HIV/AIDS in Prison:

The Public Policy Challenge for South Africa

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Dissertation submitted in partial fulfilment

of the Degree of Master of Arts in Political Science

May 2001

Dedication

This research is dedicated to the families of the men imprisoned at Westville Medium B, especially the wives whose devotion is steadfast, the mothers whose compassion comforts their dying children, and the sisters, daughters, and others whose forgiveness is absolute. Their strength is often the only source of hope for the prisoners they visit, care for, and support. It is for them that HIV in prison must be addressed, for they are the ones who have committed no crime but will bear the greatest consequences.

Acknowledgement

The author wishes to thank the many people and organisations who assisted with this research, including the Department of Political Science and the Health Economics HIV/AIDS Research Division (HEARD) at the University of Natal, Durban. Special thanks is afforded to the Rotary Foundation for providing the funding to make this research possible, and to the Rotary Club of Durban Berea (SA) and the Rotary Club of Sandy Springs, Georgia (USA) for their valued support. The opinions presented here do not represent those of the University of Natal or any Rotary organisation.

Abstract

In South Africa, both the number of people entering prison, and the number of people infected with HIV, are steadily increasing. While reliable statistics are not available on the number of HIV+ prisoners, the characteristics of the typical prisoner are those of a demographic group at high risk for HIV infection. As a result, many prisoners will already be HIV positive upon entering the prison. Additionally, the prison environment creates many situations of high risk behaviour for HIV transmission, which means there is also an as yet undetermined portion of inmates who will contract HIV while incarcerated.

The current government policy is to provide HIV testing and condoms in conjunction with counselling, although poor design and implementation of this policy has limited its impact. In addition to issues of HIV infection and transmission, the government must address the needs of prisoners who have developed full-blown AIDS and will likely die as a result while imprisoned. AIDS is already the leading cause of death for prisoners in many countries, as well as in South Africa. Adequate medical care, proper nutrition, and early release for those in the late stages of AIDS, are the international standards for minimum humane treatment of these prisoners. Today, crippling bureaucracy prevents the humanitarian release of dying prisoners from South African prisons.

Reliable data on the nature and extent of HIV/AIDS infection in South African prisons has yet to be obtained, owing to the closed nature of the prison administration. In order to design and implement effective policies, the secrecy surrounding the prison system must be eliminated so that further research and study may take place. Unlinked, anonymous HIV testing should be undertaken on a sample of the prison population so that accurate information and projections about HIV/AIDS in prison may become available. Until the government allows the issue to be quantified, the design and implementation of better policies will not be possible.

The best HIV/AIDS policies are those which recognise the impact of prisoners' health on public health in general. Because the prisoner population

consists of a core transmitter group, the prison provides a critical intervention opportunity for the prevention of HIV infection in the greater community. Further research on this issue should therefore focus on the evaluation, design, and implementation of intervention programs. Intervention in the prison environment should include targeted education and use of existing gang structures to engender behavioural change.

The issues of HIV/AIDS in prison are compounded by issues of prison reform in general. The conditions in South Africa prisons are unconsitutional, and exacerbate the problems presented by HIV/AIDS. The most pressing problem in South African prisons is overcrowding; a problem which the Department of Correctional Services is all but powerless to address. Just as HIV/AIDS in the general community requires a multi-sectoral solution, so too does HIV/AIDS in the correctional setting. The Department of Correctional Services must re-evaluate both its policies and its entire policy making process in order to address HIV/AIDS in South African prisons.

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Introduction and Methodology

Introduction

The South African government has recognised that an appropriate response to HIV/AIDS must include a multi-sectoral approach which incorporates all departments and all levels of government. The Department of Correctional Services (DCS) is part of this overall strategy, and has developed its own policies for responding to HIV/AIDS, both for DCS employees and officials as well as the prisoner population. This paper will not address the HIV/AIDS policies aimed at DCS personnel, but rather will focus on the DCS policies which are intended to address HIV/AIDS for prisoners in South Africa.

The purpose of this research is to analyse the South African government's response to HIV/AIDS in prison. The questions this paper will seek to answer include the what, how, and why of the Department of Correctional Services' (DCS) policies to address HIV/AIDS in prisons. These questions will be answered in light of the development of the prison policy process, the relevant background information regarding HIV/AIDS issues in South African prisons, the pros and cons of the policy options available, and the historical context of prison reform in South Africa. The differences between the DCS policies as they are written and as they are implemented will be examined, and an analysis of their effectiveness will be presented. Finally, recommendations will be offered as to how the DCS policy should be changed, extended, modified or discontinued in order to best respond to HIV/AIDS in South African prisons.

Methodology

This research involved the use of documentary evidence and interviews. Examination of the source documents is a necessary part of understanding the intentions and objectives of the original designers of the policy. Documentary evidence also helps to analyse the official assessment of the problem which the policy is intended to address, and an analysis of the information used by policy-makers

assists with understanding their policy decisions. The documentary evidence examined for this research included legislation and policy memoranda, as well as statistics and publications produced by the Department of Correctional Services. These sources were important because they provided information on the department's understanding of, and reaction to, HIV/AIDS in prisons. This information was of great value in analysing HIV/AIDS policy in prisons because not only did the documentary evidence present the actual position of the government, but also provided insights about the priorities of the Department of Correctional Services (DCS). The documentary evidence said as much about what DCS was doing in response to HIV/AIDS as it did about what it was not doing. An example is the inaccurate statistics provided by DCS on the extent of HIV/AIDS infection in South African prisons. Looking at what primary sources of information were available, and what information was not available, was benficial to this research as it illumned the department's attempts to understand and address HIV/AIDS and its impact on the South African prison population.

In addition to documentary evidence, interviews were conducted in order to gain an understanding of how the policy was developed and how it has affected those it was intended to assist. The use of interviews was considered necessary because of the enormous differences between the policy as it is written and that which is put into practice. The interviews were either semi-structured or structured, depending on the interviewee. There were three groups of interviewees: those who work for DCS, those who are either currently or formerly in DCS custody, and those who work on issues relevant to HIV/AIDS and prisons.

The first two groups of interviewees, DCS staff and inmates, were all selected from Westville Medium B prison, a men's prison in KwaZulu-Natal. With a capacity of 2,050 and an actual occupancy of up to 3,100, Westville Medium B (WMB) is the largest prison for sentenced prisoners in KwaZulu-Natal.[1] KwaZulu-Natal has been the province with the highest HIV infection rate for the past five years[2], and the prison hospital at WMB serves as the hospital for all prisons in the province. For these

[1] DCS 2000
[2] DOH 2001

reasons, it is hoped that data collected at WMB will provide insights on the effectiveness of HIV/AIDS policies and the nature and extent of HIV/AIDS infection in KwaZulu-Natal.

The DCS employees selected for interview included health care staff, social workers, psychologists, and administrators. These interviews were semi-structured, with the intention of allowing the interviewee to answer open-ended questions in order to gain the most information possible. The information gained from these interviewees helped to analyse the implementation of DCS policy for HIV/AIDS in prison and also provided primary data on the challenges faced by DCS staff who deal with this issue as part of their everyday work responsibilities.

In addition to interviewing staff at WMB, structured interviews were conducted with a sample of 274 voluntarily participating and randomly selected prisoners at WMB. The sample size was selected to cover approximately 10% of the prisoners at WMB, and the prisoners were randomly selected to paricipate. Participation was voluntary and anonymous, and this fact was communicated to each prisoner at the start of the interview. Structured interview questionnaires were used in order to gain quantifiable data on high risk behaviours and the impact of HIV/AIDS policy amongst the prisoner population. For each question, an option was always given of "Refuse to answer", in order to allow participants to skip questions with which they were uncomfortable. Zulu-speaking research assistants were trained to administer the questionnaire in order to obtain reliable and accurate responses. The research assistants read the questions to the prisoners and marked their answers down. This was necessary to accommodate the fact that many prisoners are illiterate and/or do not speak English.

The final group of interviewees consisted of those who are in academia or non-government organisations (NGO) whose work is pertinent to prison and/or HIV/AIDS. The interviewees were selected because of their expertise in a particular area, such as staff from an NGO which provides services to prisons in KwaZulu-Natal. A semi-structured interview format was used in order to allow the interviewees to expand on their answers as much as possible. Each of the interview templates, and the prisoner questionnaire, are included in Appendix C. It should be noted that some

interviewees directed the conversation to make specific points and thus not all questions were asked or remained relevant.

The field work for this research was conducted from October 2000 through April 2001. Official permission to conduct the field work for this dissertation was obtained only after six months of repeated phone calls and faxes which began with the Head of Prison and culminated with the Judicial Inspectorate and a Chief Deputy Commissioner (both national level government officials). Appendix A chronicles the events of this process. Eventually, research was permitted to commence after a contract was signed stipulating that no information would be published without first being cleared by the department and that:

> The research must be done in such a manner that prisoners/members cannot subsequently use it to embarrass the Department of Correctional Services, members of the Department, prisoners, or Correctional Supervision Cases.[3]

The full text of this contract is included as Appendix B, and is a good example of the lack of administrative efficiency which pervades the department. It is an almost entirely useless document, in desperate need of updating, which is an annoyance at best and perhaps even unconstitutional at worst.

Because of the difficulties experienced in obtaining permission to conduct this research, it became apparent that DCS staff would be more willing to discuss the issues candidly provided that confidentiality was assured. All interviewees at WMB, both staff and prisoners, were granted confidentiality prior to the commencement of the interview. Although all interviewees were extremely co-operative and helpful, in order to protect them from negative repercussions within the department it was decided to not list their names or include direct quotes in this dissertation. For example, as is documented in Appendix A, one of the interviewees was called into the office of the Head of Prison, reprimanded for her assistance with this research thus far and then specifically instructed not to speak to KC Goyer for any reason.

The interviewees who were not either staff or inmates at Westville were not granted confidentiality. These include interviews with academics, NGOs, and other

[3] DCS fax 2000: 12

researchers. The only exception is one interviewee who is a former prisoner from WMB, for whom anonymity and confidentiality was guaranteed due to the sensitive nature of the topics discussed.

In collecting the data for this research, the impact of the interviewer on the interviewee has been considered. Many of the staff at WMB deal with highly stressful and emotionally draining circumstances, and the interviews became an opportunity for some to air grievances and release stress. The impact of the research on the researcher has also been noted, and the result has been a deepening commitment to increasing awareness about issues of HIV/AIDS and prisons, both separately and in combination. Finally, the impact of this research on society as a whole has been considered and it is hoped that the findings and recommendations of this study will contribute towards positive change in prison conditions and HIV/AIDS policies both in South Africa and the rest of the developing world.

Summary of Chapters

Chapter one provides a literature review, and begins with theories of policy-making, followed by a review of prison research including current trends and issues affecting the modern prison. After discussing general prison issues, the specific challenges faced by prisons in South Africa are presented in relation to international trends and developments. This section is followed by a summary of HIV/AIDS research, including a discussion of transmission, treatment, and opportunistic infections. The chapter closes with a presentation of HIV/AIDS research in various countries including a review of two studies conducted in African countries.

Chapter two presents background information on HIV/AIDS issues in South African prisons, beginning with a discussion of those characteristics of populations at high risk for HIV infection which coincide with those of the prison population. Using available demographic information, an attempt is made to estimate HIV infection in the South African prison population. The next section discusses behaviours in prison which place prisoners at high risk for contracting HIV, followed by the impact of current prison conditions on HIV/AIDS issues in South Africa. The final section of

this chapter presents policy options for addressing HIV/AIDS in prison, including those which have been condemned as well as those which are advocated by international bodies such as the World Health Organisation (WHO).

Chapter three begins with a discussion of prison policy and reform in South Africa, culminating in the development of the current HIV/AIDS policy. The impact of this policy is assessed, as well as an analysis of the differences between the written policy and what is actually implemented. Chapter four provides recommendations for a more effective response to HIV/AIDS in prison as well as proposals for general prison reform. The recommendations are primarily geared towards DCS but also include recommended interactions with the Department of Health and the Department of Justice.

The conclusion summarises the findings of each chapter, followed by a section on the politics of HIV/AIDS and prison reform, and how politicisation of the issue has affected policy. The paper concludes with suggestions for further research and an appeal for action.

Chapter One

Literature Review

1.0 Introduction

This chapter covers the relevant literature and existing research related to HIV/AIDS in prison. The chapter is divided into four sections: Policy Theory, Prison, HIV/AIDS, and HIV/AIDS in Prison. In the first section, two approaches and their opposing counterparts are presented. The benefits and drawbacks of pluralism versus elitism are presented, followed by a comparison of the top-down and bottom-up approaches to policy implementation. The next section starts with an explanation of the importance of understanding prison itself before attempting to understand the policies developed to address any particular challenge faced by prison administrators. This is followed by an historical overview of the prison as an institution and the development of prisons in South Africa. The section then covers current issues in prison research overseas, how these issues have been manifested in South Africa, and specific issues affecting South African prisons today.

After presenting the various issues affecting South African prisons, the chapter then focuses on the prison issue which is main concern of this paper – HIV/AIDS. The section on HIV/AIDS presents basic information, including transmission, treatment, the nature of infection in South Africa and a discussion of the most common opportunistic infections (tuberculosis and hepatitis C). This section concludes with a discussion of legal issues surrounding HIV/AIDS. The fourth section focuses spefically on HIV/AIDS in prison research which has been conducted in various countries around the world. Special attention is drawn to two studies conducted in African countries, as these are considered more relevant to South Africa. Finally, the lack of data on HIV/AIDS in prison in South Africa is discussed and a review of the limited literature available is presented.

1.1 Policy Theory

The primary theoretical perspectives employed to analyse the HIV/AIDS policies affecting South African prisoners involve the different approaches to policy-making as well as theories on implementation. Two theories on the policy development process are utilised to analyse prison policy in this paper: pluralism and elitism. Pluralism has its roots in theories of representative democracy, in which, "A limited number of people participate in the day-to-day business of government, but they may be representatives of the people as a whole."[4] As the electorate has expanded to include more people and more diverse interests, the processes of government have increasingly been influenced by various types of organisations: political parties, trade unions, special interest groups, etc. The impact of these "pressure groups" became noticeable at all stages of the policy process,

> "negotiating the details of legislation, establishing links to influence the implementation process, monitoring policy outcomes, and so on. Thus, it is argued that the pressure groups which have grown up alongside the formal institutions of government have come to play an important direct part in representing the views of specific interests."[5]

In pluralist theory, the involvement of various groups representing different interests is accepted as the best means of ensuring that the democratic process represents the true will of the people. The source of policy is then the popular demand for a specific course of action as demonstrated by the unification of support from various pressure groups.

There are two drawbacks to the pluralist model. First, it deals only with how policy is formulated in response to an accepted agenda of issues but does not explore how those issues are placed on the agenda in the first place. In pluralism, different groups compete for influence over decisions which are made regarding the issues about which the general public is aware. The competition of interest groups to represent the will of the people is thus subverted by the power of those who determine the agenda, thus controlling which decisions will be debated and which decisions (or,

[4] Hill 1997: 30
[5] Hill 1997: 30-31

non-decisions) will never be considered at all. Critics of pluralism argue that the non-decisions as well as the decisions are a manifestation of political power.

Stephen Lukes presents a theory of the three dimensions of power. The first is that of overt conflict, where A influences B to act in a manner which B would not otherwise have acted. This is the sphere in which pluralist theory operates, with various actors affecting each other and the outcome is a policy which reflects the various degrees to which each actor has power over others. The second dimension is the exercise of power in covert conflicts, where actors will appear to act in one manner but will actually use their actions to disguise actual intentions. An illustration of this is the use of 'band-aid' solutions to social issues, where a policy will appear to address an issue but the actual intention is to put forth minimal effort or change in order to defuse or disable the momentum behind that issue. The 'solution' is thus actually an attempt to dismiss the issue rather than a commitment to solving it.[6]

The third dimension of power is the ability to influence others to the point that no conflict emerges at all, either covertly or overtly. The conflict is latent because those who are affected by an issue are shaped and influenced in a way that they are never aware of the issue at all. Thus, there is an appearance of consensus between those with the power to address a situation and those who are affected by that power. This is not a consensus at all but rather the successful shaping of information and information sources to the point that the affected parties are misled to accept their situation and will not attempt to change it all. As Lukes explains, "To assume that the absence of grievance equals genuine consensus is simply to rule out the possibility of false or manipulated consensus by definitional fiat."[7] Through exercising power in this third dimension, political actors are able to prevent issues from becoming matters of public concern and can thus control the actual agenda. The various groups then believe they are influencing policy through their "power" to affect the issues on the agenda without realising that they have been prevented from addressing matters which affect them and do not make it onto the agenda in the first place.

[6] Hill 1997: 41
[7] Lukes 1974: 24

The pluralist model also fails to recognise the existence of the ruling elite in the form of pressure groups which are able to exercise power to an extent which is out of proportion with their actual voter support. This could be because some groups will be better organised and better resourced, and thus have a higher decibel level in the ongoing debates to shape policy. Thus, the most power will rest not with those who best serve the interests of the greatest number of people but rather with those who can afford to access the most information, hire the most expertise or otherwise control political resources. In this way, the groups which already enjoy the greatest control over resources will be rewarded with a greater impact on policy as well.[8]

In response to these criticisms, pluralism has been revised to what is referred to as corporatism. In the corporatist model, the government policy process formalises interaction with pressure groups by forming a policy advisory body with representation from each of the interested groups. Establishing an umbrella group with consultative status ensures access and at least a minimum decibel level for different groups, some of which may be better resourced or organised than others. The drawbacks to corporatism is that groups are co-opted into participation with the government and may be induced to water-down their demands in order to retain their inclusion in the policy process. Thus, the incentive for the pressure groups is to maintain their ties with government. A desire to stay on the guest list could supersede the group's original mission or purpose. Also, the formation of an entity with consultative status only could become tokenism and devoid of any real influence.

An alternative model to these inclusion approaches is elite theory, in which it is recognized that all societies consist of a ruling class and a class of those who are ruled. The elite class may or may not be directly involved in the governing of a society but could also contain business and military leaders.[9] In examining the South African Department of Correctional Services' policy process, the elite class consists of government officials and bureaucrats while in the United States, the policy decisions reflect business interests as well. In South Africa, the concentration of organisational control in a centralised hierarchical agency leads to self-perpetuating

[8] Hill 1997: 36
[9] Hill 1997: 43

bureaucracy and administration. There are currently more DCS employees in "desk jobs" than there are prison wardens or guards. In this case, organisational control and institutional position become political resources, and are regarded as sources of power. When the policy process is confined to the interests of ruling elite who control these resources, the positive effect can be increased efficiency but the negative result is a loss of accountability to the will of the people.[10]

The development of policy does not stop with decision-making regarding policy design but also includes the adaptations to that policy which occur at the implementation level. In fact, the implementation of any given policy is able to fundamentally transform that policy to the extent that implementation must be considered as a dynamic part of the policy-making process.[11] The breakdown between policy as it is designed and policy as it is implemented is referred to as the "implementation deficit", and could be the result of a number of factors including the amount of resources, level of communication, and the extent of dependence on other agencies.[12]

In analysing the implementation of policies to address HIV/AIDS amongst the prisoner population in South Africa, this paper will compare two theoretical models: the top-down and the bottom-up approach. The top-down approach involves centralised decision-making by the legislature, or those national-level politicians at the top of government hierarchies. Somewhat similar to elitist theory, those governments who operate using the top-down approach view policy as the property of policy-makers at the top, and are most concerned with making sure that policy is unambiguous, that outside interference is prevented, and that implementing actors are adequately controlled.[13] The top-down approach is characterised by a rigid policy framework, where policy is seen as an input and accountability depends on deference to the legislative process.[14]

An alternative to the top-down model is the bottom-up approach, which emphasises a flexible policy development framework in which policy is the output

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[10] Hill 1997: 44
[11] Hill 1993: 213
[12] Hill 1993: 226
[13] Hill 1997: 131

and accountability is considered in terms of responding to the needs of the end-user or recipient of public services.[15] The policy-making process involves setting goals which are determined by inputs from those who are most affected by that policy. Elmore refers to this as 'backward mapping' which is defined as

> 'backward reasoning' from the individual and organisational choices that are the hub of the problem to which policy is addressed, to the rules, procedures and structures that have the closest proximity to those choices, to the policy instruments available to affect those things, and hence to feasible policy objectives.[16]

Proponents of the bottom-up approach argue that it helps eliminate incorrect assumptions or misinformation because the impetus comes from those most directly affected, and thus most knowledgeable, about the issue which the policy is intended to address.[17] This helps address the concerns over the third dimension of power, in that actual facts regarding a situation can be disseminated to relevant decision-makers, making it more difficult to shape the policy process through the use of social myths or stereotypes.

Theoretical perspectives are helpful for understanding the how and why of the South African government's response to HIV/AIDS and prisoners. However, in order to analyse HIV/AIDS policies in South African prisons, it is first important to understand the prison as an institution.

1.2 Prison

The issue of HIV/AIDS in prison is, to a certain extent, symptomatic of the larger challenges of prison reform in general. The historical legacy of prisons, both in South Africa and elsewhere, plays a significant part in the development of prison policies and prison reform to this day. Also, there are several trends in the field of correctional services which have been observed overseas, particularly in the United States, which appear to developing in South Africa as well. The following section will cover relevant literature on prison research in order to provide the appropriate

[14] Hill 1997: 140
[15] Hill 1997: 138
[16] as quoted in Hill 1997: 138

background information for analysing the South African government's response to HIV/AIDS in prison.

1.2.1 History of Prison

The prison, as the accepted institution of modern criminal justice, was initially designed as an alternative to more public and gruesome forms of punishment. During the 19th century, a reform movement swept through western civilisations which decried the practice of corporal punishment, such as public whippings, or cruel executions, such as being "drawn and quartered". At the heart of this movement was the notion that even in the worst of criminals, there still exists one element which is to be respected: his or her humanity. Eventually, the policies of the penal system moved away from the vengeful retribution implicit in acts of torture and public humiliation. Instead, criminal justice was expected simply to punish, not exact revenge.[18] The punishment of a criminal was henceforth based on deprivation of liberty rather than infliction of bodily harm, and the prison was established.

Initially, prison was intended to accomplish much more than simply house criminals and administer to their basic needs while serving their allotted sentences. The penal reforms of the 19th century emphasised the duty of the prison system to transform the individuals in its care into respectable, law-abiding citizens. The concept of imprisonment, from the outset, was incidental to its corrective task. Thus, the prison functioned originally as a medium for the state's efforts to reform individuals.[19]

In England, the forerunner of the prison was the workhouse, an institution whose development coincided with the labour trends of the Industrial Revolution. The workhouse concept was evident in the corrections strategy employed in these first prisons, where criminals were instilled with the virtues of good citizenship through solitary confinement and hard labour. It was expected that the shiftless lazy vagrant, once broken by extended isolation, would welcome the diversion of manual labour.

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[17] Hill 1997: 139
[18] Foucault 1977: 74
[19] Foucault 1977: 233

The desired result was a healthy appreciation for the rewards of hard work and a permanent memory of the torment of solitary confinement, the effect of which it was hoped would deter future criminal behaviour.[20]

1.2.2 Prison in South Africa

The concept of prison was brought to South Africa by Dutch colonists, but it was after the British occupation that penal policy, including incarceration, began to take shape. Historically in South Africa, as in England, the duty of the prison administration to reform criminals was interpreted in order to accommodate the economic needs of the age. With the abolition of slavery in 1834, policy began to be shaped by the country's labour demands. During the 1840s and 50s, many public projects were constructed using prison labour.[21] The Breakwater Prison, now a historical landmark, popular hotel and conference centre and also part of the University of Cape Town's Graduate School of Business, was originally used to house the prison labour force which constructed the breakwater which protects the Cape Town waterfront.

By the late nineteenth century, labour demands of the mining industry began to impact on policies for imprisonment. The development of the South African prison system thus began to parallel that of another typically South African institution: the mining compound. These compounds were designed to not just house but also control thousands of workers who were migrant labourers, separated from their families and homelands.[22] The first racially segregated prison was constructed in Kimberley, and eventually both prisons and mining compounds were also segregated along tribal lines as well.[23] By the end of the century, the De Beers Diamond Mining Company was using over 10,000 prison labourers daily and even constructed prisons to house this sizeable component of their workforce.[24]

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[20] Van Heerden 1996: 3
[21] Oppler 1998: 4
[22] Giffard 1997: 16
[23] Oppler 1998: 5
[24] Van Heerden 1996: 4-5

Many of the prisoners sent to work in the mines were incarcerated for violating pass laws, which had been in effect in one form or another for nearly 100 years before the Nationalist government came to power in 1948. Thus, incarceration of Africans for minor infractions such as pass offences could reliably supply the necessary labour for the growing economy throughout the 1900s. In this way, the state effectively became, "the provider of unskilled black labour for the mines through the penal system".[25]

Local convict labour was integral to the growing South African mining industry until as recently as 1952. In the later 1950's, prisoners were used for farm work, and dozens of special "farm prisons" were constructed for this purpose. In 1959, an act of parliament officially abolished prison labour, but replaced the practice with policies that prescribed "useful and healthy outdoor work" for short term prisoners. This practice was reported still in use in both Transvaal and Natal as late as 1989.[26]

1.2.3 The Modern Prison

Although the practice persists in South Africa, internationally the use of forced prison labour began to fall out of favour during the 1960s. Without the economic incentive to provide prison labour, many governments began to attempt to reduce prison populations through the introduction of parole and experimenting with alternatives to incarceration. The current trend, however, is towards increasing imprisonment and several industrialised nations have seen an explosion in their prison populations in recent decades.[27] The most notable illustration is the United States, where the number of citizens behind bars has increased eight-fold in the last 30 years.[28] Today, the United States has more than 2 million prisoners and has just surpassed Russia as the most highly incarcerated country in the world. According to The Economist, "The scale of imprisonment in America is now unmatched in any democracy, and is greater than even most totalitarian governments have ever

[25] Van Zyl Smit 1991: 15
[26] van Heerden 1996: 6
[27] Oppler 1998: 10

attempted."[29] Marc Mauer, writing for The Sentencing Project in Washington, DC, observes, "No other society in human history has ever imprisoned so many of its own citizens for the purpose of crime control."[30]

The increase in the prison population is not, however, directly related to crime levels. There are myriad factors which impact on the amount of crime which occurs in a society, in addition to many variables in the criminal justice system as to how many of those crimes result in a sentence of incarceration. The boom in the US prison population has continued steadily since the mid-1970s, yet crime levels have consistently dropped for the past ten years. Arrests for violent crimes, such as murder, rape and robbery, declined sharply from 1990 to 1996, yet the prison population still doubled by the end of 1999.[31] Prison populations have not swelled because of increasing crime or because more criminals are being caught, but because of longer and harsher sentences and a reduced use of probation and other prison alternatives.[32] Most of these stricter sentencing laws have been directed at non-violent offenders, particularly those convicted of drug-related offences.

According to Eric Schlosser, "The enormous increase in America's inmate population can be explained in large part by the sentences given to people who have committed non-violent offences."[33] This is borne out by the fact that the proportion of violent offenders in the prison population has declined as the number of prisoners has increased. In fact, from 1980 to 1995, the percentage of people entering prison for a violent offence dropped from 50% to less than a third.[34] In contrast, the number of people in prison for illegal drug use or trafficking has quadrupled since 1989.[35] In the US, similar drug-related offences that result in a prison sentence would result in fines or community service, or would not be considered a crime at all, in other

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[28] Davis 1998: 2
[29] The Economist 1999: 30
[30] Mauer 1999, as quoted in Schlosser 1998: 52
[31] The Economist 1999: 30
[32] The Economist 1999: 31
[33] Schlosser 1998: 52
[34] Schlosser 1998: 52
[35] The Economist 1999: 31

countries.[36] There are more people imprisoned in the US for drug offences than the entire prison population of England, France, Germany and Japan combined.[37]

The Reagan-Bush administration's "War on Drugs", and politicians at all levels of government claiming to be "Tough on Crime", spurred the trend towards mandatory sentencing and other policies leading towards the lengthening of prison terms for non-violent offenses including drug use. The unfortunate reality is that imprisonment does not curtail drug use. Despite increasingly harsh sentencing for drug offences and the resulting large scale imprisonment of drug users, the number of people using drugs has not changed.[38] While as many as 80% of prison inmates have a history of substance abuse, drug treatment is available to just one in ten of inmates who need it.[39] Although the building of prisons continues to increase, the number of prisoners able to access drug treatment facilities in prison has declined by more than half since 1993.[40]

An important aspect of the increasing number of drug-users in prison is the disproportional increase of black men in prison:

> Among those arrested for violent crimes, the proportion who are African-American men has changed little over the past twenty years. Among those arrested for drug crimes, the proportion who are African-American men has tripled. Although the prevalence of illegal drug use among white men is approximately the same as that among black men, black men are five times as likely to be arrested for a drug offense. As a result, about half the inmates in the United States are African-American. One out of every fourteen black men is now in prison or jail. One out of every four black men is likely to be imprisoned at some point during his lifetime.[41]

Many critics have described the US policy of mass incarceration as institutionalised racism, including the recent book "Race to Incarcerate" by Marc Mauer. In an earlier article, Mauer points out that the disparities vary by state. Nationally, the ratio of black to white incarceration rates per capita was 7.66 to one in 1994. In the District of Columbia, capital of the United States, the per capita

[36] Schlosser 1998: 52
[37] The Economist 1999: 31
[38] The Economst 1999: 31
[39] Schlosser 1998: 54
[40] Schlosser 1998: 54
[41] Schlosser 1998: 54

incarceration rate of black men was 35 times greater than that of whites.[42] In an article entitled, "Masked Racism: Reflections on the Prison Industrial Complex", Angela Davis contends that, "racist practices in arrest, conviction, and sentencing patterns" are to blame for the fact that more than 70% of prisoners are people of colour. Davis also points out that the over-representation in the prison population of certain ethnic groups, including blacks and Latinos, is the most severe for Native Americans and that black women are the fastest growing group of prisoners.[43]

Although the United States is arguably the most egregious offender, the oppression of and discrimination against minorities by criminal justice systems is an international phenomenon. In her book "A Sin Against the Future: Imprisonment in the World", Vivien Stern explores the issue of over-representation of minorities in the prison population:

> All round the world the same pattern can be seen. Prisons contain higher proportions than would be expected of people from groups that suffer from racism and discrimination. How does this disproportion happen? There are many reasons, often related to blatant discrimination in the wider society, and crude racism by the law enforcement agencies. Sometimes the disproportion arises from policies which concentrate minorities in poor areas and restrict their opportunities...The police make decisions about which areas to police most actively, and which people to stop in the street and search for forbidden articles, weapons or drugs...Discrimination can enter into sentencing and parole decisions...The cumulative effect of all this discrimination is the disproportionate number of minorities in the prisons of the world.[44]

Stern goes on to give examples in various countries where people from specific ethnic groups are more likely to be imprisoned than white people who have committed the same crime. In some countries, the issue is not a case of black and white but rather that of immigrants and foreigners, indigenous populations, and gypsies or Roma.[45]

The combination of sentencing trends, increasing prison populations, and generally flawed criminal justice policies has been attributed to a collection of

[42] Mauer 1997, as cited in Stern 1998: 119
[43] Davis 1998: 2
[44] Stern 1998: 117
[45] Stern 1998: 118 - 121

political and economic interests referred to as the prison industrial complex. In psychology, the term complex refers to an overreaction to a perceived threat. The prison industrial complex describes the misguided and ineffective reaction of using imprisonment in response to crime. The plain truth is that American voters are easily misled to believe that prisons are the answer to crime, and politicians at both ends of the political spectrum have used, or even falsely generated, a fear of crime to gain votes.[46]

The motivation for the perpetuation and propagation of the prison industrial complex is both political and economic. A political candidate can win an entire election simply by providing evidence that portrays an opponent as "soft on crime". Few politicians will risk speaking out on the behalf of drug addicts and criminals, preferring a Clint Eastwood image to the challenge of explaining basic tenets of penology to the voting public. Equally important to politicians is the provision of jobs and economic growth, and the provision of correctional services is an attractive growth industry. Prisons are labor intensive, and are often located in rural areas where they provide jobs in otherwise depressed economies. Building a prison is expensive, and private contractors are not unaware of the USD$35 billion spent each year on prison construction.[47] Prisons are big business, and at least two private prison companies are listed on the stock exchange in the United States. It is not hard to imagine that the convergence of interests which benefit from increased spending on imprisonment can be powerful enough to have an immeasurable, if not overt, impact on criminal justice policy.

