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Health, Human Rights, and the Transformation of Punishment: South African Litigation to Address HIV and Tuberculosis in Prisons

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Abstract

South Africa experiences the world's highest HIV burden and one of the highest burdens for tuberculosis (TB). People in prison are particularly vulnerable to these diseases. Globally, and internally in South Africa, increased attention is being paid to HIV and TB treatment and prevention in prisons, with the public health community arguing for reforms that improve respect for the human rights of incarcerated people, for example, by calling for the reduction of overcrowding and unnecessary incarceration. Despite the retributive rhetoric that is popular among politicians and the public, the constitution mandates and recognizes the right of people in prison to humane and dignified conditions of detention. These values are diffused through law and policy, supported by an independent judiciary, and monitored by a small but vigilant prisons-focused human rights community. These factors enable the courts to make decisions that facilitate systemic improvements in prison conditions—counter to popular sentiment favoring punitive measures—and increase access to HIV and TB services in detention. This article examines a series of strategic litigation cases that illustrate this process of change to remedy disease-inducing and rights-violating conditions in South African prisons.

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Introduction

This article examines the use of strategic litigation to develop and vindicate the health rights of incarcerated people in South Africa. As with many other countries in sub-Saharan Africa, HIV and tuberculosis (TB) in South African prisons cannot be de-linked from systemic failings—they are fueled by overcrowded and inhumane conditions and the excessive use of incarceration.[1] These diseases are often symptoms of "tough on crime" policies combined with slow and overburdened justice systems and outdated infrastructure.[2] The public health community identifies criminal justice reform and respect for human rights standards for incarcerated people as key to stemming the tide of HIV and TB behind bars.[3] While South Africa's constitutional framework incorporates human rights protections for incarcerated people, including health services at state expense, these rights have largely remained paper bound. Over-incarceration results from the excessive use of pre-trial detention and the exponential growth in life sentences.[4] Serious human rights abuses including torture are reported yearly, and the penal system has often resisted delivering essential services to prevent and treat HIV and TB.[5]

Remedying disease-fueling conditions requires contending with the popular retributive narratives that influence the politics of punishment, and the content, resourcing, and implementation of the legal frameworks that regulate it.[6] This is an onerous prospect as incarcerated people are stigmatized and unsympathetic in the eyes of many in South Africa. This hostility is informed by high levels of crime as well as resource constraints, and makes it easier for the government to de-prioritize the needs of people in prison. It is therefore important to understand how public health prescriptions for penal reform to improve health outcomes can be actualized.

This article starts by situating South African prisons within a regional comparative framework examining incarceration trends and their relationship to HIV and TB. It then describes the drivers of overcrowding and inhumane conditions of detention in South African prisons, the domestic policies that contribute to these problems, as well as the laws and policies that govern prisons and afford incarcerated people their rights. It then examines the development of reforms to address HIV and TB in prisons, told through a series of strategic litigation cases that have defined the right to health and protected the human rights of incarcerated people in South Africa.

The South African experience illustrates the value of an incremental strategic litigation strategy that begins with tackling narrow issues, such as access to anti-retroviral therapy (ART), and progresses towards challenging systemic drivers of disease, such as overcrowding and unsanitary conditions. We examine how South Africa's strong and independent judiciary has facilitated change through the courts—despite the absence of popular support for penal reform—and how sustained lobbying, coalition-building, and mass media advocacy by activists have increased the impact of litigation.

HIV, TB, and health in prisons

In 2016, the *Lancet* dedicated an issue to HIV and related infections in prisons.[7] The series sought to unpack the "unique and complex nature of an HIV epidemic in an understudied and underserved population," and "to bring widespread attention to incarcerated people as a key population in the HIV pandemic."[8] The articles emphasize the ways in which human rights violations against incarcerated people contribute to disease burden. They underscore the need to reform criminal justice systems and re-think how we punish.[9]

In the *Lancet's* article examining HIV and TB in sub-Saharan Africa, Telisinghe et al. pinpoint the excessive use of pre-trial detention and overcrowding as particular problems.[10] They recommend reforms that expand the provision of bail and reduce court delays to shorten pre-trial detention as interventions "that would probably reduce exposure to, and incidence of, disease."[11] They further describe the limitation of arbitrary and extended pre-trial detention and the release of

people incarcerated for minor, non-violent offenses as "cost-effective" criminal justice measures to reduce the risk of acquiring HIV and TB, facilitate access to care, and ensure respect for international human rights laws.[12]

