perpetuating the spread of TB, high levels of overcrowding infringe on the rights of inmates enshrined in the Constitution

In conclusion, improving prison conditions, effective early detection, and adherence to rigorous treatment regimens – in both RDFs and facilities housing sentenced offenders – are of utmost importance in the struggle to combat the spread of TB in South African prisons. Despite high levels of overcrowding at RDFs, provision of health services is scanty. Chapter 6 of the White Paper on Remand Detention states that 'the provision of programmes to RDs [remand detainees] has been somewhat haphazard. Many difficulties exist in providing programmes to such a fluid population.'[19] This sentiment was echoed by then Minister Correctional Services, Nosiviwe Mapisa-Nqakula: 'Remand detention has for a long time been the stepchild of the DCS. There was no clear policy in government as to where matters of remand should be situated and this has resulted in a situation where the needs of remand detainees were not on the forefront of developments within the DCS.' [18] Robust medical screening and provision of treatment should be enforced at RDFs to ensure that those presumed 'innocent until proven guilty' are afforded the right to health care and human dignity as enshrined in the Constitution. The state, as mandated by domestic and international legal framework, should take responsibility for inmates – a group amongst the most vulnerable to HIV/TB co-infections. ®

[1] As of March 31 2014, 44 236 – or 29% – of South African inmates were awaiting trial (JICS 2013/2014 Annual Report, p.39).
[2] Email communication with Clare Ballard, attorney at *Lawyers for Human Rights*

WHAT ARE THE BASIC HUMAN RIGHTS OF INMATES?

Right to health care and to be treated with dignity: Inmates retain all their rights, including the right to health care, after incarceration and should be treated with human dignity.

Upon admission, all inmates, irrespective of HIV status, should have immediate health briefing and TB symptom screening. This will help establish medical treatment status.

Right to refuse treatment: However, HCWs should be aware of the lack of information in prisons and ensure that refusal of treatment is based on an informed consent.

Confidentiality of private medical information should be maintained, as is done for all patients. In cases where other inmates are assisting provide health care services, they should be trained on handling sensitive & confidential medical information. Inmates should be educated regarding enclosure so that necessary steps are taken by HCWs to provided appropriate medical care.

Nutrition: Inmates have a right to balanced nutritious meals, three times a day.

Source: Guidelines for the Prevention and Treatment of HIV in Arrested, Detained and Sentenced Persons, 2008.

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