HIV/AIDS in Prison:

Treatment, Intervention, and Reform

A Submission to the Jali Commission

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Abbreviations

ARV	Anti-retroviral medication
DCS	Department of Correctional Services
DoH	Department of Health
MDRTB	Multiple drug resistant tuberculosis
NGO	Non-Governmental Organisation
PEP	Post-exposure prophylaxis
PHC	Provincial HIV/AIDS co-ordinator
STI	Sexually transmitted infection
TB	Tuberculosis
WHO	World Health Organisation
WMB	Westville Medium B
SAPOHR	South African Organisation for Prisoners' Rights

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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.

Section 35(2)(e) Constitution of South Africa

Executive Summary

In prison, HIV/AIDS exacerbates existing problems and also creates new ones, yet the potential for far-reaching positive impact remains. Prisons are an intervention opportunity to reach a segment of the population, which is most likely to need government services related to HIV/AIDS and is also least likely to receive them through any other channel. Most people who end up in prison come from marginalised communities with limited access to health, education, and/or other sources of social welfare. For many of these people, their interaction with the criminal justice system will be their most extensive exposure to public services of any kind. Without an appropriate response to HIV/AIDS in prisons, the potential consequences will be increasingly tragic for both prisoners and the communities they represent.

The people who are most likely to be in prison are also amongst the most likely to contract HIV: young, unemployed, un- or under-educated, black men. Many of the socio-economic factors that place an individual at high risk for contracting HIV, are the same factors which lead to criminal activity and incarceration. Thus, a substantial portion of prisoners will have HIV prior to entering prison. Inside prison, high-risk behaviours for transmitting HIV include sexual assault, high-risk sexual encounters, same sex intercourse, tattooing, 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. Gang activity also increases the incidence of tattooing and violence between prisoners, both of which can create the risk of HIV transmission.

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. Many of the public health issues surrounding HIV/AIDS in the general community will be present, and in some cases, magnified in prisons. Specific health

concerns related to HIV/AIDS outside of prison, such as TB and other 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, the government should 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, which have some good features that are implemented extremely well, some excellent features that are not appropriately implemented, and some features that 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 made more discreet, rather than requiring prisoners to access condoms in plain view in common areas. Furthermore, the provision of water-based lubricant in a similarly private 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 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 inhuman and may be 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. Reforms in the Department of Justice 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 reduce corruption and smuggling.

In 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.

All but a small percentage of prisoners return to the community. Hundreds of thousands of prisoners, mostly young, black men are released from prison each year. Many of these former prisoners are drawn from, and will return to, those communities that 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.

Introduction

When discussing HIV/AIDS in prison, most people are immediately concerned about transmission. The most horrific scenario imaginable is that of a young person or any person arrested for a minor infraction who, because of an inability to pay bail or some unfortunate bureaucratic delay, spends a night in jail and is assaulted or sexually assaulted 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 will be exposed to the underworld of prison and all its 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 188,000 prisoners incarcerated in South African prisons at this time.[1] However, this does not mean that 188,000 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 two years or less; only 2% are serving life sentences[2]. On average, more than 30,000 people are released from South Africa's prisons and jails each month.[3] During 2002, nearly 400,000 former prisoners returned to the community.[4] If their illnesses or infections are not properly treated while in prison, the prisoners will return with these to their communities and may constitute a health risk. The greatest concern should not be directed at the risk of HIV transmission inside of prison, but the potential impact of former prisoners living with HIV outside of prison.

While this submission concentrates on male single sex prisons, many of the conditions and problems discussed in this submission can be extrapolated to women-only prisons. The nature of sexual assault and sexual activity in women-only prisons may be

[1] Office of the Inspecting Judge, Annual Report 2002/2003
[2] Office of the Inspecting Judge, Annual Report 2002/2003
[3] Office of the Inspecting Judge, Annual Report 2002/2003; DCS Records, 2002
[4] Office of the Inspecting Judge, Annual Report 2002/2003

different from male-only prisons, but it is essential that a full range of PEP and sexual assault services should be made available to them. No extensive research studies have been done on sexual violence in female-only prisons, but anecdotal evidence suggests the prevalence of inmate-on-inmate sexual assault, warden-inmate sexual assault and coercive sexual practices between inmates and wardens. It should be noted that due to the pattern of HIV infection in South Africa, a large number of female inmates would already have HIV when they enter the prison system. As with male-only prisons, the health facilities within female-only prisons should be capacitated to manage and treat inmates with HIV/AIDS. Following the implementation of mother-to-child-transmission programmes in public health facilities, the DCS should also provide nevirapine to pregnant inmates with HIV in accordance with its AIDS Policy.

Table 1.1 People Released from Prison during 2002

People Released from Prison 01 January through 31 December 2002	
Type of Release	**Number**
Release medical	88
Release pending appeal	457
Awaiting-trial transferred to SAPS	2 107
Deportation/repatriation	2 913
Released detainees	3 833
Warrant of liberation	6 067
Parole board prisoners	12 315
Parole non-board prisoners	13 692
Fine paid	14 436
Sentenced prisoners released on sentence expiry date	21 672
Awaiting-trial bail paid	71 113
Awaiting-trial to court not returned from court	243 749
TOTAL	**392 438**

Source: Office of Inspecting Judge Annual Report 2002/3003.