1.2.4 Prison in the New South Africa

Like the countries of Eastern Europe and the former Soviet Union, South Africa is still considered a transforming democracy. After the fall of the Berlin Wall, imprisonment in the transforming political states showed two phases. The prison population decreased at first as political prisoners from the old regime were released and new government structures were organised. The next phase saw the prison

[46] Schlosser 1998: 54
[47] Schlosser 1998: 54

populations increase as the uncertainties and difficulties of a new economy, new institutions, and an entirely new government result in increased criminal activity. Particularly when the fledgling state is struggling to fill the vacuum left by the elimination of the old system, criminal activity will grow in strength in response to the weakness of the new government.[48]

South Africa is not an exception to the phenomena experienced by the transition of the formerly communist states in Europe. From 1990 to 1992, the release of 57,000 sentenced prisoners resulted in a significant decline in the South African prison population. From 1992, crime increased rapidly and stabilised in 1995. An analysis of crime trends since 1980 provides evidence that crime in South Africa increased during the transition to democracy and stabilised with political stabilisation, which is generally considered to have occurred by 1996. As Sarah Oppler points out, this should not be interpreted to mean that crime is a fundamental aspect of democracy but rather that, "dramatic changes in societies which move from authoritarian to democratic governance often weaken state and social controls, generating increased levels of crime."[49]

Crime is not only affected by political instability in a country, but also is considered an expected consequence of development. As Mark Shaw explains, "Development generates greater opportunities for crime while also causing inequalities which encourage crime."[50] Over time, however, the nature of crime changes with sustained development, as more developed nations tend to face crimes against property while the lesser developed countries deal more often with violent crimes. Crimes against property will understandably increase as more economic growth translates into more cars, jewellery or other items of value which are commonly targeted for theft. This should not be interpreted to mean that development brings higher crime, because although rates of the occurrence of crime may increase, the impact of those crimes and the non-violent nature of them makes are less serious.[51]

[48] Oppler 1998: 11
[49] Oppler 1998: 14
[50] Shaw 1995: 14
[51] Shaw 1995: 14

Since 1997, the crime rate in South Africa has stabilised but the prison population has steadily increased.[52] The prison population has continued to grow, although much of the growth can be attributed to higher numbers of prisoners awaiting trial. Appendix D, "Prison Population Growth in the New South Africa: Sentenced and Unsentenced Prisoners" shows the growth of the prison population from 1995 to 2000. The data presented in the graph illustrate that the growth in the number of South African prisoners is primarily due to the growth in the number of unsentenced prisoners, which has more than doubled in the past five years. Oppler offers four explanations for this increase: better policing and the resulting higher arrest rate, longer time taken to process awaiting trial prisoners, longer sentences, and the processing and conviction of backlog cases from 1995/6 who were awaiting trial while out on bail.[53] Justice system delays in processing awaiting trial prisoners are largely responsible for the increase in the unsentenced prisoner population in South Africa. The current estimated number of criminal cases outstanding is nearly 200,000, and this number has increased by 21% since 1999.[54]

Court backlogs and crackdowns on crime are not exclusively responsible for the continuing rise in the prison population. The implementation of harsher sentencing, the increasing proclivity of politicians to espouse "tough on crime" rhetoric, and the recent introduction of private prisons should be considered cause for alarm. These developments indicate that in spite of the problems and injustices brought by mass incarceration in the United States and elsewhere, South Africa seems to be following this unworthy example in its own criminal justice system. The critical mistake which misleads the bulk of the US population seems to be occurring also here in South Africa: the misconception that prisons can reduce crime. The primary challenges for South African prisons are not unlike those overseas, and include issues of overcrowding, awaiting trial prisoners, gang activity, recidivism, and public health. However, importing policies which have failed in other countries is unlikely to be successful. Similarly, policies which have succeeded elsewhere must be adapted for the specifically South African aspects of any given problem or situation.

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[52] Oppler 1998: 14
[53] Oppler 1998: 14
[54] Mail & Guardian 2000

1.2.5 Current Issues in South African Prisons

The majority of the prisons which exist in South Africa today were constructed during the Apartheid era, and reflect the significant link between the treatment of prisoners and the labour needs of the economy. The typical prison cell is almost indistinguishable from a typical mining dormitory. Referred to as "communal cells", each one is intended to house anywhere from 9 to18 prisoners, containing only beds and a single toilet. The cells were designed with the idea that prisoners would be out working during the day and would only be in them at night to sleep, as they do not include desks, tables, or chairs or even much room for simply moving around. Due to overcrowding and staff shortages, prisoners are regularly locked up for the greater portion of the day and may only be afforded an hour outside to exercise.

Overcrowding exacerbates the problems with the initial design of prison cells, with the number of inmates in most prisons approaching, if not exceeding, double their intended capacity. The South African prison system was designed to accommodate 100,668 and currently struggles to accommodate an actual population of 172,271.[55] The degree of overcrowding varies considerably by prison and also by province. One of the worst prisons in terms of overcrowding is Johannesburg Medium A, with 6,250 prisoners incarcerated in accommodation meant for 2,630.[56] Both at Pollsmoor in the Western Cape and Westville Medium B in KwaZulu-Natal, up to 60 prisoners are kept in cells intended for 18. Beds are triple bunked and placed directly next to each other, and sometimes there are more prisoners in a cell than there are beds. One prison in Johannesburg is faced with 393% occupancy, while the province with the severest overcrowding is Northern Cape, which is operating at 231.68% capacity.[57]

The overcrowding problem in South Africa is directly related to the increase in awaiting trial prisoners. The sentenced prisoner population has increased 17% since 1995, while the number of unsentenced prisoners has increased 164%.[58] Approximately one third of South Africa's prison population are unsentenced

[55] Office of the Inspecting Judge 2000
[56] DCS 2000
[57] DCS 2000
[58] Office of the Inspecting Judge, 31 Januray 2001: 11

prisoners awaiting trial.[59] Two factors contribute most significantly to the increase in awaiting trial prisoners: inappropriately designed and/or implemented bail laws and inefficiencies in the processing of cases by the judicial system. Recent legislation enacted by Parliament makes bail no longer an option for certain types of crime in addition to other changes in sentencing laws which are intended to reduce crime. The more likely effect will be the increasing overcrowding of the prison system as parole is delayed and longer sentences become mandatory.[60]

Delays in the processing of cases by the judicial system has resulted a dramatic increase in the average period of imprisonment for prisoners awaiting trial. The number of awaiting trial prisoners incarcerated for longer than three months has increased nearly seven fold since 1996, and the current average detention time is just over 4 ½ months.[61] It is not uncommon for unsentenced prisoners to spend up to four years awaiting trial, usually in conditions which are even worse than those of the sentenced prisoner population.

When a person is imprisoned awaiting trial, it is for one of two reasons: bail is denied, or the person cannot pay bail. Bail is denied if the court decides that the person is unsafe for release because he/she poses a danger to the community or the court believes that the person is unlikely to attend court to stand trial. If the court determines that the arrested person is not a threat to the community and is likely to appear on his or her court date, then a bail amount is set. These amounts are usually in keeping with the seriousness of the crime, but sometimes even very low bail amounts are too much for an awaiting trial prisoner to afford.[62]

Of the 59,275 awaiting trial prisoners on 31 July 2000, 40,315 had been denied bail. Of the remaining 18,960 prisoners who were granted bail, more than 60% had bail amounts fixed at R1,000 or less. Given that the Department of Correctional Services estimates that it costs R88 per day to incarcerate each prisoner,

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[59] DCS 2001
[60] Oppler 1998: 16
[61] Office of the Inspecting Judge 2001: 14
[62] Office of the Inspecting Judge 2001: 14

it follows that the state pays more than R1 million rand every day to incarcerate people as yet not guilty of any crime other than being poor.[63]

The prisons which are the most severely overcrowded are usually the "Medium A" prisons, which are designated for awaiting trial prisoners. Although programmes and activities for sentenced inmates are by no means abundantly available for the sentenced prisoners, almost none are provided for the unsentenced. However, it is also not uncommon for awaiting trial prisoners to be intermingled with convicted prisoners in the same prison.

A defining feature of the prison environment in any country is the presence of gangs. The psychology of a prisoner is often one of helplessness and insecurity which gang membership helps to alleviate.[64] Also, in overcrowded and/or understaffed conditions, the loss of order or control by the management creates a power vacuum which gang structures readily fill. In many areas, gangs flourish in prison as many gang members are involved in criminal activity, resulting in a higher concentration of gang members in prison. However, not all gang activity in prison is related to gang activity outside of the prison. In South African prisons, the prevalent gangs do not operate outside of prison, and members of the same gang from outside prison may join rival gangs inside prison. Once in prison, however, allegiance to the prison gang takes precedence over membership in outside or street gangs.[65]

Prison gangs in South Africa are unique in that they have been in existence for over 100 years and their organisation is nation-wide. The two most powerful prison gangs in South Africa are the 26s and 28s. The original 28 gang existed in the mining compounds as well as the prisons, but by 1920 was permanently entrenched in several prisons while the gang structures outside of prison had all but dissipated. Sometime in the early 1900s, a former lieutenant of the 28s started his own gang, the 27s. One explanation for the these names is that at the time of the split, the original leader had

[63] Office of the Inspecting Judge 2001: 14
[64] Oppler 1998: 36
[65] Haysom 1981: 8

28 fighters to the split-off group's 27, although others claim that the first group had 8 officers and the other had 7.[66]

When the leader of the 27s was imprisoned in Pietermaritzburg, a group of 6 non-gang members smuggled tobacco and other luxury items for him. In return, the 27 leader gave the 6 permission to start their own gang, which became known as the 26s.[67] Today, the 27s and 26s are still closely intertwined and the 27s pledge to protect the 26s in exchange for the contraband or other items of value which the 26s specialise in procuring. Other gangs exist, including the 25s and the 29s as well as others but the 26s and 28s remain predominant.[68] According to their intricate codes of conduct, the two gangs are able to co-exist although tensions exist between the established and some of the newer, recently formed gangs. Instances of gang violence are not uncommon, although they are usually not random but carefully deliberated within the gang hierarchy. Indeed, a decision to kill a non-member is considered by a judicial panel and resolved by the signing of a death warrant. The gang structures of both the 26s and 28s parallel that of a para-military institution, and the tight organisational systems help extend each gangs power nationally.[69]

The prevalence and power of gangs may be related to the incidence of prisoners consistently returning to prison. Although the Department of Correctional Services does not maintain recidivism statistics, academic research has estimated that between 85% and 94% of prisoners will re-offend.[70] Conditions in South African prisons are often traumatic, and will therefore severely undermine any attempts at a positive outcome from imprisonment. Lukas Muntingh explains, "When people are living in conditions that are inhumane and are often treated as something other than human, it is unlikely that they will treat other people humanely."[71] At least 95% of South African prisoners will return to the community after serving their sentences and a good portion of these will serve sentences of six months or less. Without reintegration services upon their release, it is not surprising that prisoners completing

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[66] Haysom 1981: 3
[67] Haysom 1981: 4
[68] Haysom 1981: 4
[69] Haysom 1981: 5
[70] Ballington 1998 as cited in Muntingh 2001: 6
[71] Muntingh 2001: 51

their first sentence will find themselves hardened by their experience and either unable or unwilling to pursue non-criminal endeavours. The conclusion of the British White Paper on Crime Justice and Protecting the Public seems to hold in South Africa as well: "Prisons can be an expensive way of making bad people worse."[72]

The department's emphasis on security overshadows programmes aimed at reintegration of offenders, perhaps because an issue which is consistently reported in the media is the preponderance of escapes from police or correctional services' custody in South Africa. Of the 459 escapes reported by the Department of Correctional Services during 1999, 213 were from prison and the remainder were from work teams, courts, hospital or in transit. The Department of Correctional Services has focused increasing attention on escapes and has introduced programmes to address the issue as well as set targets for reducing the actual number each year. The department is proud of its achievement in reducing escapes from 1,244 in 1996, to 989 in 1997 and less than 500 for the past three years.[73] Many critics argue that this is only minimal progress, and should not be applauded because the expectation is that no one should be able to escape and therefore a goal of zero is the only acceptable target.

The term escape may not be accurate, as it conjures images of diligently tunnelling or well armed convicts overcoming the state's attempts to keep them confined. A better term for the South African situation might be "self-initiated" or "extra-judicially determined" release. Most prisons are decades old and in desperate need of repair and even those which are adequately maintained still have inherent security problems, such as insufficient fencing and lighting.[74] Staffing shortages and lack of training also contribute to the number of escapes, although it is difficult to determine how many escapes are staff-assisted.

While issues of security gain more media coverage, what should be of the greatest concern to the public is the lack of sufficient attention to health issues in prison. Many prison conditions have an ill effect on prisoners' health, and many prison health issues affect the greater community and are actually issues of public

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[72] as quoted in Oppler 1998: 64

[73] DCS Annual Report 1999: 9 - 10

health. Overcrowding inevitably leads to poor sanitation and hygiene, and the strain it adds to already limited resources impacts on provision of basic services including adequate nutrition and health care. In South Africa, out of the 74,362 complaints received by representatives of the Judicial Inspectorate, one quarter were related to food and health care. Prisoners cited these two categories of complaints more frequently than any other category.[75]

Understaffing coupled with overcrowding also limits the amount of time prisoners are able to spend outside of their cells, and the resulting lack of movement, let alone exercise, will also take its toll on prisoner health. The impact of emotional stress and psychological trauma on prisoners' physical health has also been documented in other countries, although no such study has taken place in South Africa.

Because all but a very small percentage of prisoners will return to the community upon completion of their sentences, many issues related to prisoner health become issues of public health when they are released. Due to poor medical treatment of contagious diseases which thrive in the prison environment, prisoners return to the community sicker than they left and take their sicknesses with them. The cost of missing out on this intervention opportunity, to reduce sickness both inside and outside the prison, is great. The illnesses that are particularly prevalent in prisons include hepatitis B and C, syphilis, tuberculosis, and HIV/AIDS.[76]

1.3 HIV/AIDS

HIV stands for Human Immunodeficiency Virus, which develops into a condition known as Acquired Immunodeficiency Syndrome (AIDS). HIV attacks the immune system, causing the body to become more susceptible to other illnesses such as infections or cancer.[77] These illnesses are often referred to as "opportunistic" diseases or infections, because the body would be able to fight them off were it not for the weakening of the immune system by HIV. People with HIV can live for months

[74] Oppler 1998: 34
[75] Office of the Judicial Inspectorate 2001: 9
[76] UNAIDS 1997: 3

or even years before their condition develops into AIDS. In fact, research estimates that as many as half the people with HIV will not develop AIDS until 5 to 10 years after infection.[78] When an HIV+ person develops AIDS, the immune system will deteriorate to the point that the person will be progressively more sick, more often, and for longer periods of time until he or she eventually dies. The usual length of time for this final stage is 1 to 2 years.[79]

In order to determine a persons' HIV status, an HIV test must be administered, usually on a sample of blood, urine, or saliva. The tests do not actually detect the virus but rather the presence of HIV antibodies, the cells which the human body generates to fight off the attack of the virus. When a person becomes infected with HIV, these antibodies are not immediately detectable by an HIV test. It may take up to 3 months after the actual infection for an HIV+ person to test positive for HIV. This 3 month delay is referred to as the "window period", and is the reason that it is impossible to accurately determine an individual's HIV status with a singly administered test. The recommended procedure is to test a person twice, at a three month interval, in order to ensure accurate results.

As an HIV+ person's infection progresses, he or she will have an increasing number of viruses in his or her system. The number of viruses in a person's body is referred to as their viral load. A person with a higher viral load is more likely to transmit the virus, as there will be more viruses in his or her body fluids.[80] When a person first becomes infected with HIV, his or her viral load spikes upwards, then tapers down after his or her body has begun producing HIV antibodies. This process may take several weeks, and in part explains the "window period" which affects the accuracy of HIV testing. The result of this phenomenon is that an HIV+ individual will have a higher probability of transmitting HIV during the first few weeks after

[77] USAID 1999
[78] Pienaar 1989: 89
[79] USAID 1999
[80] Vernazza 1999: 157

becoming infected, during which time it is not possible to determine whether or not that person is HIV+.[81]

1.3.1 Transmission and Prevention

HIV is transmitted through contact with blood, semen, or vaginal secretions of an infected individual. It is not transmitted through casual contact, such as shaking hands, nor can it be spread as a result of kissing, spitting, or sneezing. There are only five known ways to spread HIV:

1. Anal, oral, or vaginal intercourse
2. From mother to child, before or during birth or via breast milk
3. Transfusion of contaminated blood or blood products
4. Using contaminated cutting or piercing instruments (razors, ear piercing, tattooing, ritual scarring)
5. Sharing hypodermic syringes (usually associated with intravenous drug use)[82]

The virus cannot live outside the body for more than a few minutes, and therefore dried blood or other contaminated fluids do not pose a risk for transmission. Some means of transmission are known to have a higher probability of infecting a person than others. The highest probability for HIV transmission is a blood transfusion from an HIV+ individual. Amongst sexual activities, the highest risk of transmission is receptive anal intercourse. This is because the rectal lining is thinner and more prone to tearing, which facilitates infection.[83] Activities such as sharing razor blades or toothbrushes are considered to be the lowest risk for transmission of HIV, and very few cases of this type of transmission have been adequately documented.[84]

The best way to protect against contracting HIV is to practice safe sex and to avoid exposure to potentially contaminated needles or other cutting instruments.

[81] Jacquez 1994: 1169
[82] Carelse 1994: 5
[83] Highleyman 1999: 3
[84] CDC 1993: 2

Using condoms during sexual intercourse, whether oral, anal, or vaginal, is the recommended means of preventing HIV infection. However, because no means of protection is 100% effective, additional recommendations include staying faithful to one partner or abstaining from sex altogether. If a person uses needles or other instruments which can pierce the skin, either as part of his or occupation or through a range of other activities including intravenous drug use, the needle or instrument should either be discarded after each use or carefully sterilised. Particularly in the health care profession, appropriate caution must always be emphasised when either giving injections to or taking blood from patients.

1.3.2 Treatment

There is no vaccine against infection with HIV, and there is no cure for either HIV or AIDS. The standard treatment at public health facilities in South Africa for patients with HIV is symptomatic therapy for opportunistic infections. This normally consists of heavy antibiotics, such as Bactrim, and treatments to prevent tuberculosis (TB). These drugs are fairly cheap and are effective for treating the most common illnesses associated with HIV and AIDS. They do not, however, prevent or delay the development of HIV into AIDS.

The most common treatment for an HIV+ individual is Anti-retroviral (ARV) therapy. Although complicated and expensive, ARV treatment has proved very effective. For HIV+ people who are financially able to obtain and maintain the strict regimen of drugs, ARV treatment can slow the progression of the disease and prolong life. A person undergoing ARV treatment will have a lower viral load, meaning that the number of viruses in their body is lower than if they were not undergoing the treatment. A lower viral load translates into a lower probability of transmission to other non-infected people. For this reason, the universal provision of ARV treatment is often presented as an issue of public health and an important part of stemming the spread of HIV infection, in addition to the humanitarian arguments against valuing profits for drug companies over the lives of the impoverished.

A standard ARV treatment programme consists of at least three different drugs, each of which must be taken at different times throughout the day. Some ARV medicines must be taken with a meal, and some must be taken either one hour before or two hours after a meal. Without consistent adherence to the required schedules for this kind of drug therapy, the effects of ARV treatment can be negligible and the potentially toxic side effects may counter any improvements to overall health. Furthermore, inconsistent adherence can cause drug resistant strains to develop, preventing the HIV infected person from responding to further treatment. This ARV-resistant strain of HIV can also then be transmitted to others, who will also not benefit from ARV treatment.[85] An important ethical consideration in the debate around ARV is whether the drugs should be denied to those who are unlikely to maintain appropriate adherence, such as the homeless or injection drug users.[86]

Most medical aid schemes do not cover ARV treatment and it is not available from public health facilities in South Africa. The average cost of ARV therapy in the United States is US$10,000 - $15,000 per year per patient. This does not include the monitoring and testing necessary to adapt prescriptions according to the progression of the virus, which will vary for each individual. At the current prices, the cost for providing ARV treatment to all infected people in sub-Saharan Africa would be between US$101.2 and US$161.4 billion. This represents 1763% of current health expenditures, and 66.9% of total GDP for these countries.[87] Generic drug manufacturers have offered to provide ARV drugs at much lower costs, but reduced drug costs are only part of the issue. The costs of monitoring and adherence would have to be shouldered by the public sector, where health budgets are already strained by the burgeoning pandemic.

If a person becomes exposed to HIV and ARV drugs are administered immediately, it is possible to prevent that person from becoming infected. This treatment is called post-exposure prophylaxis, and has been studied for the benefit of health workers who may encounter occupational needle-stick injuries. If a person accidentally becomes exposed to HIV contaminated fluids, perhaps as the result of an

[85] WHO/UNAIDS Module 1, 1998: 8
[86] WHO/UNAIDS Module 9, 1998: 13
[87] WHO/UNAIDS Module 9, 1998: 5

unintentional needle stick, he or she is advised to begin high dosages of ARV drugs within 36 hours of the injury and to continue the treatment for at least 4 weeks, or until that person's HIV status can be accurately determined.[88]

[88] CDC MMWR 1998: 14

1.3.3 Tuberculosis

The most common way in which HIV/AIDS presents itself in South Africa is through TB.[89] Data obtained from one hospital in Gauteng showed that as many as 80% of newly admitted TB patients were also HIV positive.[90] In South Africa overall, about half of the new cases of TB are attributable to HIV.[91] In many countries, TB has become the most recurring disease contracted in conjunction with HIV resulting in the pattern that where TB is high, HIV is high.[92]

Many adults can be TB carriers but will not develop any symptoms until their immune system is compromised, such as by infection with HIV. An asymptomatic TB carrier infected with HIV thus becomes actively contagious, contributing to increased TB infection in the rest of the population.[93] In this way, HIV causes an increase in the spread of TB, and other infectious diseases, to other HIV-negative people. It is estimated that in sub-Saharan Africa, "one out of every four TB deaths among *HIV-negative people* would not have occurred in the absence of the HIV epidemic"[94]

Unlike HIV, TB is both highly contagious and curable. The most common form of TB is pulmonary, meaning that the illness infects the lungs. Symptoms usually include violent coughing, involving the dispersion of infected sputum. Inhalation of airborne droplets of infected sputum is the most common means of contracting TB. Thus, contagiousness of TB can be compounded by areas which involve a great deal of people crowded into a small poorly ventilated space.[95]

The World Health Organisation (WHO) has published guidelines for the effective treatment of TB, referred to as Directly Observed Therapy (DOT). The term "Directly Observed Therapy" stems from the requirement that the patient is directly observed taking the medication. Direct observation is emphasised because, much like ARV treatment, poor adherence can result in drug resistant strains of the disease.

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[89] UNDP 1998: 57
[90] UNDP 1998: 57
[91] UNDP 1998: 24
[92] Moriarty 1999: 5
[93] Carelse 1994: 8
[94] USAID 1999
[95] Stern 1999: 13

DOT is a six to eight month programme, during which time the patient must take a combination of five different drugs. The cure rate for DOT averages around 90%, and can cost as low as $11 for the duration of treatment. While DOT has become widely practised in developing countries, treatment for multiple drug resistant tuberculosis (MDRTB) is usually not available because it is much more expensive.[96]

1.3.4 Hepatitis C (HCV)

While TB is the most common opportunistic infection in South Africa, other countries have discovered that Hepatitis C is also common in HIV+ patients. In US prisons, most prisoners infected with HIV are co-infected with Hepatitis C (HCV). This is difficult to detect, however, because HIV infection can result in the body not being able to produce the antibodies which show up in preliminary HCV testing.

HCV is a degenerative liver disease and is chronic in 85% of the people who contract it. It is transmitted only through blood-to-blood contact, and can lead to serious secondary illnesses, disabilities, liver transplants, and death. In some patients, severe symptoms do not occur for 20 or 30 years. According to the Centre for Disease Control (CDC) in the United States, Hepatitis C is the most common blood-borne infectious disease in the country with 1.8 percent of the population infected, excluding the homeless and the incarcerated. In the prison population, however, infection rates are as high as 60%. Many patients, both inside and outside prison, are misdiagnosed or HCV is simply not detected due to co-infection with HIV. HCV is the most common reason for liver transplantation, but with proper diagnosis, treatment, and lifestyle changes the need for a transplant can be avoided entirely.[97]

1.3.5 Legal Issues and HIV/AIDS

In addition to the health issues surrounded HIV/AIDS, there are several legal issues which must be considered. One of the most controversial is the criminalisation of HIV transmission. More than 90% of people who are HIV+ in South Africa do not

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[96] Stern 1999: 21
[97] HEPP 2000: 1

know that they are infected with HIV.[98] Because of fear of discrimination and stigmatisation, some may not want to know their HIV status. As the AIDS Law Project notes, it is not surprising, "that HIV is most frequently transmitted unwittingly by people who do not know they have HIV."[99] However, a disproportionate level of attention has been drawn to the actions of HIV+ individuals who knowingly place others at risk for transmitting the virus. A common public sentiment is that the intentional transmission of HIV should be made a criminal offence. In the United States, 29 states have already passed legislation which makes intentional transmission of HIV a criminal offence.[100]

The purpose of law which would criminalise intentional transmission of HIV would be to protect individual rights and to reduce HIV transmission. However, in South Africa, existing common law provides the necessary tools for deterrence, retribution, and punishment in the instance of intentional HIV transmission.[101] Therefore, a new law would offer few if any advantages as it would still face the challenges intrinsic to the nature of the disease and its transmission which affect the existing laws. The position of the AIDS Law Project is that criminalisation of HIV, "not only fails to advance the objectives of the criminal law; it also impedes the public health initiatives which have proven most effective in containing the spread of HIV."[102] The policy of the Department of Health (DOH) is to "ensure that punitive measures aimed at those alleged to be spreading HIV are not introduced".

The AIDS Law Project explains the potential negative consequences of the criminalisation of HIV:

> Criminal prosecutions divert scarce resources away from critical public health programme. Moreover, the criminalisation approach undermines education campaigns urging all people to recognise that it is impossible to determine who is infected with HIV, requiring all persons to take consistent precautions against inherently unsafe activities like unprotected sex. Furthermore, the enforcement of special criminal sanctions in the context of HIV will in all likelihood compound the climate of stigmatisation which alienates people from

[98] Axam 1999: 1
[99] Axam 1999: 1
[100] ACLU 1998
[101] Axam 1999: 1
[102] Axam 1999: 2

> public health services, impeding efforts to contain the epidemic through public health interventions.[103]

Additional concerns about the criminalisation of intentional HIV transmission include broader implications, such as infringement of an individual's right to privacy and the fuelling of fear, prejudice and stigmatisation regarding HIV.[104] The conclusion is that these drawbacks and risks far outweigh the potential benefits, and thus far the South African government has not passed legislation which would criminalise HIV.

Individual rights are at the centre of the legal issues regarding HIV/AIDS. International guidelines distributed by the World Health Organisation, as well as specific court cases and South African law, provide that certain rights of people living with HIV/AIDS must be respected. The discussion usually focuses around the security of the person, informed consent, pre- and post-test counselling and confidentiality. Security of the person refers to a person's right to refuse to take an HIV test. In South Africa, it is illegal to enforce compulsory HIV testing for any reason because, "Subjecting someone to an operation, or any medical procedure, without their express and informed consent is breaking the law."[105] Furthermore, "An HIV test carried out without informed consent is an unlawful infringement of that person's bodily integrity, and an invasion of his or her privacy."[106]

Informed consent must be express and specific, and many testing facilities will obtain informed consent in writing before conducting an HIV test. Informed consent is part of the necessary counselling which must be provided both before and after an HIV test. Informed consent can only be obtained once the person tested understands the nature and likely consequences of the test. Because learning one's HIV status has serious health and social implications, the AIDS Law Project has emphasised the need for pre- and post-test counselling.[107] Particularly for those living with HIV/AIDS, the right to confidentiality becomes an important part of dealing with the social realities of being HIV+ in South Africa.

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[103] Axam 1999: 2
[104] Axam 1999: 2
[105] ALP 1998: 3
[106] ALP 1998: 3
[107] ALP 1998: 3

1.4 International Comparisons

Internationally, the issue of HIV/AIDS in prison has been deplorably under-researched. A great number of countries do not have reliable data on the extent of HIV infection in the prison population. Many studies focus on the simple initial task of determining HIV prevalence, often only in one particular area or prison. Where more in-depth research has been undertaken, the focus is usually on one of two themes: prisoners are a high risk population for HIV infection, and the prison environment includes high risk behaviours for HIV transmission. In some countries, data has been obtained on rates of HIV transmission in prison although not all of these studies have produced conclusive results. In the more developed countries, research focuses primarily on IV drug use and other means of transmission. In lesser developed regions of the world, research deals with the attendant health issues of a prisoner population which consists of a high proportion of people who are already HIV+ upon entering the prison.

