

HARM REDUCTION IN STATE PRISONS

by

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DECLARATION

I declare that **HARM REDUCTION IN STATE PRISONS** is my own work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references.

Signature:.....Date:.....

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Empowering a woman is tantamount to empowering Mzansi.

ABSTRACT

Risk taking behaviours such as drug use, sexual activities and tattooing are prevalent in the correctional institutions, including those in South Africa. Such behaviours pose a serious challenge as regards health care of inmates. In particular, these behaviours contribute to the transmission of HIV/AIDS which results in morbidity and mortality. Harm reduction components are employed as effective measure to curb the spread of the pandemic. These components are lauded owing to their considerable impact.

They consist of needle exchange programmes, substitution therapy, condom provision and education. Various developing (Morocco, Brazil and Egypt) and developed (Scotland and Canada) countries make use of such components to address risk taking behaviours in correctional institutions. Although condom provision and education have been implemented by the South African Department of Correctional Services in state institutions, there is an urgent need to enhance the efforts.

This study investigates the extent of risk taking behaviours amongst inmates at the Leeuwkop Correctional Centre. It also determines the level of knowledge of inmates and staff regarding HIV/AIDS. The researcher employed a qualitative form of methodology, collecting data by means of a structured questionnaire. The data was coded and analysed by means of the Statistical Package for the Social Sciences (SPSS) software. The findings reveal that the risk taking behaviours are prevalent at the Leeuwkop Correctional Centre. Furthermore, the analysis of the knowledge items regarding HIV/AIDS indicates that there are certain deficits that require attention. They are also notable differences in the primary sources of HIV information for inmates and staff.

It was found that a dire need exists to enhance and expand current harm reduction initiatives in correctional institutions in order to offer health care services that are compliant with international conventions such as the Dublin Declaration on HIV/AIDS as well as the South African Constitution. Reluctance to do so is tantamount to housing inmates in 'de facto' death chambers. Hence the augmentation of such initiatives is strongly recommended.

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1. INTRODUCTION

This chapter serves as an introduction to the study, discussing several aspects. It provides the background to the study, as well as its problem statement and aims. Furthermore, this chapter explains the rationale of the study, definitions of key terms and the research questions. Finally, the chapter addresses the research design, covering the study's methodology, sampling, data collection techniques, data analysis as well as its limitations.

1.2. BACKGROUND

The harm reduction model has been lauded as a viable solution to prevalent risk taking behaviours and the concomitant spread of communicable diseases. Harm reduction refers to a strategy aimed at curbing or preventing serious health consequences resulting from engaging in such behaviours. A number of developed countries such as Australia, the United Kingdom, and Switzerland which have introduced comprehensive harm reduction components are said to be experiencing dwindling rates of HIV (Hope, Judd, Hickman, Lamagni, Hunter, Stimson, Jones, Donovan, Parry & Gill, 2001:38). Chitwood, Comerford, Kitner, Palacios & Sanchez (2001:92) also noted significant behavioural changes among drug users after the implementation of components of the harm reduction model.

This positive outcome of harm reduction components in the public sphere, serves as evidence of its effectiveness which may be replicated in correctional institutions. Inmates' health problems constitute an integral part of public health and cannot be treated differently. In response to the HIV epidemic in correctional institutions, representatives of fifty-five governments developed a framework called the Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia (***Annexure 1***). This framework is based on human rights, government obligations towards inmates, scientific evidence and successful international best practice. This framework consists of eight fundamental principles and eleven articles. Article 3 provides for the notion of the equivalence of health care between the public and correctional environments. It states that "good correctional centre health is good public health" (Lines, Jürgens, Stover, Kaliakbarova, Latcevschi, Nelles, MacDonald & Curtis, 2004:4). It is therefore imperative to consider the replication of harm reduction measures in the correctional setting due to the close link with public health.

Inmates constitute a mobile segment of our population, serving as possible carriers of HIV and other communicable diseases, thus posing a serious threat to the general community. It is estimated that about 95% of inmates return to the general community (Luyt, 2008:189). Goyer (2003:11) submits that out of 175 000 inmates in South Africa, about 25 000 are released back into the community on a monthly basis. Although implementation of the notion of equivalence is hindered by several factors, inter alia, a lack of political will and correctional policies (MacDonald & Berto, 2001:1), harm reduction components exert a considerable impact on risk taking behaviours.