Various other authors argue that these kinds of reforms would eliminate what they describe to be hugely damaging practices. Experts underscore the urgency of reform, since HIV is a major predictor for TB, which is also the most common presenting illness for people living with HIV—indeed, TB is the major cause of HIV-related death.[13]

Overcrowding is severe in sub-Saharan African prisons—Telesinghe et al. show that 86% of countries for which data were available had prison occupancy rates over 100%.[14] Overcrowding and poor ventilation contribute to the risk of airborne TB infection.[15] Poor conditions can also heighten tension among inmates and fuel violence, including rape, which heightens the risk of blood-borne and sexually transmitted infections, including HIV.[16] These realities are a reflection of how many prisons in the region are operated against a background of severe infrastructural constraints, under-prioritization, and relative poverty.[17]

South Africa has the 12th highest incarcerated population in the world, with 158,111 people incarcerated as of April 2018.[18] It ranks 40th in the world for the rate of incarceration at 280 per 100,000 people, and remand detainees make up 25.8% of the population.[19] The vast majority of incarcerated people are male—females comprise 2.6% of the population.[20] The prison system experiences endemic overcrowding caused by and reflecting the popular punitiveness that contributes to increasingly severe sentences, an over-reliance on pre-trial detention, and dismal conditions of confinement.[21] The prison monitoring body, the Judicial Inspectorate for Correctional Services (JICS), has been reporting "deplorable" levels of systemic overcrowding in its annual reports for more than a decade, although this problem dates back two decades.[22] Overcrowding peaked in 2003 with a national average of 175% occupancy.[23] Currently it persists at 135%, and is most acute in remand facilities, some of which experience 300% occupancy.[24]

South Africa has the highest number of people living with HIV in the world—an estimated 7 million people.[25] Despite this, data on prevalence in prisons are limited.[26] The Department of Correctional Services (DCS) reported HIV prevalence among inmates to be 19.8% in 2006, 22.8% in 2009, and 15% in 2016.[27] Most recent data are based on voluntary testing and treatment access, which suggests that actual prevalence is likely higher.[28]

South Africa's TB incidence was an estimated 454,000 in 2015.[29] It is one of six countries accounting for 60% of the global total TB incidence.[30] Multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB cases are forecast to increase due to increased transmission of these strains.[31] TB is an acute concern in prisons and, according to the most recently available statistics, is the leading cause of natural death among inmates.[32] There are no representative data regarding TB prevalence in South African prisons.[33] A 2014 study from a large Johannesburg-area prison found a 3.5% prevalence of laboratory-confirmed undiagnosed TB, and 44.1% of those prisoners were also HIV-positive.[34]

Factors propelling the spread of HIV and TB in South African prisons include overcrowding, understaffing, poor ventilation, late case detection, debilitated prison infrastructure, limited access to health care, weak preventative interventions for HIV, sexual violence, inadequate funding, and disruption to treatment.[35] The public health community has called for short-term interventions such as training and mentoring DCS nurses in TB diagnosis and treatment, and increasing the number of facilities with decentralized HIV services to enable nurses to prescribe and dispense ART.[36] To reduce overcrowding, some have argued for the state to employ restorative justice for minor offenses; for the decriminalization of petty offenses; and for the release of offenders into community supervision.[37]

It is worth noting that DCS relies on funding from foreign donors for much of its HIV and TB services, which raises concerns about the sustainability of current interventions.[38]

