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AIDS is the new struggle.

KC Goyer
Washington DC
August 2002

EXECUTIVE SUMMARY

Those who are among the most likely to contract HIV are the same people who are most likely to go to prison: young, unemployed, un- or under-educated, black men. This is because many of the same socio-economic factors which result in high risk behaviours for contracting HIV are the same factors which lead to criminal activity and incarceration.

Inside prison, high risk behaviours for transmitting HIV include homosexual activity, intravenous (IV) drug use, and the use of contaminated cutting instruments. Conditions of overcrowding, stress and malnutrition compromise health and safety and have the effect of worsening the overall health of all inmates, and particularly those living with HIV or AIDS. The institutionalised victimisation of younger, weaker prisoners appears to be a direct result of the relatively unobstructed power of gangs, facilitated by corruption within the Department of Correctional Services. Gang activity also increases the incidence of tattooing and violence between prisoners, both of which can create the risk of HIV transmission.

Many governments, with the assistance of international organisations such as the World Health Organisation (WHO) and UNAIDS, have attempted to devise policies to appropriately respond to HIV/AIDS in prison. The practice of mandatory HIV testing and segregation is not supported internationally because it violates the rights of HIV positive individuals and cannot be medically justified.

The importance of HIV/AIDS education has been emphasised by governments and non-governmental organisations alike, although any education programme must be carefully thought out and adapted to the prison environment in order to be effective. Distributing condoms and lubricant is advocated by WHO and UNAIDS although the difficulties in getting authorities to acknowledge homosexual activity in prison has impeded the development of condom policies in some countries. Equally important has been the distribution of bleach and/or needle exchange programmes in those countries where IV drug use presents a problem amongst the incarcerated population.

The challenge of treating HIV in the prison environment is related to limited resources and problems with ensuring the crucially important level of adherence to treatment programmes. International guidelines advocate the 'equivalence principle', or the idea that the same care should be provided in prisons that is available to the general public.

Specific health concerns related to HIV/AIDS outside of prison, such as Tuberculosis (TB) and other sexually transmitted infections (STIs), are of particular importance inside prison. Given that the burden of disease amongst the prisoner population is consistently greater than that of the outside community, some governments have opted to make the provision of health services in prisons the responsibility of the department of health, rather than correctional services.

The Department of Correctional Services in South Africa has introduced policies to address HIV/AIDS in prison. These policies have some good features which are implemented extremely well, some excellent features which are not appropriately implemented, and some features which are neither correctly designed nor implemented.

Correct implementation of the HIV testing policy as it is written will improve adherence to the international standard of the equivalence principle. The condom distribution policy would be considerably improved if it were to include the discreet provision of condoms in common areas rather than requiring prisoners to request condoms face to face with a member of the health staff. Furthermore, the provision of water-based lubricant in a similarly accessible manner would reduce the probability of condom breakage and/or rectal tearing, both of which contribute to the risk of HIV transmission.

For prisoners in the late stages of AIDS, the early release policy must be updated and streamlined. Additional assistance for this, and other much needed HIV-related initiatives, can be provided by various NGOs and funding organisations. The Department would do well to encourage and facilitate partnerships with NGOs, including academic and research institutions, in order to understand and provide better solutions to the challenges of the prison environment. Given the very real budget constraints faced by DCS, consolidation and re-allocation of resources, particularly in the form of increased co-operation with the Department of Health, will help make sure that more is achieved for each rand spent.

Recommended HIV/AIDS policies will accomplish little in the absence of basic prison reforms. Overcrowding has adversely affected prison conditions

to the point that they are entirely unconstitutional. Anyone who visits a prison or otherwise knows of this situation has the right to be outraged, but the demand for action must be correctly directed as the Department does not determine the size of the prisoner population. Rather reforms in the Department of Justice and Constitutional Development are necessary to reduce prison overcrowding, including addressing the problem of prisoners awaiting trial.

An endemic problem over which DCS has exclusive control is the lack of proper nutrition provided for prisoners. Outsourcing options should be explored, both to provide a higher quality of service at a lower price but also to provide an environment of greater accountability amongst kitchen workers. Finally, allowing greater access to the prison, both for purposes of research and in the interest of impacting policy, is an imperative for upgrading the effectiveness of DCS service delivery.

All but a small percentage of prisoners return to the community. Hundreds of thousands of young men are released from prison each year. Many of these former prisoners are drawn from, and will return to, those communities which are hardest hit by public health issues, including HIV. The impact of this marginalised segment on the rest of the South African population can either be that of positive change or of further hardship. The determining factor will be the appropriate design and implementation of the government's response to the challenge of HIV/AIDS in prison.

METHODOLOGY

Much of this monograph is drawn from research undertaken for a Masters thesis in Political Science at the University of Natal, Durban.The documentary evidence examined for this research included legislation and policy memoranda, as well as statistics and publications produced by the Department of Correctional Services and the Office of the Judicial Inspectorate. In addition to documentary evidence, interviews were conducted with DCS officials and employees, former and current prisoners, and academics and researchers in relevant fields. The DCS employees selected for interviews included health care staff, social workers, psychologists, and administrators. These interviews were semi-structured, with the intention of allowing the interviewee to answer open-ended questions in order to gain the most information possible.

As part of the thesis research, a one page survey was administered to a sample of 274 prisoners at Westville Medium B, a men's maximum security prison in KwaZulu-Natal. Westville Medium B (WMB) is the largest prison for sentenced prisoners in KwaZulu-Natal, and the prison hospital at WMB serves as the hospital for all prisons in the province. Participation was voluntary and anonymous, and this fact was communicated to each prisoner at the start of the interview. Structured interview questionnaires were used in order to gain quantifiable data on high risk behaviours and the impact of HIV/AIDS policy amongst the prisoner population. For each question, an option was always given of "Refuse to answer", in order to allow participants to skip questions with which they were uncomfortable. Zulu-speaking research assistants were trained to administer the questionnaire in order to obtain reliable and accurate responses.

The fieldwork for this research was conducted from October 2000 through April 2001. Official permission to conduct the fieldwork for this dissertation was obtained after six months of repeated phone calls and faxes which began with the Head of Prison and culminated with the Judicial Inspectorate and a Chief Deputy Commissioner (both national level government officials). Because of the difficulties experienced in obtaining permission to conduct this research, it became apparent that DCS staff would be more willing to discuss

the issues candidly provided that confidentiality was assured. All interviewees at WMB, both staff and prisoners, were granted confidentiality prior to the commencement of the interview. Although all interviewees were extremely co-operative and helpful, in order to protect them from negative repercussions within the Department, it was decided to not list their names or include direct quotes.

While most of the data was collected from Westville Medium B, information was also obtained through brief research visits to Pollsmoor Prison, outside of Cape Town, and Manguang Prison, in Bloemfontein. Plans to visit several other prisons and conduct more extensive research were thwarted when SABC TV's Special Assignment expose at Grootvlei brought the Department of Correctional Services a spate of bad publicity, and all prison research was temporarily discontinued. To date, there has never been a nationwide study conducted in South Africa's prisons. Prisons vary considerably in size, structural design, and management protocols and the HIV/AIDS pandemic has been shown to vary considerably between and even within provinces. Clearly, the need for a nationwide extensive study of prison health issues is an increasingly important area for future research.

INTRODUCTION

When discussing HIV/AIDS in prison, most people are immediately concerned about transmission. The most horrific scenario imaginable is that of a young man arrested for a minor infraction who, because of an inability to pay bail or even some unfortunate bureaucratic delay, spends a night in jail and is raped by another prisoner and thus contracts HIV and, in effect, a death sentence for his alleged crime. This could be construed as not just cruel and unusual punishment, but even extra-judicial execution as the arrestee has suffered his fate before being convicted, or even charged. This situation is horrifying and makes for exciting and inciting media material. The dramatic aspect comes from the possibility that a person from the general community—someone who is not a hardened criminal but was perhaps simply in the wrong place at the wrong time—will be exposed to the dark underworld of prison and all its terrifying evils and is inadvertently condemned to an early death as a result. However, while such an incident can, and probably does, take place, it does not reflect the gravest threat posed by HIV/AIDS in prison.

There are approximately 175,000 prisoners incarcerated in South African prisons at any given time. However, this does not mean that 175,000 criminals are locked away, isolated from the public, and unable to impact on the lives of those in the general community. Over 40% of prisoners are incarcerated for less than one year; only 2% are serving life sentences. On average, 25,000 people are released from South Africa's prisons and jails each month.[1] This translates into 300,000 former prisoners returning to the community each year. And they bring their illnesses, infections, and/or diseases with them. The greatest concern should not be directed at the risk of HIV transmission inside of prison, but the potential impact of prisoners on HIV transmission outside of prison.

This is not to say that HIV transmission inside prison does not need to be addressed. However, the prevention of HIV transmission in prison has more to do with improving prison conditions in general than with specifically addressing HIV. Overcrowding, corruption, and gangs are the primary culprits behind rape, assault and violence in prisons, and this environment is horrify-

ing even without the risk of HIV infection. Security and the provision of safe custody must be a priority. A just society would not accept that prisons are necessarily brutal environments. If the prison as an institution is proven to be intrinsically and inevitably violent, then the necessary course of action is to change the institution. Therefore, policies to address HIV transmission in prison cannot be effective without immediate and urgent prison reforms.

High risk population

The reality in South Africa is that one need not spend a night in jail to be at risk for HIV infection. The people who are more likely to be incarcerated are also those who are more likely to be HIV positive. The socio-economic factors which significantly contribute to the prevalence of HIV positive within a specific population are very similar to those which lead to criminal activity and incarceration. Poverty is a defining characteristic of both prisoner and HIV positive populations alike. In South Africa, HIV "flourishes most in areas that are burdened by unemployment, homelessness, welfare dependency, prostitution, crime, a high school drop-out rate, and social unrest."[2]

The impact of joblessness, illiteracy and a general environment of lawlessness, all commonly considered contributing factors towards criminal behaviour, has also been studied as a factor in HIV infection. The poor are more likely to become migrant labourers or commercial sex workers as a survival strategy. HIV prevalence has also been tied to levels of social cohesion, or the amount of unifying bonds between members of a community, usually supplied by civil society. Areas which struggle with violence, high rates of crime and substance abuse, substandard housing, and overcrowded, unsanitary living conditions are also likely to be plagued by unemployment, domestic abuse, dysfunctional relationships, and a lack of security or stability. Furthermore, the uneducated and illiterate are less likely to be reached by HIV education programmes, and have lower levels of HIV/AIDS knowledge and awareness. Finally, people in marginalised communities are less likely to have access to health care, and thus more likely to suffer from untreated sexually transmitted infections (STIs), which increases the probability of HIV transmission.[3]

In addition to similar behaviour patterns and social environments, age, race, and gender are significant predictors of HIV infection rates. Young people are at high risk for HIV infection.[4] Because people between the ages of 18 to 35 are less likely to be in monogamous relationships and have a wider sexual network, they are more likely to contract HIV as well as other sexually transmit-

ted infections (STIs). Furthermore, the presence of STIs in one or both partners increases the risk of HIV transmission not only because the presence of sores allows the virus to enter the skin, but also because untreated STIs can increase the viral load in genital fluids.[5]

In South Africa, the HIV infection rate is highest among the black population: seropositivity is ten times more common in black South Africans than in any other racial category.[6] Projected HIV prevalence for black men peaks with the 25 to 29 age group with an estimated 38.89% infected with HIV by 2002.[7] This infection rate is considerably greater—and growing faster—than infection rates in the population as a whole, making young black men a particularly high risk group.[8] Nationally, 76% of prisoners in South Africa are black men between the ages of 18 to 35, with the most significant portion between the ages of 25 and 35.[9] The people who are sent to prison are primarily young, black men from marginalized communities with HIV prevalance and low access to health care. All of these characteristics combine to make the prison population at high risk for HIV infection *prior* to their incarceration.

High risk behaviour prior to incarceration

Marginalized groups are disproportionately represented in the prison population as well as amongst the population of people living with HIV/AIDS. In addition to environmental factors, however, there are several aspects of pre-incarceration behaviour which places prisoners at high risk for HIV infection. High risk behaviour for contracting HIV includes unprotected sex, particularly with multiple partners, commercial sex work, or sex which takes place in exchange for drugs. Drug use is also high risk behaviour, in that the influence of drugs usually leads to other risk taking behaviour including high risk sex as well as sharing needles for intravenous drug use. The potential that this type of pre-incarceration risk-taking will continue after incarceration also exists, in the absence of effective intervention programmes and policies.

In the United States, one in five of all people living with HIV/AIDS pass through a correctional facility each year.[10] In a study of prisoners about to be released, 79% reported unprotected sex with their regular partner prior to incarceration. This number rose to 81% with casual, or non-regular, partners. All pre-release prisoners reported drug use, specifically crack/cocaine in the year prior to incarceration.[11] A separate study found that 17% of women and 15% of men had sex with ten or more partners during the 12 months prior to incarceration.[12] This study also found that among men, a history of homeless-

ness (OR=2.8) and selling drugs as a primary income source (OR=4.4) were associated with having ten or more sex partners prior to incarceration. Among the women, receiving money for sex was associated with having ten or more sex partners (OR=25.6).[13]

A recent study in Brazil found that 27% of sexually active prisoners have never used a condom, 67% did not use a condom in the six months prior to incarceration, 43% never used a condom with casual partners, and 41% reported that condom use "interferes in the sexual intercourse".[14] Even though 84% knew the primary means of transmission of HIV, and 60% perceived themselves to be at high risk for HIV infection, 42% did not use any protection during sexual activities.[15] The estimated HIV prevalence rate in Brazilian prisons is between 13% and 17%.[16]

A study conducted at a prison in St. Petersburg, Russia, found that 40% of subjects reported multiple sexual partners in the 12 months prior to incarceration, and of these, 61% never used a condom. Fifty eight percent of subjects reported IV drug use in the 12 months prior to incarceration, and of these, 22% shared a syringe. Amongst reported injection drug users, 46% were HIV positive. The HIV prevalence rate overall was 34%, and 35% of HIV positive prisoners knew their HIV status prior to entering prison. About one third of participants in the study had been previously incarcerated.[17]

Given the high burden of HIV in Russian prisons, a pilot HIV/AIDS prevention program has been implemented by Medecins Sans Frontieres (MSF) with the Russian Ministry of Justice. The three-year program includes health promotion publications; training prison officers, health workers and prisoners; bleach and condom distribution; peer education; pre- and post- HIV test counselling; and research. MSF and Russian counterparts are supporting the intervention based on their belief that, "targeting a high prevalence (and very likely high risk) population inside prison makes it possible to prevent the spread of HIV beyond prison walls as well."[18]

High risk behaviour during incarceration

The prevailing types of high risk behaviour for transmission of HIV in the prison environment are contaminated needles and/or other cutting instruments, and high risk sexual activity. The most common forms of transmission in a prison are usually similar to those outside of prison. In countries where intravenous (IV) drug use is endemic, the resultant needle sharing tends to be

the principal means of HIV infection. In areas where HIV is primarily transmitted through high risk sex, the same is likely to be true of transmission in the prisons. However, similarities between transmission inside and outside prison will not be exact as there are several aspects of the prison environment which create unique situations and unique risks in any country.