Risk taking behaviours pose a serious challenge to health care, especially in the correctional setting. These are in the form of the sharing and or re-use of

infected drug injecting equipment (Dolan & Croft, 2000:217; Stephens, Braithwaite & Conerly, 2005:66), engaging in unprotected sexual activities (Turnbull, Dolan, & Stimson, 1991:24), and tattooing (Singh, 2007:79). Risk taking behaviours have been closely linked to the outbreak of HIV/AIDS in correctional institutions (May & William, 2002:85; Small, Kain, Laliberte, Scheter, O'Shaughnessy & Spittal, 2005:831). The prevalence of such behaviours has been reported in several studies (Nelles, Dobler-Mikola & Kaufman, 1997:239); hence they are perceived as a permanent feature of institutional life (Lanier & Paoline III, 2005:562; Stewart, 2007:43).

Intravenous drug use by means of non-sterile equipment is prevalent among inmates (Dolan & Croft, 2000:217). Due to the non-availability of sterile equipment in correctional institutions, inmates tend to share contaminated makeshift equipment. Inmates create this from any available material ranging from pens, to eye-droppers to light bulbs (Inciardi, Lockwood & Quinlan, 1993:139; Kantor, 2006:4). The sharing of such equipment facilitates the transmission of contagious diseases, such as HIV/AIDS (Inciardi et al., 1993:123; Krebs & Simmons, 2002:54).

Closely linked with drug use, it is reported that unprotected sexual activities are rampant in correctional institutions (Stewart, 2007:34). The incarceration of same sex individuals predisposes them to seek sexual gratification from fellow inmates whatever their sexuality. Solursh, Solursh, & Meyer Jr, (1993:50) submit that "heterosexuals still need to have sex whether they are incarcerated or not". Inmates are largely drawn from the sexually active population and therefore sexual indulgences takes place largely owing to natural urges. In their study of risk taking behaviours amongst juvenile detainees, Teplin, Mericle, McClelland, & Abram (2003:906) found that more than 90% of male detainees were sexually active during incarceration. Despite this situation, condoms are regarded as

contraband in most correctional institutions; hence the high prevalence of HIV/AIDS (Xinhua News Agency, 2002:1).

Tattooing also constitutes risk taking behaviour and is reported as being prevalent in correctional institutions (Krebs & Simmons, 2002:21). Tattooing is a social activity which generally involves the use of non-sterile equipment. It is normally part of the gang culture common amongst inmates. Singh (2007:79) refers to tattooing as "a fundamental part of the correctional centre gang sub-culture". Inmates make tattooing equipment from hollowed pens, needles, toothbrushes, utensils as well as pins to create tattoos on their bodies (Olivero, 1992:39; Krebs 2002:22; Singh, 2007:78). Tattooing involves skin punctures and therefore blood-borne diseases including HIV/AIDS and hepatitis may be transmitted through the contaminated equipment. In sum, tattooing is a serious health risk that requires consideration of harm reduction measures.

Risk taking behaviours, in particular drug use, have been central to the spread of the AIDS pandemic since its advent in the early 1980s. Drug related HIV infections have been reported in about 103 countries (Chitwood et al, 2001:92). The prevalence of HIV in correctional institutions is reported to be higher than in the general community. Several studies have estimated the rate of HIV/AIDS among inmates to be between three and six times higher than in the general community (Rapposelli, Kennedy, Miles, Tinsley, Rauch, Austin, Dooley, Aranda-Naranjo & Moore, 2002:104; Swartz, Lurigio & Weiner, 2004:486; Heines, 2005:1685; Maruschak, 2005:5; Ikuteyijo & Agunbaide, 2008:280).

Ikuteyijo & Agunbaide (2008:280) stated that the HIV/AIDS prevalence in Nigerian correctional institutions was about 2.9% higher than in the general community. In a study conducted in the United States of America, Maruschak (2005:5) also found that the numbers of AIDS cases were three times higher in

the correctional institutions than in the general community. The prevalence of HIV/AIDS in correctional institutions is estimated to be five times higher than among the general population (Rapposelli et al., 2002:104; Heines, 2005:1685). This disturbing situation is largely attributed to the high incidence of risk taking behaviours in correctional institutions.