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 horrifying 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.

1.0 Origins and Causes of HIV Infection in Prison

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 have HIV. The socio-economic factors that significantly contribute to the prevalence of HIV within a specific population are very similar to those that lead to criminal activity and incarceration. Poverty is a defining characteristic of both prisoner and populations living with HIV. 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."[5]

The impact of joblessness, illiteracy and a general environment of lawlessness, all commonly considered contributing factors towards criminal behaviour, have also been studied as factors in HIV infection. The poor are more likely to become, amongst others, 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.[6] 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. [7]

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[5] Whiteside 1996: 1
[6] Cohen 1998
[7] UNAIDS (Geneva) 2000: 7-8

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 that places prisoners at high risk for HIV infection. High-risk behaviour for contracting HIV includes unprotected sex, particularly with multiple partners, commercial sex workers, or sex that 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, absent effective intervention programmes and policies.

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.[8] 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 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.[9]

In South Africa, the HIV infection rate is highest amongst the black population in comparison to other races.[10] HIV prevalence is also markedly higher for young men between the ages of 20 and 34, and peaks amongst men in the 25 to 34 age group.[11] 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.[12] Although income level and education have not shown to be indicators of HIV prevalence, locality is a significant determinant. Adults living in urban informal areas have a much higher HIV prevalence than adults living in urban formal, rural, or tribal areas.[13] The people who are sent to prison are primarily young, black men from marginalized urban communities, areas with

[8] UNDP 1998: 12
[9] UNAIDS 2000: 7-8
[10] Shisana, et al, HSRC Study of HIV/AIDS 2002: 14.
[11] Shisana, et al, HSRC Study of HIV/AIDS 2002: 20.
[12] DCS 01 February 2001
[13] Shisana, et al, HSRC Study of HIV/AIDS 2002: 20.

high HIV prevalence 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.

1.1 HIV Transmission in Prison

1.1.1 High Risk Sex and Sexual Assault

The prevailing types of high-risk behaviour for transmission of HIV in the prison environment are high-risk sexual activity, sexual assault, and contaminated needles or other cutting instruments. 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 sexual assault often result in tearing, thus, there is a higher risk of HIV transmission.[14] 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.[15]

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 3.0%. In comparison, the probability of infection for a man participating in unprotected vaginal intercourse with a woman living with HIV is .033 to 0.1%.[16] 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."[17]

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

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[14] Carelse 1994: 5
[15] USAID 1999: 1
[16] World Bank 1997: 59
[17] Highleyman 1999: 3

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 same sex intercourse, which carries persistent social stigma. However, perpetrators of same sex intercourse in the prison environment usually consider themselves to be heterosexual. Consensual same sex intercourse is not tolerated by the prison sub-culture, which also contributes to the under-reporting of sexual activity in the prison environment.[18]

Prisoner participation in sexual 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 sexual assault, is more often about power and asserting control over another human being than about sexual fulfilment.[19] Prison officials, as well as prisoners themselves, are reluctant to discuss the nature and extent of sex and sexual violence 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.

Lawyers for Human Rights estimates that 65% of inmates in South African prisons participate in sexual activity.[20] 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.[21] At several prisons in South Africa, prison staff reported that prisoners commonly participate in sexual activity either voluntarily or through threats and coercion. According to one prison social worker, even though many prisoners and prison guards will not admit or discuss it, prostitution and rape (sexual assault) are "rife."[22]

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

[18] Gear 2001: 2
[19] Donaldson 1990: 4
[20] Giffard 1997: 36
[21] AFP 2000
[22] Goyer 2002: 37

occurrence."[23] 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."[24]

Newly arrived prisoners, particularly first-time offenders, are at the greatest risk of being designated as "women" or "wyfies".[25] Usually, a naïve young prisoner is offered some sort of benefit or gift by an older prisoner, who will later force him to "repay the debt" by becoming the subservient submissive partner in a prison-context "marriage".[26] In these marriages, the "woman", whose sole purpose is to submit to sex, is essentially owned by the "man", who provides material comforts, or basic necessities, such as food or blankets.[27] The impact of this gang-related sexual exploitation 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.[28]

The impact of gangs, corruption and overcrowding increase the potential for sexual violence and victimisation in the prison environment. Prison warders will participate in the buying and selling of sex slaves, or can be paid not to notice. Wardens may simply refuse to report or follow through on complaints, and can control a prisoner's access to psychological and medical attention. Particularly in situations of extreme overcrowding and understaffing, prison wardens may be afraid for their own safety to

[23] Goyer 2002: 37
[24] Farren 2000: 33
[25] Gear 2003
[26] Gear 2003
[27] Gear 2003
[28] Goyer 2002: 37

challenge the power of gang leaders or may simply feel that they do not have the resources or the ability to stop the violent dynamics that pervade the prison system.[29]

1.1.2 Contaminated Needles and Cutting Instruments

An integral part of the prison sub-culture is the incidence of rudimentary tattooing by inmates on other prisoners using smuggled, and usually unsterilised, needles or other rudimentary cutting instruments.[30] 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. 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+ 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. The risk for HIV transmission from the 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.[31]