Contaminated needles

Many industrialised nations face a serious problem with intravenous (IV) drug use and the resultant needle sharing. The probability of transmission from shared injection drug equipment is extremely high, second only to receiving a contaminated blood transfusion amongst non-sexual means of transmission. Sentencing practices for drug-related offenses can lead to an extremely high incarceration rate amongst drug users and addicts, particularly in countries where drug policy emphasises criminalisation over rehabilitation. In the United States, there are more IV drug users in American correctional institutions than in drug treatment centres.[19] While in prison, addicts will find ways to continue their habit, but are less likely to obtain clean syringes or disinfectants and thus needle sharing is a widespread practice. The result is that IV drug use is the leading cause of HIV infection in US correctional institutions.[20]

One of the first studies on HIV in prison in Canada was conducted in a medium security prison for women in Montreal. The researchers found that injection drug use was reported by 50%, and of those who used IV drugs, needle sharing was reported by 84%.[21] The study concluded that, "Nonsterile injection drug use practices and unprotected sexual activity with an injection drug user were found to be the strongest risk factors for HIV infection."[22]

The Correctional Service of Canada (CSC) has reported that HIV prevalence in prison has increased an average of 27% per year since 1990.[23] Ralf Jürgens, executive director of the Canadian HIV/AIDS Legal Network, claims that needle sharing for injection drugs is the primary reason for the increase in HIV infection in Canadian prisons. Similarly, CSC spokeswoman Michele Pilon-Santilli attributed the high infection rates to the fact that approximately 70% of inmates have drug-related problems prior to incarceration.[24]

At Glenochill prison for men in central Scotland, 14 of the 350 (4%) prisoners were found to be HIV positive. A phylogenetic analysis of the viral sequences showed that 13 of the 14 HIV positive prisoners had been infected from a common source. The conclusion from the molecular evidence was that these

13 men were infected while incarcerated, most likely as a result of needle sharing for IV drug use.[25]

The continued use of IV drugs in prison is a pervasive problem in many prison systems. The first study on HIV conducted by HM Prison Service in England and Wales found that 41% of men, 25% of women, and 20% of juveniles who were IV drug users prior to entering prison were able to continue using IV drugs while in prison.[26] In a separate study undertaken in England, researchers also found high rates of drug use inside prison. Of 50 men and women studied by one physician, "47 ex-prisoners had taken at least one illegal drug in prison and of these 33 had done so by injection. Twenty six had shared injecting equipment."[27] Another survey in England found that 75% of respondents who admitted to using IV drugs while in prison also reported sharing needles and syringes with others. One ex-prisoner explains, "I was lending my needle to 20 prisoners and I'm HIV. They knew I was HIV."[28]

At Featherstone jail in Wolverhampton, England, drug use is so rampant that prisoners who were not users prior to incarceration are becoming addicts by the time they leave the prison. Drug problems were also cited as a cause for increasing violence in the prison, with the result that many inmates were compelled to carry knives to protect themselves. According to a report by Sir David Ramsbotham, Chief Inspector of Prisons at the time, "Many prisoners felt that people came to prisons without a drug problem, but turned to drugs to cope. They then left prison with a heroin habit and inevitably came back to prison for a drug-related crime."[29]

Attempts to curb drug use in prison have included random drug testing, but the effects have in some ways become counter-productive. In order to avoid getting caught by a random drug test, prisoners who formerly preferred cannabis, which is detectable for up to a month after use, began switching to heroin, which is out of the system in a few days.[30] Heroin is a popular IV drug, while cannabis is normally smoked, and heroin is much more addictive. Therefore, heroin leads to considerably higher risk behaviour for the transmission of HIV.

In countries and regions which do not experience a great deal of heroin or other IV drug use outside of prison, IV drugs will also not be common inside prison. However, the use of contaminated, or unsterilised, needles is not limited to IV drug use. An integral part of the prison sub-culture is the incidence of rudimentary tattooing by inmates on other prisoners.[31] Most jurisdictions will specifially prohibit tattooing, which leads to the use of smuggled, and usually unsterilised, needles or other cutting instruments.

One of the many health and safety hazards associated with this is the transmission of HIV. The risk of transmission is higher if a tool is used to puncture the skin, is contaminated with HIV positive blood, and is then immediately used on another prisoner. Less likely means for transmitting HIV include sharing razor blades or use of sharp implements in prison violence or self-mutilation. Owing to the relatively secure nature of the prison, needles as well as other cutting instruments are in short supply and are thus more likely to be shared. The risk for HIV transmission from use of contaminated cutting instruments will depend on the amount of blood involved and the time elapsed between uses, as well as the viral load of the infected person and certain biological attributes of the non-infected person.[32]

High risk sex

In the context of determining HIV transmission, the difference between sexual activity in prison and in the general population is significant. Three aspects of sexual activity inside the prison make it a higher risk for transmission: anal intercourse, rape and sexually transmitted infections (STIs). Anal intercourse and rape often result in tearing, thus, there is a higher risk of HIV transmission.[33] In addition, a common characteristic of a prisoner's background is a history of STIs. The risk for transmission and acquisition of HIV is greater among individuals with an STI.[34]

The probability of transmission of HIV from anal intercourse is much higher for the receptive partner than for the insertive partner. This is because the acceptance of semen into the rectum allows for prolonged contact with mucous membranes. Amongst sexual means of transmission, unprotected receptive anal intercourse carries the highest probability of infection, at 0.5% to 3%. In comparison, the probability of infection for a man participating in unprotected vaginal intercourse with an HIV positive woman is .033% to 0.1%.[35] Comparisons of transmission probabilities between various sexual behaviours have sometimes yielded conflicting results, yet one maxim remains true throughout the research to date: "It is clear that unprotected anal intercourse has the highest potential for transmitting the virus."[36]

The extent of sexual activity in prisons is difficult to determine because studies must rely on self-reporting, which is distorted by embarrassment or fear of reprisal. Sex is prohibited in most prison systems, leading inmates to deny their involvement in sexual activity. Sex in prison usually takes place in situations of violence or intimidation, thus both perpetrators and victims are disinclined to

discuss its occurrence. Finally, sex in prison usually takes the form of homosexual intercourse which carries persistent social stigma. However, perpetrators of homosexual intercourse in the prison environment usually consider themselves to be heterosexual. Consensual homosexual intercourse is not tolerated by the prison sub-culture, which also contributes to the under-reporting of sexual activity in the prison environment.[37]

Numerous studies have sought to gain information on sexual activity in prison. In Britain, a survey of 453 ex-prisoners found that 10% admitted to participating in unprotected anal penetrative intercourse.[38] In a survey of 50 recently released former prisoners in England, four reported having anal sex whilst in custody, with between four and 16 partners.[39] The Prison Reform Trust, a policy research NGO based in the UK, has estimated that up to 30% of prisoners become involved in homosexual activity. This estimate is supported by information obtained in a survey conducted by the National Association of Probation Officers, which concluded that "sexual relationships were not unusual between prisoners."[40]

Prisoner participation in homosexual activity is usually not related to a person's sexual orientation outside of the prison, but is rather a product of the circumstances within a prison environment. The need for sexual fulfilment is only one part of the prison sexuality dynamic. Sex in the prison environment, particularly in the form of rape, is more often about power and asserting control over another human being than about sexual fulfilment.[41] One study in the United States found that 55% of self-designated heterosexuals reported sexual activity in prison. The same study determined that while 14% of prisoners reported that they were sexually assaulted, 19% had regular sexual partners.[42]

Prison officials, as well as prisoners themselves, are reluctant to discuss the nature and extent of sexual activity in prison because it indicates a lack of control and/or weak management. With only official statistics and self-reporting to rely on, it is generally assumed that the actual incidence of sex and rape is much higher than the limited information available suggests. In a study of the Philadelphia jail system, interviews with 3,304 prisoners found that more than 2,000 sexual assaults had taken place within 26 months. Although 60,000 men passed through the system in that same time frame, only 96 assaults were reported, 64 were included in prison records, 40 resulted in disciplinary action, and 26 were reported to the police for prosecution.[43]

In 1999, a study of HIV/AIDS in Malawi prisons was conducted for Penal Reform International at the Zomba central prison complex. The study found

that most prisoners and prison officers acknowledged that homosexual intercourse was the most likely form of transmission of HIV in prison and that this activity was common. Respondents estimated that 10% to 60% of prisoners participate in homosexual activity at least once and about one third of these have habitual sex with other prisoners.[44] The impact of overcrowding was recognised by most respondents, in that most homosexual activity was reported to take place where up to 43 prisoners are kept in one cell. Some prisoners explained that a shortage of blankets would lead to prisoners sharing blankets and that sex would also occur in these situations.

Homosexual activity is referred to as an "unnatural offence" in the Malawi Penal Code and carries a prison sentence of 14 years, therefore it is understandable that homosexual activity inside the prison will be under-reported. Prisoners and wardens explained that only a small portion of prisoners who participate in homosexual activity inside the prison are homosexuals outside of prison, while the rest engage in homosexual activity only because of their situation inside the prison.[45] Those who consistently serve as the receptive partner are often described as "very needy" as the excerpt below explains:

> They are usually recently detained, either juveniles or young adults, who have no blanket, soap, plates or food. They have no relatives from the outside to help them and care of them, they are in physical need and confused by their recent detention and they turn to somebody to care for them. The ones they usually turn to are those who have outside supplies. The relationship between them was described as similar to that between a poor prostitute and a rich client.[46]

Prisoners most likely be the insertive partner were those who worked in the kitchen because they are in a position to offer food as a medium of exchange.[47]

Inquiries about homosexual rape in the Zomba study obtained mixed responses. Juveniles reported that they had, "heard of fellow juveniles having been raped" and some adults reported they had heard of it on occasion but not frequently. Other adults, however, said rape was fairly common but that authorities could be bribed to keep quiet.[48] The most alarming finding of the study was that prison officials are actively involved in prostitution rings involving juvenile offenders who are "rented" to adult prisoners:

> An adult prisoner approaches a prison officer, gives him some money and asks him to get him a boy. You know some prisoners are rich

> compared to the guards. The guard then smuggles a juvenile into the adult blocks when they are out of the juvenile wing. Once they are there they can be hidden for months, and the man who paid for them rents them out to other prisoners 'for short time', using other prisoners to get him customers.[49]

The prostitution rings are in part assisted by the inadequate segregation of juveniles from adult offenders. The adult prisoners come into contact with juveniles in the kitchen, the library, work details and the clinic and it is through this contact that prisoners are able to either abduct, lure, or 'put in an order' for juveniles. At the main gate, prisoners bribe officers to allow a juvenile into the adult facility, sometimes for as little as 30 US cents. One prisoner explains the plight of these juveniles:

> There are 22 of us in our cell, and two of my cell mates have juveniles as 'wives'. They got them by bribing the POs [Prison Officers] at the main gate. These juveniles agreed to have sex with these men because they had no clothes and no blanket, and they were hungry. One day these boys started to cry and refused to have sex. The man took away their blankets and after spending a night in the cold they agreed to allow the men to have sex with them again. We try to tell these boys that they will die of AIDS, but what can these boys do?[50]

Researchers point out that while segregation of juveniles from adults and better supervision would help protect them, the involvement of prison officers makes their abuse more difficult to prevent. Better conditions, or closer proximity to family members or other community ties could also help as the study explains that "the root causes of juveniles prostituting themselves to adult prisoners are the physical needs to food and shelter, and the need for protection."[51]

As well as the likelihood of HIV transmission, the incidence of HIV infection and AIDS related deaths in prisons in Malawi paint an equally depressing picture. AIDS is the leading cause of death in prison in Malawi, consistent with international data. In 1997, 25% of prisoners attended to by health services at Zomba central prison were HIV positive. During the first six months of 1998, just under half of prisoners treated by the health staff tested positive for HIV. The most common illnesses treated in the prison clinic were malaria, pulmonary TB, scabies, and diarrhoea.[52]

Tuberculosis (TB)

In many countries, TB has become the most recurring disease contracted in conjunction with HIV, resulting in the pattern that where TB is high, HIV is high.[53] In the United States, prisons have become an incubator for TB due to overcrowding and poor ventilation.[54] The most common form of tuberculosis is pulmonary, meaning that the illness infects the lungs. Symptoms usually include coughing, resulting in the dispersion of infected sputum. Inhalation of airborne droplets of infected sputum is the most common means of contracting TB. Thus, contagiousness of TB can be compounded by areas which involve a great deal of people crowded into a small poorly ventilated space.[55]

Many adults can be TB carriers but will not develop any symptoms until their immune system is compromised, such as by infection with HIV. An asymptomatic TB carrier infected with HIV thus becomes actively contagious, contributing to increased TB infection in the rest of the population.[56] In this way, HIV causes an increase in the spread of TB, and other infectious diseases, to other HIV-negative people. It is estimated that in sub-Saharan Africa, "one out of every four TB deaths among *HIV-negative people* would not have occurred in the absence of the HIV epidemic".[57]

The rate of TB infection in Russia more than doubled between 1991 and 1997. Of the more than 100,000 new cases reported each year, one third are found in prison. It is estimated that an additional 30,000 cases each year are undetected.[58] An Amnesty International report found that:

> Conditions in penitentiaries and pre-trial detention centres continued to amount to cruel, inhuman or degrading treatment. The Procurator General expressed concern at serious overcrowding and revealed that some 2,000 people had died of tuberculosis in prison in 1996, a death rate of ten times the rate in the general population.[59]

In 2001, the Russian prison system—the second largest in the world—experienced a "10-40 fold increase in new cases of HIV infection."[60] HIV infection is increasing in Russian prisons, and the presence of TB is compounding the problem. One study conducted in St Petersburg found that the number of new HIV/AIDS cases more than quadrupled from 1998 to 1999 and that one in four of these cases was in prison.[61] The morbidity rate for HIV outside the prison was 62 per 100,000 while inside prison the morbidity rate was 510 per 100,000.[62]

Hepatitis C (HCV)

In US prisons, most prisoners infected with HIV are co-infected with Hepatitis C (HCV). This is difficult to detect, however, because HIV infection can result in the body not being able to produce the antibodies which show up in preliminary HCV testing. HCV is a degenerative liver disease and is chronic in 85% of the people who contract it. It is transmitted only through blood-to-blood contact, and can lead to serious secondary illnesses, disabilities, liver failure, and death. In some patients, severe symptoms do not occur for 20 or 30 years.