The legal framework for prisons in South Africa

Despite challenges plaguing South African prisons, the constitutional and legal framework protecting human rights in prisons is progressive. The South African Bill of Rights enshrines the rights to dignity, equality, and humane treatment of detainees, including access to justice, adequate accommodation, health care, exercise, food and water, and reading materials.[39] Incarcerated peoples' constitutional rights are supported by various statutes, policies, and regulations that provide minimum norms and standards for conditions in prisons and the treatment of people in prison.[40] These include the 2004 White Paper on Corrections, which emphasizes rehabilitation as a core function of the prison system, the 2014 White Paper on Remand Detention, and the National Strategic Plan on HIV, TB and STIs 2017-2022.[41] It also includes the Department of Health Guidelines for the Management of TB, HIV and STIs in Correctional Facilities, as well as the National Policy to Address Sexual Abuse of Inmates in Correctional Facilities.[42] These documents collectively guide HIV and TB detection, control, treatment, and prevention in prisons. The constitution further incorporates and makes justiciable international human rights laws that protect inmates' rights.[43] This includes the international covenants on civil and political rights and economic, social, and cultural rights, and the UN Convention Against Torture, Cruel, Inhuman and Degrading Treatment and Punishment.[44] The revised UN Standard Minimum Rules for the Treatment of Prisoners, the African Charter on Human and Peoples' Rights, the Kampala Declaration on Prison Conditions in Africa, and the Robben Island Guidelines form part of South Africa's soft law.[45]

The socio-political context in which the legal protections operate is hostile to the rights of incarcerated people, with a pervasive sentiment that "criminals' rights" enjoy primacy over victims' rights within the criminal justice system.[46] This is reinforced when government officials periodically assert that incarcerated people enjoy too many rights, that prison is like a "luxury hotel," or that prisons provide better medical facilities than the public accesses.[47] The "common sense" of punishment in South Africa is reflected in this tension between rehabilitative policies that are sensitive to the rights of incarcerated people, and severe sentencing policies for certain crimes, accompanied by retributive rhetoric.

A series of legislative reforms have increased the onus placed on the accused in bail applications, making bail more difficult to secure and increasing the number of people in remand.[48] Mandatory minimum sentencing for serious crimes, initially temporarily enacted to placate the public over high rates of violent crime, became a feature of the penal system in 1997.[49] Mandatory sentencing increased the number of people receiving life sentences by over 2000% over the past 20 years.[50] Despite sentencing fewer people to terms of imprisonment, the prison population grew due to longer sentences served.[51] Meanwhile, the general public seems to support these trends. The National Victim of Crime Survey of 2016-2017 found that 41% of South Africans are satisfied that the length of sentences are sufficient to deter violent crime, and that 55% think DCS grants parole too easily.[52]

Current policies make life most difficult for those awaiting trial in detention. The punitive cascade created by mandatory sentencing means there is no room in correctional facilities to spare for those in remand.[53] With longer sentences at stake, individuals accused of serious offenses may be loath to plead guilty, contributing to systemic slow-downs, and their extended remand detention as they would be unlikely to be granted bail.[54] More than half of the remand population stays in custody for longer than three months, and nearly 20% stay in custody for longer than a year.[55] It is estimated that 15-20% of the remand population are granted but cannot afford to pay cash bail.[56]

Detention facilities are also severely outdated, as most were built prior to the democratic dispensation, when rights were limited, and were designed to cater to sentenced populations.[57] DCS acknowledges that its challenges are exacerbated by overcrowding, "with its consequent understaffing and difficulties in implementing any existing policy or new development."[58]

Litigation and advocacy to transform South African prisons

With punitive rhetoric behind it, and within a context of resource constraints and high demand for government service delivery for the general population, there is little incentive for the government to counter its inertia in complying with human rights standards. Historically, there is often little consequence for unconstitutional conditions of detention that persist. The case law that elaborates the standards set in place through the constitutional and regulatory safeguards for the rights of incarcerated people remains under-developed.[59] The community of human rights advocates focused on prisons in South Africa is also relatively small and limited in its capacity.[60] In this difficult context, rights groups and previously incarcerated people have coordinated their actions, for example, through the national coalition, the Detention Justice Forum (DJF).[61] Through this coalition, activists have leveraged public impact litigation, engaged international and domestic human rights reporting mechanisms, and advocated in the media to influence policy change.[62]

While relatively limited, there is a growing body of jurisprudence concerning the health rights of incarcerated people, with a number of emblematic cases on health and HIV and TB in prisons that set important legal precedents. This jurisprudence is underpinned by the 1993 case *S v. Makwanyane,* which abolished the death penalty in the face of overwhelming oppositional public opinion.[63] In its judgment, the court declared that its role within the newly democratic state was to protect the rights of "outcasts and marginalised people"—including people in conflict with the law—who cannot adequately assert their rights through the democratic process, and that it would do so even where its judgments would not find favor with the public.[64]