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. At one prison, social workers estimated that half of the prisoners there were tattooed while in prison.[32] According to a prisoner questionnaire, 57% of prisoners tattooed in prison were tattooed with other prisoners at the same time using the same needle or tool.[33] The inmates use home-made 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.[34] For ink,

[29] Gear 2003
[30] Neser 1993: 24
[31] Highleyman 1999:1
[32] Goyer 2002
[33] Goyer 2002: 38
[34] Goyer 2002: 38

prisoners burn rubber bands or will use shoe polish.[35] 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 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.[36]

1.2 Impact of Prison Conditions on HIV/AIDS

The conditions inside prison can contribute, in varying degree, 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."[37] In the US, AIDS inmates are dying an average of 8 months earlier than AIDS patients in the general population.[38] 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."[39] 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.

1.2.1 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.

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[35] Interview #10: Ted Leggett
[36] Interview #8: Derrick Mdluli
[37] Greene 1996: 1
[38] Moriarty 1999: 3
[39] Thomas 1994: 97

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 US, prisons have become incubators for TB due to overcrowding and poor ventilation.[40] Prison doctors cite TB as one of the most commonly treated illnesses, and in at least one prison, an entire cell block is reserved for prisoners who have tested positive for TB.[41] Many of the largest and oldest prisons in South Africa consist of communal cells originally intended for 18 beds that are crammed with an average of 50 prisoners, but can contain up to 62 prisoners. Prisoners are unlocked for breakfast around 7 am and are locked up again at 3 pm. 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 deterioration of hygiene, care, and supervision.[42] In addition to the basic health and sanitation risks, the incidence of rape within a prison varies with the intensity of overcrowding.[43] The risks for violence as well as sickness are obvious. Plainly stated, the more crowded the prison is, the more likely sexual violence and exploitation will occur.[44] The dangerous corollary to this is that increased sexual violence and exploitation means more prisoners more often are participating in high-risk behaviour for transmitting HIV.[45]

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 sexual exploitation, sometimes in exchange for the privilege of having a bed to sleep in. The only other

[40] Moriarty 1999: 5
[41] Goyer 2002: 39
[42] Thomas 1994: 38
[43] Carelse 1994: 27
[44] Thomas 1994: 32
[45] Moriarity 1999: 2

options for some prisoners is to sleep in the shower or toilet as sometimes even floor space is not available.[46]

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.

1.2.2 Nutrition

One of the most common complaints raised by prisoners concerns food. The primary cause for the lack of decent meals is not lack of resources but the incidence of smuggling and theft in the prison kitchen, by both prisoners and staff alike.[47] The problem is not alleviated by those prisoners who receive visitors wanting 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.[48] Limiting access to 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 incentives 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.[49]

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[46] Interview #7: Former Prisoner
[47] Goyer 2002: 41
[48] Goyer 2002: 41
[49] United Press International 1993: 1

1.2.3 Gang Activity

The power of the 26s and 28s gangs inside South African prisons pervades nearly every issue related to HIV/AIDS in prison. Much high-risk behaviour is 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.[50] Violence between prisoners that leads to bleeding is also a product of gang activity. Prisoners may be required to attack another prisoners and draw blood in order to be initiated into a gang.[51] 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.[52]

While the 26s engage in stabbings, the primary activity of the 28s is sex and prostitution.[53] 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. In addition to being the receptive sexual partner, the wives perform many traditional feminine roles, including washing and other domestic chores.[54] Although the 26s and 28s may claim to eschew sexual activity, and are reportedly forbidden by the gang's official code from taking a "wife", prison staff note that sex and sexual violence is common amongst all gangsters.[55]

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 cell. The former prisoner claimed that the wardens are known not only to facilitate but also engage in sexual activities as part of their

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[50] Interview #7: Former Prisoner
[51] Interview #7: Former Prisoner
[52] Interview #4: Social Worker X
[53] Interview #4: Social Worker X
[54] Interview #10: Ted Leggett
[55] Gear 2003

membership in a gang.[56] 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 the prostitution of juveniles to other prisoners.

2.0 HIV/AIDS Prevalence in South African Prisons

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".[57] However, when the Inspecting Judge of Prisons, Judge Johannes Fagan, estimated that as many as 60% of prisoners could have HIV, the Department disputed this figure as well as being "unrealistic and unreliable".[58]

2.1.0 The Westville Report: Introduction

Judge Fagan based his estimate, in part, on the findings in The Westville Report, which was presented at a DCS research workshop in May 2002. The report presents the results of a study conducted on the nature and extent of HIV prevalence at Westville Medium B (WMB), a men's maximum-security prison in KwaZulu-Natal. From January until April 2001, a team of researchers led by HEARD in conjunction with the Medical Research Council (MRC) collected urine samples from 271 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.

2.1.1 DCS Embargo of the Westville Report

[56] Interview #7: Former Prisoner
[57] BuaNews: May 24, 2002
[58] BuaNews: May 24, 2002

Prior to commencing the research, DCS required the study co-ordinator 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 WMB: 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 14 May 2002.