1.4.1 United Kingdom

Her Majesty's Prison Service, in its first report on the issue of HIV/AIDS in prison, acknowledged that, "HIV can...make prisons more difficult to manage whilst at the same time imprisonment can make the management of HIV more difficult."[108] The report also pointed out that prisoners, by definition, are rule-breakers and therefore are less likely to respond to instructions regarding safer sex and drug use. The results of the first study of HIV prevalence in England and Wales were released in July 1998. The study found that overall, prisoners in England and Wales were four times more likely to be infected with HIV than the overall UK population, and that female prisoners were thirteen times more likely to be HIV positive. The study also found that 41% of men, 25% of women, and 20% of juveniles who were IV drug users prior to entering prison were able to continue using IV drugs while in prison.[109]

[108] H.M. Prison Service 1995: 1
[109] NAPF 1998: 1

In a separate study undertaken in England, researchers put together valuable data on high risk behaviours within the prison environment. Of 50 men and women studied by one physician,

> "Forty-seven ex-prisoners had taken at least one illegal drug in prison and of these 33 had done so by injection. Twenty six had shared injecting equipment. Four of them had anal sex whilst in custody and they had between four and 16 partners."[110]

One survey found that 75% of respondents who admitted to using IV drugs while in prison also reported sharing needles and syringes with others. One ex-prisoner explains, "I was lending my needle to 20 prisoners and I'm HIV. They knew I'm HIV."[111]

At Glenochill prison for men in central Scotland, only 14 of the 350 prisoners were found to be HIV+. However, a phylogenetic analysis of the viral sequences showed that 13 of the 14 HIV+ prisoners had been infected from a common source. The conclusion from the molecular evidence was that these 13 men were infected while incarcerated, most likely as a result of needle sharing for IV drug use.[112]

At Featherstone jail in Wolverhampton, drug use is so rampant that prisoners who were not users prior to incarceration are becoming addicts by the time they leave the prison. Drug problems were also cited as a cause for increasing violence in the prison, with the result that many inmates were compelled to carry knives to protect themselves. According to a report by Sir David Ramsbotham, Chief Inspector of Prisons, "Many prisoners felt that people came to prisons without a drug problem, but turned to drugs to cope. They then left prison with a heroin habit and inevitably came back to prison for a drug-related crime."[113]

Attempts to curb drug use in prison have included random drug testing, but the effects have in some ways become counter-productive. In order to avoid getting caught by a random drug test, prisoners who formerly preferred cannabis, which is detectable for up to a month after use, began switching to heroin, which is out of the

[110] Thomas 1994: 47
[111] Thomas 1994: 47
[112] Yirrell 1997: 1
[113] The Independent 1998:1

system in a few days. Heroin is a popular IV drug, while cannabis is normally smoked.[114]

In addition to data on drug use and needle sharing, numerous studies have sought to gain information on homosexual activity in prison. One survey of 453 ex-prisoners found that ten percent admitted to participating in unprotected anal penetrative intercourse. During one prisoner's three year sentence, he shared his cell at different times with a total of 58 men. Of these, 17 had "high risk sex" with him. The same prisoner estimated that up to 85% of incarcerated men have some kind of sexual experience in prison.[115] The Prison Reform Trust, a policy research NGO based in the UK, has estimated that up to 30% of prisoners become involved in homosexual activity. This estimate is supported by information obtained in a survey conducted by the National Association of Probation Officers, which concluded that "sexual relationships were not unusual between prisoners."[116]

1.4.2 USA

In the United States, an increasing number of drug users, including intravenous drug users, are behind bars. Of the 733,374 AIDS cases reported to the CDC during 1999, 25% were injection drug users.[117] In light of these facts, it is no surprise that HIV infection and transmission, is a serious issue for the increasing number of IV drug users in US prisons. Recently, the US National Commission on AIDS observed that, "by choosing mass imprisonment as the ...governments' response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection."[118]

Studies of HIV infection in US prisons have found that seroprevalence is anywhere from 5 to 10 times higher than the general population.[119] Furthermore, the Center for Disease Control and Prevention (CDC) has estimated that, "recently

[114] The Independent 1998:1
[115] Thomas 1994: 49
[116] Thomas 1994: 49
[117] CDC website
[118] AIDS Law website
[119] CDC 1999: 5

released prisoners account for one-sixth of U.S. AIDS cases." In addition, the number of new AIDS cases in prison is 20 times that of the population at large.[120] AIDS has been the leading cause of death for prisoners in New York and Maryland since 1993.[121] And as far back as 1991, every single death among women prisoners in the state of New York was attributed to AIDS.[122] These studies have consistently found that HIV infection rates are higher among women prisoners, generally because female prisoners are more likely to have histories of injection drug use.[123]

The CDC conducted a study of male prison inmates in Illinois in an attempt to quantify the extent of custodial seroconversion. In a sample of 2,390 prisoners who tested negative at intake, there were seven confirmed seroconversions after one year's incarceration.[124] This translates into an annual transmission rate of 0.3%, which may appear small but is still far from negligible. If this rate were applied to the national population, it would mean that more than 6,000 prisoners will be infected with HIV each year.

Custodial seroconversion statistics seem to vary considerably from state to state, as the table below illustrates:

Maryland	0.41%
Illinois	0.33%
Nevada	0.19%
Alabama	0.0006%[125]

One explanation for this variation is the differences in HIV prevalence amongst those entering the prison in that particular state. These variations are evident in the table below, which lists some of the most highly infected state prison populations in the US:

[120] AIDS Info website
[121] Neser 1993: 26
[122] AIDS Info website
[123] Thomas 1994: 140
[124] Thomas 1994: 141
[125] Ruby 2000

New York	10.80%
Connecticut	5.10%
Massachusetts	3.70%
Rhode Island	3.20%[126]

Researchers offer many different explanations for the differences in seroprevalence in each state, although many cite the preponderance of drug-related crime as one of the chief factors.

1.4.3

Canada

The Correctional Service of Canada (CSC) resisted many early attempts to conduct HIV research in the prison, and presented a number of arguments against obtaining data on seroprevalence within the prison. The Director General explained that seroprevalence studies would not be undertaken because of "concerns that the procedure might further stigmatise an already stigmatised population and, as well, raise contentious ethical considerations"[127] The Prisoners with AIDS/HIV Support Action Network (PASAN) supported this view, adding that such studies would be "time-consuming and expensive" and would use "money that would be better spent improving the care of and services to prisoners with HIV/AIDS."[128]

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

[126] Ruby 2000
[127] Thomas 1994: 113
[128] Thomas 1994: 113

prior to imprisonment, and the rate of HIV infection among injection drug users in the community."[129]

One of the first studies on HIV in prison in Canada was conducted in a medium security prison for women in Montreal. The researchers found that injection drug use was reported by 49.8%, and of those who used IV drugs, needle sharing was reported by 83.7%.[130] The study concluded that, "Nonsterile injection drug use practices and unprotected sexual activity with an injection drug user were found to be the strongest risk factors for HIV infection."[131]

The most recent statistics released by the CSC have found that HIV prevalence in prison has increased an average of 27% per year since 1990. Ralf Jürgens, executive director of the Canadian HIV/AIDS Legal Network, claims that needle sharing for injection drugs is the primary reason for the increase in HIV infection in prison. Similarly, CSC spokeswoman Michele Pilon-Santilli attributed the high infection rates to the fact that approximately 70% of inmates have drug-related problems prior to incarceration.[132]

1.4.4 Portugal

Health care professionals the Oporto Central Prison in Portugal have been collecting data on HIV prevalence within the prison since 1992. In a paper presented at the XIII International AIDS Conference, three doctors from Oporto Central Prison presented their findings regarding transmission mechanisms, HIV+ prisoner demographics, and custodial seroconversion. Of the 10,980 prisoner files reviewed, 1,057 were HIV positive, representing just under 10% infection. The most common characteristic within the HIV positive population was drug addiction, namely heroin and cocaine.[133]

The most striking finding from this study was regarding transmission within the prison. The physicians claim that only 8 cases were found in which infection

[129] AIDS Law website
[130] Thomas 1994: 111
[131] Thomas 1994: 112
[132] Hamilton Spectator, 16 November 2000

occurred within the prison. However, the paper does not explain how these 8 cases were discovered. In the introduction, the authors explain that all prisoners are tested upon entrance to the prison, but they do not mention re-testing the prisoners at a later stage in order to study transmission during incarceration. The paper concludes that HIV transmission within the prison is not an issue, owing to the low rate discovered through the study, and also the claim that "a huge percentage of these patients became aware of their condition only when they entered the prison system because it was then that they were first tested for that possible infection."[134] Because the methodology is not clearly outlined in this study, it is questionable whether these conclusions can be considered valid.

1.4.5 India

A case study was recently completed in Karnataka, India – a state with one of the highest prevalence rates in India. The study consisted of HIV testing as well as group counselling, structured interviews, and focus group discussions with both inmates and staff at the Mysore Jail. The seroprevalence rate was highest amongst female inmates, at 9.5%, and was 25% amongst inmates that were also commercial sex workers. In addition to prevalence rates, researchers also obtained information on knowledge and awareness of HIV. Of all inmates surveyed, 58% had heard of HIV/AIDS, 25% were aware that it is fatal, and 38% believe it is only a sexually transmitted infection. The researchers recommend education targeted at female sex workers as a means of intervention to reduce transmission in the greater community.[135]

1.4.6 Russia

Russia is the second most highly incarcerated country in the world, just behind the United States. Like most of Eastern Europe and Central Asia, Russia also faces

[133] Morgado 2000: 4
[134] Morgado 2000: 4
[135] Nagaraj 2000

serious problems with TB.[136] The rate of TB infection in Russia more than doubled between 1991 and 1997. Over 100,000 new cases are reported each year, and one third of these are in prison. It is estimated that an additional 30,000 cases each year are undetected.[137] An Amnesty International report found that:

> Conditions in penitentiaries and pre-trial detention centres continued to amount to cruel, inhuman or degrading treatment. The Procurator General expressed concern at serious overcrowding and revealed that some 2,000 people had died of tuberculosis in prison in 1996, a death rate of 10 times the rate in the general population[138]

HIV infection is increasing in Russian prisons, and the presence of TB is compounding the problem. Being infected with HIV increases the probability that latent TB will become active.[139] One study conducted in St. Petersburg found that the number of new HIV/AIDS cases increased 4.5 times from 1998 to 1999 and that one in four of these cases was in prison.[140] More than three-fourths of new cases were injecting drug users and approximately 70% of new patients were between 15 and 29 years old. The morbidity rate for HIV outside the prison was 62 per 100,000 while inside prison the morbidity rate was 510 per 100,000.[141] Amongst the papers presented at the XIII International AIDS Conference, the highest HIV prevalence rate in prison reported was that of Russia with 34% of the prison population infected. This is substantially higher than the prevalence reported in some African countries, where HIV/AIDS is more widespread in the general population. The 2nd and 3rd highest prevalence rates reported at the XIII International AIDS Conference were from Cote D'Ivoire with 27.54% and Zambia with 27%.[142] The most likely explanation is the high level of intravenous drug use in Russia, as the same study presented at the conference found that 58% of reported IV drug use in the previous 12 months.[143]

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[136] ICPS website
[137] Stern 1999: 17
[138] as quoted in Stern 1999: 18
[139] Stern 1999: 19
[140] Rakhmanova 2000: 1
[141] Rakhmanova 2000: 1
[142] HEPP 2000: 2
[143] HEPP 2000: 2

1.5 HIV/AIDS in Prison in Africa

As with any policy challenge, the problems in lesser developed countries are considerably different to those in the richer nations of the world. While the data presented above regarding HIV in prisons in various countries around the world help to underscore the importance of appropriately addressing this issue for any government, the specific aspects of HIV infection in prison in these countries are not necessarily the same as those faced by African countries. In terms of transmission, the biggest difference is the relatively minimal, if not entirely absent, use of intravenous drugs in African prisons. The larger issue, however, is the relatively higher rate of HIV infection in the general African population compared to that of the rest of the world. In 1999, the global death toll from AIDS was 2.6 million people; 85% of these deaths occurred in Africa.[144] In South Africa, it is estimated that a total of 4.7 million people were HIV+ at the end of 2000, making South Africa the country with the highest number of HIV+ people in the world.[145] Because HIV/AIDS is such a critical issue for African governments, the issues of HIV/AIDS in African prisons should also be considered of critical importance. Unfortunately, research on HIV/AIDS in prison has been conducted in only a handful of African states. However, what little information is available is extremely useful for better understanding HIV/AIDS in South Africa.

1.5.1 Zambia

A study entitled "HIV related risk behaviours and HIV seroprevalence in an African prison establishment" was carried out at three jails in Zambia, and consisted of one to one interviews and testing for HIV and syphilis. The results found that of the 1566 prisoners tested, 27% of inmates were HIV positive and 15% had syphilis. Only 3.7% reported engaging in sex with other male inmates (MSM), 11% reported using drugs while in prison, 16.9% had tattoos and over 60% shared razor blades. Condoms are not available in any of the jails involved in the study.[146]

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[144] Bartholet 2000: 32
[145] DOH 2001: 9
[146] Simooya 2000: 1

Researchers found a correlation between HIV infection and MSM, and also a positive relationship between testing positive for HIV and for syphilis. However, there did not seem to be a connection between sharing razors, drug use, or tattoos and HIV infection. This is not surprising, as sharing razors is not thought to be a high risk behaviour for HIV transmission. However, the data collected on drug use is inconclusive as no distinction was made between intravenous and endovenous drug use. Also, the statistics on the extent of sexual activity between prisoners are not entirely reliable owing to the tendency of prisoners to under-report their participation in this type of behaviour.

The results of an earlier study, entitled "A Longitudinal Study of the Risk of HIV Transmission in an African Prison" are less conclusive. In this study, researchers attempted to follow a cohort of inmates at Kamfinsa prison to determine the extent of HIV transmission in the prison. At the start of the study, 78 inmates were tested and 18 (23%) were HIV+. Six months later, 28 inmates from the original inmates were re-tested and one inmate tested positive who had previously tested negative.[147] The inmate denied that he had participated in unprotected sex, and had not been tattooed. The explanation offered was that this inmate contracted HIV through sharing razors but insufficient evidence is given in the study to consider this finding reliable.

1.5.2 Malawi

A study of HIV/AIDS in Malawi prisons, conducted for Penal Reform International in 1999, found that most prisoners and prison officers knew that homosexual intercourse was the most likely form of transmission of HIV in prison and acknowledged that this activity was common. In Zomba prison, respondents estimated that 10% to 60% of prisoners participate in homosexual activity at least once and about one third of these have habitual sex with other prisoners.[148] The impact of overcrowding on homosexual activity in Malawi was recognised by most respondents, in that most homosexual activity was reported to take place where up to

[147] Simooya 1998: 1
[148] Jolofani 1999: 8

43 prisoners are kept in one cell. Some prisoners explained that a shortage of blankets would lead to prisoners sharing blankets and that sex would also occur in these situations.

Homosexual activity is referred to as an "unnatural offence" in the Malawi Penal Code and carries a prison sentence of 14 years, therefore it is understandable that homosexual activity inside the prison will be under-reported. Prisoners and wardens explained that only a small portion of prisoners who participate in homosexual activity inside the prison are homosexuals outside prison, while the rest engage in homosexual activity only because of their situation inside the prison.[149] This latter group was often described as "very needy" as the excerpt below explains:

> They are usually recently detained, either juveniles or young adults, who have no blanket, soap, plates or food. They have no relatives from the outside to help them and care of them, they are in physical need and confused by their recent detention and they turn to somebody to care for them. The ones they usually turn to are those who have outside supplies. The relationship between them was described as similar to that between a poor prostitute and a rich client.[150]

Prisoners most likely to obtain "wives" were those who worked in the kitchen because they are able to offer more and better food to those who comply.[151]

Inquiries about homosexual rape obtained mixed responses. Juveniles reported that they had, "heard of fellow juveniles having been raped" and some adults reported they had heard of it on occasion but not frequently. Other adults, however, said rape was fairly common but that authorities could be bribed to keep quiet.[152] The most alarming finding of the study was the discovery that prison officials are actively involved in prostitution rings involving juvenile offenders which are "rented" to adult prisoners:

> An adult prisoner approaches a prison officer, gives him some money and asks him to get him a boy. You know some prisoners are rich compared to the guards. The guard then smuggles a juvenile into the adult blocks when they are out of the juvenile wing. Once they are there they can be hidden for months, and the man who paid for them

[149] Jolofani 1999: 7
[150] Jolofani 1999: 8
[151] Jolofani 1999: 9
[152] Jolofani 1999: 9

> rents them out to other prisoners 'for short time', using other prisoners to get him customers.[153]

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

> There are 22 of us in our cell, and two of my cell mates have juveniles as "wives". They got them by bribing the POs [Prison Officers] at the main gate. These juveniles agreed to have sex with these men because they had no clothes and no blanket, and they were hungry. One day these boys started to cry and refused to have sex. The man took away their blankets and after spending a night in the cold they agreed to allow the men to have sex with again. We try to tell these boys that they will die of AIDS, but what can these boys do?[154]

Researchers point out that while segregation of juveniles from adults and better supervision would help protect them, the involvement of prison officers makes their abuse more difficult to prevent. Better conditions, or closer proximity to family members or other community ties could also help as the study explains that "the root causes of juveniles prostituting themselves to adult prisoners are the physical needs to food and shelter, and the need for protection."[155]

As well as the likelihood of HIV transmission, the incidence of HIV infection and AIDS related deaths in prisons in Malawi paint an equally depressing picture. AIDS is the leading cause of death in prison in Malawi, consistent with international data. In 1997, 2,138 (25%) of the 8,403 cases of treatment administered for prisoners in Zomba Central Prison were HIV+. During the first six months of 1998, just under half of prisoners treated tested positive for HIV. The most common illnesses treated in the prison clinic were malaria, pulmonary TB, scabies, and diarrhoea.[156]

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[153] Jolofani 1999: 9
[154] Jolofani 1999: 10
[155] Jolofani 1999: 11
[156] Jolofani 1999: 16

1.5.3 South Africa

The most comprehensive book on prison in the new South Africa is South African Prison Law and Practice, written by Professor Dirk Van Zyl Smit, currently of the Institute of Criminology at the University of Cape Town. In addition to the legal information available, Van Zyl Smit's work provides a comprehensive history of the prison in South Africa. Although no mention is made of the issue of HIV in prison, Van Zyl Smit does write about the provision for prisoners' basic needs as well as a prisoner's right to safe custody. Specifically regarding medical care of prisoners, Van Zyl Smit writes, "There is a positive duty on the prison authorities to ensure that adequate medical care is provided for all prisoners"[157] The remainder of this section explains the duty of medical officers towards the prisoners in their care, but again, makes no specific reference to HIV/AIDS.

Since 1994, most of the literature on prison issues in South Africa has been focused on the transformation of the Department of Correctional Services (DCS) from an institution of the apartheid era to a component of the new democratic government. The studies undertaken by policy research groups such as the Centre for the Study of Violence and Reconciliation, the Institute for Security Studies, and the Human Rights Commission focused on recommendations to de-militarise the prison system, relief of overcrowding, and appropriate measures to separate awaiting trial prisoners as well as juveniles. The issue of HIV/AIDS is sometimes mentioned, but usually in the context of describing the perils of overcrowding, gang prevalence, or other concerns about the prison environment in general. To date, not a single study has been undertaken which focuses entirely on HIV/AIDS in prison.

The incidental treatment of HIV/AIDS in prison throughout these studies results in a tendency to oversimplify and even underestimate the severity of the issue. One of the most in-depth studies of prison issues in South Africa is Sarah Opplers' "Correcting Corrections: Prospects for South African Prisons". Although this invaluable work was published in 1998, it gives only a brief treatment of HIV/AIDS and the information offered overemphasises the issue of transmission in prison.[158] It

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[157] Van Zyl Smit 1992: 150
[158] Oppler 1998: 37

is equally important to recognise that the population segments which are targeted for incarceration are the same segments which are already affected most severely by the HIV pandemic. Homosexual activity and drug use cause problems related to HIV *transmission* in the prison environment, but the problems of HIV *infection* are related to the same socio-economic factors which impact on crime and incarceration in the first place.

Although a comprehensive study on HIV/AIDS in prison has not yet taken place, there have been several journal articles which have dealt with the topic of HIV/AIDS in prison in South Africa. One of the first was published in Acta Criminologica in 1989, and dealt with the issue from the perspective of the risk of infection for prison and police employees. In "AIDS and the Criminal Justice Officer", Professor P. J. J. Pienaar explains that the risk of transmission from biting, hitting, spitting, or other assaults is minimal, and perhaps non-existent. The article concludes that although AIDS is a serious public health problem facing South Africa, it is not a direct occupational hazard for the employees of the criminal justice system.[159]

It wasn't until four years later that an article in the same journal addressed the issue of HIV/AIDS in prison from the perspective of the risks to the incarcerated population. Neser and Pretorius present a balanced analysis of the controversies and arguments surrounding the most commonly suggested policy options: segregation, mass testing, confidentiality, and condom distribution. Although this article does recognise the high risk behavioural characteristics of the prison population, both prior to and during incarceration, it focuses on more symptomatic approaches to the problem rather than systemic reforms. In contrast, although the extensive paper, "Correcting Corrections", published in 1998 by the Institute for Security Studies, only touches briefly on the issue of HIV/AIDS in prison, it explores an entirely new approach for the prison system as a whole and thus presents much more constructive solutions. For example, Neser and Pretorius discuss the pros and cons of providing condoms to prisoners, but never explore the possibility of creating a prison environment which is not conducive to rape.

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[159] Pienaar 1989: 90 - 92

While research on the nature and extent of HIV infection amongst convicted prisoners has not taken place, research on HIV infection amongst arrestees is currently underway. An as yet unpublished paper, "The Prevalence of HIV Infection in South African Arrestees," was presented at the XIII International AIDS Conference in Durban in July, 2000. This study, a joint project between the Medical Research Council and the Institute for Security Studies, tested men and women in police holding cells in 3 police stations in Johannesburg, 4 stations in Cape Town, and 2 in Durban. The participants were tested for drug use as well as HIV, and were also surveyed to gather demographic data, information on high risk behaviour, as well as knowledge of HIV. The findings of the study, as presented at the conference, were that prevalence amongst arrestees was consistent with prevalence amongst similar age and race classifications in the various provinces involved in the study. From the survey responses, researchers found that many arrestees never use condoms, sexually transmitted infections were fairly common, a high proportion had been previously arrested, and knowledge of HIV and modes of transmission was generally good.[160]

1.6 Conclusion

Prison began as a Western institution whose development, both in South Africa and in the countries where it began, paralleled the labour demands of industrialising economies. Several important international trends in prisons have developed in recent decades, most notably an increasing reliance on incarceration as part of criminal justice policy and the development of the prison-industrial complex. South Africa's prison issues are somewhat similar to international experiences, but also include their own unique attributes. For example, the sophistication and power of exclusively prison-based gangs is peculiar to the South African prison system. Some of the most pressing problems faced by the South African Department of Correctional Services are caused by factors outside the department's control, such as overcrowding and an increasing number of awaiting trial prisoners.

[160] Vardas 2000

HIV/AIDS is an area which has gained considerable attention in South Africa, and for good reason. South Africa is one of the countries hardest hit by the pandemic and other attendant health issues, such as increasing cases of TB. The impact of HIV/AIDS in prison, while studied to varying degrees in other countries, has not been well-researched in South Africa. Most studies of HIV/AIDS either focus on obtaining prevalence data or determining the amount and means of transmission. In the more developed countries, research deals mainly with the high incarceration rate and co-inciding high HIV infection rate of intravenous drug users and the sharing of needles when such drug use is continued inside prison. In Africa, the studies focus more on victimisation of vulnerable prisoners and the high percentage of prisoners who are already HIV+ upon entering the prison. South African studies have not yet focused exclusively on the issue of HIV/AIDS in prison, although most of the recent prison research in South Africa makes at least some mention of the problem.

Chapter Two

Primary Issues and Policy Options

2.0 Introduction

This chapter will explain the primary issues surrounding HIV/AIDS in South African prisons. The first section will explain the various factors which make the members of the prison population a group at high risk for HIV infection. The important point to remember is that because of the nature and extent of HIV infection in the general population of South Africa, a significant portion of prisoners will be HIV positive upon entering prison. The second section examines some of the activities which take place in prison that are considered high risk behaviours for transmitting the HIV virus. The third section discusses the impact of prison conditions on the incidence of high risk behaviours as well as the impact on prisoners already infected with HIV or those suffering from AIDS. The final section presents the arguments for and against some of the more controversial policy options, such as mandatory testing, segregation, and condom distribution. This section also discusses general policy options in terms of caring for prisoners with HIV. The chapter closes with a discussion of the ramifications of failing to address the issue of HIV/AIDS in prison, including legal liability issues as well as the implications for public health for all of South Africa.

2.1 High Risk Population

HIV/AIDS is an indiscriminate disease, and attacks with equal ferocity regardless of age, race, or gender. The socio-economic patterns of certain demographics, however, significantly contribute to the prevalence of HIV+ within a specific population. It has been documented that, "HIV in South Africa flourishes most in areas that are burdened by unemployment, homelessness, welfare dependency, prostitution, crime, a high school drop-out rate, and social unrest."[161] The poor, in general, are at greater risk for infection and numerous studies have

attempted to address the very real and pronounced relationship between poverty and AIDS.[162] Research also points out a pattern in medical backgrounds, in that many of the people with HIV have a history of sexually transmitted diseases.[163]

In addition to similar behaviour patterns and social environments, age, race, and gender are significant indicators of HIV infection rates. The youth, as a demographic group, have been identified as the highest risk group for HIV infection[164], ostensibly because this group is usually the most sexually active. In South Africa, the HIV infection rate is highest among the black population: seropositivity is ten times more common in black South Africans than in any other racial category.[165]

The most highly infected segment of the population is black women between the ages of 20 and 24, of whom more than 40% are HIV+ . Prevalence for black men peaks with the 25 to 29 age group, where nearly 1/3 are infected with HIV. This infection rate is considerably greater – and growing faster – than infection rates in the population as a whole.[166] Appendix E shows the current and projected HIV infection statistics for this group compared to the general South African population. As the graph illustrates, black men aged 25 to 29 in South Africa have an infection rate which is considerably higher than that of all the other races combined, and is also higher than all adult males aged 20 to 59. This shows that both age and race are important indicators for HIV infection, with young black men being a particularly high risk group.

Just as is the case with HIV infected populations, prison inmates tend to fit a standard demographic profile. The boilerplate prisoner is the same in many countries, in part because selective law enforcement tends to focus on incarcerating the crimes of the lower class, specifically people who are poor, young, uneducated, and/or unemployed.[167] The typical characteristics of a prisoner coincide almost eerily with

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[161] Whiteside (website)
[162] UNDP 1998: 11-14
[163] Neser 1993: 25
[164] UNDP 1998: 12
[165] UNDP 1998: 52-3
[166] UNDP 1998: 55
[167] Thomas 1994: 3

that of a seropositive individual. The impact of joblessness, illiteracy and a general environment of lawlessness, all commonly considered contributing factors towards criminal behaviour, has also been studied as a factor in HIV infection. On the whole, in other countries as well as in South Africa, "Prison inmates engage in more of the behaviours conducive to the transfer of this virus [HIV] and engage in them more frequently than does the general population."[168]

Most research on HIV/AIDS in prison has revealed a disproportionately high number of HIV+ individuals in the prisoner population. In the United States, the rate of confirmed AIDS cases is more than 7 times higher than the general population.[169] In Canada, the prevalence of HIV among prisoners is "at least ten times higher than in the general community."[170] In France as well, the infection rate is estimated at ten times that of the general population.[171] A report financed by the European Commission studied conditions in 26 countries, and concluded that, "From the available data, the rate of seropositivity is clearly higher in detention than within the general community."[172]

In addition to the higher percentage of seropositive inmates, the rate of growth of HIV+ infection also far exceeds that of the general population. In Poland, the doctor responsible for health care in the prison administration reported that the number of HIV+ prisoners doubles every three months.[173] In the United States, the number of new cases of AIDS in prison is 20 times that of the population at large.[174] In Canada, the number of known cases of HIV/AIDS in federal correctional facilities increased 40% over a period of only 16 months.[175] And while the rate of infection continues to increase, the number of deaths increases as well. AIDS has been the leading cause of death for prisoners in New York and Maryland since 1993.[176] And

[168] Moriarty 1999: 2
[169] AIDS in Prison Project "Facts" website
[170] Jürgens 1996: 1
[171] IPW 1996: 16
[172] IPW 1996: 16
[173] Thomas 1994: 33
[174] AIDS in Prison Project "Facts" website
[175] Jürgens 1996: 2
[176] Neser 1993: 26

as far back as 1991, every single death among women prisoners in the state of New York was attributed to AIDS.[177]

The Department of Correctional Services (DCS) includes statistics on HIV/AIDS infection in the prisons in the DCS Annual Report. However, these statistics reflect only the reported cases from the health services of each prison and are not considered reliable. To date, there has never been a nation-wide survey of HIV prevalence in the South African prison system. A pilot study to determine HIV prevalence at Westville Medium B is currently underway, but the results are not yet available. The DCS statistics underestimate the extent of HIV infection because the prisons' reporting is inconsistent and often AIDS-related deaths are recorded only as TB or pneumonia. According to the 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.[178] This translates to an infection rate of 1.6%. Given that the infection rate for the general South African population at the end of 1999 was 12.5%, the DCS statistics are clearly inaccurate.

It is possible to estimate the HIV infection rate, the AIDS prevalence, and the number of AIDS-related deaths in prison by using other more reliable sources of information. According to demographic information provided by the records department, 85% of prisoners at Westville Medium B are black, 7% are Indian, 5% Coloured and 3% White. The records department divides prisoners into three age groups: under 20, 20 to 25, and over 25. Because the last category, over 25, is such a broad range in comparison to the other two, the statistics on prisoner ages are not very helpful. To illustrate, the HIV infection rate for all South Africans over 25 will be much lower than that of South Africans between 20 and 25 because the infection rate drops considerably after middle age.

In order to arrive at a more accurate estimate, it was necessary to obtain additional information regarding prisoner ages. By examining the files of all prisoners admitted in the previous three days, it was observed that the oldest prisoner admitted was 31. Therefore, it can be assumed that while 55% of prisoners at

[177] AIDS in Prison Project "Facts" website
[178] DCS Annual Report 1999: 19

Westville are over 25, most of them are not over 30. Thus it can be expected that HIV prevalence at Westville Medium B approximates the HIV prevalence of black men between the ages of 25 and 30. According to the Metlife Doyle Model, Scenario 225, the estimated HIV infection rate for this demographic is 32% and the estimated prevalence of AIDS is 1.1%.[179]

The Department of Correctional Services' reported AIDS prevalence is 0.08%. Just as is the case with the department's HIV statistics, the AIDS statistics only reflect confirmed AIDS cases and are unrealistically low. Although the official statistics on the incidence of HIV and AIDS are not reliable, data on the number of natural deaths in prisons is more useful for understanding the real impact of HIV/AIDS on the prison population. There were 1,087 natural deaths in prison during 2000; an increase of 584% from 1995.[180] The increase in the prisoner population was 38% over the same period. Appendix F shows the actual number of natural deaths per 1000 prisoners from 1995 to 2000. By presenting the number of deaths in per capita terms, it is possible to see the marked increase in natural deaths; an increase which exceeds the increase in the size of the prisoner population. For example, there were less than 2 deaths per 1000 prisoners in 1995. Last year, there were more than 6 deaths per 1000 prisoners. It is difficult to determine how many of these deaths can be attributed to AIDS, because some records list only TB or pneumonia as the cause of death. However, it can be assumed that the dramatic increase in natural deaths in prison is a result of the same disease which is causing an increase in deaths outside of prison. The logical conclusion is that prisoners, like their counterparts in the community, are dying of AIDS.