The components of the harm reduction model include syringe or needle exchange, substitution therapy, condom provision, education, and bleach distribution. They have been implemented in several countries to address risky behaviours and their effectiveness has been proven (Reinerman & Levine, 1997:357; Inciardi & Harrison, 2000: ix; Riley & O'Hare, 2000:10; Small et al., 2005:840). Reinerman & Levine (1997) submit that there was a decrease in risk taking behaviours after the implementation of harm reduction strategies at the Merseyside project in Liverpool. In addition, findings from the evaluation of syringe exchange programmes in Switzerland, Germany, and Spain also provided encouraging results (Small et al, 2005:840).

There are several definitions and interpretations of the concept "harm reduction". This is triggered by other terms that are interchangeably used synonymously with this concept, namely harm minimization, risk reduction, risk minimization, casualty reduction, and or damage limitation (Riley & O'Hare, 2000:7; Inciardi & Harrison, 2000: vii; Hilton, Thompson, Moore-Dempsey, & Janzen, 2001:358).

Harm reduction is either poorly understood or misinterpreted as being legalization of risk taking behaviours such as drug use (Cheung, 2000:1699). As a result, it is rejected in certain public and private sectors as it is perceived to be militating against set policies and procedures. Harm reduction strategies are thought of as causing serious security infractions in correctional institutions (May

& Williams, 2002:88). Despite the prevailing negative perceptions about harm reduction, its implementation is gaining momentum and it has triggered debate around the world.

Harm reduction as a concept has its origins in Europe (Marlatt, 1996:779). The harm reduction model has gained popularity in developed countries such as the Netherlands, Australia, Britain, Switzerland, and Canada as a viable response to risk taking behaviours, in particular drug abuse. Harm reduction was first implemented during the 1980s in the Netherlands to stem the tide of hepatitis resulting largely from use of injected drugs. Subsequently, the scourge of HIV presented a challenge to the Dutch government and harm reduction components were extended to address this pandemic (Poulin, 2006:1; Inciardi & Harrison, 2000: ix; Riley & O'Hare, 2000:1).

Harm reduction is regarded as a public health measure which presents an opportunity to control the transmission of HIV and other infectious diseases. In line with the consideration of harm reduction components, there is a need to investigate the level of knowledge of both inmates and staff as regards risk taking behaviours as well as HIV/AIDS. Significant knowledge gaps with respect to the risk of HIV transmission as well as its prevalence have been identified amongst both inmates and correctional staff (Koulierakis, Power, Gnardellis, & Agrafiotis, 2003:104).

Correctional institutions are perceived as the only appropriate environment for inmates to be exposed to effective drug treatment, support and educational programmes (Butler & Milner, 2003:125). Inmates constitute a difficult-to-reach segment of the populations before incarceration. The correctional environment provides an opportunity to identify and address knowledge gaps through programmes because of its contained and controlled nature. In this environment

an obligation can be placed on inmates to participate in development programmes as part of the rehabilitation initiatives. Knowledge acquired by inmates will be of great benefit post the incarceration period (Swartz et al., 2004:487; Bryan, Robbins, Ruiz, O'Neil, 2006:155; Sifunda, Reddy, Braithwaite, Stephens, Bhengu, Ruiter, & Van den Bome, 2007:807).

1.3. STATEMENT OF THE PROBLEM

This study focuses on risk taking behaviours that are prevalent in correctional institutions and have harmful health consequences for inmates. The challenges to be met in the envisaged research is to identify harm reduction components that are used worldwide in order to address risk taking behaviours that may be recommended for implementation in the South African correctional environment. In addition, the study assesses HIV/AIDS knowledge levels of inmates and staff.

The central assumption is that harm resulting from the risk taking behaviours prevalent in correctional institutions can be managed effectively through the implementation of harm reduction components such as a needle exchange programme, substitution therapy, condom provision and education.