The following week, Judge Fagan referred to the findings of 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 28 May 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".[59]

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.[60] 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.[61]

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

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[59] South African Press Association: May 28, 2002
[60] South African Press Association: May 28, 2002
[61] BuaNews: May 24, 2002

research team also requested an opportunity to present, and defend, the findings of the report to the parliamentary committee but this request was 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, Special Assignment 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 last directive received from the Commissioner regarding the Westville report was a command to remove any and all reference to the possibility of future research, particularly any statements about the need for a study of a selection of several prisons across the country. Almost two years later, the findings of the Westville report, the only study ever conducted on HIV prevalence in a South African prison, remains under embargo by DCS. Any and all publications that draw from the data must be first submitted to DCS for review. The actual report is considered the property of DCS and cannot be released into the public domain without DCS approval.

2.1.2 Permission Granted to the AIDS Law Project and the Treatment Action Campaign

The AIDS Law Project and the Treatment Action Campaign requested and have received permission from DCS to use the findings of the Westville Report in this submission. In many respects, the information from the Westville Report is very limited, but it is the only empirical data available on the nature and extent of HIV prevalence in a prison in South Africa. Although the study was only conducted in one prison, WMB is the largest men's maximum-security prison in KwaZulu-Natal and one of the largest in the entire country. It is also the location of the prison hospital that serves the entire prison population of KwaZulu-Natal. For these reasons, although the data is drawn from just one prison, it can provide valuable insights for addressing HIV/AIDS in South African prisons in general.

2.1.3 Methodology

The study findings are based on a sample size of 271 prisoners from WMB who were tested and interviewed in January 2001. At that time, there were 2,635 prisoners in Westville Medium B, thus resulting in a sample size of 10.3%.[62] Although the Westville prison complex consists of several facilities and houses more than 5,000 prisoners, this sample was drawn only from Medium B, the men's maximum security facility, and thus the relevant population is only those prisoners who were in Medium B at the time of the study.

2.1.4 HIV Prevalence at Westville Medium B

Of the 271 individuals on whom usable specimens were obtained, 80 (30%; 95% CI 24.5 – 35.5) were infected with HIV. The age distribution differs from that of the general community, in that the highest levels are amongst 20 to 25 year olds (20/47; 43%) rather than 25 to 34 year olds as seen in the most comprehensive national study. Also, the length of incarceration is a significant determinative factor for HIV prevalence. Prisoners who have been incarcerated for less then 2 years are at the highest risk for HIV infection. This may reflect the prison sexual exploitation dynamic, where older established prisoners target younger, newly arrived prisoners for sexual assault, exploitation, and rape.

The age distribution of HIV and the relationship between length of incarceration and HIV status is shown in Table 2.

Table 2.1: The relationship between HIV infection and length of incarceration

Length of incarceration	All ages HIV +	< 25 yr HIV +	25–29 yr HIV +	30–34 yr HIV +	35–40 yr HIV +	> 40 yr HIV +
0 – 2 yrs	48/123 39%	12/27 44%	19/42 45%	9/27 33%	6/14 43%	2/13 15%

[62] Westville Medium B Records Department: 2001

> 2 – 4 yrs	23/75 31%	4/11 36%	10/31 32%	5/12 42%	2/6 33%	2/15 13%
> 4 years	9/73 12%	4/9 44%	2/27 7%	1/17 6%	2/13 15%	0/7 0%
Total	80/271 30%	20/47 43%	31/100 31%	15/56 27%	10/33 30%	4/35 11%

Source: Goyer, et. al., *HIV/AIDS at Westville Medium B: An Analysis of Prevalence and Policy*, DCS 2002

Those who have been in prison for longer than 5 years have a markedly lower risk of HIV infection. Regardless of age or race, 35.9% of prisoners who were incarcerated for less than 5 years were infected with HIV compared to 12.3% of those who had been in prison for 5 years or more (RR 2.9; 95% CI 1.67 – 5.26). There were no cases of HIV infection among the 13 inmates who have been incarcerated for more than 8 years.[63] This could be explained by the lower probability of transmission from the receptive to the insertive participant in anal intercourse, as older prisoners who have been incarcerated for a longer time are more likely to assume the male role in an exploitative sexual relationship. Also, lower rates of HIV infection for prisoners who have already served five years in prison could be attributed to the lower HIV prevalence in the general population at the time of incarceration. Finally, prisoners who have been incarcerated for more than five years may be less likely to be HIV positive because a prisoner with HIV is not expected to live more than five years in the prison environment. As a consequence of poor health care, nutrition, stress, violence and exposure to a higher concentration of disease and opportunistic infections, prisoners living with HIV/AIDS are not expected to survive a sentence longer than 5 years.

Sexually transmitted infections (STIs) are significantly related to HIV, both in prison and in the general population. Table 2.2 shows that a history or diagnosis of an STI increased the risk 2 to 3 fold of being infected with HIV.

[63] Goyer 2002: 42

Table 2.2: The relationship between HIV infection and STIs among prison inmates.