Alarmed by the increasing number of natural deaths reported in prisons and aware of the limitations of DCS statistics, the Judicial Inspectorate conducted its own study in 1999. Examining post-mortem reports, the study determined that 90% of deaths in custody are from AIDS-related causes. Using figures from the previous five years and assuming the escalation would continue, the study projected that by 2010 nearly 45,000 prisoners will die whilst incarcerated. Appendix G presents the Judicial

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[179] MetLife 2000

[180] Office of the Judicial Inspectorate 2001: 19

Inspectorate's statistics on the actual number of deaths in South African prisons from 1995 to 2000 and the projected number of deaths from 2000 to 2010. The study predicted that natural deaths in prison would increase 43.3% from 737 in 1999 to 1,056 natural deaths in custody in 2000. The projection for 2000 was admirably accurate, but the actual figure was even higher than expected. Natural deaths in prison actually increased 47.5% to 1,087 during 2000.[181]

The hospital at Westville Medium B is for all prisoners in KwaZulu-Natal, therefore information on AIDS-related deaths at this prison is useful for understanding the number of AIDS-related deaths amongst prisoners in the entire province. The number of deaths in the Westville prison hospital has been increasing at a faster rate than natural deaths in prisons nation-wide. Appendix H shows the number of deaths at Westville Medium B Hospital from 1992 to 2000. In 1992 and 1993, there were 11 deaths at WMB Hospital. Last year, this number increased more than seven-fold to 80 deaths. Looking at Appendix H, one see that most of this increase has taken place in the last four years. Of the 80 deaths during 2000, 78 were from AIDS-related causes. Most of these were also attributed to TB. As of March 29, 2001, there were 22 deaths in the prison hospital at Westville and 21 of these were attributed to AIDS.[182]

2.2 High Risk Behaviour

A major issue regarding HIV/AIDS in prison is that of custodial seroconversion, or people who contract HIV while incarcerated. The reality of prison life includes many activities which are considered high risk for HIV transmission. The most common of these are homosexual activity, IV drug use, and use of contaminated cutting instruments.

[181] Office of the Judicial Inspectorate 2000
[182] Interview #1: WMB Health Staff A

2.2.1 Homosexual Activity

In the context of determining HIV transmission, the difference between sexual activity in prison and in the general population is significant. Two aspects of sexual activity inside the prison make it a higher risk for transmission: rape and sexually transmitted diseases. Higher risk of transmission is part of prison sexual activity because, "HIV is more easily contracted when there is damage done to the epithelial linings during sexual intercourse. This often occurs during anal intercourse or rape."[183] In addition, a common characteristic of a prisoner's background is a history of sexually transmitted diseases. This means the risk is much greater because, "HIV is spread more easily in sexual intercourse if there are sores from other sexually transmitted diseases. These allow the virus more easily to enter the blood stream"[184]

Tearing and the presence of STD's notwithstanding, 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. One study found that unprotected receptive anal intercourse carried the highest probability of infection, at 0.8 to 3.2%, compared to only 0.05 to 0.15% for unprotected receptive vaginal intercourse.[185] 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."[186]

Homosexual activity, including rape, is a frequent occurrence in prison. In the United States, researchers estimate that up to 60% of prisoners participate in homosexual activity.[187] Because many studies rely on self-reporting and because most government departments seem reluctant to admit that any such activity exists, it is generally assumed that the actual incidence of sodomy and rape is much higher than the limited information available suggests. In a study of the Philadelphia jail system, interviews with 3,304 prisoners found that more than 2,000 sexual assaults had taken

[183] Carelse 1994: 5
[184] USAID 1999: 1
[185] Highleyman 1999: 4
[186] Highleyman 1999: 3

place within 26 months. Although 60,000 men passed through the system in that same time frame, only 96 assaults were reported, 64 were included in prison records, 40 resulted in disciplinary action, and 26 were reported to the police for prosecution.[188]

Prisoner participation in homosexual activity is usually not related to a person's sexual orientation outside of the prison, but is rather a product of the circumstances within a prison environment. One study in the United States found that 55% of self-designated heterosexuals reported sexual activity in prison. The same study determined that while 14% of prisoners reported that they were sexually assaulted, 19% had regular sexual partners.[189] A popular explanation for this pattern is that because most prisoners are young and sexually active, incarceration in a single-sex institution prevents them from continuing the sexual patterns and relationships to which they are accustomed. Even prisons which allow conjugal visits, (which are not permitted in any South African institution), are scarcely considered to be "fulfilling the sexual drive of prisoners in anything other than in its most basic form."[190]

The need for sexual fulfilment is only one part of the prison sexuality dynamic. Sex in the prison environment, particularly in the form of rape, is more often about power and asserting control over another human being than about sexual fulfilment. One theory explains, "deprived of almost all areas of power over his own life by the regime of incarceration, a 'man' often seeks to stake out a small arena of power by exerting control over another prisoner."[191] Given that many countries still have laws against homosexual activity, it is not surprising that many prisons expressly forbid sex between inmates, even in countries where homosexual acts are not illegal in the general community. The psyche of a prisoner is usually that of a rule-breaker, and so it follows that participating in forbidden sexual acts is a prisoners' means of rebellion, "against the total institution, hence a demonstration that the institution's control over that person is less than complete."[192]

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[187] Moriarity 1999: 2
[188] Donaldson 1990: 12
[189] Donaldson 1990: 11
[190] Thomas 1994: p.2
[191] Donaldson 1990: 4
[192] Donaldson 1990: 4

Lawyers for Human Rights estimates that 65% of inmates in South African prisons participate in homosexual activity.[193] Among prisoners awaiting trial, many of whom are held in the same cells as convicted prisoners, an estimated 80 percent are robbed and raped by other prisoners before they are officially charged.[194] At Westville Medium B Prison in South Africa, social workers reported that prisoners commonly participate in sodomy either voluntarily or through threats and coercion. A social worker at Westville Medium B commented that while many prisoners and prison guards will not admit it or discuss it, sodomy and rape are "rife"[195].

One former prisoner, when asked to estimate or quantify the amount of sodomy which takes place in South African prisons, simply stated that it is an "every night, every day occurrence." Of particular interest was the interviewee's explanation of sodomy 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."[196] The impact of this gang regulated sex trade is so far reaching as to be inescapable. According to one former prisoner, if a prisoner with money and/or influence wishes to acquire a certain prisoner as his passive partner, the chosen prisoner may not have a choice as the gang system is powerful enough to engineer changes in cell assignments with the assistance of the prison guards and officials.

2.2.2 Drug Use

Many of the richer industrialised nations face a serious problem with intravenous (IV) drug use and the resultant needle sharing. The probability of transmission from shared injection drug equipment is extremely high, second only to

[193] Giffard 1997: 36
[194] AFP 2000
[195] Interview #6: WMB Social Worker Z

receiving a contaminated blood transfusion amongst non-sexual means of transmission. In the United States, there are more IV drug users in American correctional institutions than in drug treatment centres.[197] While in prison, these addicts find ways to continue their habits but do not have access to clean syringes or disinfectants and thus needle sharing is a widespread practice. The result is that IV drug use is the leading cause of HIV infection in US correction institutions.[198]

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

Since South Africa's transformation, illegal drugs are obtained to a large extent from Nigerian drug syndicates. Heroin, the most commonly injected drug in the United States, is provided in South Africa by Nigerian syndicates.[199] Heroin has not found the same popularity in South Africa, and those who do use it tend to smoke it rather than take it by injection. This seeming aversion to injecting drugs could be related to previous negative associations or bad experiences with pinks. However, an increasing number of younger people have taken to smoking heroin who were perhaps not involved with drugs when pinks were popular. Once a person is a heroin addict, it is not entirely unlikely that they will take to injecting in addition to, or perhaps instead of, smoking their drug of choice. Given that the Nigerian syndicates control an estimated 40% of the United States heroin market, it is likely that the supply will become available should the demand increase in South Africa.[200]

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[196] Farren 2000: 33
[197] Moriarty 1999: 11
[198] Moriarty 1999: 11
[199] Interview #10: Ted Leggett
[200] Interview #10: Ted Leggett

Intravenous drug use is not common in South African prisons, perhaps because these types of substances are far too expensive and are normally used by socio-economic segments of the population that are typically not sent to prison.[201] A recent study on AIDS and human development has confirmed that, "drug use through injections appear to be limited and sharing of needles does not, at this stage, appear to be a very significant mode of HIV transmission [in South Africa]."[202] However, a survey of incarcerated juveniles in Western Cape found that 5.4% reported using IV drugs.[203] While this amount is not high, it is also not negligible and the potential for growth is compounded by the fact that those interviewed were all between the ages of 12 and 18.

Both prisoners and staff interviewed from WMB confirmed that IV drug use does not happen at all at Westville Medium B. From interviews with 274 prisoners at Westville Medium B, only 6 had ever tried intravenous drugs, only three had used IV drugs in the 12 months prior to incarceration, and none had used IV drugs since entering prison. Although IV drug use doesn't take place in prison, use of mandrax and marijuana (dagga) is more common inside prison than outside.[204] Of the prisoners surveyed at Westville Medium B, 72% reported smoking marijuana and 5% reported taking mandrax while in prison.[205] It is difficult to predict whether IV drug use will increase in South Africa, but if an injection culture develops outside of prison it can be expected to erupt inside prison as well.

2.2.3 Contaminated Cutting Instruments

An integral part of the prison sub-culture is the incidence of rudimentary tattooing by inmates on other prisoners.[206] 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

[201] Interview #7: WMB Former Prisoner
[202] UNDP 1998: 50
[203] Carelse 1994: 7
[204] Interview #10: Ted Leggett
[205] Prisoner Questionnaire

include sharing razor blades or use of sharp implements in prison violence or self-mutilation. Owing to the relatively secure nature of the prison, cutting instruments are in short supply and are thus more likely to be shared. The risk for HIV transmission from use of contaminated cutting instruments will depend on the amount of blood involved and the time elapsed between uses, as well as the viral load of the infected person and certain biological attributes of the non-infected person.[207]

In South Africa, tattooing is part of the extremely powerful gang structure within the prisons. Because everyone's clothing is standard issue, identifying tattoos become the medium for communicating who belongs to which gang. A social worker at Westville Medium B Prison estimated that about half of the 3,100 or so prisoners there had been tattooed while in prison.[208] 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.[209] For ink, prisoners burn rubber bands or will use shoe polish.[210] 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.[211]

2.3 Impact of Prison Issues

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

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[206] Neser 1993: 24
[207] Highleyman 1999:1
[208] Interview #4: WMB Social Worker X
[209] Interview #4: WMB Social Worker X
[210] Interview #10: Ted Leggett
[211] Interview #8: Derrick Mdluli

expectancy of those with HIV seropositivity."[212] In the US, AIDS inmates are dying an average of 8 months earlier than AIDS patients in the general population.[213] Although definitive data from South African prisons is not available, it appears that the finding in that US remains applicable, that "Incarceration speeds the progress of the disease from infectious stage into the full-blown malady."[214] 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.

2.3.1 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. Because it is an airborne communicable disease, TB is easily spread wherever conditions combine a large number of people and low sanitary standards. In the United States, prisons have become an incubator for TB due to overcrowding and poor ventilation.[215] The prison doctor at Westville Medium B cited TB as one of the most commonly treated illnesses for prisoners. One nurse is assigned as the TB co-ordinator, and an entire cell block is reserved for prisoners who have tested positive for TB. Westville Medium B consists of communal cells, originally intended for 18 are crammed with an average of 50 prisoners, but can contain up to 62 prisoners.[216] Prisoners are unlocked for breakfast around 7 am and are locked up again at 3 p.m. This means that a typical cell contains 50 people who spend 18 hours each day in close proximity to each other with no ventilation or air circulation. There are no statistics available on the full extent of TB in South African prisons, but given the

[212] Greene 1996: 1
[213] Moriarty 1999: 3
[214] Thomas 1994: 97
[215] Moriarty 1999: 5
[216] Prisoner Questionnaire

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.[217] In addition to the basic health and sanitation risks, the incidence of rape within a prison varies with the intensity of overcrowding.[218] The risks for violence as well as sickness are obvious. Plainly stated, "...the more crowded is the prison, the greater is the likelihood of acts of rape and homosexuality."[219] And the dangerous corollary to this is that increased homosexual activity means more prisoners more often are participating in high risk behaviour for transmitting HIV.[220]

In South African prisons, overcrowding can lead to high risk behaviour in that the increasing scarcity of simple items such as blankets and shoes are then used as commodities which can be exchanged for sexual acts. One former prisoner explained that in the particularly crowded cells there are fewer beds than there are people. It is not surprising that sharing a bed with another prisoner can lead to homosexual activity, sometimes in exchange for the privilege of having a bed to sleep in. The only other options for some prisoners is to sleep in the shower or toilet as sometimes even floor space is not available.[221]

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.

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[217] Thomas 1994: 38
[218] Carelse 1994: 27
[219] Thomas 1994: 32
[220] Moriarity 1999: 2
[221] Interview #7: WMB Former Prisoner

2.3.2 Nutrition

One of the most common complaints raised by prisoners is about the food. At Westville Medium B, inmates are fed twice a day. At breakfast, they receive porridge with one teaspoon of sugar, 2 slices of bread and tea. In mid-afternoon, they receive their only other meal of the day and are then locked up until the following morning. The mid-afternoon meal normally consists of samp, miele pap, or minced fish which still contains bones and is more reminiscent of cat food than of anything fit for human consumption. This meal is accompanied by 5 slices of bread, and no butter or condiments of any kind are provided.[222] The kitchen at WMB is in need of new equipment; in order to prepare breakfast the outmoded ovens must start cooking at 3 am.[223] Meals are often served cold, and might not even be cooked at all. A former prisoner explained that dinner would sometimes be raw pap; simply the powdered miele mixed with water.[224]

More than one staff member at the Westville Medium B prison cited the incidence of smuggling and theft in the prison kitchen, by both prisoners and staff alike, as a primary cause for the lack of decent meals.[225] The problem is not even alleviated by those prisoners lucky enough to receive visitors who wish to bring them food. Many of these items are confiscated or disallowed because of the risk of containing contraband. Even fresh fruit and vegetables are not permitted, as these could potentially be injected with drugs.[226] Limiting access to such things as fruits and vegetables or other much desired foods increases demand, and thus the profit to be had from selling these items inside the prison increases creating additional incentive to steal and smuggle. The resulting restricted access to adequate nutrition has an impact on health concerns of all kinds. In particular, prisoners living with HIV are affected because proper nutrition and vitamins may postpone the development of HIV into AIDS.[227]

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[222] Interview #7: WMB Former Prisoner
[223] Interview #3: WMB Health Staff C
[224] Interview #7: WMB Former Prisoner
[225] Interview #1: WMB Health Staff A, Interview #2: WMB Health Staff B, and Interview #4: WMB Social Worker X
[226] Interview #7: WMB Former Prisoner
[227] United Press International 1993: 1

2.3.3 Stress

The staff at WMB who provide counselling to HIV+ prisoners unanimously agreed that a prisoner's mental state has a significant impact on the prisoner's health. Social workers and psychologists attested that those who lost hope and resigned themselves to die were those for whom the disease progressed most rapidly.[228] Being imprisoned carries with it a number of stresses, including being separated from family and other support structures, frustration of goals or plans for the future, interruption of familiar activities, and intimidation and fear resulting from bullying or victimisation from other prisoners.[229] The otherwise heavy psychological burden of imprisonment is then further intensified by the knowledge that one is infected with HIV. Few people would doubt that life in prison is unpleasant and is likely to be stressful at the very least, thus the negative effects of prison life on HIV/AIDS prisoners are understandable given that, "stress enhances depression of the immune system, thereby hastening the progress of the disease."[230]

2.3.4 Gang Activity

The power of the 26s and 28s gangs inside South African prisons pervades nearly every issue related to HIV/AIDS in prison. Many high risk behaviours are directly related to gang activity. Membership in both gangs frequently includes tattooing, and it is not uncommon for more than one inmate to be tattooed at a time using the same needle.[231] Violence between prisoners which leads to bleeding is also a product of gang activity. Prisoners may be required to attack another prisoner and draw blood in order to be initiated into a gang.[232] 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.[233]

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[228] Interview #5: WMB Social Worker Y, and Interview #6: WMB Social Worker Z
[229] Interview #5: WMB Social Worker Y
[230] Thomas 1994: 97
[231] Interview #7: WMB Former Prisoner
[232] Interview #7: WMB Former Prisoner
[233] Interview #4: WMB Social Worker X

- Safety and Security
- Welfare

6. In South Africa, of the estimated 5.3 million people in the country that are living with HIV, more than half are people aged 15-49 years.
   True or False

7. What is the unemployment rate in South Africa?

   a. about 10%
   b. about 20%
   c. about 30%
   d. about 40%

8. Is social welfare a provincial competence or a national competence in terms of the Constitution of South Africa? Why do you think this is an important question for social policy?

9. Who do you think said these words and when: "Health, social security and housing! These will be the three pillars of our new reconstruction and development!"

10. What does NEPAD mean?

11. Who is the current Minister of Social Development in Kwa Zulu Natal?

12. Who is the present national minister of welfare?

SOCIAL POLICY QUIZ

1. List the countries which make up the G8?

2. In the year 2000 half the world's poor – nearly 3 billion people live on less than:

   - 200 dollars a day
   - 2 dollars a day
   - 20 dollars a day
   - 2000 dollars a day

3. 35% of Africa's 840 million people live below the breadline?
   True or False

4. More than 6000 people are infected with the HIV virus in SA every day? True or False

5. The following are some ministries which are allocated a budget every year. Order them according to which received the highest budget and which the smallest budget in 2009.

   - Education
   - Defence

While the 26s engage in stabbings, the primary activity of the 28s is sodomy.[234] In 1906, the 28s gang began to take shape as two loosely connected associations, one inside prison and the other in the mining compounds. Both warehoused young men away from their families with minimal opportunities for diversion or normal social interaction, thus "the practice of sodomy is not perhaps so strange given the institutions and laws which kept men in all-male institutions and excluded women from the cities."[235] When the gang leader, Nongoloza, was imprisoned in 1908 he consolidated his criminal empire from his prison base in Pretoria. The prison environment, then and now, provides the ideal location to recruit new members and train them in the tight discipline necessary to maintain gang hierarchical structures. Although stories vary about the split of the 27s from the 28s, one reason given is the 27s refusal to accept the custom of homosexuality which had become an accepted feature of Nongoloza's gang by that stage.[236]

The 28s hierarchy consists of two lines: one is the "men" and the other is their "wives". The men do the fighting and protecting, and the wives are the sexual partners of the fighters, or "men". In addition to being the receptive sexual partner, the wives perform many traditionally considered feminine roles, including washing and other domestic chores.[237] Although the 26s and 27s may claim to eschew sodomy, and are reportedly forbidden by the gang's official code from taking a "wife", staff at Westville Medium B noted that sodomy has become common amongst all gangsters. When asked about the impact of the 28s gang on the incidence of sodomy at Westville, one interviewee responded that the 26s are also taking "wives" even though they claim it is something only the 28s do.[238]

According to one former prisoner, prison wardens are also involved in gang activities, and gang members will actively recruit prison wardens as a means of increasing their power. For example, if a member of the 28s wishes to obtain a specific prisoner as a wife, he may be able to gain the complicity of a warden in transferring the targeted prisoner to the gangster's own cell. The former prisoner

[234] Interview #4: WMB Social Worker X
[235] Haysom 1981: 3
[236] Haysom 1981: 4
[237] Interview #10: Ted Leggett

claimed that the wardens are also known to not only facilitate but also engage in the sodomy as part of their membership in a gang.[239] The wardens involvement with either the 26s or 28s can also extend to the smuggling in of food, weapons, cigarettes, drugs, and other items. In one instance, a prison employee smuggled liquor into the prison in an empty fire extinguisher.[240]

2.4 Policy Options for Addressing HIV/AIDs in Prison

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

> All prisoners have the right to receive health care, including preventive measures, 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[241]

The WHO guidelines were publicly supported and endorsed by the Joint United Nations Programme me on HIV/AIDS (UNAIDS) in a statement issued in April 1996. The UNAIDS statement explained that ignorance and lack of government support in addressing HIV/AIDS in prison has led to denial, ineffective policies, violence and discrimination.[242] Many different policy options have been explored in response to HIV/AIDS in prison with varying results in different countries and contexts. However, an international consensus confirmed by the WHO and UNAIDS has declared that some of the more popular policies are not only ineffective but unnecessary and unjustified. The policies which have been condemned by

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[238] Interview #4: WMB Social Worker X
[239] Interview #7: WMB Former Prisoner
[240] Interview #7: WMB Former Prisoner
[241] WHO 1993: 1
[242] UNAIDS 1996: 3

international bodies include mandatory testing, and segregation. Other policies employed in various prison systems include education, condoms, disinfectant and sterilised needles, and general penal reform.

2.4.1 Mandatory Testing

The primary goal of most policies regarding prisoners with HIV is to prevent transmission either to inmates or prison staff. The most severe policy combines mandatory mass testing and isolation of HIV+ inmates. Testing for HIV is not entirely straightforward, and complicates the effectiveness of this policy. There is no such thing as an AIDS test, rather a person is tested for the antibodies which the body develops in response to HIV. The most commonly used test in South Africa is the enzyme-linked immunosorbent assay (ELISA) test. The immunofluorescent antibody test, IFA or Western Blot, is also used although it is usually more expensive and less sensitive. No single test is 100% accurate. Researchers at the Medical Research Council use a combination of three ELISA tests, each with a varying degree of sensitivity, to weed out false positives and guarantee more accurate results. Further complicating the matter is the fact that sometimes the body does not develop enough HIV antibodies to be detected by a test for up to three months after infection. The result is that if all prisoners are tested upon admission to the prison, they must be tested again three months later to be assured of the reliability of the results.

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

The notable difference between HIV and either small pox or TB is that HIV is not a contagious condition with the potential to infect unprotected citizens. HIV is

not transmitted through casual contact, or by a person simply functioning in the community. In fact, not one study has found a case in which AIDS was transmitted, "through ordinary nonsexual contact in a family, work, or social setting."[243] Furthermore, the effects of mandatory testing can have far-reaching impacts on the lives of prisoners after release, as they can potentially suffer from insurance or employment discrimination. For these reasons, HIV cannot be compared to TB or other curable medical conditions when discussing the ethics vs. necessity of mandatory HIV testing.

Detecting HIV as early as possible is the most cost-beneficial means of providing treatment in prisons. The premise behind this argument is that it is cheaper to prevent HIV from developing into AIDS than it is to care for prisoners with full-blown AIDS.[244] However, this argument only holds if prisoners who test positive for HIV will receive treatment that can delay the onset of AIDS. Treatment of opportunistic infections does not delay the progression of HIV. Rather, ARV therapy and a high-protein diet can accomplish this feat for many HIV+ patients. Unless a standard of care can be provided to prisoners that will delay the development of AIDS, one cannot use the argument for early detection in support of a mandatory testing policy.

Proponents of mandatory mass testing argue that determining exactly how many prisoners, and specifically which ones, are HIV positive will enable correctional services to improve care, target education programmes, gather information on transmission, provide special supervision, and plan and budget effectively for HIV-related programmes and policies.[245] A further argument employed to support mandatory testing is that voluntary testing will be ineffective, as a good portion of inmates will not agree to participate. A survey conducted in the US revealed that 85% of inmates would consent to a voluntary HIV test, and 66% would voluntarily attend counselling or education programmes.[246] This argument does not take into account the effectiveness of statistical sampling techniques to determine HIV prevalence of a

[243] Pienaar 1989: 89
[244] Moriarty 1999: 4
[245] Neser 1993: 28
[246] Moriarty 1999: 4

specific population. Academic studies to determine HIV prevalence frequently rely on randomly selected voluntary participation, often with a sample size which consists of only 10% of the prisoners at a given correctional facility. Assuming that the prison administration legitimately wishes and is able to provide additional services and care for HIV+ prisoners, a sample size which covers 85% of the population would be more than adequate to make projections for budget and programme planning purposes.

2.4.2 Segregation

Whether testing is mandatory or voluntary, the issue of confidentiality is important. In some instances, a prisoner's HIV status is disclosed discreetly to prison officials on a "need to know" basis, and in more extreme situations, prisoner cells or files are clearly marked so that anyone who cared to know would be aware of their HIV status. Maintaining confidentiality of a prisoner's HIV status is important because of the social stigma associated with the disease. In an independent report issued on the British prison system, the importance of confidentiality was underlined, with the understanding that, "HIV prisoners must not and need not become the pariahs of the prison system"[247]

Issues of confidentiality are usually not considered by those proponents of mandatory testing who also argue for the isolation or segregation of HIV+ prisoners. The intention is that by identifying and separating HIV+ prisoners, the prison will be able to provide increased health monitoring, additional surveillance of high risk behaviour, elimination of transmission within prison, and protection from discrimination or violence from other inmates.[248] There is a very real concern that not segregating HIV+ inmates will lead to increased prison violence, in that HIV prisoners will threaten cell mates with infection and other prisoners will target HIV inmates for abuse. In this respect, segregation is for the seropositive inmate's protection as much as it is for the protection of the general prison population.

Some countries report considerable success with HIV segregation programmes. In Poland, prisoners with HIV were held on a separate, less crowded

[247] Thomas 1994: 52

floor and allowed access to more facilities, such as additional health care staff and recreational activities. The general atmosphere was one of support and specialised care, as opposed to the discrimination and insults endured in the rest of the prison. In Polish institutions where segregation was not initiated, prisoners refused to share eating or toilet facilities, or even shake hands with HIV+ prisoners. In some cases, medical doctors would refuse assistance and encourage protest from the staff against the non-segregation policy.[249]

The risk for abuse in a segregated system is great, as it is conceivable that HIV+ inmates held in a separate facility would be denied access to the same health, training, and educational services that are available to the rest of the prisoners. For this reason, proponents of segregation have cautioned that segregation, "not be used a method of punishment or as a means of reduction of care for inmates."[250] Rather, the idea is that appropriately implemented segregation can have beneficial effects for all prisoners, whether HIV+ or not. The argument is that "it is the negative implementation of these programmes, not the concept of segregation itself, that has prevented the success of segregation."[251] On the other hand, the lessons of history have shown us that regardless of the noblest intentions of any segregation policy, the reality is that "separate but equal" simply does not exist.

Segregation of HIV+ prisoners is a declining practice in most countries. WHO Guidelines explain that,

> "Since segregation, isolation, and restrictions on occupational activities, sports, and recreation are not considered useful or relevant in the case of HIV- infected people in the community, the same attitude should be adopted towards HIV-infected prisoners."[252]

Segregation is no longer accepted as a sensible strategy because it contributes to the stigmatisation of HIV+ people and presents numerous logistical problems.[253] Opponents of segregation point out that even assuming equal treatment was

[248] Moriarty 1999: 3
[249] Thomas 1994: 34
[250] Moriarty 1999: 4
[251] Moriarty 1999: 3
[252] WHO, §D.27
[253] Moriarty 1999: 7

maintained, the result is a costly duplication of services which is neither medically necessary nor reliably effective.

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

The counter argument is that the number of recently-infected prisoners who were in the window period upon entering the prison would be much less than the number of prisoners who were already HIV+ and so the policy would still substantially reduce the risk of transmission. The rationale is that it is better to only have a few who were recently infected held in common with others for a little while than to have all the HIV+ prisoners intermixed with all the other prisoners for the duration of incarceration. This does not take into account that research has determined that the viral load of an HIV+ person peaks in the first few weeks after transmission, when the virus is still undetectable because the body has not yet produced the antibodies which are detected by an HIV test.[254] Once the body begins to fight the virus by producing sufficient antibodies, the viral load declines dramatically and then only slowly creeps upwards over the next several years. It is at this point that a person tests positive for HIV because the test is able to detect the presence of HIV antibodies in the person's blood, urine, or saliva.

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

transmitting HIV is also high.[255] Thus, during the window period when viral load is very high, a recently infected HIV+ prisoner has a much greater probability of transmitting the virus. Add on to this the fact that many prisoners in the "undetermined status" will have a false sense of security owing to the fact that all of them have tested negative upon entry to the prison and the known positives have already been segregated. The result is the potential that every single HIV negative prisoner could be confined for three months with HIV positive prisoners who have a higher probability of transmitting the virus than a good portion of those who have already tested positive for HIV. Clearly, this would negate the intended benefits of this policy and could possibly be counter-productive.

2.4.3 Education

Both sides of the debate on segregation agree that education is one of the most important ingredients of an effective HIV/AIDS in prison policy. However, HIV/AIDS education in the prison environment presents specific challenges which are unlike those for the general population. The personality profile of many prisoners often includes a deep-seated suspicion of anything "official" or government related, which can negate the efforts of programmes which enjoyed significant success in the general community.[256] 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.[257] Scare tactics have also proven ineffective, and may possibly be counterproductive to the extent they elicit a denial response.[258] Also, prisoners in South Africa are normally members of the lower socio-economic strata, and have had very little formal education.[259] Education materials must cater to the wide diversity of languages spoken in prisons, and need also take into account the low literacy rate of the prison population.