According to the Centre for Disease Control (CDC) in the United States, Hepatitis C is the most common blood-borne infectious disease in the country with 2% of the population infected, excluding the homeless and the incarcerated. In the prison population, however, infection rates are as high as 60%. Many patients, both inside and outside of prison, are misdiagnosed or HCV is simply not detected due to co-infection with HIV. HCV is the most common reason for liver transplantation, but with proper diagnosis, treatment, and lifestyle changes the need for a transplant can be avoided entirely.[63]

HIV/AIDS prevalence in prisons

Studies of HIV infection in US prisons have found that seroprevalence is anywhere from five to ten times higher than the general population.[64] In addition, the number of new AIDS cases in prison is 20 times that of the population at large.[65] One of the few studies to determine custodial seroconversion was conducted by the Center for Disease Control (CDC) on a sample of male prisoners in Illinois. Out of 2,390 prisoners who tested negative at intake, there were seven confirmed seroconversions after one year's incarceration.[66] This translates into an annual transmission rate of 0.33%.

In Canada, a comprehensive study of over 12,000 people entering Ontario prisons was conducted in 1993. The results found HIV infection rates of approximately 1.0% for adult men and 1.2% for adult women. While these infection rates may seem low, they are more than ten times that of the Canadian population. The findings in this, as well as other less extensive studies, have reiterated the same conclusions: rates of HIV-infection amongst inmates are much higher than in the general population. One explanation offered is that this higher prevalence is related to two factors, "the proportion of prisoners who injected drugs prior to imprisonment, and the rate of HIV infection among injection drug users in the community."[67]

A number of studies have noted higher prevalence rates amongst women prisoners. HIV prevalence amongst female prisoners in England and Wales is 13 times that of the general population, compared to a combined prevalence for both male and female prisoners which is four times that of the general population.[68] Studies in the US have found that HIV infection rates are higher among women prisoners because female prisoners are more likely to have histories of injection drug use.[69] A case study conducted at the Mysore Jail in Karnataka, India—a state with one of the highest prevalence rates in India—found that the seroprevalence rate was highest amongst female inmates, at 9.5%, and was 25% amongst inmates who were also commercial sex workers.[70]

CHAPTER 1
HIV/AIDS IN SOUTH AFRICAN PRISONS

The South African Department of Correctional Services (DCS) includes statistics on HIV/AIDS infection in the prisons in its Annual Report. However, these statistics reflect only the reported cases from the health services of each prison and are not considered reliable. The DCS statistics underestimate the extent of HIV infection because reporting is inconsistent and often AIDS-related deaths are recorded only as TB or pneumonia. According to the DCS Annual Report, there were 2,600 registered HIV positive cases, 136 prisoners with AIDS, and 2,897 new cases of TB as of 31 December 1999.[71] This translates to an HIV prevalence rate of 1.6% and AIDS prevalence of .08%. According to UNAIDS, HIV/AIDS seroprevalence for adults in the general population in South Africa in 1999 was estimated at 19.9%.[72] Clearly, the DCS statistics significantly underestimate HIV/AIDS prevalence in South African prisons.

The data on the number of natural deaths in prisons is more useful for understanding the real impact of HIV/AIDS on the prison population. There were 1,087 natural deaths in prison during 2000; an increase of 584% from 1995.[73] The increase in the prisoner population was 38% over the same period. Table 1 shows the increasing number of natural deaths in prison per 1,000 prisoners.

Table 1: Natural deaths in South African prisons per 1,000 prisoners

Year	Per 1,000
1995	1.65
1996	1.68
1997	2.30
1998	3.65
1999	4.53
2000	6.38

Source: Office of the Judicial Inspectorate, 2001

It is difficult to determine how many of these deaths can be attributed to AIDS, because some records list only TB or pneumonia as the cause of death. However, it can be assumed that the dramatic increase in natural deaths in prison is a result of the same disease which is causing an increase in deaths outside of prison. The logical conclusion is that prisoners, like their counterparts in the community, are dying of AIDS.

Alarmed by the increasing number of natural deaths reported in prisons and aware of the limitations of DCS statistics, the Judicial Inspectorate conducted its own study in 1999. Examining post-mortem reports, the study determined that 90% of deaths in custody are from AIDS-related causes. Using figures from the previous five years and assuming the escalation would continue, the study projected that by 2010 nearly 45,000 prisoners will die whilst incarcerated. The study predicted that natural deaths in prison would increase 43% from 737 in 1999 to 1,056 natural deaths in custody in 2000. The actual figure was even higher than expected, as natural deaths in prison actually increased 48% to 1,087 during 2000.[74]

HIV prevalence in South Africa's prisons: who knows?

The Department of Correctional Services does not know the HIV prevalence rate in prison. The Annual Report does not disclose how the current estimate, about 3%, is determined, but the Department has acknowledged that this figure is "unrealistically low".[75] However, when the Inspecting Judge of Prisons, Judge Johannes Fagan, estimated that as many as 60% of prisoners could be HIV positive, the Department disputed this figure as well as being "unrealistic and unreliable".[76]

Judge Fagan based his estimate on a report which was presented at a DCS research workshop in May 2002. The report presents the findings of a study conducted on the nature and extent of HIV prevalence at Westville Medium B, a men's maximum security prison in KwaZulu-Natal. From January through April 2001, a team of researchers led by the Health Economics & HIV/AIDS Research Division (HEARD) at the University of Natal, Durban in conjunction with the Medical Research Council (MRC) collected urine samples from 274 prisoners for anonymous, unlinked HIV tests. The samples were connected to a survey questionnaire which included questions on age, race, income, education and criminal activity, as well as high risk behaviour both prior to and during incarceration. In addition to this data collected from prisoners, semi-structured interviews were conducted with prison

management and staff as well as DCS officials and relevant NGOs and academics.

Prior to commencing the research, DCS required the study co-ordinator (who is also the author of this monograph) to sign a contract agreeing not to release the results without prior approval from DCS. During the latter half of 2001, with the assistance of funding from the Ford Foundation, the findings of the study were compiled in a report entitled, "HIV/AIDS at Westville Medium B: An Analysis of Prevalence and Policy". The research team was invited to present the findings at a research workshop, attended by the DCS National Commissioner Linda Mti and approximately 30 other high level DCS officials, in Pretoria on May 14 2002.

The following week, Judge Fagan referred to the findings in the Westville report in his presentation to the Parliamentary Portfolio Committee for Correctional Services. When newspapers ran headlines with the Judge's estimate that HIV prevalence could be as high as 60% in prisons, DCS immediately distanced itself from the estimated figure and the Judge was called to report back to the committee to provide further explanation. On the same day that a copy of the Westville report was given to committee chairman Ntshikiwane Mashimbye, the primary author received a fax from Commissioner Mti prohibiting release of the report into the public domain until seven "concerns" were resolved. The following week, on May 28 2002, Judge Fagan apologised to the portfolio committee, explaining that his 60% HIV prevalence statistic was "a guestimate, which was not intended to be taken as a scientific fact".[77]

In a press conference later that day, Commissioner Mti said the report from the Westville study was confidential, and that much of its content was being seriously questioned by the Department. "The judge found himself vulnerable to an unscrupulous NGO with a particular agenda (to obtain more funding). Let us forgive him," Mti said.[78] A few days earlier DCS Communications Director Luzuko Jacobs released an official statement which criticised the Judge for disclosing such information and also told the press that there had never been a prevalence survey conducted in prisons.[79]

The researchers of the Westville study wrote a detailed response to the seven concerns presented in Commissioner Mti's fax, but received no further communication from the Commissioner or the Department regarding publication of the findings. The research team also requested an opportunity to present,

and defend, the findings of the report to the parliamentary committee but this request was flatly refused. ANC MP and chairman Mr Mashimbye explained that the report was intended for the Commissioner and thus presentation to the committee would be "inappropriate."

A few weeks after the Commissioner specifically prohibited the release of the report, SABC TV's Special Assignment programme aired an expose of corruption at Grootvlei prison in Bloemfontein. Less than a week later, Commissioner Mti declared a three month moratorium on all prison research. The findings of the Westville report, the only study ever conducted on HIV prevalence in a South African prison, remain under embargo by the Department of Correctional Services and thus have not been included in the research presented in this monograph.

The prison hospital at Westville Medium B (WMB) is the only prison hospital in KwaZulu-Natal. This means that prisoners from anywhere in KwaZulu-Natal are sent to the hospital at WMB if they require in-patient care. Therefore, information on AIDS-related deaths at this prison is useful for understanding the number of AIDS-related deaths amongst prisoners in the entire province. The number of deaths in the WMB prison hospital has been increasing at a faster rate than natural deaths in prisons nationwide. In 1993, there were 11 deaths at WMB Hospital. By 2000, this number had increased more than ten-fold to 122 deaths. Of these, 95% were from AIDS-related causes. During the first 15 days of 2002, five deaths were recorded and AIDS was listed as the cause of death for four of them; the cause of death for the fifth was unspecified.[80]

The most common way in which HIV/AIDS presents itself in South Africa is through TB.[81] Data obtained from one hospital in Gauteng showed that as many as 80% of newly admitted TB patients were also HIV positive.[82] In South Africa overall, about half of the new cases of TB are attributable to HIV.[83] Among deaths at Westville Medium B in 2001, pulmonary tuberculosis was listed as cause of death for 47%.[84]

Prisoners are a high risk population not just for HIV but also for other STIs and there is a significant correlation between STIs and HIV.[85] Ulcerative STIs, such as syphilis, exhibit symptoms of genital sores and ulcers which increase the risk of HIV transmission. High levels of STIs have been referred to by one author as "the most significant bio-medical factor driving the [HIV/AIDS] epidemic in South Africa."[86]

In South Africa, the prevalence of sexually transmitted infections (STIs) in the general community is very high. For example, whereas the prevalence of syphilis in the USA or UK is no higher than 15 cases per 100,000 population, in South Africa there are between 5,000 to 15,000 cases per 100,000. Studies conducted in rural KwaZulu-Natal have shown that about 25% of rural women will have at least one STI at any moment in time, 50% of women attending antenatal clinics in the same area have at least one STI, and 18% have more than one.

During the first half of 2001, a study on HIV prevalence and the relationship with STIs and other factors, was conducted by the Health Economics & HIV/AIDS Research Division (HEARD) at the University of Natal, Durban, in conjunction with the Medical Research Council. The results of this study were presented to the Department of Correctional Services in May 2002, but the National Commissioner has prohibited the public release of the findings. To date, this study represents the only prevalence data from a prison in South Africa. However, both the general public and even other relevant decision-makers in the criminal justice system, have been denied access to the report.

HIV prevalence amongst prisoners in South Africa can only be estimated using demographic data provided by the Department of Correctional Services and applying it to projections from antenatal clinic data in the general community. The Actuarial Science Society of South Africa has published a detailed projection of HIV/AIDS infection and death rates, commonly referred to as the ASSA 2000 model. According to DCS, 88% of female prisoners and 84% of male prisoners are between the ages of 20 and 65.[87] Table 2 shows the ASSA Model projections for these age groups in South Africa.[88]

Table 2: HIV prevalence rates

	2000	2001	2002	2003	2004
Antenatal clinics	25%	27%	29%	30%	31%
Women aged 15–49	22%	24%	26%	27%	29%
Adult women (ages 20–65)	20%	22%	24%	25%	26%
Adult men (ages 20–65)	21%	23%	25%	26%	27%
Adults (ages 20–65)	20%	22%	24%	25%	26%
Total population	12%	13%	14%	15%	16%

Source: ASSA, 2000

Table 3: Projected HIV prevalence in the South African prison population

	2000	2001	2002	2003	2004
Prisoners male	34.3%	38.2%	41.4%	43.5%	45.2%
Prisoners female	34.4%	38.3%	41.3%	43.8%	45.3%
Total prison population	34.3%	38.2%	41.4%	43.5%	45.2%
Source: Author's projections					

Given what is known about the high risk behaviour of prisoners prior to their incarceration, the high risk profile of the prisoner demographic, and the risk of transmission inside prison, most researchers agree that HIV prevalence in South African prisons is expected to be twice that of the prevalence amongst the same age and gender in the general population. Therefore, a conservative estimate of HIV prevalence amongst South African prisoners is approximately 41% for the year 2002. Table 3 presents the projected HIV prevalence in South African prisons, assuming the age and gender proportions of the prison population remain constant.

Contaminated needles

Intravenous drug use is not common in South Africa. Until the early nineties, the primary injected drug was a pink prescription pill which was dissolved in water and then injected for an energising rush. Referred to as 'pinks', the drug gradually declined in popularity because of unpredictable fatalities. Unlike deaths from overdoses, people died from taking pinks quite unexpectedly and with no particular pattern. Some would die after only using a few times, others would remain addicts for years and then suddenly die after taking the usual dose. Because of this reputation, pinks declined in popularity and was eventually looked down upon as a drug only for the most hopeless junkies.[89]

Since South Africa's transformation, illegal drugs are obtained to a large extent from Nigerian drug syndicates. Heroin, the most commonly injected drug in the United States, is provided in South Africa by Nigerian syndicates.[90] Heroin has not found the same popularity in South Africa, and those who do use it tend to smoke it rather than take it by injection. This seeming aversion to injecting drugs could be related to previous negative associations or bad experiences with

pinks. However, an increasing number of younger people have taken to smoking heroin who were perhaps not involved with drugs when pinks were popular. Once a person is a heroin addict, it is not entirely unlikely that they will take to injecting in addition to, or perhaps instead of, smoking their drug of choice. Given that the Nigerian syndicates control an estimated 40% of the United States heroin market, it is likely that the supply will become available should the demand increase in South Africa.[91]

Intravenous drug use is not common in South African prisons, perhaps because these types of substances are far too expensive and are normally used by socio-economic segments of the population that are typically not sent to prison.[92] A recent study on AIDS and human development has confirmed that, "drug use through injections appears to be limited and sharing of needles does not, at this stage, appear to be a very significant mode of HIV transmission [in South Africa]."[93] However, a survey of incarcerated juveniles in Western Cape found that 5% reported using IV drugs.[94] While this amount is not high, it is also not negligible and the potential for growth is compounded by the fact that those interviewed were all between the ages of 12 and 18.

Both prisoners and staff interviewed from WMB confirmed that IV drug use does not happen at all in that particular prison. From interviews with 274 prisoners at Westville Medium B, only six had ever tried intravenous drugs, only three had used IV drugs in the 12 months prior to incarceration, and none had used IV drugs since entering prison. Although IV drug use did not occur in this prison, use of mandrax and marijuana (dagga) is more common inside prison than outside.[95] Of the prisoners surveyed at Westville Medium B, 72% reported smoking marijuana and 5% reported taking mandrax while in prison.[96] It is difficult to predict whether IV drug use will increase in South Africa, but if an injection culture develops outside of prison it can be expected to erupt inside prison as well.