	Prevalence of HIV infection		Relative Risk	Confidence intervals
	History of STI	No history of an STI		
Previous history of an STI diagnosis	59 / 156 37.8%	20 / 112 17.9%	2.1	1.4 – 3.2
Previous history of genital sores	65 / 159 40.9%	14 / 109 12.8%	3.2	2.0 – 5.0
Diagnosis of an STI in prison	16 / 24 66.7%	64 / 241 26.6%	2.5	1.6 – 3.9

Source: Goyer, et. al., *HIV/AIDS at Westville Medium B: An Analysis of Prevalence and Policy*, DCS 2002

The nature of a prisoners' offence was not a determinative factor of HIV prevalence, even for prisoners serving sentences for sexual crimes. Knowledge about HIV/AIDS and prevention methods was very high. The HIV testing for this study was anonymous and unlinked, but many prisoners requested voluntary counseling and HIV testing. Only 16 of the prisoners tested reported having tested positive for HIV previously, but 8 of those actually tested negative.[64]

2.2 DCS Statistics

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 1999 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.[65] This translates to an HIV prevalence rate of 1.6% and AIDS prevalence of 0.08%. According to UNAIDS, HIV/AIDS sero-prevalence for adults in the general population in South Africa in 1999 was estimated at 19.94%. [66]

[64] Goyer 2002: 44
[65] DCS Annual Report 1999: 19
[66] UNAIDS (South Africa) 2000: 3

Clearly, the DCS statistics significantly underestimate HIV/AIDS prevalence in South African prisons.

2.3 Deaths from AIDS in Prison

Because prevalence statistics are not presently available, the data on the number of natural deaths in prisons can be useful for understanding the real impact of HIV/AIDS on the prison population. There were 1,389 natural deaths in prison during 2002; an increase of 647% from 1995.[67] The increase in the prisoner population was 52% over the same period. Table 2.3 shows the increasing number of natural deaths in prison per 1000 prisoners.

Table 2.3: Natural Deaths in South African Prisons per 1000 Prisoners

Year	Per 1000
1995	1.65
1996	1.68
1997	2.30
1998	3.65
1999	4.53
2000	6.38
2001	6.61
2002	7.75[68]

Source: *1999, 2000, 2001, and 2002/2003 Annual Reports*, Office of the Inspecting Judge

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, based on examinations of death records at Westville Medium B, as well as the investigations of the Judicial Inspectorate, 90 to 95% of natural deaths in prisons can be attributed to AIDS. The dramatic increase in prison deaths shows that prisoners are particularly and increasingly likely to die from AIDS.

[67] Office of the Judicial Inspectorate 2001: 19
[68] Office of the Judicial Inspectorate 2001

2.4 The Judicial Inspectorate

Aware of the limitations of DCS statistics, the Judicial Inspectorate conducted its own investigation into rising prison deaths. Examining post-mortem reports, the office determined that 90% of deaths in custody are from AIDS-related causes. Using figures from 1995 until 1999 and assuming the escalation would continue, the projection showed that by 2010 nearly 45,000 prisoners will die whilst incarcerated. According to this calculation, natural deaths in prison were predicted to increase 43.3% 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 47.5% to 1,087 during 2000.[69]

[69] Office of the Judicial Inspectorate 2000

3.0 HIV/AIDS Policy

3.1 Previous Policies

The first policy to address HIV/AIDS in the South African prison system was formulated in 1992 and was criticised as based on 'fear, lack of knowledge, and prejudice'.[70] The DCS approach was to segregate prisoners living with HIV, 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 HIV, and then segregating prisoners with HIV in a separate facility from the general prison population.

Prisoners considered "high risk" were those who were illegal aliens, 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"[71]

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.[72] 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.[73] According to the policy paper, test results were to be kept confidential, but were required to be reported to the head of the prison.[74]

By the mid 90'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 "high risk" inmates and inmates living with HIV 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

[70]Achmat 1996: 13
[71] DCS 1992: 2
[72] DCS 1992: 4
[73] DCS 1992: 2
[74] DCS 1992: 5

government with regard to HIV/AIDS policies. Minister 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.[75] In 1994, the DCS produced a White Paper that declared, "Sex, in whatever form, cannot be condoned and authorised for prisoners in South Africa."[76] The paper went on to specifically dismiss any suggestions concerning condom distribution within the prison, citing that sexual activity in prisons is neither permitted nor tolerated.[77]

3.2 Initial Reforms

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."[78] The concept of universal precautions is that all potentially contaminated fluids are to be treated as if they are HIV+, and 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 on 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.[79] Nurses were also instructed to monitor the condition of patients with HIV/AIDS, arrange diet supplements

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[75] Giffard 1999: 41
[76] DCS 1994: 8
[77] DCS 1994: 10
[78] DCS "Desegregation" 1996: §2.1 – 2.2
[79] DCS "Desegregation" 1996: §3.2.2

and consultations with psychologists, social workers, medical specialists and other professionals.[80]

As well as the policy amendment paper, a separate policy document circulated to the provincial commissioners related 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."[81] 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.'"[82] Condoms could be supplied to prisoners only on request and only by a nurse trained as an AIDS counsellor.[83] The condoms would be supplied and paid for by the Department of Health (DOH), and therefore the DCS was not to purchase condoms with departmental funds.[84]

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.[85] 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.[86]

In the case of **C v Minister of Correctional Services 1996 (4) SA 292 (T)**, a prisoner was given an HIV test. He had been told that the test was an HIV test and that he had the right to refuse. Even though there was a prison policy that the testing of prisoners could only be done with informed consent, he was not given pre-test or post-test counselling and was given very little time to decide whether or not to have the test. When he had found out that he had HIV, the prisoner issued summons against the Minister for

[80] DCS "Condoms" 1996: §3.2
[81] DCS "Condoms" 1996: §1
[82] DCS "Condoms" 1996: §2
[83] DCS "Condoms" 1996: §4.5
[84] DCS "Condoms" 1996: §4.1
[85] DCS "Desegregation" 1996: §3.2.1
[86] DCS "Condoms" 1996: §3.1

violating his right to privacy. The Court agreed that as the prisoner had not been given proper pre-test and post-test counselling and had had little time to decide, he had not been able to give informed consent to the test.