1.4. AIMS OF THE STUDY

The aims of the study are multifold. The study will be utilized:

1.4.1. To investigate and describe risk taking behaviours prevalent among inmates at Leeuwkop Correctional Centre.

1.4.2. To highlight the value of harm reduction components implemented in other countries that may assist to manage and control risk taking behaviours and the consequent spread of HIV/AIDS.

1.4.3. To assess the HIV/AIDS knowledge levels of staff and inmates at Leeuwkop Correctional Centre in order to suggest measures for improvement.

1.4.4. To provide the Department of Correctional Services with the results of the study in order to serve as an impetus for new and or revised programmes as regards management of risk taking behaviours.

1.5. RATIONALE OF THE STUDY

There is a growing body of research on the prevalence of risk taking behaviours in correctional institutions as well as the implementation of harm reduction components. The importance of the data on the prevalence of risk taking behaviours is that it informs appropriate intervention and policy planning. However, there is a paucity of in-depth research in South Africa that offers a detailed analysis of risk taking behaviours amongst inmates.

It would be impossible to recommend implementation of harm reduction components without an in-depth analysis of the risk taking behaviours in a correctional environment. There are anecdotes of a high prevalence of risk taking behaviours amongst inmates in South African correctional institutions (Lubisi & Mapiloko, 2007:16) but there has not been a structured in-depth study investigating the prevalence of such behaviours with specific emphasis on considering harm reduction components as a possible solution. The available local studies that have covered risk taking behaviours made only cursory

reference to any harm reduction model (Rothfuchs, 1999; Goyer, 2003; Singh, 2004).

Rothfuchs (1999:66) has conducted a study on harm reduction with specific focus on drug use and implications for economic and social development in South Africa. He held that South Africa should consider adopting the harm reduction approach to drug use implemented in Europe rather than relying on repressive measures that have failed in other countries. Also, Goyer (2003:1) looked at risk taking behaviours, the prevalence of HIV/AIDS as well as policy options for the Department of Correctional Services. The study did not address HIV/AIDS knowledge levels of inmates and staff nor harm reduction components that are currently implemented worldwide.

Such components are currently being implemented in several countries such as the Netherlands (Korf & Buning, 2000), Australia (Makkai, 2000), the United Kingdom (Marlatt, 1996), and Brazil (Surrat & Telles, 2000). In response to its drug problem, the Netherlands decriminalized soft drugs like marijuana and introduced needle exchange and methadone maintenance programmes. The Netherlands drug policy addressed supply reduction, demand reduction, and harm reduction (Korf & Buning, 2000:116). Australia implemented needle exchange policies as part of the national campaign against drug abuse in 1985 (Makkai, 2000:174).

Surrat and Telles (2000:140) states that harm reduction components were introduced in Brazil as a response to HIV/AIDS and drug use. The Brazil Federal National Council approved a syringe exchange programme in 1994. The United Kingdom took the lead in implementing a 'medicalization' approach towards drug use as a harm reduction component (Marlatt, 1996:784). Despite these global initiatives, the Department of Correctional Services in South Africa is still lagging

behind. The reported harm reduction components currently implemented in the South African correctional environment consist of condom provision and education programmes although these are found wanting (Luyt, 2005:81). This situation warrants further research that will offer perspectives on the best international practices currently utilized in developed countries.

In sum, the focus of the study is to identify risk taking behaviours prevalent in the Leeuwkop correctional centre, assess HIV/AIDS knowledge levels and highlight effective harm reduction components that may be considered to address risk taking behaviours. The results of this study will be provided to the Department of Correctional Services in order for it to evaluate current policies and develop appropriate responses to challenges posed by prevalent risk taking behaviours.

1.6. RESEARCH QUESTIONS

The main research questions in this study are:

1.5.1. What types of risk taking behaviours are prevalent at Leeuwkop Correctional Centre?

1.5.2. What is the level of knowledge of inmates and staff regarding HIV/AIDS at the Leeuwkop Correctional Centre?

1.5.3. Which harm reduction components may be appropriate for a South African correctional environment and how can they be implemented?

1.7. DEFINITION OF TERMS

1.7.1. HARM REDUCTION

This comprises a set of pragmatic, realistic and humane approaches aimed at preventing and reducing negative harm or consequences of risk taking behaviours (World Health Organization, 2005: 5).