Next, we examine a series of cases that illustrate a progressive trajectory in the jurisprudence for state accountability for rights to health and dignity in prison. The courts first established that the state has a higher duty of care to incarcerated people for health services, and determined and enforced the state's obligation to deliver ART for free in prison. Then, where adequate medical care could not be or was not delivered, the courts granted medical parole, incentivizing the improvement of health services. The courts then moved beyond ordering the delivery of specific medical treatment, and held the state responsible for its inadequate services and procedures to prevent the transmission of disease (TB). Finally, the courts countenanced a challenge to the overall disease-inducing and overcrowded detention conditions, which were roundly held unconstitutional.

In the 1997 case, *Van Biljon v. Minister of Correctional Services*, HIV-positive incarcerated people took DCS to court for denying them ART at state expense when they had reached a symptomatic stage of their disease and their CD4 count fell below 500/ml.[65] At the time, DCS policy was to provide incarcerated people with treatment equivalent to that provided at provincial hospitals, which in a context of severe budget constraints meant that only some patients qualified for free ART.[66] The state argued that it owed no higher duty in providing health services to incarcerated people than to citizens in general.[67] The court disagreed, holding that DCS bears a higher duty of care towards incarcerated people because it has incarcerated them, and ordered DCS to provide ART to those who had been prescribed treatment.[68] At first blush, *Van Biljon* was a major victory for incarcerated people, but it has been described as a "pyrrhic victory" given its limited impact.[69] Not all the incarcerated people who took part in the litigation received ART, and others received only some.[70] There was limited policy impact as external NGOs who would be able to provide follow-up advocacy were not involved.[71] Subsequently, DCS continued to refuse treatment to many HIV-positive incarcerated people, resulting in a large number of unnecessary deaths.[72]

After *Van Biljon*, the question of medical parole was raised in 2004 in two cases—*Stanfield v. Minister of Correctional Services*, and *Du Plooy v. Minister of Correctional Services*.[73] These cases had obvious implications for HIV-positive incarcerated people whose health was rapidly deteriorating without access to ART.[74] In *Stanfield*, the court ruled in favor of an incarcerated person with ter-

minal cancer who sought the review of a decision by the director of a prison to deny him medical parole.[75] The court held that because the medical facilities at the prison were inadequate to provide the incarcerated person with palliative care, the director's refusal to grant medical parole violated the right to conditions of detention consistent with human dignity.[76] The court required DCS to reconsider its restrictive practices relating to the release of terminally ill incarcerated people on medical parole.[77] Similarly, in *Du Plooy*, the court held that DCS's refusal to grant medical parole to an incarcerated person in need of palliative care that DCS could not provide was "in total conflict" with the person's rights to dignity, health care, and to not be punished in a cruel, inhuman, or degrading manner.[78] After these cases, the AIDS Law Project (now SECTION27) began lobbying for the medical parole of HIV-positive incarcerated people for whom ART remained unavailable.[79] Around the time of *Du Plooy*, it was estimated that 90% of deaths in prison were the result of HIV/AIDS.[80] But many incarcerated people still struggled to access ART, and the issue arose in the court again two years later.[81]

In 2006, with *EN and Others v. Government of RSA and Others*, a group of HIV-positive incarcerated people, together with the Treatment Action Campaign (TAC), sought a court order mandating the provision of ART to all people qualifying for treatment in Westville prison.[82] The court ruled in favor of the incarcerated people. Going beyond *Van Biljon*, the court ordered that all HIV-positive incarcerated people at the prison who qualified for treatment according to national policy be given ART—a group much larger than those who had already been prescribed treatment.[83] The judgment was sympathetic to the particular vulnerability of incarcerated people to HIV infection, and to the likelihood that many people in prison would in fact die from AIDS.[84] Initial non-compliance with the order was overcome by a supervisory interdict requiring DCS to report back to the court on its plan for providing treatment.[85] Nonetheless, it took three years and two more court orders to secure full roll-out of ART in Westville.[86]