In yet another case, **W and others v Minister of Correctional Services (Unreported, Cape Town Supreme Court, Case No: 2434/96)**, the judge ordered that prisons must:

Treat the status of all prisoners with HIV/AIDS confidentially;

Protect prisoners from stigmatisation because of their HIV status or sexual orientation;

Make sure that condoms are provided to prisoners;

Make treatment available to prisoners with HIV and AIDS;

Only test prisoners for HIV with their informed consent;

Not deny prisoners work solely on the basis of HIV status;

Not discriminate against prisoners with HIV as far as accommodation and ablution facilities;

Provide education and information on HIV and AIDS to all prisoners and prison staff.

3.3 Current Policy

In October 2002, DCS again updated its policies for HIV/AIDS in prisons. The most significant change was that condoms are now to be easily accessible and available at all times. Prisoners no longer have to gain access to a member of the health staff and request condoms in person one at a time, but instead, condoms are to be available from dispensers in common areas. This is an important improvement in the condom policy but it still not enough. The condoms are still not lubricated and therefore may break during anal intercourse. Water based lubricants are not available at all, either from dispensers or upon request, in the prison. Also, the condom dispensers are in common areas, where any prisoner who wishes to access condoms, can be observed doing so by wardens and

other prisoners. Given that sex is against prison regulations, and consensual sex goes against the norm of violence and exploitation of sex in the prison sub-culture, few prisoners are likely to brave the watchful eye of their captors or in their peers to access condoms.

Post Exposure Prophylaxis (PEP) is available only to prison staff and officials who are exposed during the course of their duties, and to prisoners who are exposed while working in the health facilities. There is no policy for the provision of PEP to those who report sexual assault or other potential exposure to HIV. Given that the DoH has pledged to provide PEP to survivors of sexual violence in the general community, prisoners should also be afforded the opportunity to preventative treatment for HIV/AIDS, as well as the basic treatment required for the many other physical and mental harms associated with sexual violence.[87] There is currently a protocol for the provision of PEP, however it is unclear when this protocol will be implemented. Underreporting of sexual violence in prison is indicative of the lack of security in their persons that prisoners face. Providing life-saving treatment could be a start to encouraging survivors of sexual violence in prison to come forward, seek treatment, and help to address the problem.

3.3 Implementation

3.3.1 Testing

According to the 1996 policy document, "testing for the HIV 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."[88] However, prisoners are often not able to receive a test upon request because of cost constraints.[89] When HEARD conducted anonymous unlinked HIV testing in January 2001, more than half of the prisoners who voluntarily participated, asked to be informed of their HIV status. When a proposal was submitted to the DCS Provincial Commissioner to offer testing and counselling for these

[87] See, generally, Human Rights Watch, Deadly Delay: South Africa's Efforts to Prevent HIV in Survivors of Sexual Violence 2004
[88] DCS "Desegregation" 1996: 1
[89] Interview #3: WMB Health Staff C

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 when appropriate medical treatment, anti-retroviral therapy and better nutrition are not available, could cause considerable unrest, particularly in light of the expected number of prisoners 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 and may be a violation of the constitutional rights of prisoners.

3.3.2 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 (SAPOHR). Unfortunately, the policy does not achieve its objectives because of both poor design and implementation. Prisoners will not request a condom in a face-to-face encounter with a member of the health staff, and are unlikely to take them from dispensers in common areas when the guards are watching. However, even assuming that the condom distribution policy was appropriately designed, the policy would still fail because the actual condoms issued are not strong enough for anal intercourse. According to health staff, the condoms provided break during anal intercourse thus negating any effort to reduce HIV transmission.[90] The condoms are issued by the DoH and are the same as those provided in the general community. However, this is one instance where the standard which applies to the general community is not appropriate in the prison environment.