An integral part of the prison sub-culture is the incidence of rudimentary tattooing by inmates on other prisoners.[97] One of the many health and safety hazards associated with this is the transmission of HIV. The risk of transmission is higher if a tool is used to puncture the skin, becomes contaminated with HIV positive blood, and is then immediately used on another prisoner. Less likely means for transmitting HIV include sharing razor blades or use of sharp implements in prison violence or self-mutilation. Owing to the relatively secure nature of the prison, cutting instruments are in short supply and are thus more likely to be shared. The risk for HIV transmission from use of contaminated cutting instruments will depend on the amount of blood involved

and the time elapsed between uses, as well as the viral load of the infected person and certain biological attributes of the non-infected person.[98]

In South Africa, tattooing is part of the extremely powerful gang structure within the prisons. Because everyone's clothing is standard issue, identifying tattoos become the medium for communicating who belongs to which gang. A social worker at Westville Medium B Prison estimated that about half of the 3,100 or so prisoners there had been tattooed while in prison.[99] The inmates use homemade tools for the procedure, either a bit of metal, or even a spoon, that has been sharpened to a point which is able to cut the skin. The prisoners do not have access to any materials to clean these implements, such as bleach or disinfectant.[100] For ink, prisoners burn rubber bands or will use shoe polish.[101]

Tattooing is against the regulations in prison, so a prisoner is not likely to seek medical attention for an infected wound resulting from a tattoo. A representative at the South African Prisoners' Organisation for Human Rights (SAPOHR) confirmed this information, explaining that sometimes the prison staff will supply needles or in other ways promote tattooing within the prison. The prison guards are often involved in the gang power structures themselves as they are easily bribed into complicity or bought into association with a specific gang.[102]

High risk sex

Lawyers for Human Rights estimates that 65% of inmates in South African prisons participate in homosexual activity.[103] Among prisoners awaiting trial, many of whom are held in the same cells as convicted prisoners, an estimated 80% are robbed and raped by other prisoners before they are officially charged.[104] At Westville Medium B Prison, social workers reported that prisoners commonly participate in sexual activity either voluntarily or through threats and coercion. A social worker at Westville Medium B commented that while many prisoners and prison guards will not admit it or discuss it, homosexual intercourse and rape are "rife".[105]

One former prisoner, when asked to estimate or quantify the amount of sex which takes place in South African prisons, simply stated that it is an "every night, every day occurrence." Of particular interest was the interviewee's explanation of sex as currency in prison. If a prisoner is poor and does not have any money, he will not be able to buy influence or protection within the powerful prison gang system. Often his only option is to agree to be the passive partner of another prisoner with power or money in order to obtain his

protection and influence. The *Mail & Guardian* carried the story of a 15 year old boy who, "in exchange for protection in the lethal environment of the prison gang network…eventually became the *tronkmaat* (sex slave) of a bigger, stronger gang member."[106]

The impact of this gang regulated sex trade is so far reaching as to be inescapable. According to one former prisoner, if a prisoner with money and/or influence wishes to acquire a certain prisoner as his passive partner, the chosen prisoner may not have a choice as the gang system is powerful enough to engineer changes in cell assignments with the assistance of the prison guards and officials.

Impact of prison conditions

The conditions inside prison can contribute, in varying degrees, to the risk for HIV transmission, the progression of HIV, and the deterioration in health of a person with full-blown AIDS. According to one author, "Incarceration cuts in half the life expectancy of those with HIV seropositivity."[107] In the US, AIDS inmates are dying an average of eight months earlier than AIDS patients in the general population.[108]

Although definitive data from South African prisons is not available, it appears that the finding in the US remains applicable, that "Incarceration speeds the progress of the disease from infectious stage into the full-blown malady."[109] Several factors contribute to this phenomenon, with stress and malnutrition leading the list. While overcrowding, gangs, drugs, and violence are realities of prison life in every country, specific aspects of these issues as they are manifested in South African prisons will have different impacts on prisoners already infected or at risk for contracting HIV/AIDS.

Overcrowding

Overcrowding can impede efforts to deal with HIV/AIDS in that it exacerbates the health problems of those who are already ill, and also leads to increased high risk behaviours. Conditions of overcrowding in prisons are linked to the spread of TB. Because it is an airborne communicable disease, TB is easily spread wherever conditions combine a large number of people and low sanitary standards. In the United States, prisons have become an incubator for TB due to overcrowding and poor ventilation.[110]

The prison doctor at Westville Medium B cited TB as one of the most commonly treated illnesses for prisoners. One nurse is assigned as the TB co-ordinator, and an entire cell block is reserved for prisoners who have tested positive for TB. In Westville Medium B, communal cells originally intended for 18 are crammed with an average of 50 prisoners, but can contain up to 62 prisoners.[111] Prisoners are unlocked for breakfast at around 7 a.m. and are locked up again at 3 p.m. This means that a typical cell contains 50 people who spend 18 hours each day in close proximity to each other with no ventilation or air circulation. There are no statistics available on the full extent of TB in South African prisons, but given the conditions of overcrowding there is every reason to believe that the disease affects the prison population to an alarming degree.

Prison overcrowding has a direct bearing on many aspects of a prisoner's life in that it inevitably leads to a deterioration of hygiene, care, and supervision.[112] In addition to the basic health and sanitation risks, the incidence of rape within a prison varies with the intensity of overcrowding.[113] The risks for violence as well as sickness are obvious. Plainly stated, "…the more crowded is the prison, the greater is the likelihood of acts of rape and homosexuality."[114] And the dangerous corollary to this is that increased homosexual activity means more prisoners more often are participating in high risk behaviour for transmitting HIV.[115]

In South African prisons, overcrowding can lead to high risk behaviour in that the increasing scarcity of simple items such as blankets and shoes are then used as commodities which can be exchanged for sexual acts. One former prisoner explained that in the particularly crowded cells there are fewer beds than there are people. It is not surprising that sharing a bed with another prisoner can lead to homosexual activity, sometimes in exchange for the privilege of having a bed to sleep in. The only other options for some prisoners is to sleep in the shower or toilet as sometimes even floor space is not available.[116]

Even if enough beds are available, the practical reality of fitting 50 beds in a space intended for 18 means that beds are not only triple or even quadruple bunked, but placed right next to each other so that they are touching other beds on almost all sides. In a typical South African prison cell, the prisoners fortunate enough to have beds are literally sleeping side by side and toe to toe. It is not hard to imagine the implications of this lack of defined or sufficient personal space on the incidence of high risk sexual behaviour.

Nutrition

One of the most common complaints raised by prisoners is about the food. At Westville Medium B, inmates are fed twice a day. At breakfast, they receive porridge with one teaspoon of sugar, two slices of bread and tea. In mid-afternoon, they receive their only other meal of the day and are then locked up until the following morning. The mid-afternoon meal normally consists of samp, *mielie pap*, or minced fish which still contains bones and is more reminiscent of cat food than of anything fit for human consumption. This meal is accompanied by five slices of bread, and no butter or condiments of any kind are provided.[117] The kitchen at WMB is in need of new equipment; in order to prepare breakfast the outmoded ovens must start cooking at 3 a.m.[118] Meals are often served cold, and might not even be cooked at all. A former prisoner explained that dinner would sometimes be raw *pap*; simply the powdered *mielie* meal mixed with water.[119]

More than one staff member at the Westville Medium B prison cited the incidence of smuggling and theft in the prison kitchen, by both prisoners and staff alike, as a primary cause for the lack of decent meals.[120] The problem is not even alleviated by those prisoners lucky enough to receive visitors who wish to bring them food. Many of these items are confiscated or disallowed because of the risk of containing contraband. Even fresh fruit and vegetables are not permitted, as these could potentially be injected with drugs.[121] Limiting access to such things as fruits and vegetables or other much desired foods increases demand, and thus the profit to be had from selling these items inside the prison increases, creating additional incentive to steal and smuggle. The resulting restricted access to adequate nutrition has an impact on health concerns of all kinds. In particular, prisoners living with HIV are affected because proper nutrition and vitamins may postpone the development of HIV into AIDS.[122]

Stress

The staff at WMB who provide counselling to HIV positive prisoners unanimously agreed that a prisoner's mental state has a significant impact on the prisoner's health. Social workers and psychologists attested that those who lost hope and resigned themselves to die were those for whom the disease progressed most rapidly.[123] Being imprisoned carries with it a number of stresses, including being separated from family and other support structures, frustration of goals or plans for the future, interruption of familiar activities, and intimidation and fear resulting from bullying or victimisation from other prisoners.[124]

The otherwise heavy psychological burden of imprisonment is then further intensified by the knowledge that one is infected with HIV. Few people would doubt that life in prison is unpleasant and is likely to be stressful at the very least, thus the negative effects of prison life on HIV/AIDS prisoners are understandable given that, "stress enhances depression of the immune system, thereby hastening the progress of the disease."[125]

Gang activity

The power of the 26s and 28s gangs inside South African prisons pervades nearly every issue related to HIV/AIDS in prison. Many high risk behaviours are directly related to gang activity. Membership in both gangs frequently includes tattooing, and it is not uncommon for more than one inmate to be tattooed at a time using the same needle.[126] Violence between prisoners which leads to bleeding is also a product of gang activity. Prisoners may be required to attack another prisoner and draw blood in order to be initiated into a gang.[127] For members of the 26s, the practice of stabbing another person, usually a non-gang member, is referred to as *phakama* and allows the gang member to move up in rank depending on the severity of the attack and the situation of the person who is attacked.[128]

While the 26s engage in stabbings, the primary activity of the 28s is sex and prostitution.[129] In 1906, the 28s gang began to take shape as two loosely connected associations, one inside prison and the other in the mining compounds. Both structures warehoused young men away from their families with minimal opportunities for diversion or normal social interaction. When the gang leader, Nongoloza, was imprisoned in 1908 he consolidated his criminal empire from his prison base in Pretoria. The prison environment, then and now, provides the ideal location to recruit new members and train them in the tight discipline necessary to maintain gang hierarchical structures. Although stories vary about the split of the 27s from the 28s, one reason given is the 27s' refusal to accept the custom of homosexuality which had become an accepted feature of Nongoloza's gang by that stage.[130]

The 28s' hierarchy consists of two lines: one is the 'men' and the other is their 'wives'. The men do the fighting and protecting, and the wives are the sexual partners of the fighters, or 'men'. In addition to being the receptive sexual partner, the wives perform many traditionally considered feminine roles, including washing and other domestic chores.[131] Although the 26s and 27s may claim to eschew homosexual activity, and are reportedly forbidden by

the gang's official code from taking a wife, staff at Westville Medium B noted that homosexual activity has become common amongst all gangsters. When asked about the impact of the 28s gang on the incidence of sexual activity at Westville, one interviewee responded that the 26s are also taking 'wives' even though they claim it is something only the 28s do.[132]

According to one former prisoner, prison wardens are also involved in gang activities, and gang members will actively recruit prison wardens as a means of increasing their power. For example, if a member of the 28s wishes to obtain a specific prisoner as a wife, he may be able to gain the complicity of a warden in transferring the targeted prisoner to the gangster's own cell. The former prisoner claimed that the wardens are also known to not only facilitate but also engage in sexual activities as part of their membership in a gang.[133] The wardens involvement with either the 26s or 28s can also extend to the smuggling in of food, weapons, cigarettes, drugs, and other items as well as the prostitution of juveniles to other prisoners.

CHAPTER 2
POLICY OPTIONS

The issue of HIV/AIDS in prisons has become an important topic world-wide, both in countries where HIV prevalence is minimal as well as where the impact of HIV is much more severe. In March 1993, the World Health Organisation (WHO) distributed guidelines on HIV infection and AIDS in prison. The guidelines covered HIV testing, preventive measures, management and care of HIV-infected prisoners, confidentiality, tuberculosis, and early release policies. The general principle advocated by the WHO is that of the 'equivalence principle':

> All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality. The general principles adopted by a national AIDS programme should apply equally to prisoners and to the community.[134]

The WHO guidelines were publicly supported and endorsed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in a statement issued in April 1996. The UNAIDS statement explained that ignorance and lack of government support in addressing HIV/AIDS in prison has led to denial, ineffective policies, violence and discrimination.[135] Many different policy options have been explored in response to HIV/AIDS in prison with varying results in different countries and contexts. However, an international consensus confirmed by the WHO and UNAIDS has declared that some of the more popular policies are not only ineffective but unnecessary and unjustified. The policies which have been condemned by international bodies include mandatory testing, and segregation. Other policies employed in various prison systems include education, condoms, disinfectant and sterilised needles, and general penal reform.

Mandatory testing

The primary goal of most policies regarding prisoners with HIV is to prevent transmission either to inmates or prison staff. The most severe policy com-

bines mandatory mass testing and isolation of HIV positive inmates. Testing for HIV is not entirely straightforward, and complicates the effectiveness of this policy. There is no such thing as an AIDS test, rather a person is tested for the antibodies which the body develops in response to HIV.

The most commonly used test in South Africa is the enzyme-linked immunosorbent assay (ELISA) test. The immunofluorescent antibody test, IFA or Western Blot, is also used although it is usually more expensive and less sensitive. No single test is 100% accurate. Researchers at the Medical Research Council use a combination of three ELISA tests, each with a varying degree of sensitivity, to weed out false positives and guarantee more accurate results. Further complicating the matter is the fact that sometimes the body does not develop enough HIV antibodies to be detected by a test for up to three months after infection. The result is that if all prisoners are tested upon admission to the prison, they must be tested again three months later to be assured of the reliability of the results.

Assuming the resources were available for multiple testing, both upon entrance and three months later, the concept of involuntary testing runs into many legal and ethical roadblocks. The WHO stresses that a prerequisite for any medical intervention is the informed consent of the patient. This doctrine of informed consent does not apply in circumstances where the general health of society are at stake. This is the case with a mass immunisation programme intended to contain a contagious disease, such as small pox, or standard testing in health facilities for highly contagious diseases, such as TB.

The notable difference between HIV and either small pox or TB is that HIV is not a contagious condition with the potential to infect unprotected citizens. HIV is not transmitted through casual contact, or by a person simply functioning in the community. In fact, not one study has found a case in which AIDS was transmitted, "through ordinary nonsexual contact in a family, work, or social setting."[136] Furthermore, the effects of mandatory testing can have far-reaching impacts on the lives of prisoners after release, as they can potentially suffer from insurance or employment discrimination. For these reasons, HIV cannot be compared to TB or other curable medical conditions when discussing the ethics versus necessity of mandatory HIV testing.