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[254] Jacquez 1994: 1169
[255] Vernazza 1999: 157
[256] Thomas 1994: 36
[257] Carelse 1994: 13
[258] Carelse 1994: 14
[259] Van Heerden 1996: 2

The unfortunate truth is that increase in HIV/AIDS related knowledge is not always translated into altering or reducing high risk behaviour.[260] HIV/AIDS information needs to be specifically targeted, and take into account the common characteristics or lifestyles that put prisoners at risk for HIV. The influence of peer groups has proven to be essential in any successful intervention strategy as the credibility of the communicator has a significant impact on the capacity of the message to engender behavioural change. This credibility should be determined within the context of the prison population, because what might be valued by the average citizen outside of the prison is not the same as that appreciated by the average prisoner.[261] 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."[262]

A study in Scotland attempted to determine the effectiveness of two different HIV/AIDS education programmes, one designed by prisoners and one designed by the state. The study found that a video followed by a group discussion was the most effective means of conveying information about HIV/AIDS to prisoners. Two videos were shown in the study. One, "AIDS: A Bad Way to Die", was put together by prisoners at Sing Sing prison in New York City and the other was produced by the British government. The prisoners in the survey responded significantly better to the New York video, which featured three actual prisoners who spoke about how they contracted HIV, how it affected their lives and their families, and also discussed their symptoms. In addition to the prisoners' stories, the video showed medical experts who discussed transmission precautions and also emphasised that HIV cannot be transmitted by casual contact. The video concluded with each of the three prisoners' death from AIDS. In the discussion groups which followed, prisoners filled out questionnaires to asses the impact of the video. The study found that of the prisoners who watched the New York video, more than 90% responded that they would stop

[260] Carelse 1994: 12
[261] Carelse 1994: 14
[262] Carelse 1994: 15

sharing or would try to sterilise injection equipment and the same percentage also claimed that they would use condoms.[263]

2.4.4 Condoms

A policy to distribute condoms in prison is often very controversial because government officials do not wish to discuss homosexual activity in prisons, and a good portion deny that any such activity takes place at all. If sex is thought a taboo subject even in a modern democracy, homosexual activity is even more often considered not a topic fit for parliamentary debate. In some countries, condoms are not available in prison because top prison officials either refuse to acknowledge that homosexual activity takes place or have set regulations which forbid such activity in their correctional facilities. The argument is then that condom distribution would compromise the authority and security of the prison because it implicitly condones an activity which is explicitly prohibited. However, this is a relatively minor obstacle compared to the significant number of countries which outlaw homosexual activity in the general population. In Malawi, where HIV prevalence and the incidence of homosexual activity are both high, condoms are not available. Any attempts to introduce a condom distribution policy must first deal with the fact that homosexual activity is illegal in Malawi. Described as an "unnatural offence" in the Malawi Penal Code, conviction results in a prison sentence of fourteen years [264]

One reason that prison officials may not be willing to admit that sex takes place in prison is because then they would be forced to address the increased risk of HIV transmission created by the unprotected sexual activities of inmates. With the understanding that many prisoners are not willing to disclose their participation in homosexual activities, the policy recommended by UNAIDS is to provide "discreet and easy access to condoms."[265] Because sex in prison is primarily anal sex between men, it is also important to make lubricant available. One reason that receptive anal intercourse carries the highest probability of HIV transmission is because of the

[263] SPS 1994: 36
[264] Jolofani 1999: 7
[265] UNAIDS 1997: 2

attendant tearing in the rectum.[266] Not only can this tearing can be reduced by using lubrication, but the likelihood that a condom will break during anal intercourse is also reduced by the presence of appropriate lubrication. In France, condoms and lubricant are available, and are placed "in open containers in reception, the health care centre, and other locations where potential users...have the opportunity to take them unobserved."[267]

2.4.5 Disinfectants and Sterilised Needles

Use of contaminated cutting or piercing instruments has been shown to be a high risk behaviour for transmitting HIV in prisons, particularly in the case of sharing needles for IV drug use. Distributing sterilisation tablets, or bleach, to prisoners is a policy that is gaining popularity in countries where IV drug use is a primary means of transmission. At Hindlebank women's prison in Switzerland, a one year experimental project provided sterile needles to the 100 inmates, most of whom were convicted of drug offences. The sterile needles were available from dispensing machines in accessible locations, such as toilets, showers and storage areas. Prisoners were not permitted to keep more than one needle and were required to store their injecting equipment in a designated cabinet. An evaluation of the project found that there were no new cases of HIV, prisoner health had improved, needle-sharing decreased, drug use remained stable, and there were no instances of needles being used as weapons. At the end of the year, the project was considered a success and the project was continued.[268]

Rather than provide sterile needles, a more popular approach to the problem of shared IV drug use equipment is to provide sterilisation materials for the inmates. This policy meets with similar arguments as the condom distribution policy, citing the principle that providing bleach or other disinfects implies approval of illegal or prohibited activities. Nonetheless, an increasing number of prison systems are introducing bleach distribution programmes. In Spain, a bottle of bleach is provided

[266] Highleyman 1999:3
[267] Shaw 1999: 1
[268] UNAIDS 1997: 5

to each prisoner upon entry into prison and each month thereafter, in addition to being available as needed. Other countries which distribute bleach to a similar extent include Australia, Belgium, Canada, France, Germany, the Netherlands, and Luxembourg.[269]

The arguments against providing disinfectant materials for prisoners are that it is not necessary or that the disinfectant will be used as a weapon or in some other manner that would constitute a threat to security. After a bleach distribution pilot project in Canada, an evaluation questionnaire found that 99% of respondents felt that having bleach available to inmates is "very important" and all but one injecting drug user responded that they would use bleach to sterilise injecting equipment.[270] According to Ralf Jürgens of the Canadian HIV/AIDS Legal Network, "There are no reported incidents of any negative consequences of making bleach available. This is consistent with the Canadian experience."[271]

2.4.6 HIV Treatment

The recommended treatment for HIV is anti-retroviral (ARV) therapy. This is a combination of several drugs, which usually must be taken at different times with various specific directions as to accompaniment with meals or fluids and other such requirements. ARV treatment is complicated and expensive, and the prison environment poses serious challenges to its effectiveness. The administration of the complicated treatment regime is usually the realm of specialists, and not something a typical prison health facility is able to provide. ARV treatment is not available from state hospitals in South Africa, primarily because of the high cost of the drugs which are protected by international patent laws. Although the drama is currently unfolding as the South African government attempts to obtain generic ARV drugs at a much lower cost, it is still not likely that these will be made universally available to the extent that access would be extended to prisoners. Finally, the lack of privacy intrinsic to any prison situation means that a prisoner undergoing ARV treatment will

[269] Jurgens 1995: 2
[270] Jurgens 1995: 2
[271] Jurgens 1995: 2

have difficultly concealing his or her HIV status from prison officials or other prisoners.

In the absence of ARV therapy, the recommended treatment for HIV+ individuals is "symptomatic management" of the disease.[272] This usually requires treating and preventing the more common opportunistic infections associated with HIV, namely pneumonia and TB. Both of these illnesses can be cheaply treated and even prevented. Prison hospitals normally administer INH and Bactrim for HIV+ patients, but their supplies are sometimes changed and interrupted as a result of unreliable distribution services.[273] Consistent and continued doses as part of the prescription programme for TB is 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 and the required medicines are more expensive and have deleterious side effects. MDRTB can result in death if treatment is not available.[274] 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.

2.4.7 Early Release

WHO guidelines advocate early release of prisoners in the advanced stages of AIDS. The motivation behind a policy of early release is to allow a person to die in dignity, either in their own home or with their family, rather than forcing them to die isolated and alone in prison. Italian law prevents anyone with overt AIDS from being held in prison custody. The definition of "overt AIDS" is clinically established as a patient whose number of T/CD4+ lymphocytes are equal to or lower than 100/mmc. To determine this, the prisoner is administered two consecutive tests, 15 days apart.[275] Other alternatives suggest that prisoners with AIDS be released from prison but held

[272] Whiteside (website)
[273] Interview #2: WMB Health Staff B
[274] Stern 1999: 17

under house arrest, admitted to a public health institution, or that the sentence be remitted indefinitely.

There are some unintended consequences of establishing an early release programme for prison inmates with AIDS. In Poland, a policy was adopted very early on which allowed AIDS prisoners to be released and transferred to an open hospital. The unfortunate result was that prisoners began to buy infected blood from HIV+ prisoners in hopes of getting released.[276] A particularly disturbing report describes a prisoner who traded a pack of cigarettes and some tea for an inch of HIV+ blood. When he couldn't find a vein with the borrowed syringe, he was worried he wouldn't become infected and so he asked for another inch of infected blood in order to be sure. His actions were encouraged by an HIV+ inmate who assured him that HIV+ status was a guaranteed way to be released from prison.[277]

2.4.8 Liability

When considering policy options in any given situation, there is always the alternative of inaction. In regards to the problem of HIV infection in prison, the costs of this inaction could be extremely high. Many countries have seen legal battles arising from HIV transmission in prison. Prisoners in two Australian states have taken legal action against their prison systems for failing to provide measures to prevent the spread of HIV.[278] In the United States, non HIV-infected inmates have filed cases against the prison system for failing to test and segregate HIV+ inmates, correctional staff have filed against facilities for failure to warn, and families of HIV+ inmates have filed against the prison system for failure to inform.[279] If a prisoner is infected with HIV as a result of negligence on the part of the corrections system, then it is not farfetched to imagine that the department can be held criminally liable for failure to provide safe custody. However, keeping in mind that HIV transmission is not a criminal offence in South Africa, DCS would not be charged with attempted

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[275] Thomas 1994: 88
[276] Thomas 1994: 35
[277] Thomas 1994: 36
[278] Jürgens 1996: 2
[279] Moriarty 1999: 5

murder as some might assume. Rather, a court case is more likely to be associated with the failure of the state to provide a prison environment which is consistent with conditions of humane detention.

While the liability issues which can arise from inadequate policies to prevent HIV transmission in prison are very real, there is a much bigger impact to be accounted for should the Department of Correctional Services fail to appropriately address the issue of HIV/AIDS in prison. This is the impact on public health. Prisoners come from marginalised communities which are hardest hit by the HIV/AIDS pandemic. Using the demographic profile of a typical prisoner at WMB, one can estimate that approximately one in three prisoners will be HIV+ prior to entering prison. The impact of prison conditions, including poor nutrition and stress, accelerates the progression of the disease. As HIV progresses, viral load increases and the probability of transmission will also increase. More than 98% of prisoners are eventually released and return to the community.[280] For the most part, these are communities already struggling to deal with poverty, unemployment, illiteracy, high levels of crime and a staggering rate of HIV infection. Prisoners will therefore return to these neglected impoverished communities sicker than when they left, and will bring with them a higher probability of transmission and a lower probability of contributing meaningfully to society. The impact of HIV/AIDS in prison, if not appropriately addressed, will clearly affect the entire country and specifically those areas which are already in the most dire need of assistance and support.

2.5 Conclusion

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

[280] DCS Annual Report 1999: 13

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 sodomisation of younger, weaker prisoners appears to be a direct result of the relatively unobstructed power of gangs over limited access to both simple necessities and contraband in the prison environment. Gang activity also increases the incidence of tattooing and violence between prisoners, both of which can create the risk of HIV transmission.

Many governments, with the assistance of international organisations such as WHO and UNAIDS, have attempted to devise policies to appropriately respond to HIV/AIDS in prison. The practice of mandatory HIV testing and segregation is not supported internationally because it violates the rights of HIV+ individuals and cannot be medically justified. The importance of HIV/AIDS education has been emphasised by governments and non-governmental organisations alike, although any education programme must be carefully thought out and adapted to the prison environment in order to be effective. Distributing condoms and lubricant is advocated by WHO and UNAIDS although the difficulties in getting authorities to acknowledge homosexual activity in prison has impeded the development of condom policies in some countries. Equally important though considerably less controversial has been the distribution of bleach in those countries where IV drug use presents a problem amongst the incarcerated population.

The challenge of treating HIV in the prison environment is related to limited resources and problems with ensuring the crucially important level of adherence to treatment programmes. The high cost of ARV therapy precludes most governments from providing this level of care to the general population, thus it is unlikely for ARV to become a viable option for treating HIV+ prisoners. An inexpensive and relatively easy policy for most countries to implement is the early release of prisoners in the late stages of AIDS. International opinion supports early release in the interest of allowing people to die with dignity in their own community.

For any public policy challenge, there is always an option to simply not do anything. It makes sense for governments to weigh the costs, benefits, and risks of all

options before making a decision and the decision to not act should be considered in terms of the risks involved. In regards to HIV/AIDS in prison, the cost of inaction, both for prisoners and for the greater community, is so great as to not even be quantifiable. All but a small percentage of prisoners return to the community, and 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.

Chapter Three

Analysis of South African Policy

3.0 Introduction

This chapter covers a brief history of prison legislation and reform in South Africa, beginning with Union in 1910. Special attention is paid to the departure of the apartheid state from internationally accepted theories of penology and the resulting emphasis on security and control rather than on prisoner development. Significant changes in prison policies accompanied South Africa's transition to democracy, culminating in the Correctional Services Act of 1998.

The Department of Correctional Services' initial response to HIV/AIDS, and the eventual reversal of these policies are discussed in the second section of this chapter. The current HIV/AIDS policies are then explained as well as the department's documented plans for implementation of these policies. The chapter concludes by examining the actual effect of the current HIV/AIDS policies at Westville Medium B (WMB) and covers the theoretical explanations for the policies failure. The weaknesses of the policies in terms of both design and implementation are explored, and the strengths and limitations of independently developed programmes by WMB staff are presented.

3.1 History of Prison Legislation

The first prison legislation in South Africa was passed into law shortly after the Union of South Africa in 1910. The Prisons and Reformatories Act of 1911 was designed largely by the then Director of Prisons, Jacob de Villiers Roos. The intention of the 1911 act was to provide legislation which would incorporate , "the most modern principles of modern penology."[281] According to Roos,

[281] as quoted in Van Zyl Smit 1992: 23

> "[T]he essential principles on which the modern reformatory system should be based are that no person, no matter what his age or past record, should be assumed to be incapable of improvement. That it is in the interest of the public, not merely to impose a sentence which is retributive and deterrent, but also to make an earnest effort to reform the criminal, which is most likely to be attained by religious and moral instruction, mental quickening, physical development, and such work as will best enable the prisoner to gain his livelihood in the future."[282]

In spite of Roos' ardent belief in reform as the purpose of prison, the Act itself did not explicitly lay down these specific purposes. By the time of he retired as Director of Prisons in 1918, the principles of reform-focused penology were not being implemented. If anything, the shift in focus during the next two decades was away from reform and towards the meeting the country's growing demand for labour.

The issue of prison reform did not gain attention in South Africa until the 1940s. In 1943, Mrs. VML Ballinger, MP, and Dr HJ Simmons authored a document entitled "Memorandum on the Need for Penal Reform in South Africa", which cited racial discrimination as the primary obstacle to change in the prison system. The basis of their observation was that, "by far the greater portion, in fact some 85% of our prison population is non-European."[283] In addition, Ballinger and Simmons argued that the prison officials had deliberately engineered to "keep outside observers out of the prisons so that they should not be subject to scrutiny, and that the prisons were filled by people who ought not to be there at all."[284]

In 1945, the South African government appointed a judicial commission which came to be known as the Lansdown Commission. The impetus came from the Penal Reform Committee of the South African Institute of Race Relations, who requested that a commission be set up with the objectives of:

> "greater use by the courts of remedial and rehabilitative measures in place of imprisonment; the abolition of racial discrimination resulting in unequal sentences; improvements in prison regulations and the abolition of spare diet, solitary confinement, corporal punishment"[285]

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[282] as quoted in Van Zyl Smit 1992: 23
[283] as quoted in Van Zyl Smit 1992: 27
[284] Van Zyl Smit 1992: 27
[285] as quoted in Van Zyl Smit 1991: 26

The Lansdown Commission heard evidence from a wide range of perspectives, including reformists as well as government officials and members of various political parties. The primary findings of the commission included recommendations to abandon forced labour schemes, gradually implement single (rather than communal) cells, and also discouraged the movement towards increasing militarisation of the prison system. More broadly, the Lansdown Commission officially recognised that the reformist ideals of Roos' Prison and Reformatories Act of 1911 had not been achieved and that instead, the prison had become the very opposite: a harsh and discriminatory institution.[286]

The final report of the Lansdown Commission was published in 1947, and the timing could not have been more unfortunate. Although the United Party government was not entirely sympathetic to the prison reform movement, the Nationalist Party was outright hostile. When the Nationalist Party came to power in 1948, the entire theory of criminology was altered and recommendations such as those propagated by the Lansdown Commission were considered 'un-South African' and dutifully discarded. Forced labour was not only continued but increased, and the entire prison system was officially organised along para-military lines.[287]

3.1.1 The Prison Act of 1959

The efforts and momentum of the reform movement embodied in the Lansdown Commission were finally lost with the enactment of The Prisons Act of 1959. The major points of this act included the explicit extension of apartheid policies to the prison system, including the racial segregation of prisoners, as well as further mechanisms to prevent any monitoring of the prison. Whereas the Lansdown Commission recommended introducing a new system of inspectors, the 1959 act not only ignored this suggestion but also eliminated the existing system whereby magistrates and a board of visitors were to regularly visit the prisons. The act also continued the practice of corporal punishment, including lashings, even though this practice was specifically forbidden by the Standard Minimum Rules for the Treatment

[286] Van Zyl Smit 1991: 29
[287] Van Zyl Smit 1991: 30

of Prisoners adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders in August 1955.

Although prison staff members were considered civil servants, the Prison Act of 1959 effectively gave prison personnel paramilitary status. Throughout the apartheid era, the Department of Correctional Services (DCS) was organised as a quasi-military institution. In addition to a general culture of strict discipline for both prisoners and staff, the DCS functioned with a military-style chain of command as well as similar regulations in regards to rank, uniforms, saluting and many other trappings usually associated with the armed forces. With this hierarchical management style, wardens were not expected to interact with prisoners, nor were employees trained to rehabilitate or assist with the development of prisoners.

Perhaps the most drastic and most dangerous aspects of the Prison Act of 1959 were the measures to curb media and research access to the prisons. Under the seemingly benign heading "Penalty for loitering in vicinity of prison, etc.," Section 44 prohibited any outside access to any prison, and even prohibited anyone to be within 100 metres of a prison, without the written consent of the Commissioner. In addition, §44(f) made the publication of any "false" information on prisons or prisoners a punishable offence and also forbade the publication of photographs of prison conditions. Anyone found in violation of this section would be fined a maximum of R8,000 and/or imprisoned for up to 2 years. The leeway granted to prison officials by this impenetrable shroud of secrecy enabled the abuses of the apartheid era to be all that more ferocious behind prison walls, away from any scrutiny by the South African public, let alone international monitors.

The Prisons Act of 1959 was frightening not only because of its more obvious departures from widely accepted social norms as well as contemporary theories of penology, but also because of the manner in which it projected an illusion of being in line in international standards. For example, the act abolished the forced labour scheme where prisoners were sent to work on farms, and replaced it with a system of "parole". The concept of parole was gaining popularity in many countries as a means of integrating prisoners back into the community based on assessment of such criteria as reform in character or good behaviour. Thus, the 1959 act appeared to bring the

South African prison system in line with modern international movements in criminal justice. However, the deception lies in the South African definition of "parole" as outlined in the Prison Act of 1959. Short-term African prisoners were offered the choice to be "paroled" if they agreed to work on the farms as cheap manual labour. If the prisoner refused, then his "parole" would be revoked. In this way, the South African prison system managed to perpetuate the forced labour scheme while still presenting a façade of complying with modern shifts in penology.[288]

3.1.2 Prisons and the Struggle Against Apartheid

In the 1960s, the prison system began to become a battleground for the struggle against apartheid as a result of the incarceration of political detainees and sentenced political prisoners. In 1964, the African National Congress distributed a pamphlet entitled, "Brute Force: Treatment of Prisoners in South African Gaols" which combined an attack on the forced labour system, a first-hand account of the general treatment of prisoners (from a note written by Nelson Mandela and smuggled out of Pretoria Central Prison), and a condemnation of the detaining of political prisoners. The response of the South African government to this publication was straight denial, not only of the severity of conditions in the prisons but also a denial that political prisoners were detained or incarcerated at all.[289] The effective 'gag order' provided by the 1959 Act, preventing any outside access to the prisons, helped to perpetuate this propaganda response.

With increasing attention focused on South Africa in general because of the human rights abuses of the apartheid government, international attention also began to focus on South African prisons. In 1967, representatives of the International Red Cross were permitted to visit South African prisons and published a critical report which concentrated on the treatment and detention of political prisoners. The South African government eventually conceded that some prisoners were incarcerated for 'security' reasons, as they were considered a threat to the security of the state, but still remained evasive about the incarceration of political prisoners.

[288] Van Zyl Smit 1992: 31
[289] Van Zyl Smit 1992: 33

The influx of political prisoners in the prison system had a significant impact on prison reform from a judicial standpoint as well. The education and awareness of these prisoners meant that they had the skills and resources available to bring legal action against the state for abuses endured while imprisoned. Several court cases brought to light the unjust practices of prison officials, although most of them were unsuccessful when tried in court. The most notable case was Goldberg v Minister of Prisons in which the judgement found that discretion regarding the treatment of prisoners rested ultimately with the Commissioner. The impact of this decision was a significant increase in the power of the prison authorities to determine the rights of prisoners. The enormity of this ruling did not go unnoticed however, and unleashed a torrent of academic and international criticism. The unintended result of further restricting prisoner's rights was to renew attention on the topic and thus create even stronger lobbying for change within the prison system.[290]

By the 1980s, pressure to reform the prison system gained considerable momentum with the publication of Breyten Breytenbach's *The True Confessions of an Albino Terrorist*. In spite of Section 44(1)(f), Breytenbach's first-hand account of conditions within South African prisons was published and provided a compelling glimpse of the reality which the prison authorities had fought for so long to hide from public view. Soon afterwards, the forced labour schemes were slowly phased out, although it could be argued that this occurred more because of the reduced economic need for prison labour than because of mounting public disapproval. A significant milestone was achieved, however, in 1988 when all references to racial classifications were eliminated from prison regulations and the total racial segregation of the prisons was eventually reversed.

In 1991, major amendments to the Prison Act of 1959 marked the beginning of a new era for the South African prison system, including changing the official name to the Department of Correctional Services. By the early 1990s, political prisoners were released and various amendments to the prison act during this time helped to dismantle apartheid as it existed within the prison system.[291] Several amendments to

[290] Van Zyl Smit 1992: 33
[291] Van Zyl Smit 1992: 38-39

the original prison act were passed in the early 1990s which ended the practice of racial segregation and also introduced programmes of correctional supervision as an alternative to incarceration.[292] Eventually, the demilitarisation of the prison service was announced in July 1995, and implemented rather abruptly on 1 April 1996.

3.1.3 Prison Reform in the New South Africa

The first hints of penal reform in post-apartheid South Africa were contained in the Reconstruction and Development Programme (RDP). In regards to the prison system, this policy document emphasised, among other things, the human rights of prisoners and the need to focus on rehabilitation and training. The first Minister of Corrections in the ANC government was Dr. Sipo Mzimela, a former prison chaplain, who immediately prioritised staff training, reducing overcrowding, and prisoner education.[293] In addition to the need for prison reforms, the need for entirely new prison legislation did not go unnoticed by the new government.

In early 1995, a pluralist approach to prison policy-making was attempted for the first time. Then deputy-president Thabo Mbeki called together the relevant interest groups and decision makers, and the Transformation Forum on Correctional Services was formed. The Transformation Forum consisted of representatives from the Department of Correctional Services (DCS), the Parliamentary Portfolio Committee, the Police and Prisons Civil Rights Union (POPCRU), Public Servant's Association (PSA), Correctional Officers' Union of South Africa (COUSA), South African Prisoner's Organisation for Human Rights (SAPOHR), the Minister's National Advisory Council, Lawyers for Human Rights, National Institute for Crime and the Rehabilitation of Offenders (NICRO), the Centre for the Study of Violence and Reconciliation (CSVR), and the Penal Reform Lobby Group (PRLG). The Forum first identified and prioritised several areas for transformation, which included demilitarisation, health care, independent inspection, human resource management, and the establishment of a change management team.[294]

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[292] Oppler 1998: 6
[293] Giffard 1999: 33
[294] Giffard 1999: 35

Despite high aspirations in the beginning, the Forum soon fell apart with the failure of the Minister, or any of his representatives, to show up at any of the meetings. Within a few months, Minister Mzimela officially withdrew the Department's participation in the forum until President Mandela instructed him to return. In spite of renewed promises of Ministry involvement, again the Minister remained absent and un-represented at the forum's meetings. The Minister's example was for the most part followed by the Department as well, which seemed to resent the 'interference' of the Forum. Thus, the department perpetuated the familiar pattern of appearing to achieve legitimacy, this time through a guise of co-operative involvement with the community, while remaining a closed, highly centralised authoritarian institution reminiscent of the apartheid era.

While the South African executive, as represented by President Mandela and Deputy-President Mbeki, attempted to introduce a pluralist approach to policy-making in the Department of Correctional Services, the top level bureaucrats clearly preferred the elite ruling class model. DCS effectively mobilised the second dimension of power, that of covert conflict, by not actually participating in the debate. This is a particularly insidious course of action, because DCS never actually confronts the interest groups, indeed the department does not physically show up at all. A further promise of participation was only obtained once the non-participation of the department became an overt conflict between the wishes of the President and the actions of the Minister.

The Department of Correctional Services has successfully mastered the passive power provided by ensuring that conflicts remain latent. If there is never a clash of interests, just a passive resistance, it becomes more difficult for the various actors to do battle at all. This is also evident in the lower level bureaucracy as well. Appendix A details the painful process through which access to WMB was obtained. What made this entire procedure infuriating was that DCS did not actually refuse permission but rather continually shifted responsibility and referred the inquiry elsewhere. Access to the prison was only obtained after the matter became an overt conflict between the directions from Director of Corporate Planning in Pretoria and

the orders of the Provincial Commissioner for Correctional Services (KwaZulu-Natal).

3.1.4 The Correctional Services Act of 1998

Although the Transformation Forum never achieved the intended co-ordination of policy decision making with the DCS, the participants forged on nonetheless and were able to present the Minister with a set of recommendations for the transformation of the department. Many of these recommendations, as well as those written by independent studies, were eventually incorporated into the much anticipated Correctional Services Act of 1998. Thus, the pluralist method eventually prevailed, perhaps assisted by a change in management with the appointment of Minister Ben Skosana. Not only the did the 1998 act reflect the input of the pressure groups, the legislation itself established a corporatist policy-making framework. These changes to the policy process are perhaps the most impressive reforms contained in this legislation: the establishing of the National Council for Correctional Services, and the introduction of the Judicial Inspectorate.

Reminiscent of the ill-fated Transformation Forum, the National Council is intended to be an advisory body for the Minister of Correctional Services, and is chaired by two judges from the Supreme Court of Appeal and/or the High Court of South Africa. The members of the National Council consist of 6 state- and 6 non-state employees, including two officials from the Department of Correctional Services as well as representatives from the police, public prosecutions, the Department of Welfare, and a regional magistrate. The remaining six members must consist of, "two persons with special knowledge of the correctional system who are not in full-time service of the State; and four or more persons not in full-time service of the State...appointed as representatives of the public"[295] One significant difference between these participants and those of the Transformation Forum is that representatives from the three major trade unions involved with the DCS are not specifically included. The Minister must refer all draft legislation pertaining to

[295] Correctional Services Act of 1998, §83(2)(g)-(h)

correctional services to the National Council for comment, and the National Council has the authority to, "examine any aspect of the correctional system and refer any appropriate matter to the Inspecting Judge" [§84(4)].

The establishment of a judicial inspectorate to monitor the prison system is based on a recommendation first introduced more than 50 years earlier by the Lansdown Commission. The act describes the Judicial Inspectorate of Prisons as an independent office, headed by the Inspecting Judge, who is responsible for facilitating the inspection of prisons in order to, "report on the treatment of prisoners...and on conditions and any corrupt or dishonest practices in prisons."[296] The Inspecting Judge is appointed by the President, and must be an active or retired judge of the High Court of South Africa. According to the act, the Inspecting Judge may only receive and deal with complaints submitted by the National Council, the Commission of Correctional Services, or a Visitors' Committee. Only in cases of "urgency" may the Inspecting Judge deal with a complaint from any other person or group, including an officially appointed Independent Prison Visitor.[297]

Independent Prison Visitors are appointed by the Inspecting Judge for one or more prisons. The duties of an Independent Prison Visitor are to deal with the complaints of prisoners by means of regular visits, private interviews, recording and monitoring complaints, and discussing complaints with the Head of Prison with the intention of resolving the issue internally. In order to complete his or her duties, the Independent Prison Visitor is given access to any part of the prison including any documents or records and the Head of Prison must assist an Independent Prison Visitor in the performance of his or her duties. Furthermore, should the Head of Prison refuse any request from an Independent Prison Visitor, the dispute is referred to the Inspecting Judge, whose decision is considered final.[298]

The Correctional Services Act of 1998 in large part marked a return to the original principles of penology as espoused by Director Roos in nearly 100 years earlier. In the opening paragraphs, this emphasis is explicitly stated:

[296] Correctional Services Act of 1998, §84(4)
[297] Correctional Services Act of 1998, §90(2)
[298] Correctional Services Act of 1998, §93(2)-(4)

> The purpose of the correctional system is to contribute to maintaining and protecting a just, peaceful and safe society by detaining prisoners in safe custody while ensuring their human dignity"[299]

The act can be considered an enormous step forward for correctional services in that several safeguards are put in place to prevent a return to previous abuses of authority and power, and many of the restrictions on outsiders' access to the prisons are repealed. However, no mention is made of HIV/AIDS in prison. In fact, this issue has yet to be addressed at the legislative level although it has been the focus of prison policy documents and, increasingly, a topic presented for judicial decision as well.

3.2 HIV/AIDS Policy

The first policy to address HIV/AIDS in the South African prison system was formulated in 1992 and was based on 'fear, lack of knowledge, and prejudice'.[300] The DCS approach was to segregate HIV+ prisoners, a policy which was not officially implemented until 1995. The procedure consisted of interviewing new prisoners to determine if they were involved in high-risk behaviour, testing those who were considered at high risk for being HIV positive, and then segregating HIV positive prisoners in a separate facility from the general prison population.

Prisoners considered "high risk" were those who were illegal 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"[301] The department's definition of high risk populations is indicative of a lack of appropriate information or understanding. There is no evidence to suggest that illegal aliens or sexual offenders in South Africa are more likely to be HIV+. Inclusion of IV drug users as high risk is theoretically valid although realistically not useful given the low incidence of IV drug use in South Africa. Finally, the specific reference to countries with greater than 10% HIV

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[299] Correctional Services Act of 1998, §2(b)
[300] Achmat 1996: 13
[301] DCS 1992: 2

prevalence would not be useful in South Africa today, as the current prevalence rate is more than 12%.[302]

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.[303] 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.[304] According to the policy paper, test results were to be kept confidential, but were required to be reported to the head of the prison.[305]

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

By the mid 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 HIV+ and "high risk" inmates and the distribution of condoms to prisoners on the same basis as they are available in the general community. The issue of condom distribution provides an excellent context for examining the denialist tendencies of the South African government in 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.[306] In 1994, the DCS produced a White Paper which declared that "sex, in

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[302] DOH 2001
[303] DCS 1992: 4
[304] DCS 1992: 2
[305] DCS 1992: 5
[306] Giffard 1999: 41

whatever form, cannot be condoned and authorised for prisoners in South Africa."[307] The paper went on to specifically dismiss any suggestions for condom distribution within the prison, citing that sexual activity in prisons is neither permitted nor tolerated.[308]

In June of 1996, the national policy on HIV in prison was challenged when 10 inmates at Pollsmoor Prison in the Western Cape filed a court case against the DCS. Amongst the plaintiffs was one prisoner who had tested negative for HIV upon entering the prison, repeatedly tested negative every three months, and then tested positive for HIV after having been incarcerated for one year. This prisoner also testified that he had repeatedly asked for condoms during his incarceration, but that his requests were consistently denied. The judicial order which settled the case coincided with the DCS decision to reverse its policy of segregating HIV+ prisoners and to make condoms available in prison.[309]

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."[310] The concept of universal precautions is that all potentially contaminated fluids are to be treated as if they are HIV+, and the appropriate safety measures to prevent infection should be followed in every instance.