3.3.3 Resources

The DCS policies for addressing HIV/AIDS include 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:

[90] Interview #2: WMB Health Staff B

1. To advise Commanders and Heads of Prisons on the implementation of [HIV/AIDS] policy
2. To co-ordinate the practice of "Universal Precautions" in all prisons in the province
3. To monitor the efficiency of STD clinics in all the prisons in the province
4. 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.
5. All other duties as indicated in the directive on the provision of condoms.[91]

The province of KwaZulu-Natal contains 28,375 prisoners in 38 prisons from Ladysmith to Port Shepstone, Durban and Vryheid.[92] The PHC for KwaZulu-Natal is responsible for programme 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 with transport or reimbursed for the use of her personal vehicle.[93] 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 were 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 absent 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

[91] DCS De-segregation 1996: 6-7
[92] DCS 30 June 2000
[93] Interview #1: WMB Health Worker A

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 prisoners with HIV, although it is sometimes not possible for prisoners to attend due to staff shortages: there aren't any guards available to escort them to the room where the support group meets.[94] One social worker described an exercise from the HIV support group where prisoners are asked to identify positives as well as negative aspects in their personal situation and encouraged to emphasise the positive aspects 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.[95]

While the support group helps address the needs of prisoners living with HIV, 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 that 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.[96]

The ability of social workers and psychologists at WMB to provide HIV education is considerably constrained by the lack of basic infrastructure requirements

[94] Interview #5: Social Worker Y
[95] Interview #4: Social Worker X
[96] Interview #4: Social Worker X

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.

3.4 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.[97]

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 consists of numerous bureaucratic levels, with the result that most prisoners die before their release is approved. If the health staff believes 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 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.[98] 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

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[97] WHO 1993: 9

[98] Interview #4: Social Worker X

does not wish to care for the prisoner, either as a result of misguided fears associated with HIV or because of they cannot afford the cost of burial services.[99]

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, and on April 16th, the approval for early release was granted.[100] 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.[101]

In the case of **S v Cloete 1995 (1) SACR 367 (W)**, in an appeal made in 1994, a prisoner serving a five year sentence for fraud was released early from prison and placed under correctional supervision. The Judge revised a decision made by the Magistrate and ruled that the prisoner's medical condition (his HIV status) was a good reason to release him and agree that "his condition is such and has changed so that to continue to serve imprisonment would be a far harsher sentence for him than for any other person serving a similar sentence."

[99] Interview #4: Social Worker X
[100] Interview #2: Health Worker B
[101] Interview #4: Social Worker X

4.0 Solutions

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 that specifically pertain to the issue of HIV/AIDS.

4.1 Overcrowding: Reduce the Number of Unsentenced Prisoners

The primary challenge facing the DCS 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 section 35(2)(e) of the Constitution:

> **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 these constitutional rights are compromised. Overcrowding is the primary culprit. The solution to overcrowding is not to build more prisons, however, but to reduce the prison population.

Prisoners include those who are awaiting trial, prisoners who have been convicted of petty theft or non-violent crimes or crimes of necessity due to economic needs. These are crimes born of poverty and employment; factors which are not alleviated by a prison sentence. Legislators and policy-makers involved in stricter bail-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.[102]

While the overcrowding issue is largely beyond DCS control, there are some aspects that it is able to address. Most notably, DCS can and should focus attention on 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 of the prison buildings themselves. A better solution is to knock them down entirely and build a new prison that 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.[103]

4.2 Prison Health Care should be the Responsibility of the Department of Health

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:

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[102] Judicial Inspectorate 2001: 17
[103] Interview #11: Chris Giffard

> “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.”[104]

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 within 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.

In March 1993, the WHO distributed guidelines on HIV infection and AIDS in prison. The guidelines covered HIV testing, preventive measures, management and care of prisoners infected with and living with HIV, 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, equivalence to that available in the community without discrimination, in particular with respect to their legal status or nationality. The general principles adopted by national AIDS programme should apply equally to prisoners and to the community[105]

The **equivalence principle** mandates that the same treatment that is available in the general community must be made available in prisons. Now that the government has committed to a national treatment plan, ARV and PEP must also be provided to prisoners to the same extent.

The prison context provides unique challenges as well as unique opportunities for the provision of anti-retroviral treatment. Treatment regimen adherence inside the prison is made simpler by the highly regimented environment, and the impact of targeted education efforts can be extremely effective given that the prison population is a ‘captive audience’. However, the administration of the complicated treatment regime is usually

[104] UNAIDS 1997: 4
[105] WHO 1993: 1

the realm of specialists, and not something a typical prison health facility is able to provide. Furthermore, the lack of privacy intrinsic to any prison situation means that a prisoner undergoing ARV treatment will have difficulty concealing his or her HIV status from prison officials or other prisoners. Finally, the links between the community and the prison are crucial for maintaining treatment regimen adherence before and after incarceration. It is imperative that a seamless treatment plan coordinates the provision of ARVs for prisoners so that treatment is not interrupted by incarceration. If ARVs are extended to the general community, but not to prisoners, then the effectiveness of any universal treatment plan will be gravely endangered.

In addition to ARV therapy, the recommended treatment for individuals living with HIV/AIDS is "symptomatic management" of the disease.[106] This usually requires treating and preventing the more common opportunistic infections associated with HIV, including pneumonia and TB. Both of these illnesses can be cheaply treated and even prevented. Prison hospitals normally administer INH and Bactrim for patients living with HIV/AIDS, but their supplies are sometimes changed and interrupted as a result of unreliable distribution services.[107] Consistent and continued doses as part of the prescription programme for TB are extremely critical 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.[108] 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.

DCS has shown an inability to effectively provide correctional services, its core mandate. It should not provide health care services as well. The entire health care function should be removed from DCS and brought under the control of DoH at the

[106] Whiteside (website)
[107] Interview #2: Health Staff B
[108] Stern 1999: 17

provincial level. This becomes especially imperative when considering solutions for HIV/AIDS in prison, where treatment regimen adherence and links with community health services become critical.