1.7.2. RISK

This term signifies the “per capita frequency (rate) at which the occurrence of any kind of harm can be observed, estimated or predicted among a group of persons over a certain interval of time” (Jones, 1976:4). In this study, the focus falls on harmful risk taking behaviours that expose inmates to communicable diseases and lead to far reaching and serious health consequences, which may be fatal. It is important to state this emphasis as inmates are allegedly also exposed to penal harm by virtue of their incarceration (Hay & Sparks, 1992:302).

1.7.3. HARM REDUCTION COMPONENTS

The harm reduction components refer to exchange schemes involving sterile needles and syringes for drug users, drug substitution therapy, provision of condoms, educational programmes, and bleach distribution (World Health Organization, 2005:7).

1.7.4. PRISONIZATION

This denotes “the taking on in greater or lesser degree of the folkways, mores, customs, and general culture of the penitentiary... or inmate conformity to deviant normative proscriptions” (Clemmer, 1940:270). Inciardi (1993:568)

defines prisonization as “the process by which the inmate learns the rules and regulations of the institution and the informal rules, values, customs, and general culture of the penitentiary”. This process is the acculturation of the inmate after admission into the institution.

1.7.5. KNOWLEDGE

Knowledge refers to basic understanding of a concept and the ability to use such knowledge for a specific purpose (<http://en.wikipedia.org/wiki/knowledge>).

1.7.6. DRUG USE

The phrase signifies the use of drugs that cause adverse physical, psychological, economic, legal or social consequences to the user or others affected by the user’s behaviour (Cheung, 2000:1697). In this study, drug use refers to illicit use of drugs.

1.8. RESEARCH DESIGN

This study forms part of a larger research project under the auspices of the University of South Africa, funded by the National Research Foundation. Although uniform questionnaires were used, the study was conducted independently of the larger research project. The results were also analyzed separately. The site of the study was the Leeuwkop Correctional Centre located in the northern suburb of Johannesburg, Gauteng Province. The Centre is an old complex built in the 1930s (Dissel, 1996:2). The complex consists of three types of correctional institutions, namely: maximum security, medium security, and a juvenile section. As at 4th July 2006, the inmate and staff population at the Centre was as follows:

TABLE 1: INMATE AND STAFF STATISTICS AT LEEUWKOP CORRECTIONAL CENTRE

	Maximum	Medium	Juvenile
Inmates	1720	1200	426
Staff	185	130	97

Source: Leeuwkop Management

The following steps were utilized in gathering the data:

1. Consultation with management to make arrangements for the survey.
2. Distribution of the survey instrument.
3. Literature review.
4. Data analysis.

1.8.1. METHODOLOGY

The researcher will make use of qualitative methodology in this study. This method attempts “to capture and understand definitions, descriptions of things, characteristics, and meanings of events” (Burns, 2000:388; Dantzer & Hunter, 2000:74). Qualitative methodology is process oriented and uses narrative description rather than figures. It is conducted in a natural setting using direct data collection methods (Thomas, Nelson, & Silverman, 2005:346). In contrast, quantitative methodology “counts and measures occurrences” (Burns, 2000:388). It assigns numerical values to concepts using complex statistical applications for data analysis (Hagan, 1997:14).

Qualitative methodology enables the researcher to understand the phenomenon under investigation. Data collected by means of this approach can be used to diagnose behavioural phenomena and or advocate a new concept, such as the

harm reduction model. In a qualitative study, the researcher may employ surveys, case studies and document analyses when collecting data. Qualitative methodology is not without flaws. It is known to be subjective and lacks validity due to the personal bias of the researcher. In comparison, quantitative methodology is said to be objective and free of personal bias (Champion, 1993:10).

1.8.2. SAMPLING

Sampling refers to a method of selecting a sample for the study so that findings can be generalized to the larger population (Toriola, 2007:21). A sample is a subset of a larger population. Two non-probability sampling techniques will be used to identify the sample of inmates and staff respectively (Hagan, 1997:136). The completion of the survey instrument requires the ability to read and understand English. Therefore, the selection of the sample will largely be dependent on the person's English literacy level.