Detecting HIV as early as possible is the most cost-beneficial means of providing treatment in prisons. The premise behind this argument is that it is cheaper to prevent HIV from developing into AIDS than it is to care for prisoners with full-blown AIDS.[137] However, this argument only holds if prisoners

who test positive for HIV will receive treatment that can delay the onset of AIDS. Treatment of opportunistic infections does not delay the progression of HIV. Rather, ARV therapy and a high-protein diet can accomplish this feat for many HIV positive patients. Unless a standard of care can be provided to prisoners that will delay the development of AIDS, one cannot use the argument for early detection in support of a mandatory testing policy.

Proponents of mandatory mass testing argue that determining exactly how many prisoners, and specifically which ones, are HIV positive will enable correctional services to improve care, target education programmes, gather information on transmission, provide special supervision, and plan and budget effectively for HIV-related programmes and policies.[138]

A further argument employed to support mandatory testing is that voluntary testing will be ineffective, as a good portion of inmates will not agree to participate. A survey conducted in the US revealed that 85% of inmates would consent to a voluntary HIV test, and 66% would voluntarily attend counselling or education programmes.[139] This argument does not take into account the effectiveness of statistical sampling techniques to determine HIV prevalence of a specific population. Academic studies to determine HIV prevalence frequently rely on randomly selected voluntary participation, often with a sample size which consists of only 10% of the prisoners at a given correctional facility. Assuming that the prison administration legitimately wishes and is able to provide additional services and care for HIV positive prisoners, a sample size which covers 85% of the population would be more than adequate to make projections for budget and programme planning purposes.

Segregation

Whether testing is mandatory or voluntary, the issue of confidentiality is important. In some instances, a prisoner's HIV status is disclosed discreetly to prison officials on a 'need to know' basis, and in more extreme situations, prisoner cells or files are clearly marked so that anyone who cared to know would be aware of their HIV status. Maintaining confidentiality of a prisoner's HIV status is important because of the social stigma associated with the disease. In an independent report issued on the British prison system, the importance of confidentiality was underlined, with the understanding that, "HIV prisoners must not and need not become the pariahs of the prison system".[140]

Issues of confidentiality are usually not considered by those proponents of mandatory testing who also argue for the isolation or segregation of HIV positive prisoners. The intention is that by identifying and separating HIV positive prisoners, the prison will be able to provide increased health monitoring, additional surveillance of high risk behaviour, elimination of transmission within prison, and protection from discrimination or violence from other inmates.[141] There is a very real concern that not segregating HIV positive inmates will lead to increased prison violence, in that HIV prisoners will threaten cell mates with infection and other prisoners will target HIV inmates for abuse. In this respect, segregation is for the seropositive inmate's protection as much as it is for the protection of the general prison population.

Some countries report considerable success with HIV segregation programmes. In Poland, prisoners with HIV were held on a separate, less crowded floor and allowed access to more facilities, such as additional health care staff and recreational activities. The general atmosphere was one of support and specialised care, as opposed to the discrimination and insults endured in the rest of the prison. In Polish institutions where segregation was not initiated, prisoners refused to share eating or toilet facilities, or even shake hands with HIV positive prisoners. In some cases, medical doctors would refuse assistance and encourage protest from the staff against the non-segregation policy.[142]

The risk for abuse in a segregated system is great, as it is conceivable that HIV positive inmates held in a separate facility would be denied access to the same health, training, and educational services that are available to the rest of the prisoners. For this reason, proponents of segregation have cautioned that segregation, "not be used a method of punishment or as a means of reduction of care for inmates."[143] Rather, the idea is that appropriately implemented segregation can have beneficial effects for all prisoners, whether HIV positive or not. The argument is that "it is the negative implementation of these programmes, not the concept of segregation itself, that has prevented the success of segregation."[144] On the other hand, the lessons of history have shown us that regardless of the noblest intentions of any segregation policy, the reality is that 'separate but equal' simply does not exist.

Segregation of HIV positive prisoners is a declining practice in most countries. WHO guidelines explain that:

> Since segregation, isolation, and restrictions on occupational activities, sports, and recreation are not considered useful or relevant in the

> case of HIV negative infected people in the community, the same attitude should be adopted towards HIV-infected prisoners.[145]

Segregation is no longer accepted as a sensible strategy because it contributes to the stigmatisation of HIV positive people and presents numerous logistical problems.[146] Opponents of segregation point out that even assuming equal treatment was maintained, the result is a costly duplication of services which is neither medically necessary nor reliably effective.

Although the philosophical arguments against segregation of HIV positive prisoners are sound, the most convincing argument is based on medical facts. As discussed previously, the 'window period' means that when a person first becomes infected with HIV, he or she may test negative for HIV for approximately three months. The duration of this window period varies by person and is impossible to predict. To accommodate this reality, prisoners would have to be tested upon entrance and those who test negative would then have to be isolated in an 'undetermined status' section for the first three months of their incarceration. They would then have be tested again after three months, and moved to either the 'HIV' or 'non-HIV' sections of the prison according to their status. This means that recently-infected and non-HIV infected prisoners could be confined together in the 'undetermined status' section for the first three months.

The counter argument is that the number of recently-infected prisoners who were in the window period upon entering the prison would be much less than the number of prisoners who were already HIV positive and so the policy would still substantially reduce the risk of transmission. The rationale is that it is better to only have a few who were recently infected held in common with others for a little while, than to have all the HIV positive prisoners intermixed with all the other prisoners for the duration of incarceration.

This does not take into account that research has determined that the viral load of an HIV positive person peaks in the first few weeks after transmission, when the virus is still undetectable because the body has not yet produced the antibodies which are detected by an HIV test.[147] Once the body begins to fight the virus by producing sufficient antibodies, the viral load declines dramatically and then only slowly creeps upwards over the next several years. It is at this point that a person tests positive for HIV because the test is able to detect the presence of HIV antibodies in the person's blood, urine, or saliva.

The probability of HIV transmission is related to a number of factors, including viral load. If a person has a high viral load, the probability of that person

transmitting HIV is also high.[148] Thus, during the window period when viral load is very high, a recently infected HIV positive prisoner has a much greater probability of transmitting the virus. Add on to this the fact that many prisoners in the 'undetermined status' will have a false sense of security owing to the fact that all of them have tested negative upon entry to the prison and the known positives have already been segregated. The result is the potential that every single HIV negative prisoner could be confined for three months with HIV positive prisoners who have a higher probability of transmitting the virus than a good portion of those who have already tested positive for HIV. Clearly, this would negate the intended benefits of this policy and could possibly be counter-productive.

Education

Both sides of the debate on segregation agree that education is one of the most important ingredients of an effective HIV/AIDS in prison policy. However, HIV/AIDS education in the prison environment presents specific challenges which are unlike those for the general population. The personality profile of many prisoners often includes a deep-seated suspicion of anything 'official' or government related, which can negate the efforts of programmes which enjoyed significant success in the general community.[149]

In addition, mass education programmes have not proven effective at changing behaviour because they are not presented in the context of specific lifestyles. The prisoners perceive them as irrelevant and will not relate the information to their own lives.[150] Scare tactics have also proven ineffective, and may possibly be counterproductive to the extent that they elicit a denial response.[151] Also, prisoners in South Africa are normally members of the lower socio-economic strata, and have had very little formal education.[152] Education materials must cater to the wide diversity of languages spoken in prisons, and need also take into account the low literacy rate of the prison population.

The unfortunate truth is that an increase in HIV/AIDS related knowledge is not always translated into altering or reducing high risk behaviour.[153] HIV/AIDS information needs to be specifically targeted, and take into account the common characteristics or lifestyles that put prisoners at risk for HIV. The influence of peer groups has proven to be essential in any successful intervention strategy as the credibility of the communicator has a significant impact on the capacity of the message to engender behavioural change. This credibility should be determined within the context of the prison population, because

what might be valued by the average citizen outside of the prison is not the same as that appreciated by the average prisoner.[154]

The general consensus regarding peer education is that, "accepted norms of the target group play a larger part in influencing behaviour than does outside intervention by authorities or health educators."[155]

A study in Scotland attempted to determine the effectiveness of two different HIV/AIDS education programmes, one designed by prisoners and one designed by the state. The study found that a video followed by a group discussion was the most effective means of conveying information about HIV/AIDS to prisoners. Two videos were shown in the study. One, "AIDS: A Bad Way to Die", was put together by prisoners at Sing Sing prison in New York City and the other was produced by the British government. The prisoners in the survey responded significantly better to the New York video, which featured three actual prisoners who spoke about how they contracted HIV, how it affected their lives and their families, and also discussed their symptoms.

In addition to the prisoners' stories, the video showed medical experts who discussed transmission precautions and also emphasised that HIV cannot be transmitted by casual contact. The video concluded with each of the three prisoners' death from AIDS. In the discussion groups which followed, prisoners filled out questionnaires to asses the impact of the video. The study found that of the prisoners who watched the New York video, more than 90% responded that they would stop sharing or would try to sterilise injection equipment and the same percentage also claimed that they would use condoms.[156]

Condoms

A policy to distribute condoms in prison is often very controversial because government officials do not wish to discuss homosexual activity in prisons, and a good portion deny that any such activity takes place at all. If sex is thought a taboo subject even in a modern democracy, homosexual activity is even more often considered not a topic fit for parliamentary debate. In some countries, condoms are not available in prison because top prison officials either refuse to acknowledge that homosexual activity takes place or have set regulations which forbid such activity in their correctional facilities. The argument is then that condom distribution would compromise the authority and security of the prison because it implicitly condones an activity which is prohibited.

However, this is a relatively minor obstacle compared to the significant number of countries which outlaw homosexual activity in the general population. In Malawi's prisons, where HIV prevalence and the incidence of homosexual activity are both high, condoms are not available. Any attempts to introduce a condom distribution policy must first deal with the fact that homosexual activity is illegal in Malawi. Described as an "unnatural offence" in the Malawi Penal Code, conviction results in a prison sentence of 14 years.[157]

One reason that prison officials may not be willing to admit that sex takes place in prison is because then they would be forced to address the increased risk of HIV transmission created by the unprotected sexual activities of inmates. With the understanding that many prisoners are not willing to disclose their participation in homosexual activities, the policy recommended by UNAIDS is to provide "discreet and easy access to condoms."[158]

Because sex in prison is primarily anal sex between men, it is also important to make lubricant available. One reason that receptive anal intercourse carries the highest probability of HIV transmission is because of the attendant tearing in the rectum.[159] Not only can this tearing be reduced by using lubrication, but the likelihood that a condom will break during anal intercourse is also reduced by the presence of appropriate lubrication. In France, condoms and lubricant are available, and are placed "in open containers in reception, the health care centre, and other locations where potential users…have the opportunity to take them unobserved."[160]

Disinfectants and sterilised needles

Use of contaminated cutting or piercing instruments has been shown to be a high risk behaviour for transmitting HIV in prisons, particularly in the case of sharing needles for IV drug use. Distributing sterilisation tablets, or bleach, to prisoners is a policy that is gaining popularity in countries where IV drug use is a primary means of transmission.

At Hindlebank women's prison in Switzerland, a one year experimental project provided sterile needles to the 100 inmates, most of whom were convicted of drug offences. The sterile needles were available from dispensing machines in accessible locations, such as toilets, showers and storage areas. Prisoners were not permitted to keep more than one needle and were required to store their injecting equipment in a designated cabinet. An evaluation of the project found that there were no new cases of HIV, prisoner

health had improved, needle-sharing decreased, drug use remained stable, and there were no instances of needles being used as weapons. At the end of the year, the project was considered a success and was continued.[161]

Rather than provide sterile needles, a more popular approach to the problem of shared IV drug use equipment is to provide sterilisation materials for the inmates. This policy meets with similar arguments as the condom distribution policy, citing the principle that providing bleach or other disinfectants implies approval of illegal or prohibited activities. Nonetheless, an increasing number of prison systems are introducing bleach distribution programmes. In Spain, a bottle of bleach is provided to each prisoner upon entry into prison and each month thereafter, in addition to being available as needed. Other countries which distribute bleach to a similar extent include Australia, Belgium, Canada, France, Germany, the Netherlands, and Luxembourg.[162]

The arguments against providing disinfectant materials for prisoners are that it is not necessary or that the disinfectant will be used as a weapon or in some other manner that would constitute a threat to security. After a bleach distribution pilot project in Canada, an evaluation questionnaire found that 99% of respondents felt that having bleach available to inmates is "very important" and all but one injecting drug user responded that they would use bleach to sterilise injecting equipment.[163] According to Ralf Jürgens of the Canadian HIV/AIDS Legal Network, "There are no reported incidents of any negative consequences of making bleach available. This is consistent with the Canadian experience."[164]

HIV treatment

The recommended treatment for HIV is anti-retroviral (ARV) therapy. This is a combination of several drugs, which usually must be taken at different times with various specific directions as to accompaniment with meals or fluids and other such requirements. ARV treatment is complicated and expensive, and the prison environment poses serious challenges to its effectiveness. The administration of the complicated treatment regime is usually the realm of specialists, and not something a typical prison health facility is able to provide. In addition, the lack of privacy intrinsic to any prison situation means that a prisoner undergoing ARV treatment will have difficultly concealing his or her HIV status from prison officials or other prisoners.

ARV treatment is not available from state hospitals in South Africa. Although the drama is currently unfolding as the South African government is pressured

to roll out a national treatment plan including the use of lower cost generic drugs, it is still not likely that these will be made universally available to the extent that access would be extended to prisoners in the near future.

Some of the arguments in favor of a national treatment plan include the premise that providing treatment will help to reduce transmission, and that targeted education accompanied by political leadership and a multi-level multi-sectoral commitment will reduce if not eliminate concerns about regimen adherence. The prisons are an excellent opportunity to apply these recommendations with maximum effect. If ARV is extended to the general community, but not to prisoners, then the effectivness of any universal treatment plan will be gravely endangered.

In the absence of ARV therapy, the recommended treatment for HIV positive individuals is "symptomatic management" of the disease.[165] This usually requires treating and preventing the more common opportunistic infections associated with HIV, namely pneumonia and TB. Both of these illnesses can be cheaply treated and even prevented. Prison hospitals normally administer INH and Bactrim for HIV positive patients, but their supplies are sometimes changed and interrupted as a result of unreliable distribution services.[166]

Consistent and continued doses as part of the prescription programme for TB is extremely important because non-adherence to the treatment regime can result in treatment resistance. Those who develop a treatment resistant strain of TB can infect others, who will then also not be cured by the usual drug treatments. Multi-drug resistant tuberculosis (MDRTB) is much more difficult to cure, the required medicines are more expensive and have deleterious side effects. MDRTB can result in death if treatment is not available.[167] For these reasons, it is critical that prison administrations implement appropriate policies to ensure that TB medicine is both consistently and readily available and that sufficient health staff are on hand to ensure treatment adherence.