4.3 Testing

Prisoners should receive HIV testing upon request. HIV testing is available free of charge in the general community and as such it should be provided without exception inside prison. The prisoners tested in the Westville study 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. The tests must provide for the pre-test, post-test counselling and informed consent as required in **C v Minister of Correctional Services 1996 (4) SA 292 (T).**

4.4 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 staff 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 could be an attractive opportunity for catering companies. 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 the smuggling is discovered, and the ubiquitous natures of such activity make them seem more or less acceptable. In a situation of employment, the environment may change considerably.

4.5 Condoms, Lubricant, and Bleach

Condoms and lubricants must be made available in latrines, showers, the cafeteria in addition to other common areas to which the prisoners have access and 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.

4.6 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 that have enjoyed significant success in the general community.[109] 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.[110] Scare tactics have also proven ineffective, and may possibly be counterproductive to the extent they elicit a denial response.[111] 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.

[109] Thomas 1994: 36
[110] Carelse 1994: 13
[111] Carelse 1994: 14

The unfortunate truth is that increase in HIV/AIDS-related knowledge is not always translated into altering or reducing high-risk behaviour.[112] 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.[113] 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."[114]

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 that utilise a small group format and encourage prisoner participation. In spite of the resource limitations that constrict the efforts of prison staff, several such programmes have been implemented in prisons, 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 a tremendous return on investment if programmes which affect the awareness and behaviour of this high-risk target group are adequately funded and expanded.

4.7 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, confirmed by a visiting specialist. 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 signature required to approve the early release of the prisoner. The social worker assigned to contact the family and ensure that appropriate

[112] Carelse 1994: 12
[113] Carelse 1994: 14
[114] Carelse 1994: 15

care is available upon release should be notified as soon as possible, perhaps when the patient is admitted for an 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.

4.8 Partnership

DCS has recognised the importance of intervention programmes for HIV/AIDS in prison by appointing a 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 has 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, are suggested resources 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 NGOs, in partnership with DCS, 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.

4.9 Authorization of Research Should Come from the National Council

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 that must be adhered to for gaining permission and access to prisons to conduct research. 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. The National Council for Correctional Services is an existing policy advisory body, comprised of both academics and government officials that could play this co-ordinating function. 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.

DCS has an exceptionally hierarchical and dogmatic approach to policy making. Appropriate policy can only be developed to respond to a problem once that problem is appropriately understood.

The closed nature of the prison at the local and provincial level extends to policy making at the national level as well. The DCS policy-making process takes place in a nearly complete vacuum, and the results are apparent. Parliamentary discussions of

HIV/AIDS in prison policy in parliament in recent years have included comments which range from attitudes of persistent denial to alarmist reactionism. Members of the Correctional Services Portfolio Committee continue to propose the re-implementation of mandatory testing and segregation, policies that have been universally discredited throughout the world. These debates demonstrate the extent to which national-level decision makers are both uninformed and unrealistic.

The solution is to adopt a culture of complete and total transparency. Access to prison must be made available so that information can be gathered, and appropriate oversight and monitoring can commence. There must be an independent oversight agency, separate from the National Council and from the Office of the Inspecting Judge, to monitor and report on corruption and misdeeds by prison officials and staff. The amount of power entrusted to prison authorities is enormous and should carry with it an equally serious amount of oversight and monitoring. Independent groups, outside of the DCS hierarchy, must be able to access and report on DCS and the use of its power in the state interest. The DCS should not be in a position to block access to prisons for research or publication of research results. If the Department is permitted to control the information that comes out of the prisons, then they will never be called fully to account for their actions.

4.10 Recommendations for Further Research

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 2.5% and 16% of the prison population respectively[115]. Both women and juvenile populations have specific characteristics and needs that 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 that 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 prison 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

[115] DCS 2001

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 nation-wide problem that can only be solved with a nation-wide response.

Conclusion

Prison health is public health. Prisoners come from communities that 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".[116]

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 black 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, DCS could make significant contributions towards an AIDS-free generation in South Africa.

[116] Hammett 1999: 1

Interviews

All interviews were conducted in person using a semi-structured format. 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. Health Staff A - 29 March 01.
2. Health Staff B - 29 March 01.
3. Health Staff C - 29 March 01.
4. Social Worker X - 20 April 01.
5. Social Worker Y - 20 April 01.
6. Social Worker Z - 20 April 01.
7. Former Prisoner - 16 March 01 at the University of Natal, Durban.
8. Derrick Mdluli, President, South African Prisoners Organisation for Human Rights (SAPOHR) - 16 March 01 at the SAPOHR Durban office.
9. Irene Cowley, Program Manager, NICRO - 05 March 01 at the NICRO Durban office.
10. Ted Leggett, Editor, Crime & Conflict - 06 March 01 at the University of Natal, Durban.
11. Chris Giffard, Centre for the Study of Violence and Reconciliation (CSVR) - 07 March 2001 at Pollsmoor Prison, Western Cape.
12. Judge J. J. Fagan, Inspecting Judge - 08 March 01 at the Office of the Judicial Inspectorate, Cape Town.

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