In addition to reversing the earlier policy of segregation, the amendment also introduced a number of specific programmes to be implemented on the provincial as well as the prison level. The first of these was the provision of STD clinics at all prison hospitals. These clinics would be run by the nursing staff, and would provide

[307] DCS 1994: 8
[308] DCS 1994: 10
[309] Goyer 2000: 4
[310] DCS "Desegregation" 1996: §2.1 – 2.2

testing, treatment, counselling, and information regarding STD's for prisoners.[311] Nurses were also instructed to monitor the condition of patients with AIDS/HIV, arrange diet supplements and consultations with psychologists, social workers, medical specialists and other professionals.[312]

As well as the policy amendment paper, a separate policy document was 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."[313] 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.'"[314] Condoms could be supplied to prisoners only on request and only by a nurse trained as an AIDS counsellor.[315] 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.[316]

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 STD clinics, arranging information sessions for both staff and inmates on the policy change, and organising the distribution of condoms.[317] 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.[318]

The policies outlined in the two documents circulated in 1996 remain to this day the official position of the DCS regarding HIV/AIDS in prison. The issue is consistently mentioned in the DCS Annual Reports, parliamentary discussions, and press releases and speeches by both Minister Skosana and Commissioner Mbete,

[311] DCS "Desegregation" 1996: §3.2.2
[312] DCS "Condoms" 1996: §3.2
[313] DCS "Condoms" 1996: §1
[314] DCS "Condoms" 1996: §2
[315] DCS "Condoms" 1996: §4.5
[316] DCS "Condoms" 1996: §4.1
[317] DCS "Desegregation" 1996: §3.2.1
[318] DCS "Condoms" 1996: §3.1

although never in great detail and usually with vague promises but no specific actions described. In the 1995 Annual Report, §6.4.3 "AIDS and HIV cases" consisted of one paragraph and was not accompanied by any statistics. Official statistics regarding HIV and AIDS have been included in the Annual Report since 1996, although the report still only contains a few paragraphs on the issue. The 1999 Annual Report discusses several projects and strategies, and even mentions a video-conference between South Africa and the US on the issue, but makes no reference to either the design or implementation of new policies.

3.3 HIV/AIDS Policy at Westville Medium B

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

3.3.1 HIV/AIDS 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."[319] However, prisoners at WMB are not able to receive a test upon request because of cost constraints.[320] This appears to be an example of implementation deficit due to insufficient resources. The Health Economics and HIV/AIDS Research Division (HEARD) at the University of Natal conducted anonymous unlinked HIV testing at WMB in January 2001, and more than half of the prisoners who voluntarily participated asked to be informed of their HIV

[319] DCS "Desegregation" 1996: 1
[320] Interview #3: WMB Health Staff C

status. When a proposal was submitted to the Department of Correctional Services Provincial Commissioner to offer testing and counselling for these prisoners *at no cost to the department*, the request was denied on the grounds of security issues. Arguably, informing a prisoner of his HIV status while appropriate medical treatment (ARV, better nutrition) is not available could cause considerable unrest, particularly in light of the high number of prisoners expected to be infected. However, denying prisoner requests to learn their HIV status not only contravenes DCS policy but also violates the equivalence principle as prescribed by WHO guidelines.

Although prisoners are not able to be tested for HIV upon request, HIV testing is conducted at the recommendation of the prison doctor at WMB. A doctor visits WMB for two hours in the morning and two hours in the afternoon, Monday through Friday. During each two hour session, the doctor will see an average of 60 prisoners. Of these, the doctor will recommend an HIV test for an average of 5 prisoners. Every prisoner who has or displays symptoms of TB is recommended for an HIV test. Prisoners who have significant weight loss, persistent skin infections, chronic diarrhoea, oral thrush, or an STD are also recommended for an HIV test.[321]

Once a prison doctor recommends an HIV test for a prisoner, he is first referred to a member of the nursing staff to receive pre-test counselling. The counselling session covers a variety of HIV-related issues including the explanation of the prisoner's rights to privacy and dignity and that the prisoner can refuse to take the test. If the prisoner agrees to have the HIV test, he will sign an informed consent form. Out of every ten prisoners who are recommended to be tested for HIV at WMB, one or two will refuse. For those who give their informed consent, the test is conducted on a blood sample and sent to a private lab and the results are usually available in two weeks.[322]

The nurse responsible for HIV counselling will submit a list of all the prisoners whose results have arrived, whether they are positive or negative. The wardens will then bring those prisoners to see the nurse for their post-test counselling session. One reason given for arranging a post-test counselling session with all tested

[321] Interview #1: WMB Health Staff A
[322] Interview #1: WMB Health Staff A

prisoners regardless of whether the test was positive or not is to protect confidentiality. As one nurse explained, most prisoners know that she is the one who gives prisoners their HIV results and so if she only meets with those who test positive for HIV then anyone who is called out from his cell to be sent to see her will be labelled as HIV+. Only the nurse knows the results of a prisoner's HIV test and she does not inform anyone except the prisoner himself, although a prisoner's HIV status will be recorded in his medical file. This reflects a very in-depth understanding of the crucial issues of privacy and confidentiality which actually exceeds that provided by DCS policy. The 1996 policy document provides that, "The diagnosis of HIV/AIDS must be kept absolutely confidential and must only be communicated to disciplinary staff on a 'need-to-know' basis." [323] Examples given of those who "need to know" include a prison guard who is injured by an HIV+ prisoner and psychological or welfare counsellors.[324] Amongst organisations devoted to defending the rights of people living with HIV/AIDS, the phrase "need to know" is considered antithetical to the principles of confidentiality; the only person who actually needs to know is the HIV positive individual himself.

Although the HIV nurse insists on seeing all HIV tested prisoners for post-test counselling irrespective of a positive or negative result, the reality is that 80 to 90% of those tested are actually HIV+.[325] Aware of the psychological distress of learning that he has tested positive for HIV, the nurse has implemented her own policy of always informing prisoners of their results first thing in the morning so that she can monitor them throughout the day. She emphasises the importance of a prisoner's mental health and believes it is an important part of her duties to check on her patients' psychological condition before leaving for the day. The nurse elaborated, saying that she will never give a prisoner his HIV test results just before lock-up in the afternoon because of the emotional stress involved and the need for support as an important part of caring for a prisoner's health and well-being.[326]

[323] DCS De-segregation 1996: 10
[324] DCS De-segregation 1996: 10
[325] Interview #1: WMB Health Staff A
[326] Interviews #1: WMB Health Staff A

The policies and actions of the health staff at WMB in regards to HIV testing reflect a much better degree of understanding and compassion than the DCS official policy. This is a good illustration of the benefits of a bottom-up approach to policy making, rather than a top-down process. While policy makers at the cabinet and parliamentary level debate the appropriate response to HIV/AIDS, those who actually come in contact with and care for the large number of prisoners living with HIV are taking the initiative to develop their own policies and procedures. As the actions of the HIV nurse at WMB have demonstrated, "local actors often deflect centrally-mandated programmes toward their own ends."[327] Fortunately, the ends of the local actors at WMB are very much in line with the best interests of prisoners being tested for HIV, an attribute that cannot be as easily identified in the centrally-mandated policies handed down by the DCS.

3.3.2 Condom Distribution

The DCS policy to distribute condoms was the result of a hard fought battle, waged by several pressure groups including Lawyers for Human Rights and the South African Prisoners Organisation for Human Rights. Unfortunately, the policy does not achieve its objectives because of both poor design and implementation. The policy document states that condoms are to be provided to the prisoners, "on the same basis as condoms are provided in the community."[328] This seems an appropriate policy, were it not for the very next paragraph which effectively prevents condom availability in the prison from bearing any resemblance at all to the manner in which condoms are available in the community:

> A prisoner may not receive condoms before having undergone education/counselling regarding AIDS, the use of condoms and the dangers of "high risk behaviour." The fact that prisoner received counselling must be recorded on his/her medical file.[329]

In effect, a prisoner who wishes to obtain a condom must endure a face to face interaction with a member of the health staff to make his request and then receive a

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[327]Hill 1993: 272
[328] DCS Condoms 1996: 1
[329] DCS Condoms 1996: 1

lecture regarding his sexual behaviour. Imagine the impact if all South African citizens had to request condoms from their pharmacist, who would then require them to undergo counselling, and would then record the incident in their medical files. Any legislator who attempted to implement a policy such as this in the general community would be ridiculed, and few would doubt that such an outrageous procedure would result in a drastic reduction of condom use. In the general community, condoms are available discreetly and free of charge at universities and clinics and are even provided by some employers. Clearly, the DCS policy on condom distribution is poorly designed to the point that even with perfect implementation it is likely to be counter-productive.

Interviews with prisoners and health staff at WMB confirmed the ineffectiveness of the condom distribution policy as it was determined that prisoners very rarely request condoms. Of the 274 prisoners interviewed, only one reported requesting a condom while in prison. This may or may not be a result of the flawed design of the condom distribution policy, as some would argue that sodomy in prison is at a minimum coerced under threat, when it is not forcible rape, and the perpetrators would not agree to using a condom anyway. Furthermore, more than three-quarters of the prisoners interviewed reported that they never used a condom prior to their incarceration.[330] One can scarcely be surprised that the same behaviour regarding condom usage outside of prison would persist inside the prison.

However, even assuming that the condom distribution policy was appropriately designed and that prisoners were genuinely interested in practising safer sex and avoiding high risk behaviour, the DCS condom distribution policy would still fail because the actual condoms issued are not strong enough for anal intercourse. According to health staff at WMB, the condoms provided break during anal intercourse thus negating any effort to reduce HIV transmission.[331] The condoms are issued by the Department of Health (DOH) and are the same as those provided in the general community. However, this is one instance where the standard which applies for the general community is not appropriate in the prison environment.

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[330] Prisoner Questionnaire
[331] Interview #2: WMB Health Staff B

While the involvement of DOH in the condom distribution policy may seem like a laudable effort to conserve resources and not duplicate efforts, it has instead contributed to poor implementation. This is a classic example of an implementation deficit caused by a dependency relationship. Hogwood and Gunn describe the minimisation of dependency relationships as a condition of "perfect implementation" which requires that,

> ...there is a single implementing agency which need not depend on other agencies for success, or if other agencies must be involved, that the dependency relationships are minimal in number and importance.[332]

Unfortunately, the dependency on DOH to provide appropriate condoms for prevention of HIV transmission in the prison environment cannot be considered minimal in either number or importance, thus the resulting breakdown between policy design and implementation.

3.3.3 Insufficient Resources

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

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.

[332] Hill 1993: 220

5. All other duties as indicated in the directive on the provision of condoms.[333]

The province of KwaZulu-Natal contains 28,375 prisoners in 38 prisons from Ladysmith to Port Shepstone, Durban to Vryheid.[334] The PHC for KwaZulu-Natal is responsible for programming and education to reach each of these prisons, including both prisoners and staff, *in addition* to her regular duties as a full-time member of the nursing staff. She is not paid any additional salary for her role as PHC, nor is she provided transport or reimbursed for the use of her personal vehicle.[335] 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 of any official instruction or support, the health and social workers at WMB have succeeded in implementing successful programmes for addressing HIV/AIDS. The positive results of these bottom-up approaches to HIV/AIDS attest to the benefits of incorporating local implementation structures in the policy development process. To illustrate, social workers and psychologists have organised a support group for HIV+ prisoners, 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.[336] One social worker described an exercise from the HIV support group where prisoners are asked to identify positives as well as negatives in their personal situation and encouraged to emphasise the positive as a coping strategy for their situation. The group has also learned to beadwork skills and meets to make beaded AIDS awareness pins. This project does not receive any funding from the department however and the

[333] DCS De-segregation 1996: 6-7
[334] DCS 30 June 2000
[335] Interview #1: WMB Health Worker A
[336] Interview #5: WMB Social Worker Y

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.[337]

While the support group helps address the needs of HIV+ prisoners, peer education programmes have been organised to respond to the needs of the general prison population. With the assistance of prisoners, guards, and other staff at WMB, certain peer leaders have been identified and engaged in an education programme aimed at disseminating HIV/AIDS information in a manner which will be best received by other prisoners. As with other social settings, prisoners are more likely to absorb information that is obtained from people with similar backgrounds and experiences, thus peer education programmes have become a common recommendation for effective HIV/AIDS intervention. The peer .education programme at WMB consists of around 20 prisoners but faces many of the same limitations as the HIV support group due to the lack of resources.[338]

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

3.3.4 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:

[337] Interview #4: WMB Social Worker X

> 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.[339]

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

The official policy regarding early release at Westville Medium B consists of numerous bureaucratic levels, with the result that most prisoners die before their release is approved. If the health staff 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 WMB once a week, and must see the patient twice: once to order additional tests and x-rays, and a second time to review the results. The specialist recommendation is then sent on to the parole board, and a social worker is notified who must determine if the prisoner will have adequate housing and care upon release.[340] This is no mean feat as many prisoners come from township areas where their families live in makeshift substandard housing and access to postal services or phone lines is considerably limited. Sometimes the family does not wish to care for the prisoner, either as a result of misguided fears associated with HIV or because of they cannot afford the cost of burial services.[341]

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

338 Interview #4: WMB Social Worker X
339 WHO 1993: 9
340 Interview #4: WMB Social Worker X
341 Interview #4: WMB Social Worker X

granted.[342] 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.[343]

3.4 Conclusion

Prison policy in South Africa has swung from an emphasis on prisoner development advocated by the first commissioner in the early 1900s, to becoming a tool of control utilised to great effect by the apartheid state, and then returned to the original ideals of nearly a century earlier with the Correctional Services Act of 1998. However, many vestiges of apartheid still remain within the department, including an approach to policy making which does not welcome the input, or interference, of outsiders. The development of HIV policies reflects this reluctance, as the department for some time employed the internationally condemned practices of segregating HIV+ prisoners. This policy was officially reversed in 1996, and the new policies reflect a certain level of respect for prisoners' rights to confidentiality and informed consent.

A policy of condom distribution was also introduced in 1996, although the top-down development of this policy contributed to its flawed design. The poor design of the policy, compounded by poor implementation, has rendered the condom distribution policy all but useless in preventing HIV transmission in South African prisons. The staff at WMB have implemented their own policies which complement and even exceed the intentions of the official response to HIV/AIDS in prison, although problems of insufficient resources hamper the success of these initiatives.

The policy for early release of terminally ill prisoners has not been adapted or updated to accommodate the impact of an increasing number of AIDS-related deaths in prison. International guidelines stress the importance of providing prisoners the opportunity to face death with dignity by releasing those in the late stages of AIDS to the care of their families. Unfortunately, endless bureaucracy and inefficiency prevents this for all but a handful of South African prisoners. The waste and

[342] Interview #2: WMB Health Worker B
[343] Interview #4: WMB Social Worker X

senselessness of the DCS procedures for early release are a disheartening example of the human costs of ineffective policy.

Chapter Four

Policy Recommendations

4.0 Introduction

The previous chapter presented the development of HIV/AIDS policy and the strengths and weaknesses of such policy as it is observed in action at Westville Medium B (WMB). This chapter seeks to offer recommendations to both complement and supplement the existing HIV/AIDS in prison policies. The first section covers specifically HIV/AIDS policy, and makes suggestions regarding HIV testing, condom distribution, sterilisation of cutting instruments, access to resources and early release. In reality, no HIV/AIDS policy will be successful if the prisons continue to exist in their current state. General prison reform is addressed in the second section, including overcrowding, nutrition, and the closed nature attributed both to actual prisons and the development of prison policy.

4.1 HIV/AIDS Policy

The current HIV/AIDS policy as it is implemented at WMB does not adequately address the issue of HIV/AIDS in South African prisons. An effective HIV/AIDS policy must take into account the interests of four different groups of stakeholders: prisoners who are HIV+ upon admission to the prison, prisoners at risk of contracting HIV while imprisoned, prisoners who are in the late-stages of AIDS, and the communities to which prisoners will return upon their release.

4.1.1 Testing

Prisoners should receive HIV testing upon request. A prisoner has the right to receive the same standard of care as the general community. HIV testing is available free of charge in the general community and as such it should be provided without exception inside prison. The prisoners at WMB have demonstrated their interest in knowing their HIV status, an encouraging start for any intervention programme. The

pre- and post-test counselling procedure should continue, as well as the commendable emphasis on confidentiality and prisoner's mental health.

4.1.2 Prevention of Transmission

Condoms and lubricants must be made available in latrines, showers, the cafeteria and any other common area to which the prisoners have access. Prisoners should no longer be required to personally request condoms, although the required HIV and STD 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 during anal intercourse. 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 sodomy 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 illustrate, one interviewee recounted a conversation with a formerly a high-ranking member of the 28s gang, who asked for additional information on HIV transmission in order to be able to pass this information on others. The prisoner responded positively when it was suggested that he could become a leader in the effort to stop the spread of HIV, and was enthusiastic about improving his own knowledge with the intention of assisting others.[344]

[344]Interview #11: Chris Giffard

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.

4.1.3 Resources

The Department of Correctional Services is struggling with an overextended budget, which partly explains the lack of resources dedicated to HIV/AIDS policies in the prisons. There are several changes which could result in better and more efficient use of the existing funds available. One of the first reforms to improve prison health care attempted in other countries is to discontinue the separation of prison health services from the general public health agency. As discussed previously, all but a small fraction of prisoners return to the community. Therefore, issues of prison health are issues of public health. Providing suggestions for UNAIDS, Professor Tim Harding was emphatic about this first step in appropriately addressing HIV/AIDS in prison:

> "If there is one thing, more than anything else, which should be done, it is that health in prisons must come under the responsibility of the public health authorities. The link between health in the community and health in prisons must be made as strong as possible."[345]

Prison health care facilities were never designed nor intended to care for such a large proportion of chronically or critically ill patients. The prison hospital should be run and funded as a public hospital, the budget for prison health should come from the DOH, and the staff and management should be the realm of public health, not correctional, services. Expanding the responsibilities of the DOH to include the

[345] UNAIDS 1997: 4

prisons would reduce funds wasted on the duplication of efforts and amend the disparities in the quality of health care provided in prison.

One of the most effectively designed responses of the DCS to HIV/AIDS in prison was the appointment of the Provincial HIV/AIDS Co-ordinators (PHC), but it is made less effective because it 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 added responsibilities for an already over-worked individual.

In spite of the resource limitations which constrict the efforts of staff at WMB, several useful programmes have been implemented including an HIV support group and a peer education programme. The social workers, psychologists, and health staff who have helped with these projects have an extremely valuable depth of knowledge pertaining to the challenges of addressing HIV/AIDS in the prison environment. 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 never been a national conference of PHCs, and there does not even appear to be a phone list distributed. The achievements of each PHC should be shared with other DCS and DOH staff in order that the entire prison system can benefit. Inter-provincial and even inter-prison co-ordination and communication will be critical if the DCS is to address HIV/AIDS in the country's prisons in a meaningful way. Although the bulk of this research focussed on one prison, 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.

4.1.4 Early Release

One health worker at Westville Medium B prison estimated that of the prisoners for whom early release is requested, at least 90% die before permission is granted.[346] This is due entirely to the several levels of bureaucracy through which such a request is passed. Also, the criteria are not clearly defined for determining if a prisoner is sick enough to no longer be a security threat and close enough to death to be released. The decision for early release should involve the input of the nurses who care for the prisoner on a day to day basis, perhaps confirmed by a visiting 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 care is available upon release should be notified as soon as possible, perhaps when the patient is admitted for AIDS-related illness rather than waiting until the prisoner is near death. In this way, the social worker will have more time to contact the family, and can also provide assurances to the prisoner that may encourage him to hang on to life a little longer so that he may be rejoined with his family before dying.

4.2 General Prison Reform

Any attempt to address HIV/AIDS in prison in South Africa will be affected if not entirely thwarted by the problems with prison in general which are in desperate need of reform. While conditions in prison have been shown to frustrate HIV/AIDS policies and aggravate problems faced by prisoners either infected or affected by HIV/AIDS, the following reforms will be discussed in terms of the benefit to the entire prison population. Just as HIV/AIDS policies impact on the greater community, including both infected and affected prisoners, the need for prison reform is an issue which should be of concern to all South Africans regardless of HIV status or criminal record.

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[346] Interview #3: WMB Health Staff B

4.2.1 Overcrowding

The primary challenge facing the Department of Correctional Services is overcrowding. Reducing overcrowding will accomplish a great deal in the interest of general prison health as well as a number of other conditions which impact on the nature and extent of HIV infection in the prisons. Unfortunately, DCS does not decide either the number of prisoners entrusted to its care or the duration of their stay. However, the DCS is given the unenviable and all but unmanageable task of incarcerating nearly twice as many prisoners as the prison system can accommodate. No other government agency's core mandate is so adversely affected by the actions of another agency. In this case, it is the policy and performance of the Department of Justice with which the Department of Correctional Services must cope, yet DCS is not involved at any stage of the DOJ policy-making process. Still, DCS is expected to maintain the same standard of service delivery as any other government department even in the face of nearly insurmountable difficulties beyond the department's control.

No successful government policy operates in isolation. Rather, the most effective means of addressing any issue, particularly one such as HIV/AIDS, requires a multi-sectoral approach. Far from obtaining co-operation, the Department of Correctional Services is burdened with both neglect and exploitation by other departments of government.

The rights of prisoners to conditions of humane detention are guaranteed in the South African constitution's bill of rights, article 35(2)(e):

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

Any prisoner, former prisoner, prison employee or anyone that has ever visited a prison in South Africa will agree that not a single one of these constitutional rights is respected in South African prisons. Overcrowding is the primary culprit. How could 55 grown men sharing one cell with a broken toilet and not even enough beds possibly be considered "conditions of detention that are consistent with human

dignity"? The current prison conditions in South Africa are unconstitutional, and as such a court case should be brought on behalf of all prisoners against the government of South Africa to force the authorities to act.

The most effective agent to champion the cause of prisoners is not angry citizens or pressure groups or even the prisoners themselves as none of these voices will be as loudly resounding in their criticism than the Department of Correctional Services itself. The DCS is extremely defensive and secretive because it is attempting to cover-up its failure to provide safe custody and meet the obligations of its mandate. But how can the Department of Correctional Services pursue its purposes when the actions of the rest of the government create an unmanageable situation in which the delivery of correctional services is all but impossible? Granted it is unlikely if not impossible that national level politicians, such as the Minister, would be willing to support a court action against themselves. The most effective agents for change would be the Heads of Prisons and the Provincial Commissioners, who should unite to force a systemic transformation. What would happen if the next busload of awaiting trialists were turned away from the prison gates? What if the same were to happen at every prison? What then? Rather than continuing to struggle with the aftermath of poorly designed and/or implemented policies on the part of the DOJ, the DCS should demand to be involved in the policy process and refuse to accept any more prisoners on the grounds that to do so would violate the constitution.

If the DOJ were to consult with DCS regarding policy decisions which affect prison, there are several recommendations which DCS should present. One, the judges and prosecutors and legislators involved in sentencing laws and decisions should be made aware of exactly what prison can and cannot achieve and the appropriate instances for which incarceration is warranted. If an arrested person is considered not 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.[347]

The prison population consists of a significant number of people who simply should not be there at all. These include not just prisoners who are awaiting trial, but also prisoners who have been convicted of petty theft or non-violent crimes of a strictly economic nature. These are crimes born of poverty and employment; factors which are not alleviated by a prison sentence. The National Institute for Crime Prevention and the Rehabilitation of Offenders (NICRO) runs several successful programmes which help former prisoners to obtain marketable skills and to find means of contributing to, rather than disrupting, society. The South African government should fund initiatives such as those run by NICRO in an effort to reduce the pressure on the DCS and the DOJ, as it is these programmes which are actually able to reduce crime. The add-on effect will be that as crime is reduced so too will the burdens of DOJ and DCS as there become fewer cases and fewer criminals to process through the already overloaded system.

While the overcrowding issue is largely beyond DCS control, there are some aspects which the department is able to address. Most notably, the inadequate accommodation provided by outdated prison facilities. First and foremost, the use of communal cells should be discontinued. Warehousing prisoners in large cells with minimal space and privacy is inconsistent with human dignity even in the absence of overcrowding. Many prisons in South Africa were designed with communal cells and to abandon this practice would require significant structural changes of the prison buildings themselves. A better solution is to knock them down entirely and build a new prison which will be designed for both better security and better conditions, including cells which contain a maximum of six 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

[347] Judicial Inspectorate 2001: 17

complex. The profits from the sale of this enormously valuable stretch of land alone could probably fund new prisons for the entire Western Cape.[348]

On a considerably smaller scale than the razing of existing prison facilities is the recommendation that DCS attempt to ameliorate the detriments caused by overcrowding. The more familiar day to day impact of overcrowding is the shortage of basic necessities for decent living conditions. This would include the appropriate amount of food, clothing, shoes, blankets, and beds to provide a minimum level of comfort for each and every prisoner. The scarcity of these commodities not only compromises the constitutional rights of prisoners but also reinforces the gang structures which derive power from control over items which are in high demand. Prisoners will undoubtedly be more likely to pledge allegiance to a gang when the potential reward is having a bed to sleep in. Gangs will lose their attractive appeal to a certain extent when the most they can offer is cigarettes and contraband as compared to a blanket and a place to sleep.

4.2.2 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.

[348] Interview #11: Chris Giffard

This could not only generate savings to the government but, if implemented conscientiously, would result in improved nutrition and decreased smuggling and other instances of corruption associated with the currently prison-run kitchens. A contract to provide food services to the entire prison system would be an attractive opportunity for any catering company. The sheer scale of operations combined with assured future cash flows should be used as leverage in negotiating a financially advantageous outsourcing contract for the department. Furthermore, the private catering firm should be permitted to hire prisoners, provided they are trained and paid a normal wage. This will create an incentive on the part of kitchen staff to keep their jobs, which carries along with it an incentive not to steal. In the current situation, prisoners have little to lose if their smuggling is discovered, and the ubiquitous nature of such activities make them seem more or less acceptable. In a situation of employment, the environment will change considerably and it can only be hoped that this change would be for the better as it could scarcely get any worse.

4.2.3 Open the prison

The Department of Correctional Services is notorious for its hierarchical and dogmatic approach to policy making. Few other government agencies can match its mulish espousal of the top-down policy approach, and thus few other departments suffer more from the flaws of this rigid policy process. As Paul Sabatier explains,

> The fundamental flaw in top-down models... is that they start from the perspective of (central) decision-makers and thus tend to neglect other actors. Their methodology leads top-downers to assume that the framers of the policy decision are the key actors and that others are basically impediments. This, in turn, leads them to neglect strategic initiatives coming from the private sector, from street-level bureaucrats or local implementing officials and from other policy sub-systems.[349]

The view of other stakeholders as impediments is reinforced by the Department's continued insistence on secrecy, begrudging if not entirely artificial consultations with pressure groups, and the difficulties encountered for anyone who attempts to gain access to prisons for the purposes of either journalistic investigation or academic research. Appropriate policy can only be developed to respond to a

problem once that problem is appropriately understood. The DCS, by frustrating the efforts of those who wish to use their own funds to study the challenges faced by the department, is only depriving itself of valuable insights and information which could assist in the design of better policies and more efficient use of resources.

The department should adopt a co-operative relationship with researchers and the organisations they represent in order to derive maximum mutual benefit, rather than wasting valuable time and resources trying to prevent access to the prison or piling endless levels of bureaucratic red tape in the hope that pesky students will eventually go away. In the United Kingdom, the International Centre for Prison Studies (ICPS) is well known throughout the world for the research it supports and distributes regarding prison issues. ICPS is part of the Kings College of Law, and is neither funded nor controlled by the British government or HM Prison Service. However, its executive director and a number of the research associates are former prison governors with extensive experience in correctional services. The relationship enjoyed by ICPS with HM Prison Service produces an enviable level of academic research and valuable data collection, and is a model which could provide equally beneficial results in South Africa. By allowing an outside organisation to consolidate and co-ordinate prison research, DCS can improve public relations, gain valuable information, and eliminate a great deal of headaches for the beleaguered Heads of Prison and Provincial Commissioners who seem to work as hard at keeping prisoners inside of prison as they do at keeping every other private citizen out.

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. The most recent meeting of the Correctional Services Portfolio Committee continues to debate the implementation of mandatory testing and segregation. Many MPs still vehemently oppose condom distribution, while others raise the question of whether ARV treatment can be made available. These debates demonstrate the extent to

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[349] Hill 1993: 279-280

which national-level decision makers are both uninformed and unrealistic. Not surprisingly, these two attributes have consistently characterised the South African government's response to HIV/AIDS in prison since the issue first made it to the agenda nearly a decade ago.

4.3 Conclusion

The DCS policy for HIV/AIDS in prison has some good features which are implemented extremely well, some excellent features which are not appropriately implemented, and some features which are neither correctly designed nor implemented. Correct implementation of the HIV testing policy as it is written will improve adherence to the international standard of the equivalence principle. The discreet provision of condoms and water-based lubricants, will enable the condom distribution policy to achieve its intended objective of reduced HIV transmission in the prison environment.

Given the very real budget constraints faced by DCS, consolidation and re-allocation of resources, particularly in the form of increased co-operation with the Department of Health, will help make sure that more is achieved for each rand spent. The early release policy must be updated and streamlined, in order to be useful in the context of increasing prisoner deaths from AIDS-related causes.

Recommended HIV/AIDS policies will accomplish little in the absence of basic prison reforms. Overcrowding has adversely affected prison conditions to the point that they are entirely unconstitutional. Anyone who visits a prison or otherwise knows of this situation has the right to be outraged, but the demand for action must be correctly directed. The department has a limited say in decisions which affect the size of the prisoner population, and drastic action is required on the part of DCS to attract the appropriate level of attention necessary to affect systemic changes. Some of the options available to DCS to improve prison conditions include the larger scale recommendation to raze existing prisons and build entirely new ones better suited to their intended purposes, as well as the smaller scale proposal to simply ensure that at least a minimum standard of decently humane living conditions are maintained.

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

Conclusion

The purpose of this research was to analyse the South African government's response to HIV/AIDS in prison, in terms of how this policy was developed, designed, and implemented and to determine in what ways the policy has succeeded and in what ways it has failed. The introduction provided an overview of what the research hoped to achieve and the areas to be covered as well as those which are beyond the scope of this study. The introduction also explained the methodology used for primary data collection and a synopsis of the contents of each chapter.

The literature review was an attempt to summarise and critique previous relevant research. Because very little has been written about HIV/AIDS in prison in South Africa, a more general approach was used in defining the relevant research to be reviewed. The chapter began with an overview of prison research, from its initial development to the modern institution today. This section was followed by a discussion of basic HIV/AIDS research to the extent necessary for understanding HIV/AIDS issues in the prison context. The chapter concluded with an examination of HIV/AIDS in prison research in various countries as well as in South Africa.

Chapter two provided information specifically on HIV/AIDS in prison, as applied to the South African context. Because reliable data on HIV infection in South African prisons is not available, an attempt was made to estimate current infection rates in the incarcerated population through an analysis of the demographic profile of a typical South African prisoner. The incidence of high risk behaviours in South African prisons was explored, as illustrated by primary data collected from Westville Medium B prison in KwaZulu-Natal. Finally, various policy options for addressing HIV/AIDS in prison were presented as well as the arguments both for and against some of the more controversial policies such as mandatory testing and segregation.