Early release

WHO guidelines advocate early release of prisoners in the advanced stages of AIDS. The motivation behind a policy of early release is to allow a person to die in dignity, either in their own home or with their family, rather than forcing them to die isolated and alone in prison.

Italian law prevents anyone with overt AIDS from being held in prison custody. The definition of 'overt AIDS' is clinically established as a patient whose

number of T/CD4+ lymphocytes are equal to or lower than 100/mmc. To determine this, the prisoner is administered two consecutive tests, 15 days apart.[168] Other alternatives suggest that prisoners with AIDS be released from prison but held under house arrest, admitted to a public health institution, or that the sentence be remitted indefinitely.

There are some unintended consequences of establishing an early release programme for prison inmates with AIDS. In Poland, a policy was adopted very early on which allowed AIDS prisoners to be released and transferred to an open hospital. The unfortunate result was that prisoners began to buy infected blood from HIV positive prisoners in the hope of getting released.[169] A particularly disturbing report describes a prisoner who traded a pack of cigarettes and some tea for an inch of HIV positive blood. When he couldn't find a vein with the borrowed syringe, he was worried he wouldn't become infected and so he asked for another inch of infected blood in order to be sure. His actions were encouraged by an HIV positive inmate who assured him that HIV positive status was a guaranteed way to be released from prison.[170]

CHAPTER 3
HIV/AIDS POLICY IN SOUTH AFRICAN PRISONS

The first policy to address HIV/AIDS in the South African prison system was formulated in 1992 and has been described as based on "fear, lack of knowledge, and prejudice".[171] The DCS approach was to segregate HIV positive prisoners, a policy which was not officially implemented until 1995. The procedure consisted of interviewing new prisoners to determine if they were involved in high risk behaviour, testing those who were considered at high risk for being HIV positive, and then segregating HIV positive prisoners in a separate facility from the general prison population.

Prisoners considered high risk were those who were illegal immigrants, those convicted of sexual crimes, intravenous drug users, or those "who have had sexual contact whilst abroad, specifically in those countries where HIV-infection is present in 10% or more of the population."[172] The Department's definition of high risk populations is indicative of a lack of appropriate information.

There is no evidence to suggest that illegal immigrants or sexual offenders in South Africa are more likely to be HIV positive. Inclusion of IV drug users as high risk is theoretically valid although realistically not useful given the low incidence of IV drug use in South Africa. Finally, the specific reference to countries with greater than 10% HIV prevalence would not be useful in South Africa today, as the current prevalence rate is more than 14%.[173]

If a prisoner was determined to be high risk, he or she was segregated from the general prison population as well as from the HIV/AIDS section until an HIV antibody test was administered.[174] The policy, as it was written, also required that all high risk prisoners be referred to a medical officer, where they were given pre-test counselling, asked for their informed consent to the test, and then given post-test counselling.[175]

According to the policy paper, test results were to be kept confidential, but were required to be reported to the head of the prison.[176] Interestingly, most policies which violate the fundamental principles of confidentiality regarding

an individual's HIV status usually mention the importance of preserving confidentiality and how this confidentiality will be maintained. The telling language is that which follows the word 'confidential'. The words 'but', 'except', and 'need-to-know' are among the most popular linguistic tools for violating the right to confidentiality. There is no such thing as partial confidentiality in terms of HIV status: the only person who has the right to know is the person who has been tested.

By the mid-nineties's, the DCS policy came under scrutiny in light of the WHO Guidelines on HIV Infection and AIDS in Prison which condemned segregation policies. The primary changes to be considered included the desegregation of HIV positive and high risk inmates and the distribution of condoms to prisoners on the same basis as they are available in the general community.

The issue of condom distribution provides an excellent context for examining the denialist tendencies of the South African government with regard to HIV/AIDS policies. The former Minister of Correctional Services, Sipho Mzimela "led the chorus of denials" when he said that condoms would not be distributed in the prisons until he was presented with irrefutable evidence that sexual activity took place.[177] In 1994, the DCS produced a White Paper which declared that "sex, in whatever form, cannot be condoned and authorised for prisoners in South Africa."[178] The paper went on to specifically dismiss any suggestions for condom distribution within the prison, citing that sexual activity in prisons is neither permitted nor tolerated.[179]

Current policy

During the second half of 1996, a policy amendment paper was distributed to prison officials which ended the practice of segregating HIV positive prisoners. Instead of recommending prisoners for HIV testing upon admission, prisoners were only to be tested when they requested a test or were tested upon recommendation by the district surgeon. In either case, the prisoner's written consent was required before the test could be administered.

In order to try to prevent HIV transmission in the prison, the revised policy advocated extensive AIDS education and counselling for the inmates and staff, and encouraged all prison staff to practice "universal precautions."[180] The concept of universal precautions is that all potentially contaminated fluids are to be treated as if they are HIV positive, and the appropriate safety measures to prevent infection should be followed in every instance.

In addition to reversing the earlier policy of segregation, the amendment also introduced a number of specific programmes to be implemented at the provincial as well as the prison level. The first of these was the provision of STI clinics at all prison hospitals. These clinics would be run by the nursing staff, and would provide testing, treatment, counselling, and information regarding STI's for prisoners.[181] Nurses were also instructed to monitor the condition of patients with HIV/AIDS, arrange diet supplements and consultations with psychologists, social workers, medical specialists and other professionals.[182]

As well as the policy amendment paper, a separate policy document was circulated to the provincial commissioners relating to the distribution of condoms to prisoners. The new policy allowed for condoms to be "provided to the prison population on the same basis as condoms provided in the community."[183] Part of the implementation required that a prisoner would not receive condoms, "before having undergone education/counselling regarding AIDS, the use of condoms and the dangers of 'high risk behaviour.'"[184] Condoms could be supplied to prisoners only on request and only by a nurse trained as an AIDS counsellor.[185] The condoms would be supplied and paid for by the Department of Health (DOH), and therefore the DCS was not to purchase condoms with its own departmental funds.[186]

In order to help with implementation of these new policies, DCS directed that each province appoint a member of the nursing staff to act as Provincial HIV/AIDS Co-ordinator. The duties of the co-ordinator include training inmates and staff on "universal precautions" practices, monitoring STI clinics, arranging information sessions for both staff and inmates on the policy change, and organising the distribution of condoms.[187] The provincial co-ordinator is also expected to liase with AIDS counsellors at each of the prisons in the province, and identify and train AIDS counsellors for those prisons which do not have one.[188]

The policies outlined in the two documents circulated in 1996 remain the official position of the DCS regarding HIV/AIDS in prison. The issue is consistently mentioned in the DCS Annual Reports, parliamentary discussions, and press releases although never in great detail and usually with vague promises but no specific actions described.

In the 1995 Annual Report, the section on "AIDS and HIV cases" consisted of one paragraph and was not accompanied by any statistics. Official statistics regarding HIV and AIDS have been included in the Annual Report since 1996, although the report still only contains a few paragraphs on the issue. The 1999

Annual Report discusses several projects and strategies, and even mentions a video-conference between South Africa and the US on the issue, but makes no reference to either the design or implementation of new policies.

Implementation

The South African government's response to HIV/AIDS in prison cannot be appropriately evaluated by examining policy documents, acts of parliaments, and court cases. Policy as it is written and policy as it is implemented are not always the same. At Westville Medium B (WMB), the Department of Correctional Services policies were not fully communicated to the staff and were not uniformly implemented. Furthermore, programmes developed at WMB but not outlined by the national policy were better able to achieve the intended goals of DCS policies for addressing HIV/AIDS in prison.

Testing

According to the 1996 policy document, "testing for the HI-virus must only be done on medical grounds on recommendation of the District Surgeon or by request of the prisoner and with his/her written consent."[189] However, prisoners at WMB are not able to receive a test upon request because of cost constraints.[190] This appears to be an example of implementation deficit due to insufficient resources.

The Health Economics and HIV/AIDS Research Division (HEARD) at the University of Natal conducted anonymous unlinked HIV testing at WMB in January 2001, and more than half of the prisoners who voluntarily participated asked to be informed of their HIV status. When a proposal was submitted to the Department of Correctional Services Provincial Commissioner to offer testing and counselling for these prisoners *at no cost to the Department*, the request was denied on the grounds of security issues.

Arguably, informing a prisoner of his HIV status while appropriate medical treatment (ARV, better nutrition) is not available could cause considerable unrest, particularly in light of the high number of prisoners expected to be infected. However, denying prisoner requests to learn their HIV status not only contravenes DCS policy but also violates the equivalence principle as prescribed by WHO guidelines.

Although prisoners are not able to be tested for HIV upon request, HIV testing is conducted at the recommendation of the prison doctor at WMB. A doctor visits WMB for two hours in the morning and two hours in the afternoon, Monday through Friday. During each two hour session, the doctor will see an average of 60 prisoners. Of these, the doctor will recommend an HIV test for an average of five prisoners. Every prisoner who has or displays symptoms of TB is recommended for an HIV test. Prisoners who have significant weight loss, persistent skin infections, chronic diarrhoea, oral thrush, or an STI are also recommended for an HIV test.[191]

Once a prison doctor recommends an HIV test for a prisoner, he is first referred to a member of the nursing staff to receive pre-test counselling. The counselling session covers a variety of HIV-related issues including the explanation of the prisoner's rights to privacy and dignity and that the prisoner can refuse to take the test. If the prisoner agrees to have the HIV test, he will sign an informed consent form. Out of every ten prisoners who are recommended to be tested for HIV at WMB, one or two will refuse. For those who give their informed consent, the test is conducted on a blood sample and sent to a private lab and the results are usually available in two weeks.[192]

The nurse responsible for HIV counselling will submit a list of all the prisoners whose results have arrived, whether they are positive or negative. The wardens will then bring those prisoners to see the nurse for their post-test counselling session. One reason given for arranging a post-test counselling session with all tested prisoners regardless of whether the test was positive or not is to protect confidentiality.

As one nurse explained, most prisoners know that she is the one who gives prisoners their HIV results and so if she only meets with those who test positive for HIV, then anyone who is called out from his cell to be sent to see her will be labelled as HIV positive. Only the nurse knows the results of a prisoner's HIV test and she does not inform anyone except the prisoner himself, although a prisoner's HIV status will be recorded in his medical file. This reflects a very in-depth understanding of the crucial issues of privacy and confidentiality which actually exceeds that provided by DCS policy.

The 1996 policy document provides that, "The diagnosis of HIV/AIDS must be kept absolutely confidential and must only be communicated to disciplinary staff on a 'need-to-know' basis."[193] Examples given of those who "need to know" include a prison guard who is injured by an HIV positive prisoner and psychological or welfare counsellors.[194] Amongst organisations devoted

to defending the rights of people living with HIV/AIDS, the phrase 'need to know' is considered antithetical to the principles of confidentiality; the only person who actually needs to know is the HIV positive individual himself.

Although the HIV nurse insists on seeing all HIV tested prisoners for post-test counselling irrespective of a positive or negative result, the reality is that 80 to 90% of those tested are actually HIV positive.[195] Aware of the psychological distress of learning that he has tested positive for HIV, the nurse has implemented her own policy of always informing prisoners of their results first thing in the morning so that she can monitor them throughout the day.

She emphasises the importance of a prisoner's mental health and believes it is an important part of her duties to check on her patients' psychological condition before leaving for the day. The nurse elaborated, saying that she will never give a prisoner his HIV test results just before lock-up in the afternoon because of the emotional stress involved and the need for support as an important part of caring for a prisoner's health and well-being.[196]

Condoms

The DCS policy to distribute condoms was the result of a hard fought battle, waged by several pressure groups including Lawyers for Human Rights and the South African Prisoners Organisation for Human Rights. Unfortunately, the policy does not achieve its objectives because of both poor design and implementation. The policy document states that condoms are to be provided to the prisoners, "on the same basis as condoms are provided in the community."[197] This seems an appropriate policy, were it not for the very next paragraph which effectively prevents condom availability in the prison from bearing any resemblance at all to the manner in which condoms are available in the community:

> A prisoner may not receive condoms before having undergone education/counselling regarding AIDS, the use of condoms and the dangers of "high risk behaviour." The fact that a prisoner received counselling must be recorded on his/her medical file.[198]

In effect, a prisoner who wishes to obtain a condom must endure a face to face interaction with a member of the health staff to make his request and then receive a lecture regarding his sexual behaviour. In the general community, condoms are available discreetly and free of charge at universities and

clinics and are even provided by some employers. Clearly, the DCS policy on condom distribution is poorly designed to the point that even with perfect implementation it is not likely to be effective.

Interviews with prisoners and health staff at WMB confirmed the ineffectiveness of the condom distribution policy as it was determined that prisoners very rarely request condoms. Of the 274 prisoners interviewed, only one reported requesting a condom while in prison. This may or may not be a result of the flawed design of the condom distribution policy, as some would argue that sex in prison is at a minimum coerced under threat, when it is not forcible rape, and the perpetrators would not agree to using a condom anyway. Furthermore, more than three-quarters of the prisoners interviewed reported that they never used a condom prior to their incarceration.[199] One can scarcely be surprised that the same behaviour regarding condom usage outside of prison would persist inside the prison.

However, even assuming that the condom distribution policy was appropriately designed and that prisoners were genuinely interested in practising safer sex and avoiding high risk behaviour, the DCS condom distribution policy would still fail because the actual condoms issued are not strong enough for anal intercourse. According to health staff at WMB, the condoms provided break during anal intercourse thus negating any effort to reduce HIV transmission.[200] The condoms are issued by the Department of Health (DOH) and are the same as those provided in the general community. However, this is one instance where the standard which applies for the general community is not appropriate in the prison environment.

Liability and legal issues

Many countries have seen legal battles arising from HIV transmission in prison. Prisoners in two Australian states have taken legal action against their prison systems for failing to provide measures to prevent the spread of HIV.[201] In the United States, non HIV-infected inmates have filed cases against the prison system for failing to test and segregate HIV positive inmates, correctional staff have filed against facilities for failure to warn, and families of HIV positive inmates have filed against the prison system for failure to inform.[202] If a prisoner is infected with HIV as a result of negligence on the part of the corrections system, then it is not farfetched to imagine that the Department can be held liable for failure to provide safe custody. However, keeping in mind that HIV transmission is not a criminal

offence in South Africa, DCS would not be charged with attempted murder as some might assume. Rather, a court case is more likely to be associated with the failure of the state to provide a prison environment which is consistent with conditions of humane detention.