The *EN and Others* ruling was handed down at an auspicious time: in 2006, the same year in which the government finally reversed President Mbeki's AIDS-denialist policies.[87] While the supervisory interdict was critical, the lawsuit's success is also likely owed to the robust advocacy around the case conducted by the incarcerated people and NGOs.[88] People in prison undertook a hunger strike to demand access to treatment.[89] TAC activists also protested at the International AIDS Conference in Toronto, and conducted a sit-in at the South African Human Rights Commission, garnering media attention that publicly shamed the government.[90]

In 2012, in *Lee v. Minister of Correctional Services*, the Constitutional Court considered whether DCS could be held liable for damages due to its negligent omissions resulting in a remand detainee, Dudley Lee, contracting TB.[91] Mr. Lee had spent nearly five years in Pollsmoor remand detention before ultimately being acquitted.[92] He entered the facility in reasonably good health, but was diagnosed with active TB after his third year in custody.[93] The court held that DCS breached its constitutional obligations to provide adequate health care and conditions of detention that respected his human dignity.[94] It reasoned that TB was prevalent in the facility, that DCS was aware of the risk of TB infection, and that instead of implementing a comprehensive system to identify and manage TB cases, it had relied on a system of incarcerated people self-reporting their symptoms.[95] Pollsmoor remand was notoriously congested, and confined people to close contact for up to 23 hours a day in cells with poor ventilation—ideal conditions for TB transmission.[96] DCS had failed to provide Mr. Lee with adequate medical treatment to cure and prevent further spread of TB to others once he was diagnosed.[97] The court found that on the balance of probabilities, DCS's negligent omissions caused Mr. Lee's illness.[98] This case made DCS vulnerable to additional claims for monetary damages by other people who have contracted TB in prison, so long as the kind of accommodation and health services deemed inadequate under *Lee* persist.

The Lee case benefited from the support of human rights organizations that were admitted as *amici curiae*.[99] Their advocacy ensured widespread

media attention and coordinated direct action, like protests outside of Pollsmoor.[100] The risk of additional legal claims also spurred DCS to make policy reforms. DCS and the Department of Health adopted new guidelines on TB and HIV, and established a National Task Team on TB and HIV in Correctional Facilities to guide the implementation of this policy.[101] The government procured GeneXpert testing machines to expedite the identification of TB cases, and began screening people for TB upon admission. Within two years, nearly 10,000 incarcerated people at Pollsmoor had been tested, 701 of whom were diagnosed with TB, and 28 with MDR-TB.[102] However, DCS still did not address overcrowding, and reports of health care dysfunction, understaffing of health professionals, and treatment disruption in prisons continued to surface.[103]

Most recently, in 2016, *Sonke Gender Justice v. The Government of the Republic of South Africa* finally put the overcrowding of prisons on trial, once more focusing on Pollsmoor.[104] The NGOs Sonke Gender Justice and Lawyers for Human Rights challenged the severe overcrowding and inhumane conditions of confinement for remand detainees. When the litigation commenced, Pollsmoor's remand facility was operating at over 238% capacity, accommodating nearly 2,000 people more than approved under national regulations.[105] This meant that there were up to 70 detainees crammed into cells built for 30 people.[106] Individuals were doubled up on beds or forced to sleep on the floor, even underneath beds.[107] For 23 hours a day, detainees remained in their cells with no space to maneuver, and had only monthly access to exercise in the yard.[108]

The same conditions that were adjudicated under *Lee* persisted, but the narrative in the *Sonke Gender Justice* case captured the grim details. The complainant leveraged findings from a scathing report by an esteemed judge of the Constitutional Court, Justice Edwin Cameron, who had conducted an inspection of the facility in early 2015. Justice Cameron's report confirmed the testimonies of current and former remand detainees and found the conditions in Pollsmoor to be "daily hazardous and degrading" to its inhabitants.[109] The vivid report influenced public opinion and the presiding judge in the case who cited its descriptions of how the facility was "thick with a palpable lack of ventilation," and that the conditions were "so filthy that detainees [had] boils, scabies, wounds and sores from lice-infested bedding that [had] never been washed."[110] Justice Cameron also reported frequent shortages in medicines for TB treatment, and difficulties for HIV-positive inmates in accessing ART.[111]