The development of prison policies was covered in chapter three, as well as an overview of the evolution of penal theory from Union through to the present. The next section covered penal reform in post-apartheid South Africa including the development of HIV/AIDS policy. The section also included observations on the

drawbacks of the DCS policy-making process and the propensity of the department to exercise overt power and preclude external participation. The actual implementation and impact of HIV/AIDS policy at Westville Medium B was then evaluated and many of the same weaknesses from the policy design approach could be observed in the resulting implementation deficits. The policies as they are written are neither appropriately designed nor implemented, and these flaws can be traced to the heavy reliance on top-down decision making within the department.

Chapter five provided recommendations for improving and supplementing DCS policies in response to HIV/AIDS. The first set of recommendations was directed specifically at HIV/AIDS in prison policy, followed by recommendations for general prison reform. The current policies are based on sound principles and are in line with international guidelines, but they are out of touch with the actual realities faced by prison staff and inmates in South Africa. The condom distribution and HIV testing policies must be updated and revised, and the existing procedure for early release must be streamlined. The ideal response to HIV/AIDS in prison would emphasise education and targeted intervention programmes, however the success of any new initiatives will be limited in light of the dire need for general prison reform.

Many of the challenges faced by prison administrators in South Africa are symptomatic, and the root cause is overcrowding. The growth in the prison population is directly attributed to an increase in both the number of awaiting trial prisoners and the length of time these prisoners are incarcerated pending their trial. The Department of Correctional Services has no control over policies which affect the number of prisoners or the length of their sentence, yet the effects of these policies have the most significant impact on the departments ability to provide correctional services. Instead of covering up and attempting to shield the problem from public view, the Department should take a stand to correct the root cause of the unconstitutional conditions in South African prisons. The first step for transforming the dynamic of the DCS relationship with the rest of the government is to involve DCS in the Department of Justice policy process.

Politics of Prison Reform

The United Nations has specifically addressed the question of prisoners' rights in a publication referred to as the UN Blue Book. Chapter five, entitled Detainees and Prisoners, lists first and foremost that "All persons deprived of their liberty shall be treated humanely"[350] and also requires that,

> "The place where the prisoner is kept, especially the place where the prisoner sleeps, should be designed to preserve the prisoner's health. The prisoner shall be provided with adequate food, shelter, and clothing, as well as equal and easy access to medical services, exercise, and items for personal hygiene."[351]

The World Health Organisation (WHO) has also set standards for minimum required treatment of prisoners, and reiterates the premise that individuals are sent to prison *as* punishment, not *for* punishment.[352] Finally, the basic human rights of all people, regardless of status or offence, are guaranteed by international law in the International Bill of Human Rights, which emphatically states in Article One that "All human beings are born free and equal in dignity and rights."

But what do all of these laws and guidelines mean in the South African context? What rights exactly do prisoners have? If a prisoner has the right to food, clothing, and shelter, does that not mean that the prisoner will actually have a better living standard than a good portion of South Africa's law-abiding citizens who live in makeshift housing, suffer from poor nutrition, and struggle through conditions of extreme poverty every day in order to survive? Add to this dilemma the reality of constrained government resources, and the important detail that the limited funds which the government does have are entirely provided by tax-paying citizens. In light of this, it hardly seems fair to spend money taken from the innocent in order to provide a lifestyle for criminals, the quality of which exceeds hundreds of thousands of other citizens who have their freedom and their rights but not the state-provided food, shelter, and clothing which prisoners are "entitled" to enjoy.

Determining the guidelines for appropriate treatment of prisoners within their rights as human beings is a tricky issue, and usually an unpopular one with a large

[350] UN Blue Book, §5.1
[351] UN Blue Book, §5.10

portion of voters. For this reason, it is often skirted or ignored by politicians and legislators, simply because the political risks are too high and the potential reward is so limited. However, there is an additional challenge which faces the South African prison system. This challenge will force a re-evaluation not just of prisoners' rights, but of the entire prison system and its role in the Department of Justice as well. It is a challenge which looms large for the entire government, at every level, but it is of particular importance for those who make decisions regarding prisons in South Africa. This is because not only has it been all but ignored thus far, but the more it is ignored, the more far reaching, costly, and dangerous its effects will become. This challenge is the challenge of HIV/AIDS.

Politics of HIV/AIDS

In 1999, the global death toll from AIDS was 2.6 million people; 85% of these deaths occurred in Africa.[353] Last year, 5.6 million more people became infected with HIV. In South Africa, it is estimated that a total of 4.7 million people were HIV+ at the end of 2000; this means that one in nine South Africans are infected. Current antenatal statistics reveal that 36.2% of pregnant women attending public health facilities in KwaZulu-Natal were HIV+ during the year 2000. Observing HIV prevalence rates for the general population (not just pregnant women attending antenatal clinics), KwaZulu-Natal continues to have the highest and fastest growing infection rate.[354] These statistics speak for themselves: HIV/AIDS is a challenging problem for all of Africa, it is an especially important issue in South Africa, and it is now a crisis in KwaZulu-Natal.

As Virginia van der Vliet observed in 1994, one could hope that "a human tragedy of these proportions [would] unite South Africans in a strategy to combat the epidemic. Instead, as people of all ideological persuasions interpret and manipulate it to suit their own political agenda, AIDS has become yet another stick with which to

[352] Thomas 1994: 5
[353] Bartholet 2000: 32
[354] DOH 2001: 9-11

beat opponents."[355] While politicians usually avoid prison issues, HIV/AIDS has become increasingly politicised. Conservative political parties, particularly those aligned with Christian fundamentalism, consider AIDS to be divine retribution for sinful behaviour. Amongst rural communities where access to HIV education is limited and the influence of hearsay is unchecked, fear and discrimination against people living with HIV/AIDS is fuelled by ideologies that claim HIV infection is visited upon those who have sinned or somehow forfeited their right to live.[356] These attitudes impact HIV policy when political leaders oppose HIV education and condom distribution on the grounds that it inappropriately brings private matters into the public sphere and condones promiscuity.[357]

The Politics of HIV/AIDS in Prison

The political treatment of both prison issues and HIV/AIDS share common attributes, most notably the tendency of both to be distorted to further the ends of competing political interests. Knowing the unwillingness of politicians to propose or support sensible prison policy, it is not surprising that HIV/AIDS in prison policies has received the same short shrift in national debates. For one thing, issues pertaining to HIV/AIDS in prison involve several topics which are unpleasant to discuss, if not considered entirely inappropriate for polite conversation. One can hardly imagine an MP would wish to publicly debate the usefulness of providing lubrication as well as condoms to prisoners in order to reduce potential transmission of HIV. Not many MPs wish to see their name in print next to a quote which mentions the words "rectal tearing". The same taboos which prevent relevant HIV/AIDS policy from being pragmatically discussed are even more effective at preventing rational discussions about HIV/AIDS in prison policy. Discussing HIV/AIDS requires discussing sex, and discussing sex in prison requires discussion of homosexual activity. Given the homophobic track record of South African public figures, most recently demonstrated by Durban Mayor Mhlaba's comments regarding Cape Town's gay community, the realistic discussion of HIV/AIDS in prison issues seems unlikely to occur.

[355] Feldman 1994: 109
[356] Feldman 1994: 116

The queasiness national politicians feel about tackling the issue of HIV/AIDS in prison is understandable, given that these individuals' livelihoods depends on their ability to gain favourable public opinions. However, the reluctance to deal with the issue is not confined to national level officials but can also be found amongst low-level bureaucrats as well. The challenges of managing a prison in South Africa are great, and for some, acknowledging the added difficulties brought by HIV/AIDS is too much of an additional strain. The result is a "head in the sand" approach, as evidenced by a general reluctance to allow HIV/AIDS research to commence. This reaction on the part of prison authorities is also understandable, however, because acceptance of the realities of HIV/AIDS in prison also requires acceptance that high risk behaviour takes place as well as the existence of exacerbating substandard conditions. By acknowledging the presence of sodomy, rape, overcrowding, tattooing, and gang activities in their prisons, the DCS official responsible for that prison is also acknowledging a failure to maintain control and evidence of mismanagement and mal-administration. Few government employees have found success by publicly discussing their mistakes and shortcomings. Someone who has attained the rank of Head of Prison is not likely to be a person who is unaware of how to keep a government job.

The policy process for prison reform in South Africa has consistently been monopolised by top-level politicians. The process through which HIV/AIDS policies have been developed is a prime example. If external participation from pressure groups is permitted, it is usually extremely limited if not entirely artificial. The legacy of apartheid in the Department of Correctional Services policy process is to be found in its defensiveness and its secrecy. By frustrating attempts to conduct HIV/AIDS research, some members of the DCS are attempting to keep HIV/AIDS in prison issues off the agenda. However, this reliance on passive resistance to reform and avoidance of overt conflict will not serve its purposes for long. The conditions in South African prisons are exacerbating problems with HIV/AIDS, and will eventually become the focus of public attention. The career-politicians in the department have recognised this and have already begun to mention HIV/AIDS in their public

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[357] Feldman 1994: 116

speeches. The remainder of the department would do better to confront its failings now and request the co-operation and support necessary to address them. A good place to start would be the re-evaluation and re-design of HIV/AIDS in prison policies.

Concluding Remarks

Prison health is public health. 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.[358]

The people who enter and leave prison are young men from marginalised communities. They may be in prison for six months or less, and may not join a gang, have unprotected sex, or be tattooed. But without any attempt to reach them with HIV/AIDS education, they will return to their communities and continue to engage in the same high risk behaviours which have caused their social group to be disproportionately affected by the HIV/AIDS epidemic.

The most urgent need for further research regarding HIV/AIDS in South African prisons is in the field of development, implementation, and evaluation of HIV/AIDS intervention programmes. Dr. Helene Gayle, Director of the National Centre for HIV, STD, and TB Prevention at the Centre for Disease Control in the United States advises, "Prisons and jails provide a critical opportunity to provide lifesaving HIV prevention services to a population that might otherwise be missed."[359] The information available on HIV/AIDS in South African prisons is very limited, and there still are no reliable statistics on the nature and extent of HIV infection or transmission in South African prisons. However, given the limitations of prison research and the necessity of maximum effect for public health policies in the interest

[358] Hammett 1999: 1
[359] Henderson 1999: 8

of reducing the spread of HIV/AIDS, research into appropriate intervention programmes is of singular importance.

A serious problem for South African prisoners is boredom and idleness. They are locked up for 2/3 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. Not only would these young men become ambassadors for HIV awareness to the under-served communities they represent, but could also empower former prisoners with a purpose that could lead them to develop societal bonds and a resulting sense of community responsibility, the absence of which precipitated their criminal behaviour in the first place.

As van der Vliet laments, "It is a cruel irony of South African history that the ending of apartheid should coincide with the beginning of the AIDS epidemic."[360] If only one in ten prisoners is reached or affected by an HIV/AIDS programme in prison, the annual result is still 30,000 South Africans with a new mind-set. And potentially, from that 30,000, there may be as many as 10,000 HIV+ South Africans who will do their part to prevent transmission. It is not hard to imagine the impact this kind of behavioural change would have on HIV infection in South Africa. Indeed, it is precisely this kind of inspirational spark which could cause the second great transformation of South Africa, and could once again make the small country at the tip of Africa a model of hope and a beacon for change in an otherwise despairing world.

[360] Feldman 1994: 107

Appendix A

Gaining Access to Conduct Research at Westville Medium B Prison: A Diary of Events

In order to conduct research at a prison in South Africa, one must first obtain "official" permission. However, the procedures for obtaining such permission do not appear to be standardised or communicated to the various members of the Department of Correctional Services. The entire process for obtaining permission for this research started in September 2000. The field work was not able to commence until late January, 2001. The process was unnecessarily complicated, and very frustrating. However, when access was granted, it seemed to happen almost magically – after months of faxes and phone calls, a planning meeting was suddenly arranged and the research went forward. The following timeline chronicles the difficulties encountered in gaining access to the prison for this research.

September	I contact the social worker responsible for HIV/AIDS programmes at WMB via phone. She is interested in participating in the study but explains that the HOP must approve any research conducted at the prison.
	I fax a one page research proposal to Westville Medium B Head of Prison (HOP). The proposal is followed up by a phone call, although it is difficult to phone WMB because sometimes the entire phone system does not function. Assuming the phone system is working, the phone is often not answered. Also, the receptionist (for lack of a better term) claims to not know when the HOP will be available, when his meetings will end, or when he will next be in the office.
	I send the research proposal to the Office of the Judicial Inspectorate. The Inspecting Judge (Judge) pledges full support for the research to commence. The judge recommends following DCS procedures to obtain permission, but encourages me to phone his office should I run into problems.

I obtain a different phone number for the HOP, and eventually I am able to speak with the HOP. HOP refers the matter to the Provincial Commissioner (PC).

October I send the research proposal to the PC via fax and regular mail. One week later, I receive a letter from PC acknowledging receipt of proposal. One week after receiving acknowledgement of receipt of proposal, I phone the PC to determine status of my request. The PC is not available and does not return my calls. Eventually, the PC instructs me to contact "Pretoria" as the decision to allow research does not rest with him. The PC is not specific about exactly whom should be contacted in Pretoria.

The research proposal is sent to National HIV/AIDS Co-Ordinator via fax, and is then followed up with phone call and email. No response is received.

The research proposal is sent to the National Commissioner of Correctional Services and is followed by a phone call. No response is received.

The research proposal is sent via fax to the Director of Prisons in Pretoria. I follow up the fax with a phone call, and reach the Director of Prisons on the first try. He is co-operative but refers me to the Director of Corporate Planning, who is responsible for research in the department.

I send the research proposal to the Director of Corporate Planning (DCP). I follow up the fax with a phone call and the DCP asks me to phone back in one week. When I phone back one week later, I am asked to phone back in one more week.

November I phone the judge to update him on my progress trying to get official permission to conduct research at WMB. The judge suggests that I phone DCP again, and to let him know if I still get no response.

I then phone DCP and offer to write an official letter of permission and fax it to her to be signed. The DCP agrees and I immediately draft a letter granting permission for research to commence and fax it to the DCP. The official letter granting permission is faxed back to me later that afternoon, on letterhead and signed by the DCP.

I write a fax to the HOP and to the social worker responsible for HIV/AIDS programs at WMB requesting a meeting the following week, and attach the official letter of permission from the DCP.

I write a fax to the judge thanking him for his help with the process and letting him know that I have obtained the necessary permission. I attach the letter from the DCP to the fax.

I phone the HOP at Westville and he is not available, and the receptionist does not know when he will become available.

I phone the social worker and she tells me she has just returned from a meeting with the HOP. She was called in to his office to discuss the fax which I had sent to both her and the HOP. The HOP instructs her not to speak to me and that she should not have been in contact with me at all without the HOP permission. HOP reminds her of the department policy not to discuss matters of a confidential nature with those outside the department.

I phone the HOP and the receptionist puts me through. The HOP will not allow me into the prison to conduct the research without the approval of the Provincial Commissioner (PC). I explain that the PC referred me to Pretoria, and that I have obtained permission from Pretoria therefore the research should be able to commence. HOP refuses to accept the letter from the DCP and states that he takes his instructions from the PC.

I phone the PC and am put through without a problem. The PC has apparently already been in contact with the HOP and supports the HOP refusal to allow me into the prison. The PC informs me that he has not received any instructions from Pretoria and that HOP is acting correctly by referring me back to PC. I offer to fax the official letter from the DCP to the PC. PC states that while he would like to see this letter, he does not take instructions from me but from Pretoria only. I immediately fax official letter to PC.

Next, I phone the DCP in Pretoria and there is no answer. (None of the DCS officials, either at the national, provincial, or local level, have voice mail.)

Exasperated, I phone the judge, who advises that I fax DCP to inform her of situation with PC. The judge will be seeing PC at the opening of the new prison in Mpumalanga and offers to speak with him about the need for this research to commence.

I then fax the DCP in Pretoria explaining that PC would like to receive instructions directly from Pretoria and that he will not accept the official letter from me which the DCP has signed granting permission for the research to commence.

I follow up the fax to the DCP with a phone call and she is sympathetic but explains that she "does not have a procedure to handle this." The DCP offers to look in to the matter and get back to me.

After a few days, I speak to the DCP and she explains that the PC has refused to let the research commence until I sign a letter saying I will not make generalisations about all prisons based on research conducted only at Westville Medium B.

I immediately draft letter in which I promise not to make generalisations about all South African prisons based on research conducted only at Westville Medium B. I then fax the letter to the PC and the DCP. I also send a fax to the judge with an update on the situation and the letter to the PC.

The next morning, I phone the PC. I am told that the PC is not available, but is enroute to Pretoria. I ask if he will be meeting with the DCP and learn that his first meeting is with the Director of Prisons.

I phone the Director of Prisons in Pretoria, who is about to meet with the PC. I inform him of the situation, and he asks for copy of the letter from the DCP which grants permission for the research to take place. I immediately fax a copy of the DCP letter to the Director of Prisons.

During the next week, I repeatedly phone the PC, but he is not available. Eventually, I am informed by his secretary that the PC is waiting to hear back from a Chief Deputy Commissioner (CDC) in Pretoria.

I phone the Director of Prisons and leave a message to find out how his meeting with the PC went and if he can help me contact the CDC. I leave a message with the Director of Prisons secretary, and he phones me back the next day. He is unusually terse and does not think the research will take place, but gives me the number for the CDC.

I then prepare a fax for the CDC which includes the research proposal, the official letter of approval from DCP, and a copy of the letter to PC stating that I will not make generalisations about all prisons based on my research at one prison.

I follow up the fax with a phone call and the CDC phones back the next day. He informs me that he will be speaking to the Commissioner and will get back to me. I offer to have the judge speak to the Commissioner as well. The CDC does not feel this is necessary.

I phone the judge and update him on the situation. He remains supportive and suggests I give the CDC a little more time, then follow up again.

December — I receive a phone call from the CDC office. There are two forms I must fill out that should have been completed at the start of the process. These forms are then sent to me via fax by the DCP office.

Soon thereafter, I receive two forms from DCP: "Application to Conduct Research in the Department of Correctional Services" and "Agreement Regarding Conditions Applicable to Research Done in Institutions which are under the Authority of the Commissioner of Correctional Services." This second form, a contract which I was required to sign, is included as Appendix B.

I fill out these forms, a total of 15 pages, and fax them back to the DCP. Later that afternoon, I receive phone call from the DCP office requesting copies of any surveys or questionnaires I will be using. I immediately fax a copy of the prisoner questionnaire, included as Appendix C.1.

A few days later, I follow up with the DCP, but there is no answer. I also attempt to follow up with CDC, but he is on leave until after the holidays. As it is now mid-December, I accept that no further progress can be made until January.

January	Because I am out of the country at this point, I ask a research associate to phone the PC and arrange meeting to discuss research. The research associate will be supervising the Zulu-speaking research assistants who are administering the prisoner questionnaire.
	Research associate is able to meet with PC, HOP, and social worker and the research commences the following week. The Zulu-speaking research assistants interview 274 prisoners over four days. The staff at WMB are all extremely co-operative and helpful.
February	I phone the PC to follow up regarding successful data collection for first half of research. I explain that for the second half of the research, I will personally be visiting WMB in order to interview the staff. The PC requests second planning meeting, which he will organise for later the following week and get back to me.
	One week later, I follow up with PC regarding second planning meeting but PC is out of town.
March	I again follow up with PC regarding second planning meeting. PC decides to forego the second planning meeting and instead refers me to contact the acting HOP, because HOP is on leave.
	I then phone the acting HOP, but he is not available. Secretary does not know when he will be available, and is not able to make an appointment to meet with him. The secretary advises that I continue phoning throughout the day.
	After repeatedly phoning the acting HOP and receiving the same response from the secretary, I phone HOP's cell phone, who is on leave, and obtain the number for the acting HOP's direct line. I then phone the acting HOP and reach him immediately. He agrees to a meeting the following week and will ensure that the social worker and the Director of Nursing Services will be present.
	The following week, I meet with the acting HOP and the social worker and Director of Nursing Services and everyone is very co-operative. We agree to commence the second stage of the research the following week on a date when all the interviewees will be available.

On the specified date, I arrive at WMB and I am not even stopped at the gate but drive right through. I drive up to the prison and inform the guards at the front door that I have an appointment with the social worker. I am immediately and cheerfully escorted to see her. At no point am I asked for any proof of identification, or if I have permission to enter the prison to conduct research. No further contact with either the HOP or the PC is required.

Appendix B – "Agreement Regarding Conditions Applicable to Research Done in Institutions which are Under the Authority of the Commissioner of Correctional Services"

AGREEMENT REGARDING CONDITIONS APPLICABLE TO RESEARCH DONE IN INSTITUTIONS WHICH ARE UNDER THE AUTHORITY OF THE COMMISSIONER OF CORRECTIONAL SERVICES.

9920ISK.RH

1. I Kathryn Campbell (KC) Goyer (Full name) wish to conduct research titled HIV Prevalence at Westville Medium B in/at institutions which fall under the authority of the SA Commissioner of Correctional Services. I undertake to use the information which I acquire in a balanced and responsible manner, taking in account the perspectives and practical realities of the Department of Correctional Services (hereafter referred to as "the Department") in my report/treatise. I furthermore take note of and agree to adhere to the following conditions:-

1.1 INTERNAL GUIDE

The researcher accepts that an Internal Guide, appointed by the Department of Correctional Services will provide guidance on a continual basis, during the research. His duties will be:

1.1.1 To help with the interpretation of policy guidelines. He will therefore have to ensure that the researcher is conversant with the policy regarding functional areas of the research.

1.1.2 To help with the interpreting of information/statistics and terminology of the Department which the researcher is unfamiliar with.

1.1.3 To identify issues which could cause embarrassment to the Department, and to make recommendations regarding the utilization and treatment of such information.

1.1.4 To advise Correctional Management regarding the possible implementation of the recommendations made by the researcher.

With regard to the beforementioned the research remains the researcher's own work and the internal guide may therefore not be prescriptive. His' task is assistance and not to dictate a specific train of thought to the researcher.

1.2 GENERAL CONDITIONS WHEN DOING RESEARCH IN PRISONS

1.2.1 Participation in the research by members/prisoners must be voluntary, and such willingness must be indicated in writing.

1.2.2 Prisoners may not be identified, or be able to be identified in any way.

1.2.3 Research Instruments such as Questionnaires/Schedules for interviews must be submitted to the Department (Internal Guide) for consideration before they may be used.

1.2.4 The Department (Internal Guide) must be kept informed of progress and the expected completion dates of the various phases of the research and progress reports/copies of completed chapters furnished for consideration to the Department should this be requested by the Department.

1.2.5 Research findings or any other information gained during the research may not be published or made known in any other manner without the written permission of the Commissioner of Correctional Services. The Department (Internal Guide) must therefore be provided with an unbound copy of the researcher's report/-essay/treatise/thesis/article at least two months before presentation for evaluation to an university or before it is presented for publication.

1.2.6 A copy of the final report/essay/treatise/thesis must be submitted to the Department for further use.

1.2.7 Research will to be done in the researchers own time and at his own cost unless explicitly stated otherwise at the initial approval of the research.

1.3 CONDUCT IN PRISON:

1.3.1 Arrangements to visit a prison/s for research purposes must be made with the Head of that particular prison. Care should be taken that the research be done with the least possible disruption of prison routine.

1.3.2 Office-space for the conducting of tests and interviews must be determined in consultation with the Head of the particular Prison.

1.3.3 Research instruments/interviews must be used/done within view and hearing distance of a member/members of the South African Correctional Services, otherwise only within view of a member(s) of the Department.

1.3.4 Documentation may not be removed from files or reproduced without the prior approval of the Commissioner of Correctional Services.

1.3.5 Any problem experienced during the research must be discussed with the relevant Head of the Prison without delay.

1.3.6 Identification documents must be produced at the prison upon request and must be worn on the person during the visit.

1.3.7 Weapons or other unauthorized articles may not be taken into the prison.

1.3.8 Money and other necessary articles which are worn on the researcher's person are taken into the prison at his own risk. Nothing may be handed over to prisoners except that which is required for the process of research, eg : manuals, questionnaires, stationery; etc.

1.3.9 The research must be done in such a manner that prisoners/members cannot subsequently use it to embarrass the Department of Correctional Services, members of the Department, prisoners, or Correctional Supervision Cases.

1.3.10 Researchers must be circumspect when approaching prisoners with regard to their appearance and beha-

viour, and researchers must be careful of manipulation by prisoners. The decision of the Head of the Prison in this regard is final.

1.3.11 No prisoner may be given the impression that his/her co-operation could be advantageous to him/her personally.

2. INDEMNITY

The researcher waivers any claim which he may have against the Department of Correctional Services and indemnifies the Department against any claims, including legal fees at an attorney and client scale which may be initiated against the latter by any other person, including a prisoner.

3. CANCELLATION

The Commissioner of Correctional Services retains the right to withdraw and cancel authorization for research at any time, should the above conditions not be adhered to or the researcher not keep to stated objectives. In such an event or in event of the researcher deciding to discontinue the research, all information and data from the liaison with the Department must be returned to the Department and such information and data may in no way be published in any other publication without the permission of the Commissioner of Correctional Services. The Commissioner of Correctional Services also retains the right to allocate the research to another researcher.

4. SUGGESTIONS

The researcher acknowledges that no other suggestions except those contained in this agreement, were made which had led him/her to the entering into this Agreement.

Signed at Univ of Natal on 4th day of December 19 2000

RESEARCHER

WITNESSES:

Abovementioned researcher signed this Agreement in my presence

Date: 4.12.00

ENDORSEMENT BY PROMOTOR OR EMPLOYER OF THE RESEARCHER WHERE APPLICABLE

I have taken cognizance of the contents of this agreement and do not have any problem with the conditions/have the following reservations about the conditions of this agreement:

SIGNATURE

9920TSK.RH

Appendix C

Prisoner Questionnaire and Semi-Structured Interview Questions

C.1 Prisoner Questionnaire

C.2 Health Staff, Westville Medium B

C.3 Social Workers, Westville Medium B

C.4 Former Prisoner, Westville Medium B

C.5 Derrick Mdluli, President, South African Prisoners' Organisation for Human Rights (SAPOHR)

C.6 Irene Cowley, Program Manager, National Institute for Crime Prevention and Reintegration of Offenders

C.7 Mr. Ted Leggett, Editor, Crime and Conflict

C.8 Mr. Chris Giffard, Centre for the Study of Violence and Reconciliation

C.9 Judge J. J. Fagan, Inspecting Judge

C.1 Prisoner Questionnaire

INFORMED CONSENT

My name is ____________. I am one of several researchers doing interviews here for an independent study by the University o Natal. The study is investigating HIV/AIDS and the prison system.

We do not work for the police, courts or prisons. If you agree to be interviewed I would like to ask you some questions that should take about 30 minutes to answer. Some questions are personal but your name will not be linked to any information that we collect. You have been randomly selected and if you do not wish to participate, nothing bad will happen to you. You will merely be taken back to your cell and we will interview someone else.

If you agree to be interviewed, you may ask me at any time to stop the interview or repeat a question or to explain anything you do not understand. I'd rather you told me you did not want to answer the question than to answer it untruthfully.

Do you have any questions? (circle) **YES / NO**

Before signing this consent, would you like more time to consider whether you would like to take part in this study?*

I have separated this page from your questionnaire and it will be kept separately so that we can have a record that subjects agreed to participate in the study.

Witness **NAME**:__________________(print in capital letters) **SIGNATURE**____________**DATE**__/__/2000

Subject **NAME**:__________________(print in capital letters) **SIGNATURE**____________**DATE**__/__/2000

*** THIS PAGE MUST BE REMOVED FROM THE QUESTIONNAIRE AND SUBMITTED SEPERATELY**

1. ADMINISTRATIVE INFORMATION

Survey Reference Number	Place sticker here			Interviewer number		Race of respondent	1=Indian 2=African 3=Coloured 4=White	
Date of interview	D	M	2000	Time of interview *(00:00 – 24:00)*				:

2. DEMOGRAPHIC INFORMATION

How old are you in years?	
What is the highest level of school education you personally have achieved? *0=No schooling* *Enter Grade 1-12 for actual year completed* *13=Artisan's Certificate*	
What is the highest post school qualification you have achieved? *1=Technikon diploma / degree obtained* *3=Professional Certificate* *5=Secretarial Certificate* *2=University degree completed* *4=Technical Certificate* *6=Other specify*	

3. PROFILE OF SUBSTANCE USAGE BEFORE ENTERING PRISON

Question		A	B	C	D	E
		Dagga	Mandrax	Crack	IV Drug	Other
Have you ever tried...? (*First read all drugs across.*)	*1=yes 2=no 3=DK 4=refusal*					
When you first tried ... how old were you?	*In years*					
In the 12 months prior to incarceration, did you use...	*1=yes 2=no 3=DK 4=refusal*					
If injected, did you share a needle while taking?	*1=yes 2=no 3=DK 4=refusal*					
Since entering prison, regardless of whether you used it yourself, did you get any drug? (Tick where appropriate)						

4. QUESTIONS ON BEHAVIOUR PRIOR TO INCARCERATION

Did you have a regular sex partner during the 12 months prior to incarceration?	*1=yes 2=no 3=DK 4=refusal*	
How often did you use a condom when having sex with your regular partner?	*1=always 3=sometimes 2=never*	
How often do you use a condom when having sex with any non-regular or casual partners?	*1=always 3=sometimes 2=never*	
Has a partner asked you to wear a condom?	*1=yes 2=no 3=DK 4=refusal*	
Would you wear a condom if a partner asked you to?	*1=yes 2=no 3=DK 4=refusal*	

5. PRISON CONDITIONS

What is the length of your current sentence?		
For how long have you been in prison?		
How many prisoners do you share a cell with?		
Were you a member of a gang before entering prison?		
Have you joined a gang since entering prison?		
Have you been forced to participate in sexual acts while in prison?	*1=Yes 2=No 3=DK 4=Refusal*	
When participating in sexual acts, do you use condoms?	*1=Yes 2=No 3=DK 4=Refusal*	
Have you ever requested a condom from the health staff?	*1=Yes 2=No 3=DK 4=Refusal*	

C.2 Questions for WMB Health Staff

1. What is your job description/what do you do here at Westville? Describe an ordinary day for you.
2. Describe the relationship between your efforts and the Department of Health. Is the DOH involved at all? Does DOH fund or supplement DCS in any way?
3. Are prisoners ever sent to public hospitals? What circumstances would result in this? How is security provided in these cases?
4. Do you work with NGOs in the prison? Are you encouraged to build partnerships with outside agencies? Who would have to approve such a collaboration? What are the procedures for seeking outside help?
5. What is the capacity of the hospital and health services at Westville Medium B? How many beds? How many staff? How often is the doctor there? How many prisons does the hospital serve? Do you need more beds? Staff? How many?
6. What are the most common ailments of prisoners?
7. How does overcrowding affect you and your ability to do your job? How does it impact on the everyday lives of prisoners?
8. From your experience, how many prisoners do you see each week that have been sodomised?
9. How often do prisoners come to health services with injuries sustained from knives or other similar weapons?
10. Are you aware of the "official" policy for HIV in prison? How does this differ from what is actually implemented?
11. How often do prisoners request an HIV test? What is the procedure for fulfilling these requests? Is counselling available? Is confidentiality respected?
12. How often are condoms requested? What is your assessment of the condom policy?
13. Are HIV+ prisoners targets of abuse or stigmatisation? Have you received reports of assaults on prisoners because of their HIV status?
14. What are the health services available for HIV+ prisoners? What are the difficulties faced in caring for HIV+ prisoners?
15. How important is nutrition for an HIV+ prisoner? Is something that prison health services are able to address? What is your assessment of nutrition in prison?
16. How many prisoners each week are treated for TB? How many of these are also known to be HIV+? Are prisoners tested for TB and HIV concurrently? What challenges does co-infection of HIV and TB present for prisoner health care?
17. How are you involved in the process for the early release of prisoners in the late stages of AIDS? What is your assessment of this procedure?
18. How many prisoners died of AIDS related causes during the past year?
19. Do you have a role in discharge planning for prisoners with HIV? What are the services provided specifically for HIV positive prisoners prior to being released?