One such case, PW vs Minister of Correctional Services, is currently pending regarding a prisoner who contracted HIV while incarcerated. PW was a prisoner at Pollsmoor from November 1993 through December 1994, and repeatedly tested negative for HIV. PW had been engaging in homosexual intercourse with another prisoner, and he asserts that the prison officials knew this, yet consistently denied him access to condoms. On or about 27 November 1994, the prisoner tested positive for HIV. The plaintiff alleges that during his incarceration:

> 7.1 it was common for prisoners generally, and for the inmates of the prison in particular, to engage in sexual intercourse;
> 7.2 a material proportion of prisoners generally, and of the inmates of the prison in particular, were HIV positive;
> 7.3 it was consequently inevitable that some of the prisoners who engaged in sexual intercourse with those who were HIV positive, would also become HIV infected.[203]

The response from DCS was to admit to the above assertions, with the exception that the prisoners referred to in 7.2 above were not necessarily the same as those referred to in 7.1. The plaintiff charges that the prison officials knew of both the existence and risk of homosexual activity in the prison and failed to take steps to prevent the activity or minimise the risk of infection. According to the plaintiff, the responsible authorities:

> 11.1 ignored and tolerated the practice; and
> 11.2 prohibited all prisoners from having access to condoms.
> 12 The above prohibition policy was not necessary for the achievement of any of the purposes for which the responsible authorities were vested with their powers of control and management of the prison. It was revoked in 1996 without any ill-effect.[204]

The Department's response to point 12 above was:

> Save to admit that the aforesaid departmental policy was changed in 1996 that thereafter prisoners were provided with condoms by

> Defendant, the remainder of the contents of this paragraph are denied and Plaintiff is put to the proof thereof.[205]
>
> The plaintiff asserts that the conduct of the prison authorities violated his rights under the Correctional Services Act 8 of 1959, his common-law rights, and his rights under the Constitution, in particular:
>
> 23.1 His right in terms of Section 25(1)(b) to be detained under conditions consistent with human dignity, and to be provided with adequate medical treatment at State expense.
> 23.2 His right in terms of Section 11(1) to freedom and security of the person.
> 23.3 His right in terms of Section 11(2) not to be subjected to torture of any kind, whether physical, mental, or emotional, and not to be subjected to cruel, inhuman, or degrading treatment or punishment.
> 23.4 His right to life in terms of Section 9.
> 23.5 His right in terms of Section 10 to respect for and protection of his dignity.[206]
>
> The plaintiff is claiming damages of R1,118,000 for future medical expenses, loss of earnings, and pain, suffering and risk of shortened life expectancy. The trial date is currently set for 10 Feburary 2003.

Resources

The DCS policies for addressing HIV/AIDS includes an encouraging emphasis on HIV/AIDS education and other programmes with the establishment of a Provincial HIV/AIDS Co-ordinator (PHC). The PHC is identified as a member of the nursing staff in each province whose duties include:

- to advise Commanders and Heads of Prisons on the implementation of [HIV/AIDS] policy;
- to co-ordinate the practice of "Universal Precautions" in all prisons in the province;
- to monitor the efficiency of STI clinics in all the prisons in the province;
- to arrange information sessions in consultation with all the commanders at all prisons in order to inform the staff and the prison population of the policy amendment;
- all other duties as indicated in the directive on the provision of condoms.[207]

The province of KwaZulu-Natal contains 28,375 prisoners in 38 prisons from Ladysmith to Port Shepstone, Durban to Vryheid.[208] The PHC for KwaZulu-Natal is responsible for programmes and education to reach each of these prisons, including both prisoners and staff, *in addition* to her regular duties as a full-time member of the nursing staff. She is not paid any additional salary for her role as PHC, nor is she provided transport or reimbursed for the use of her personal vehicle.[209]

From her experience, inmates have revealed a startling lack of knowledge about HIV and a keen, almost desperate, desire to learn more about HIV/AIDS. However, many do not even know that a provincial co-ordinator exists or that HIV/AIDS educational programmes are supposed to be available in the prison. While the DCS policy succeeded in identifying the need for a PHC position to address HIV/AIDS issues in the prisons, the policy is not able to achieve maximum effect because of the lack of any, let alone sufficient, resources to support the efforts of the PHC.

In spite of the lack of resources and absence any official instruction or support, the health and social workers at WMB have succeeded in implementing successful programmes for addressing HIV/AIDS. The positive results of these bottom-up approaches to HIV/AIDS attest to the benefits of incorporating local implementation structures in the policy development process. To illustrate, social workers and psychologists have organised a support group for HIV positive prisoners, although it is sometimes not possible for prisoners to attend due to staff shortages: there are not any guards available to escort them to the room where the support group meets.[210]

One social worker described an exercise from the HIV support group where prisoners are asked to identify positives as well as negatives in their personal situation and encouraged to emphasise the positive as a coping strategy for their situation. The group has also learned beadwork skills and meets to make beaded AIDS awareness pins. This project does not receive any funding from the Department however and the prisoners must use their own money, usually provided by relatives, to buy the beads and other materials necessary to make the pins. When the prisoners finish making a batch of pins they are given to the relatives to try and sell outside the prison. This programme is entirely run by social workers who do not receive extra compensation or even their own budget for AIDS-related programmes.[211]

While the support group helps address the needs of HIV positive prisoners, peer education programmes have been organised to respond to the needs of

the general prison population. With the assistance of prisoners, guards, and other staff at WMB, certain peer leaders have been identified and engaged in an education programme aimed at disseminating HIV/AIDS information in a manner which will be best received by other prisoners. As with other social settings, prisoners are more likely to absorb information that is obtained from people with similar backgrounds and experiences, thus peer education programmes have become a common recommendation for effective HIV/AIDS intervention. The peer education programme at WMB consists of around 20 prisoners but faces many of the same limitations as the HIV support group due to the lack of resources.[212]

The ability of social workers and psychologists at WMB to provide HIV education is considerably constrained by the lack of basic infrastructure requirements such as computers and internet access. Few staff members at WMB have email, some do not even have computers, and many do not have printers or even reliable phone services. Frequently, the phone lines at WMB simply stop working and no calls are able to go in or out, sometimes for the entire Westville prison complex.

Early release

No mention was made in either of the May 1996 policy documents of a programme of early release for prisoners dying of AIDS. WHO Guidelines on HIV Infection and AIDS in Prison eventually led South African policy makers to discontinue segregation practices, but did not seem to have an official impact regarding early release. In the WHO Guidelines, Section L.51 states:

> If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom.[213]

Prior to the AIDS epidemic, prisons normally maintained a programme of early release for the relatively rare occurrence of prisoners who were terminally ill. Today, this policy desperately needs to be updated to accommodate the increasing number of prisoners who are dying of AIDS while incarcerated.

The official policy regarding early release at Westville Medium B consists of numerous bureaucratic levels, with the result that most prisoners die before

their release is approved. If the health staff believe that a prisoner should be released, the prisoner must be seen by the district surgeon as well as a specialist from the outside. This specialist only visits WMB once a week, and must see the patient twice: once to order additional tests and x-rays, and a second time to review the results. The specialist recommendation is then sent on to the parole board, and a social worker is notified who must determine if the prisoner will have adequate housing and care upon release.[214]

This is no mean feat as many prisoners come from township areas where their families live in makeshift substandard housing and access to postal services or phone lines is considerably limited. Sometimes the family does not wish to care for the prisoner, either as a result of misguided fears associated with HIV or because they cannot afford the cost of burial services.[215]

Assuming the social worker is able to surmount these difficulties, there is still the matter of the parole board which must visit the prisoner to make sure that the prisoner listed on the records submitted is the same prisoner that is sick and dying in the prison hospital. This entire process usually takes several weeks and can even stretch out for more than two months. According to one interviewee in the prison hospital, an application for early release was sent in for a prisoner in February 2000. The prisoner died in March of that year, and on April 16th, the approval for early release was granted.[216] For one social worker, who processes an average of five prisoners for early release each week, only one of her cases has lived long enough to go home to die.[217]

CHAPTER 4
RECOMMENDATIONS

Any attempt to address HIV/AIDS in prison in South Africa will be affected, if not entirely thwarted, by the problems with prisons in general which are in desperate need of reform. For this reason, the following recommendations cover issues of prison reform in general, as well as those which specifically pertain to the issue of HIV/AIDS.

Overcrowding

The primary challenge facing the Department of Correctional Services is overcrowding. Reducing overcrowding will accomplish a great deal in the interest of general prison health as well as a number of other conditions which impact on the nature and extent of HIV infection in the prisons. The rights of prisoners to conditions of humane detention are guaranteed in the South African Constitution's Bill of Rights, article 35(2)(e):

> 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.

Any prisoner, former prisoner, prison employee or anyone that has ever visited a prison in South Africa will agree that not a single one of these constitutional rights is respected in South African prisons. Overcrowding is the primary culprit. The solution to overcrowding is not to build more prisons, however, but to reduce the prison population.

The prison population consists of a significant number of people who simply should not be there at all. These include not just prisoners who are awaiting trial, but also prisoners who have been convicted of petty theft or non-violent crimes of a strictly economic nature. These are crimes born of poverty and unemployment; factors which are not alleviated by a prison sentence.

Legislators and policy makers involved in sentencing laws and decisions should be made aware of exactly what prison can and cannot achieve and the appropriate instances for which incarceration is warranted. If an arrested person is not considered a threat to society and likely to appear on his or her court date, then the person should be released on bail. If the person cannot afford bail, then the amount should be suspended or reduced. Additional measures to reduce the prisoner population include pre-trial diversion, admission of guilt and payment of fine without a court appearance, release on warning, correctional supervision, electronic monitoring, and use of non-custodial sentences.[218]

While the overcrowding issue is largely beyond DCS' control, there are some aspects which the Department is able to address. Most notably, the inadequate accommodation provided by outdated prison facilities. First and foremost, the use of communal cells should be discontinued. Warehousing prisoners in large cells with minimal space and privacy is inconsistent with human dignity even in the absence of overcrowding.

Many prisons in South Africa were designed with communal cells and to abandon this practice would require significant structural changes to the prison buildings themselves. A better solution is to knock them down entirely and build a new prison which will be designed for both better security and better conditions, including cells which contain a maximum of four prisoners.

One means of financing such a large-scale initiative is to identify prisons which were originally built on the outskirts of urban centres but now find themselves taking up prime suburban real estate. These prisons should be knocked down and the land sold, and newer better prisons should be built and located elsewhere. The location of Pollsmoor Prison, for example, is amongst golf courses, housing developments and a brand new business complex. The profits from the sale of this enormously valuable stretch of land alone could probably fund new prisons for the entire Western Cape.[219]

Prison health care

One of the first reforms to improve prison health care attempted in other countries is to discontinue the separation of prison health services from the general public health agency. As discussed previously, all but a small fraction of prisoners return to the community. Therefore, issues of prison health are issues of public health. Providing suggestions for UNAIDS, Professor Tim

Harding was emphatic about this first step in appropriately addressing HIV/AIDS in prison:

> If there is one thing, more than anything else, which should be done, it is that health in prisons must come under the responsibility of the public health authorities. The link between health in the community and health in prisons must be made as strong as possible.[220]

Prison health care facilities were never designed nor intended to care for such a large proportion of chronically or critically ill patients. The prison hospital should be run and funded as a public hospital, the budget for prison health should come from the DOH, and the staff and management should be the realm of public health, not correctional, services. Expanding the responsibilities of the DOH to include the prisons would reduce funds wasted on the duplication of efforts and amend the disparities in the quality of health care provided in prison.

Sexually transmitted infections (STIs)

Over the last few years, the DOH has made the detection and treatment of STIs a top national priority mainly because these infections increase the chances of an individual transmitting and acquiring HIV. For the same reasons it is recommended that the DOH in conjunction with DCS develop a comprehensive programme to reduce the incidence and prevalence of STIs in prisons. In line with WHO recommendations, the DOH has adopted the strategy of 'syndromic' treatment of STIs and has issued national guidelines to assist clinicians in managing a patient who presents with an STI. It is strongly recommended that the same guidelines be adopted by the DCS and the DOH doctors who work in the prisons.

Because of the limited access that prisoners have to the broader community, the possibility exists that curable STIs may be completely eradicated within prisons. This may be done by screening for STIs on admission to prison using a combination of history taking, examination and laboratory testing. Because of the high cost of laboratory testing and the fact that many STIs do not produce symptoms in everyone, consideration should be given to presumptive treatment on admission. In other words, all prisoners are given antibiotics aimed at eradicating STIs upon arrival at the prison.

Many of the symptoms of STIs can be embarrassing to discuss, and lack of knowledge about the treatment available can prevent people from seeking appropriate

care. Through presumptive treatment upon admission, combined with information about the symptoms and treatments for STIs, a prisoner may become more likely to seek treatment for an STI both during his incarceration and upon his release. The incidence of STIs could thus not only be eradicated in the prison environment, but could also be reduced in the greater community.

Tuberculosis (TB)

Prison conditions are conducive to the spread of TB. The current ad hoc approach to health care in prisons in general will not control the spread of this epidemic and places both prisoners and staff at risk. The lack of a comprehensive response also carries with it the added danger of multiple drug resistant TB (MDRTB).

The World Health Organisation (WHO) has published guidelines for the effective treatment of TB, referred to as Directly Observed Therapy (DOT). The term 'Directly Observed Therapy' stems from the requirement that the patient is directly observed taking the medication. Direct observation is emphasised because, much like ARV treatment, poor adherence can result in decreased cure rates and drug resistant strains of the disease. DOT is a six to eight month programme, during which time the patient must take a combination of five different drugs. The cure rate for DOT averages around 90%, and can cost as little as US$11 for the duration of treatment. While DOT has become widely practised in developing countries, treatment for multiple drug resistant tuberculosis (MDRTB) is usually not available because it is much more expensive.[221]

Nutrition

The nutrition in prisons is abysmal to the point that the food provided can scarcely be considered adequate sustenance for a normal healthy adult. The solution to this problem is not for the Department to spend more money and buy more and better food, as internal corruption will prevent additional food from actually reaching the bulk of the prisoner population. Prisoners often work in the prison kitchens although they are usually not paid for their work. Instead, they take their compensation in the form of smuggling. What was originally intended to be distributed equitably and free of charge is then sold to the highest bidder. As is the case outside the prison, those who control the market have the greatest power to benefit—as the prison meals get worse, the profit incentive to smuggle food increases.

Food service is an entirely separate industry and a well-developed one in South Africa. As food service is not a core function of the prison system, it is advisable that DCS outsource this component to a national food service provider. This could not only generate savings to the government but, if implemented conscientiously, would result in improved nutrition and decreased smuggling and other instances of corruption associated with the currently prison-run kitchens. A contract to provide food services to the entire prison system would be an attractive opportunity for any catering company. The sheer scale of operations combined with assured future cash flows should be used as leverage in negotiating a financially advantageous outsourcing contract for the Department.

Furthermore, the private catering firm should be permitted to hire prisoners, provided they are trained and paid a normal wage. This will create an incentive on the part of kitchen staff to keep their jobs, which carries along with it an incentive not to steal. In the current situation, prisoners have little to lose if their smuggling is discovered, and the ubiquitous nature of such activities make them seem more or less acceptable. In a situation of employment, the environment will change considerably and it can only be hoped that this change would be for the better as it could scarcely get any worse.