The court ruled against the government in *Sonke Gender Justice*, and declared the conditions of detention to be a violation of detainees' constitutional rights to health and conditions of detention consistent with human dignity.[112] The court ordered the government to reduce overcrowding to no more than 150% of its approved capacity within six months.[113] It also ordered DCS to develop a plan for rectifying detention conditions and to report to the court regularly on inspections of cell accommodation.[114]

While it is too close to the precipitating events to know the full impact *Sonke Gender Justice* will have, the government has taken some promising steps. By June 2017, DCS had reduced occupancy in Pollsmoor to 147%—the lowest level of overcrowding in the facility since 2002—although this space was created not by releasing remand detainees, but by shifting sentenced people to less crowded facilities.[115]

DCS leadership's rhetoric has also become less defensive—the National Commissioner for Correctional Services appealed to government security agencies to work together to reduce overcrowding.[116] The Minister of Justice and Correctional Services acknowledged that some "factors contributing to overcrowding [were] internal [to DCS] in nature," including management inefficiencies.[117] He noted that the criminal justice cluster intended to work with DCS to divert remand detainees from custody, develop alternatives to incarceration—including parole or community supervision for sentenced offenders—and redistribute incarcerated people across institutions.[118]

The court order did indeed spur some cooperation among criminal justice departments to address the upstream causes of overcrowding in remand detention.[119] The government's final plan to improve conditions in Pollsmoor remand indicated that they would be applying to the courts to review

bail conditions of detainees accused of non-violent offenses and those too poor to afford a small cash bail.[120] Further, the government adjusted the procedures for these bail review applications so they could be filed in bulk, which increases efficiency.[121]

The lack of cross-ventilation necessary to drastically reduce the risk of TB is impossible to address without an infrastructural intervention, but detainees are now able to exercise at least four times per week, as opposed to once or twice per month prior to the litigation. Detainees no longer share beds, and their blankets are washed regularly.[122] DCS also expedited the filling of staff vacancies for both custodial and health care staff, in order to improve safety and security of inmates, and increase access to medical services and more regular exercise.[123]

Like *Lee* and *EN and Others*, the *Sonke Gender Justice* case benefited from coordinated advocacy by NGOs and formerly incarcerated people. DJF members amplified the findings in Justice Cameron's report.[124] They identified people who had been detained in Pollsmoor Remand to provide testimony for the case and be featured in a short documentary about the lawsuit.[125] NGOs reported on the issues through the UN's Universal Periodic Review mechanism.[126] And local, national, and international media gave substantial attention to the case.[127]

Conclusion

The impact of the cases discussed has varied in degree and reach, but collectively they provide content to constitutional rights to humane and dignified conditions of detention, access to adequate accommodation, and medical care in prison. *Van Biljon* clarified that the government has a heightened duty of care to incarcerated people with regard to their health care. *Stanfield*, *Du Plooy*, *EN and Others,* and *Lee* elaborated on what this heightened duty requires of DCS—granting medical parole for terminally ill people that prisons are unequipped to care for; providing ART to all qualified HIV-positive incarcerated people; and providing adequate TB prevention and treatment services. These cases incentivized reform to DCS health policies. With *Sonke Gender Justice*, the conditions of confinement, and not just the delivery of specific health services, were adjudicated. The order to reduce overcrowding prompted the government to reflect on the wider criminal justice system, including systems of bail. The jurisprudence demonstrates that the government is vulnerable to constitutional challenge and to courts' supervision for failure to respect human rights in prisons.

Penal reform efforts in South Africa clearly benefit from a progressive legal framework that provides strong rights protections in prisons. This has enabled incarcerated people and human rights groups to challenge the rights abuses that drive HIV and TB in prison. South Africa's fiercely independent judiciary has proved willing to hold the executive branch accountable and make decisions counter to popular punitiveness.

While progress has been made, change requires more than litigation. However, the South African experience illustrates that it can be worthwhile to litigate on narrow legal issues, beginning with the low-hanging fruit, such as access to ART. As the rights were further articulated in case law, the courts demonstrated a willingness to countenance demands for larger systemic changes. Litigation was especially promising where it was part of a shared advocacy agenda among activists who employed complementary advocacy strategies. The South African experience gives reason for optimism that in other resource-constrained contexts, where the judiciary is receptive, incremental systemic changes may be achieved through litigation, lobbying, and mass media advocacy.

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