C.3 Questions for WMB Social Workers

20. What is your job description/what do you do here at Westville? Describe an ordinary day for you.

21. Do you have your own budget? Who sets it? How much is it? Is it enough? If not, how much more do you need?

22. Describe the relationship between your efforts and the Department of Health. Is the DOH involved at all? Does DOH fund or supplement DCS in any way?

23. Describe the relationship between your efforts and private organisations, such as NICRO or SAPOHR. Do you work with NGOs in the prison? Are you encouraged to build partnerships with outside agencies? Who would have to approve such a collaboration? What are the procedures for seeking outside help?

24. How does overcrowding affect you and your ability to do your job? How does it impact on the everyday lives of prisoners?

25. Absent overcrowding issues, what do you think of communal cells?

26. What is the prison's policy for addressing HIV in prison? Is it effective? How would you change it? Are you aware of the "official" policy for HIV in prison? How does this differ from what is actually implemented?

27. Have you had any reports of HIV+ prisoners being targets of violence and abuse by other prisoners? Have you had any reports of HIV+ prisoners being targets of abuse by prison members?

28. Are there regulations at Westville which forbid sex between inmates? What are the regulations concerning criminal conduct while incarcerated? What happens if a prisoner is found to have raped or assaulted another prisoner? A member?

29. What are the procedures for assisting prisoners who have been raped? How many prisoners each week initiate these procedures? How many refuse to?

30. Is sex among prisoners related to gang activity? Can you corroborate reports of prisoners become 'trongaats' in exchange for gang protection?

31. What is the nature of gangs at Westville? What percentage of prisoners are members of gangs? What gangs are most prevalent? Are the wardens members of gangs as well?

32. Do prisoners have access to knives, needles, or other piercing instruments? How are these items obtained?

33. What drugs are most prevalent in prison? Do prisoners use intravenous drugs? Have you noticed any trends or changes in the types of drugs which prisoners use? Are IV drugs becoming more or less popular, or remaining the same?

34. How are you involved in the process for the early release of prisoners in the late stages of AIDS? What is your assessment of this procedure?

C.4 Questions for Former Prisoner, WMB

1. When were you imprisoned at Westville? For how long? Were you convicted or on remand?
2. Describe a typical day at Westville Medium B.
3. Describe the meals provided. How many meals were served each day?
4. How many people were in your cell? How many beds were there? Was there a toilet?
5. Were you able to receive visitors while in prison? How often? What were the limitations or rules regarding visitors? Were they permitted to bring you anything? Was anything confiscated?
6. Are there regulations at Westville which forbid sex between inmates?
7. What can a prisoner do if he has been a victim of rape/assault in prison? Does he have any recourse? Can a prisoner report another prison without fear of reprisal?
8. Is sex among prisoners related to gang activity? Can you corroborate reports of prisoners become 'trongaats' in exchange for gang protection?
9. What is the nature of gangs at Westville?
10. Do prisoners have access to knives, needles, or other piercing instruments? How are these items obtained?
11. Did you receive HIV/AIDS counselling or education while incarcerated at Westville?
12. Were you ever tested for HIV during your incarceration? Did you give consent for the test? Did you receive pre- and post-test counselling? Were your results kept confidential?
13. If HIV testing and counselling were available upon request in the prison, would you want to know your HIV status?
14. Have you seen HIV+ prisoners suffer abuse or assault by other prisoners? By wardens?
15. Did you know that condoms are available from the health staff? Did you request them? Were you ever denied access to condoms?
16. Were you able to access drugs while in prison? What kinds? How did you get them? Did you use IV drugs? If so, did you share a needle?

C.5 Questions for Mr. Derrick Mdluli, SAPOHR

1. What is the mission of your organisation? What is your position/job description?
2. Describe your organisation's relationship with the DCS.
3. Who or what do you feel has had the most impact on the development of DCS policy?
4. What are the avenues available for making genuine reforms within DCS?
5. What are the procedures for visiting the prison? Have you encountered any difficulties in gaining access to prison officials and/or prisoners themselves?
6. What are the most common complaints you hear from prisoners?
7. Do you feel that the prisons are adequately monitored? Why or why not?
8. How have you or your organisation been involved in developing the current policy for HIV/AIDS in prison?
9. What is your assessment of the current HIV/AIDS policy? What changes would you make?
10. What can a prisoner do if he has been a victim of rape/assault in prison? Does he have any recourse? Can a prisoner report another prison without fear of reprisal?
11. What do you think of the condom distribution policy? How would you change it?
12. What can you tell me about the gang situation at Westville? How powerful are gangs? How do they gain power? How do gang activities affect prison life?

C.6 Questions for Mrs. Irene Cowley, NICRO

1. What is the mission of your organisation? What is your position/job description?
2. Describe your organisation's relationship with the DCS.
3. What rehabilitation services are available to prisoners? Education? Job skills? Work programs?
4. What are the procedures for visiting the prison? Have you encountered any difficulties in gaining access to prison officials and/or prisoners themselves?
5. What are the most common complaints you hear from prisoners?
6. How have you or your organisation been involved in developing the current policy for HIV/AIDS in prison?
7. What is your assessment of the current HIV/AIDS policy? What changes would you make?
8. What do you think of the condom distribution policy? How would you change it?
9. What has been your experience in assisting prisoners who qualify for early release? Have you been able to assist them? Have you been in contact at all?
10. Do you have a role in discharge planning for prisoners with HIV? What are the services provided specifically for HIV positive prisoners prior to being released?
11. Do you feel that the prisons are adequately monitored? Why or why not?
12. Who or what do you feel has had the most impact on the development of DCS policy? What are the avenues available for making genuine reforms within DCS?

C.7 Questions for Mr. Ted Leggett, Crime & Conflict

1. What can you tell me about trends in intravenous drug use in South Africa? What drugs are taken intravenously? Is IV drug use increasing or decreasing?
2. What are the factors that influence the use of a particular drug? Are there discernable patterns, perhaps related to overseas trends?
3. In the US, the booming prisoner population is partly due to introduction of harsher drug laws. How have South African drug laws changed in the past five or ten years? How have these changes affected prisoner populations? Are there more drug users in prison?
4. What is the relationship between drug use and poverty?
5. What is the relationship between drug use and HIV transmission?
6. Are prison gangs involved in drug trafficking? Is this a source of power for prison gangs?
7. What do you think of mandatory testing of HIV+ prisoners? Isolation/segregation?
8. What do you think of the condom distribution program in prison?
9. How would literacy programs in prison affect recidivism? HIV education? Drug use?
10. What are the primary weakness of the South African criminal justice system?
11. Do you think alternative models of criminal justice should be explored in South Africa? For example?
12. How well does the DCS involve the help of NGOs?
13. What can South African criminal justice policy makers learn from the United States' mistakes?
14. What do you think of the Correctional Services Act of 1998? What are the strengths and weaknesses?
15. What do you think of the Judicial Inspectorate program? The National Council? The Parliamentary Portfolio Committee on Correctional Services?

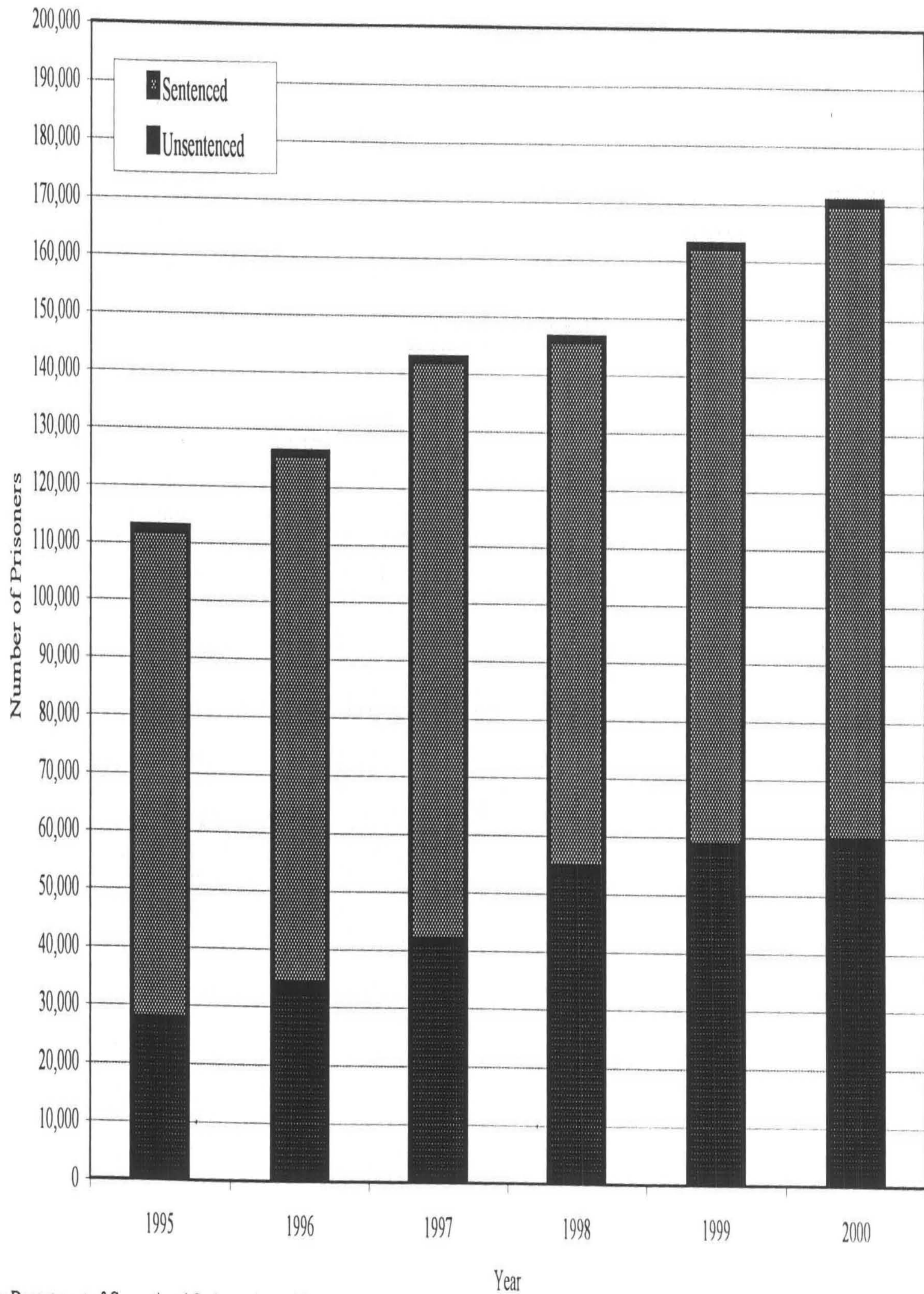
C.8 Questions for Mr. Chris Giffard, CSVR

1. What is the nature of your research in prison? What have you learned so far?
2. Have you been involved with any research or programs which involve HIV/AIDS in prison?
3. What is your assessment of prison conditions? What reforms would help?
4. What is your assessment of gang activity in prison?
5. What have you learned about drug use in prison?
6. Are you aware of the current policies for addressing HIV/AIDS in prison?
7. What do you think of mandatory testing and segregation of HIV+ prisoners?
8. What do you think of the condom distribution program in prison?
9. What have you learned about high risk behaviours for the transmission of HIV in prison?
10. Have you observed discrimination or abuse of prisoners with HIV?
11. What programs or policies would you suggest to address HIV/AIDS in prison?
12. What difficulties have you faced in the course of conducting your research in prison?
13. How well does the DCS involve the help of NGOs?
14. What do you think of the Correctional Services Act of 1998? What are the strengths and weaknesses?
15. What do you think of the Judicial Inspectorate program? The National Council? The Parliamentary Portfolio Committee on Correctional Services?

C9. Questions for Judge J.J. Fagan, Inspecting Judge

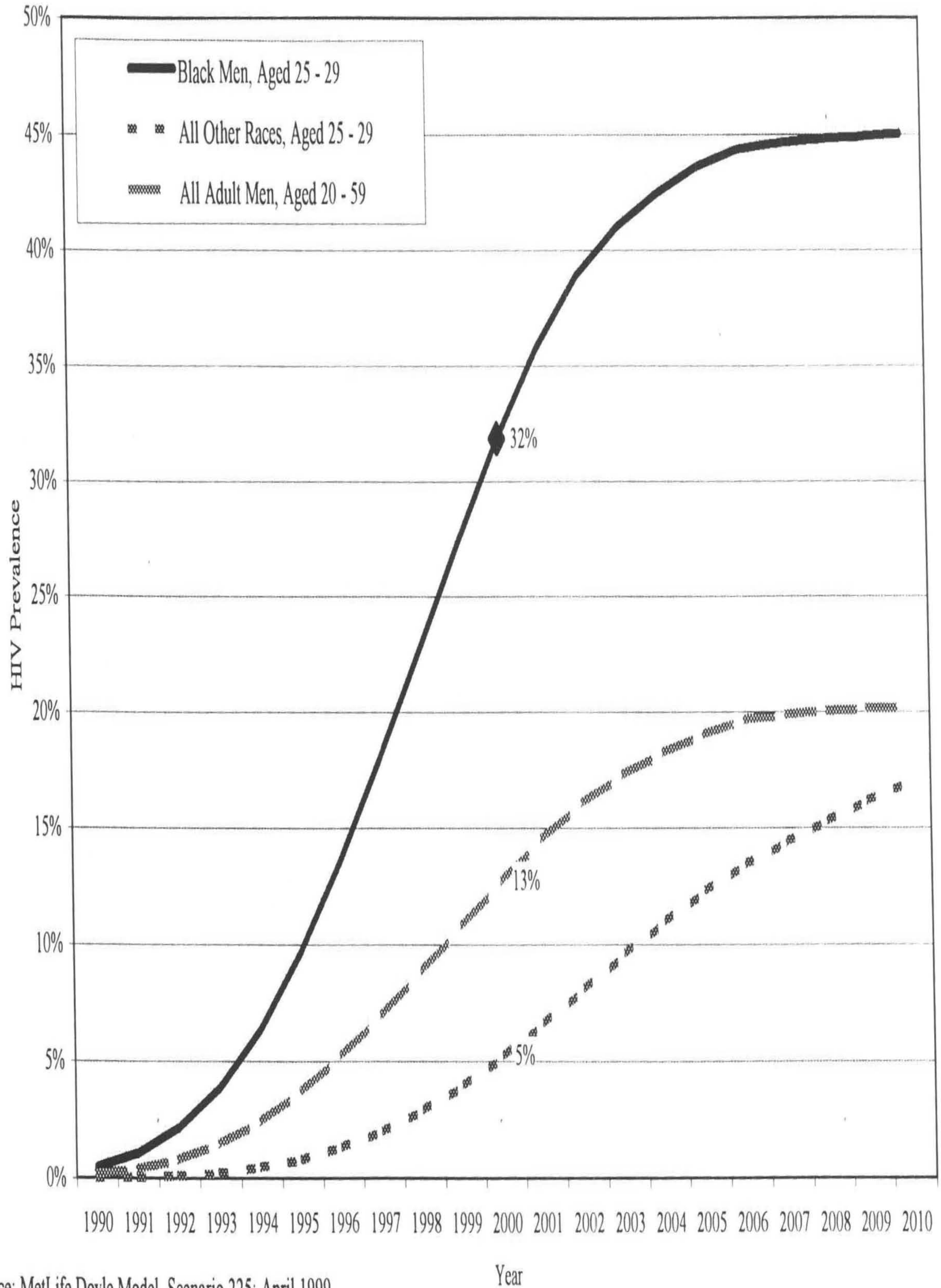
1. What is your official title? How were you appointed? How long does your appointment last? What do your duties include?
2. How has the creation of the judicial inspectorate been received by the DCS? How would you characterise the relationship between your office and the DCS?
3. How many prison visitors have been assigned? How is this program progressing?
4. Were you involved in the 1995 Transformation Forum? What were your impressions of this forum? Do you think it was successful?
5. Many of the leadership positions, both nationally and in KwaZulu-Natal, are filled by members of the IFP while the remainder of the government is dominated by the ANC. What effect do you think partisan agendas have had on prison policy-making?
6. Do you think that the prisons should be opened up, made more accessible for research, journalists, the general public?
7. What is your assessment of the Correctional Services Act of 1998? What are its strengths? Are there issues which it fails to address?
8. What is your assessment of the National Council for Correctional Services? Who is in charge of this? Is it an 'appeasement' move or does it have impact on policy? Who appoints the members? The chair?
9. What do you think of the Judicial Inspectorate program? Do you think it has been successful? What are the strengths? What are the limitations or drawbacks?
10. According to the Correctional Services Act of 1998, you are only allowed to receive complaints from the National Council, the Commission, or a Visitors Committee. How does this requirement impact your effectiveness?
11. What are the most common concerns raised by the above groups? Do you ever receive complaints from prisoners? What are the most common concerns raised by NGOs, such as LFHR and SAPOHR?
12. Who is in charge of the Portfolio Committee for Correctional Services in parliament? What is the purpose of this entity? How does it work with or relate to the National Council? The Judicial Inspectorate?

APPENDIX D: Prison Population Growth in the New South Africa: Sentenced and Unsentenced Prisoners



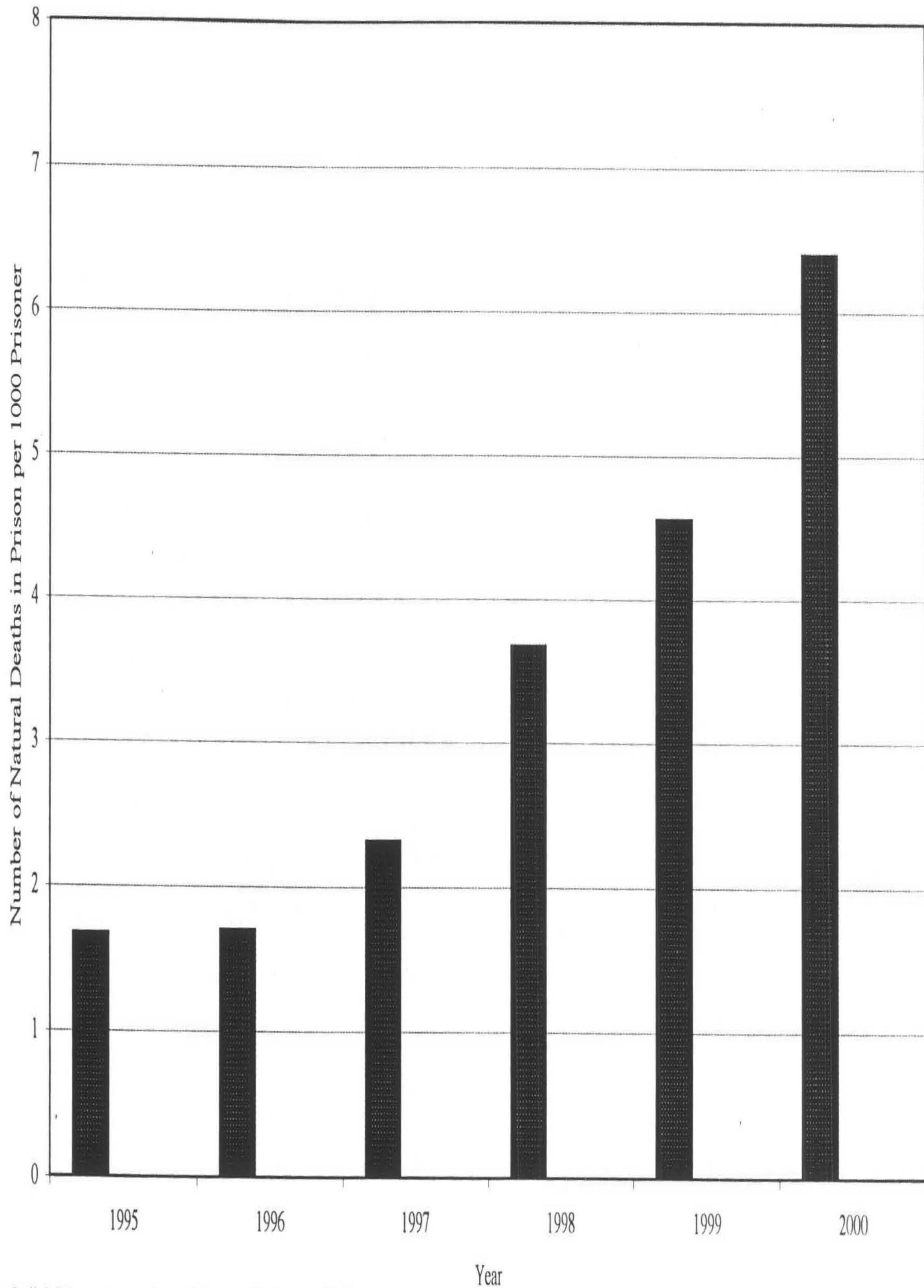
Source: Department of Correctional Serivces Annual Reports

APPENDIX E: Estimated and Projected HIV Infection in South Africa:
Black Men Aged 25 - 29 vs All Other Races and All Adult Men



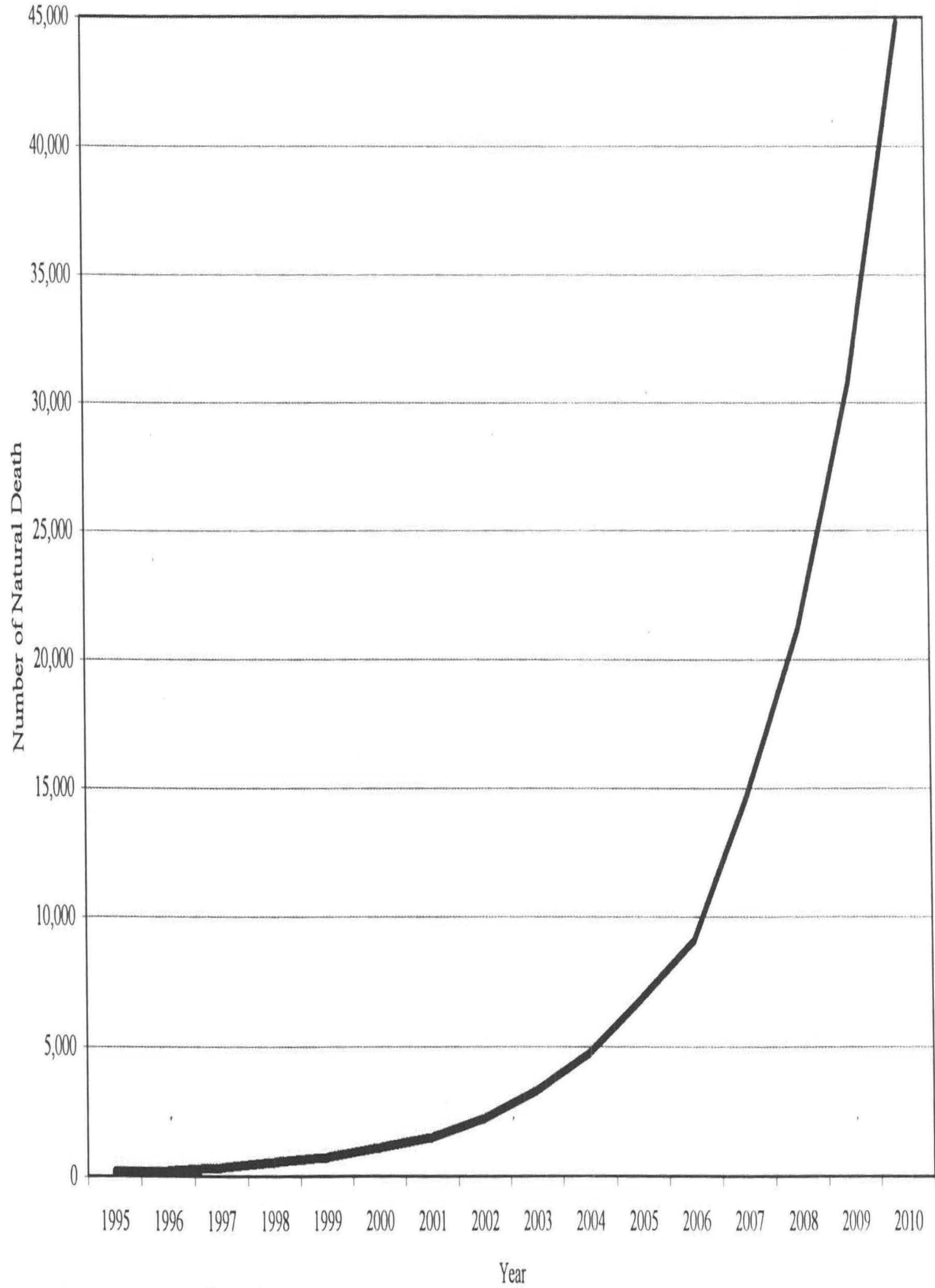
Source: MetLife Doyle Model, Scenario 225: April 1999.

APPENDIX F: Actual Number of Natural Deaths per 1000 Prisoners
in South African Prisons from 1995 to 2000



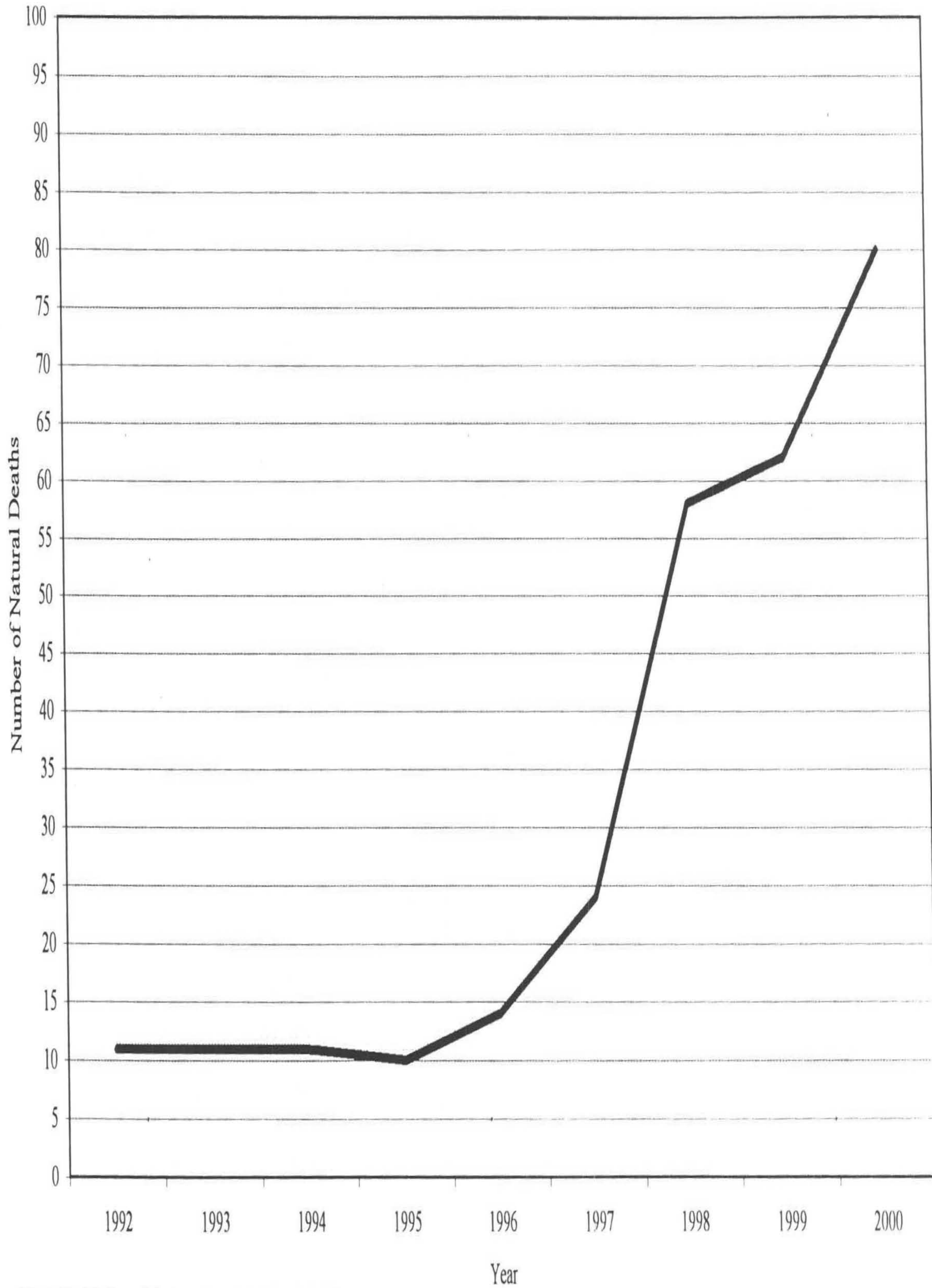
Source: Judicial Inspectorate Annual Report, 31 January 2001.

APPENDIX G: Natural Deaths in South African Prisons
Actual from 1995 - 2000 and Projected for 2001 - 2010



Source: Judicial Inspectorate Annual Report, 31 January 2001.

APPENDIX H: Natural Deaths in Custody
Westville Medium B Prison Hospital



Source: Westville Medium B Prison Hospital, March 2000

Interviews

All interviews were conducted in person by the author.

1. Westville Medium B Health Staff A - 29 March 01 at Westville Medium B.
2. Westville Medium B Health Staff B - 29 March 01 at Westville Medium B.
3. Westville Medium B Health Staff C - 29 March 01 at Westville Medium B.
4. Westville Medium B Social Worker X - 20 April 01 at Westville Medium B.
5. Westville Medium B Social Worker Y - 20 April 01 at Westville Medium B.
6. Westville Medium B Social Worker Z - 20 April 01 at Westville Medium B.
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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