Testing

Prisoners should receive HIV testing upon request. A prisoner has the right to receive the same standard of care as the general community. HIV testing is available free of charge in the general community and as such it should be provided without exception inside prison. The prisoners at Westville Medium B have demonstrated their interest in knowing their HIV status, an encouraging start for any intervention programme. The pre- and post-test counselling procedure should continue, as well as the commendable emphasis on confidentiality and prisoner's mental health.

Condoms, lubricant and bleach

Condoms and lubricants must be made available in latrines, showers, the cafeteria and any other common area to which the prisoners have access. Prisoners should no longer be required to personally request condoms, although the required HIV and STI counselling should remain available. This counselling should not, however, be a prerequisite for obtaining condoms.

Condoms should rather be available in a manner that they can be obtained discreetly and without requiring face-to-face interaction.

Water-based lubricant should be provided in a similar manner as condoms in order to prevent condom breakage and reduce rectal tearing. The use of water-based lubricants can help prevent condom breakage during anal intercourse, thus making the condoms currently available more useful in the prison context. Also, because lubrication reduces tearing of the rectum as a result of anal intercourse, the risk of transmission is further reduced.

In order to foster increased condom usage for the purposes of reducing HIV transmission, both within the prison and also upon release, the appropriate gang leaders should be engaged. Knowing that the 28s, and to a lesser extent the 26s, regularly participate in high risk sex as part of their gang's entrenched tradition and activities, the leaders of these gangs should be incorporated into any strategy to increase condom use in the prison. One approach could be identifying gang leaders for peer intervention programmes, and harnessing their demonstrated leadership skills to effect positive change.

To the same extent that condoms and lubricants are made available, bleach tablets should be distributed so that prisoners can sterilise implements used for tattooing. Although IV drug use has not yet presented a problem in South African prisons, laying the groundwork now to introduce bleach and to educate prisoners about the need to sterilise cutting or piercing instruments will prove a useful preventative measure against HIV transmission should IV drug use increase. The involvement of gang leaders to promote this initiative should also be explored, as prison tattooing is directly related to gang membership.

Education

Education is one of the most important ingredients of an effective HIV intervention programme. However, HIV/AIDS education in the prison environment presents specific challenges which are unlike those in the general population. The personality profile of many prisoners often includes a deep-seated suspicion of anything 'official' or government related, which can negate the efforts of programmes which have enjoyed significant success in the general community.[222]

In addition, mass education programmes have not proven effective at changing behaviour because they are not presented in the context of specific

lifestyles. The prisoners perceive them as irrelevant and will not relate the information to their own lives.[223] Scare tactics have also proven ineffective, and may possibly be counterproductive to the extent that they elicit a denial response.[224] Not just the content, but also the medium of education materials must be tailored to the prison environment. Written materials must cater to the wide diversity of languages spoken in prisons, and need also to take into account the low literacy rate of the prison population.

The unfortunate truth is that an increase in HIV/AIDS-related knowledge is not always translated into altering or reducing high risk behaviour.[225] HIV/AIDS information needs to be specifically targeted, and must consider the common characteristics or lifestyles that put prisoners at risk for HIV. The influence of peers is essential in any successful intervention strategy as the credibility of the communicator has a significant impact on the capacity of the message to engender behavioural change. This credibility should be determined within the context of the prison population, because what might be valued by the average citizen outside of the prison is not the same as that appreciated by the average prisoner.[226]

The general consensus regarding peer education is that, "accepted norms of the target group play a larger part in influencing behaviour than does outside intervention by authorities or health educators."[227]

Suggested means of education and intervention programmes for prisoners include drama and video presentations followed by small group discussions. The most effective intervention programmes are those which utilise a small group format and encourage prisoner participation.

In spite of the resource limitations which constrict the efforts of staff at Westville Medium B, several such programmes have been implemented including an HIV support group and a peer education programme. These efforts should be encouraged and continued, with the assistance of appropriate staff and resources. The potential exists for tremendous return on investment if programmes which affect the awareness and behaviour of this high risk target group are adequately funded and expanded.

Early release

The decision for early release should involve the input of the nurses who care for the prisoner on a day to day basis, perhaps confirmed by a visiting spe-

cialist. The application should be sent to one correctional services official who is responsible for making sure that the prisoner in the application is the same one as the prisoner in the hospital. This same official should be the only signatory required to approve the early release of the prisoner.

The social worker assigned to contact the family and ensure that appropriate care is available upon release should be notified as soon as possible, perhaps when the patient is admitted for AIDS-related illness rather than waiting until the prisoner is near death. In this way, the social worker will have more time to contact the family, and can also provide assurances to the prisoner that may encourage him to hang on to life a little longer so that he may be rejoined with his family before dying.

Partnership

DCS has recognised the importance of intervention programmes for HIV/AIDS in prison by appointing a Provincial HIV/AIDS Co-ordinator (PHC) in each province. However, the effectiveness of this position is severely hindered by the lack of funds available. As the PHC is appointed from the existing nursing staff, he or she must perform all the duties of co-ordinating HIV/AIDS programmes in an entire province in addition to his or her regular duties as a member of the prison health staff.

In order for the PHC to be effective, he or she must be relieved of at least a portion if not all of his or her nursing duties. It will remain important that the PHC has first hand experience with providing health care in the prison environment, and thus it is recommended that the PHC still be appointed from a member of the nursing staff. However, appointment as PHC should be constituted as a new and separate position, rather than the assignment of additional responsibilities for an already over-worked individual.

The social workers, psychologists, and health staff who have set up the existing HIV/AIDS intervention programmes have an extremely valuable depth of knowledge. However, the staff in each province operate in near isolation without the benefit of sharing experiences and information with their counterparts in other prisons. There does not even appear to be a phone list distributed.

The achievements of each PHC should be shared with other DCS and DOH staff in order that the entire prison system can benefit. Inter-provincial and

even inter-prison co-ordination and communication will be critical if the DCS is to address HIV/AIDS in the country's prisons in a meaningful way.

The not-for-profit sector, in the form of NGO's and donor agencies, could provide capacity for complementing and supplementing current DCS efforts. International donor agencies are increasingly taking notice of the HIV/AIDS pandemic in the southern African region, and are willing to make funds available for effective intervention programmes.

The Center for Disease Control (CDC) in the United States has set up offices in several African countries, and has demonstrated a commitment to prison health initiatives. South African NGO's, in partnership with the Department of Correctional Services, could tap into these funding sources and provide education and other intervention programmes in the prison system. Voluntary HIV testing and counselling, peer education, workshops and training for both prisoners and staff could be implemented with the assistance of local organisations.

The Department must invite proposals and express a willingness to meet and work with outside organisations to assist in developing successful intervention strategies for addressing HIV/AIDS as well as other public health issues in South African prisons.

DCS culture

The first policy to address HIV/AIDS in the South African prison system was formulated in 1992 and, according to Achmat and Heywood, was based on "fear, lack of knowledge, and prejudice".[228] In early 1995, a pluralist approach to prison policy making was attempted for the first time. Then deputy president, Thabo Mbeki, called together the relevant interest groups and decision makers, and the Transformation Forum on Correctional Services was formed.

The Transformation Forum consisted of representatives from the Department of Correctional Services (DCS), the Parliamentary Portfolio Committee, the Police and Prisons Civil Rights Union (POPCRU), Public Servant's Association (PSA), Correctional Officers' Union of South Africa (COUSA), South African Prisoner's Organisation for Human Rights (SAPOHR), the Minister's National Advisory Council, Lawyers for Human Rights, National Institute for Crime Prevention and the Rehabilitation of Offenders (NICRO), the Centre for the Study of Violence and Reconciliation (CSVR), and the Penal Reform Lobby

Group (PRLG).The forum first identified and prioritised several areas for transformation, which included demilitarisation, health care, independent inspection, human resource management, and the establishment of a change management team.[229]

Despite high aspirations in the beginning, the forum soon fell apart with the failure of the Minister, or any of his representatives, to attend any of the meetings. Within a few months, Minister Mzimela officially withdrew the Department's participation in the forum until the then President Mandela instructed him to return. In spite of renewed promises of Ministry involvement, again the Minister remained absent and un-represented at the forum's meetings. The Minister's example was for the most part followed by the Department as well, which seemed to resent the "interference" of the forum.[230] Thus, although the Department appeared to achieve legitimacy, through an attempt at co-operative involvement with the community, it remained a closed, highly centralised authoritarian institution reminiscent of the apartheid era.

Developments such as those outlined above have created the impression of a hierarchical and dogmatic approach to policy making in the Department of Correctional Services. The apparent view of other stakeholders as impediments is reinforced by the Department's continued insistence on secrecy, and the difficulties encountered for anyone who attempts to gain access to prisons for the purposes of either journalistic investigation or academic research.

Further research

The Department should encourage further research in the prisons, and should attempt to streamline the process through which permission is obtained to conduct such research. Currently, various members of the Department at various levels seem to have conflicting information about the appropriate person responsible for co-ordinating research and the appropriate processes which must be adhered to for gaining access to conduct research at a prison.

Given the sensitive nature of prison research, and the propensity for media distortion, there is a need for a co-ordinating body to facilitate co-operative and constructive relations between researchers and DCS officials. Previous research findings and general statistical information, both internal and external, should be accessible to policy makers and researchers alike. In this way, specific information which legislators and DCS officials require in order to inform their policy decisions would be more readily available.

The information available on HIV/AIDS in South African prisons is very limited. Currently, the Department has prohibited the release of the only prevalence study ever conducted in a South African prison. Not only should this study be released to the public, but additional studies should be encouraged and proposals seriously and expeditiously considered. Research should be conducted at minimum and medium security prisons where inmates serve much shorter sentences, as the turnover at these facilities, and thus the access for intervention programmes, will be much greater.

Further research should be conducted at facilities for women and juveniles, as these groups make up 3% and 16% of the prison population respectively.[231] Both women and juvenile populations have specific characteristics and needs which must be better understood in order to inform appropriate policies and intervention programs.

Juveniles as a target group for intervention programmes are particularly important as they represent a significant opportunity to prevent future HIV infection. Juveniles, defined as prisoners under the age of 21, are just beginning to engage in high risk behavior and also represent a group which may not be reached by more conventional programmes, such as those which are administered in schools. Research into the knowledge, attitudes and practices regarding HIV in juvenile correctional facilities would yield extremely valuable information for health, education, and DCS policy makers.

One third of the prison population is made up of awaiting trial prisoners. These unsentenced prisoners are usually held separately from sentenced prisoners, and facilities for unsentenced prisoners are among the most severely overcrowded in the country. For example, awaiting trial prisoners in Johannesburg are held in a prison which is currently at 393% capacity. The circumstances of awaiting trial prisoners vary considerably from those who participated in this study, and thus this is a segment of the prisoner population which merits further research.

Addressing HIV/AIDS in prison effectively also means addressing other public health concerns, such as TB and STIs. The prison provides an opportunity to obtain valuable data on the interaction between HIV/AIDS and TB. In addition, the controlled environment afforded by prison can assist with STI control, if not eradication, in the South African prison population. Further research should be encouraged in order to realistically pursue the goal of eradicating STIs in the prisons, as the positive impact both within the prison and in the general community would be enormous.

The optimal course of action would be to conduct a national study of health issues in the various types of prisons, in each of the nine provinces, in both men's and women's prisons, and also in juvenile correctional facilities. This national study should incorporate the incidence and prevalence of TB and STIs as well as HIV/AIDS in order to better understand the broader concerns of general public health in the prison environment. Only when this kind of comprehensive data is obtained will the most effective policies and successful intervention programmes become possible. Although the nature and extent of HIV will vary, there is no reason to believe that a single prison in South Africa has escaped the impact of HIV/AIDS. It is a nationwide problem that can only be solved with a nationwide response.

CONCLUSION

Prison health is public health. Prisoners come from communities which have limited access to public health services, and these are the same communities to which they will return. Recognising this, Dr Theodore Hammett explains the importance of appropriate HIV/AIDS programmes in prisons:

> The disproportionately high burden of disease in correctional institutions identifies an extremely important opportunity to intervene aggressively with prevention and treatment programmes. Such interventions promise to benefit not only inmates themselves and their partners and families, but also the broader public health.[232]

The impact of HIV/AIDS on prisoners is most visible in the rising number of deaths in prison each year. What must be envisioned is the positive impact prisoners can have on HIV/AIDS. A serious problem for South African prisoners is boredom and idleness. They are locked up for two-thirds of the day, in crowded cells, with minimal lighting or space. Yet even these decrepit surroundings could become a classroom, if peer education programmes are supported and expanded.

If gang leaders are encouraged and empowered to become leaders in the movement for an AIDS free generation, then even the dark, dirty, and frightening quarters where prisoners spend the bulk of their time could become the seeds of behavioural change amongst young men in South Africa.

With targeted treatment and education regarding HIV, STIs and TB, former prisoners could be encouraged to develop a new identity as ambassadors for public health awareness to the under-served communities they represent. By providing prisoners with better health services, increasing their awareness, and reducing high risk behaviour, the Department of Correctional Services could make significant contributions towards an AIDS-free generation in South Africa.

APPENDIX 1
LIST OF INTERVIEWS CONDUCTED

All interviews were conducted in person by the author. Anyone employed by the Department of Correctional Services as well as all current and former prisoners were granted confidentiality prior to the commencement of the interview.

1. Westville Medium B Health Staff A, 29 March 2001 at Westville Medium B.

2. Westville Medium B Health Staff B, 29 March 2001 at Westville Medium B.

3. Westville Medium B Health Staff C, 29 March 2001 at Westville Medium B.

4. Westville Medium B Social Worker X, 20 April 2001 at Westville Medium B.

5. Westville Medium B Social Worker Y, 20 April 2001 at Westville Medium B.

6. Westville Medium B Social Worker Z, 20 April 2001 at Westville Medium B.

7. Former prisoner, 16 March 2001 at the University of Natal, Durban.

8. Derrick Mdluli, President, South African Prisoners Organisation for Human Rights (SAPOHR), 16 March 2001 at the SAPOHR Durban office.

9. Irene Cowley, Program Manager, NICRO, 5 March 2001 at the NICRO Durban office.

10. Ted Leggett, Institute for Security Studies (at the time of the interview he was editor of *Crime & Conflict*), 6 March 2001 at the University of Natal, Durban.

11. Chris Giffard, Centre for Conflict Resolution (CCR), (at the time of the interview working for Centre for the Study of Violence and Reconciliation), 7 March 2001 at Pollsmoor Prison, Western Cape.

12. Judge JJ Fagan, Inspecting Judge, 8 March 2001 at the Office of the Judicial Inspectorate, Cape Town.

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