The inmate population comprises both literate and illiterate individuals from diverse social background. A snowball sampling technique was used for this population to facilitate the identification of a relevant sample. This technique enables the researcher to identify the first subject, who in turn introduces others that fit the requirement for participation (Hagan, 1997:138). All staff members are literate and therefore there was no need to use the snowball sampling technique on them.

The convenience or accidental sampling technique was used to identify respondents from the staff. Convenience sampling enables the researcher to gather data from as many participants as possible (Champion, 1993:103). The staff works according to set rosters and therefore the researcher's access to

them was limited to only those on duty when the questionnaires were administered.

1.8.3. DATA COLLECTION

The data was collected by using structured questionnaires consisting of pre-determined items (Annexure 2). Questionnaires enable the researcher to obtain data "sometimes buried within the minds or within the attitudes, feelings or reactions [of the participants-GM]" (Leedy, 1993:187). The questionnaire consists of restricted dichotomous responses as well as items containing four alternative responses ranging from 'agree' to 'disagree strongly' on the Likert Scale. The responses to the questions were weighted numerically (Champion, 1993:208). The items measured general knowledge on HIV/AIDS, personal views about sex, and the prevalence of risk taking behaviours. Other questions tapped into biographic information and HIV/AIDS education.

The researcher personally administered the questionnaires to ensure a better return rate and to offer clarification, where needed during completion. The use of a questionnaire in data collection offers both advantages and disadvantages. It provides uniformity of measurement and enhances reliability. On the other hand, questionnaire may encourage participants to provide inappropriate and superficial responses (Burns, 2000:572).

1.8.4. DATA PROCESSING AND ANALYSIS

Data processing refers to "data coding, data entry and data cleaning" (Dantzker & Hunter, 2000:173). Data coding enables the researcher to convert qualitative data into numerical feedback, providing a quantitative perspective. After data

collection, the researcher assigned values to the data in order to facilitate statistical data analysis. Thereafter, the data was captured onto the computer in order to produce a statistical report. This report was handed over to an expert for data analysis by means of the Statistical Package for Social Sciences (SPSS) software.

1.9. LIMITATIONS OF THE STUDY

The research methodology of a study conducted within a confined and highly regulated setting is invariably negatively affected. In a correctional institution, safety and security related arrangements dictate access to and participation of inmates. The researcher was accompanied by a correctional officer during the administration of the questionnaires. The selection of the participants was largely informed by administrative and security arrangements.

The completion of the questionnaire required basic literacy and therefore the participation was restricted to those who can read and write. This requirement invariably excluded other inmates who may contribute valuable information if interviewed. Also, the presence of the officer, although vital, may affect the openness and honesty of the inmates due to the fear of their responses being shared with the official thus compromising their quality of life during incarceration. The researcher explained the process to inmates and emphasized confidentiality, but inmates are generally suspicious of outsiders.

Harm reduction components have been tried and tested in developing countries. These countries generally have put progressive correctional policies in place and are well resourced. Importing these harm reduction components into a developing country therefore requires a major paradigm shift. Also, due to

limited resources and a number of competing priorities in the public sector and correctional environment such as housing and overcrowding respectively, it may be a long time before the implementation of harm reduction can be considered.

In sum, the limitations of the study may be, *inter alia*, the possibility of incorrect, manipulated answers just to complete the process, dishonesty, low participation by respondents, incomplete questionnaires and importing the findings of studies conducted in developed countries.

1.10. SUMMARY

The focus of this chapter was to describe the aims, rationale, research design of the study, and to state the research questions. It also provided the definitions of key concepts and limitations of the study. The next chapter gives an overview of the history and philosophy of harm reduction model. It also offers an explanation of how individuals engage in risk taking behaviours using four theoretical models: social learning, indigenous influence, cultural drift, as well as the integration model.

Other ensuing chapters undertake an in-depth analysis of risk taking behaviours in correctional institutions, of harm reduction components currently utilized in developed countries as well as an overview of HIV knowledge of inmates and staff. The last chapter provides a list of findings, recommendations and concluding remarks.

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CHAPTER 2

HARM REDUCTION: HISTORY, PHILOSOPHY, AND THEORIES

2.1. INTRODUCTION

This chapter considers harm reduction in terms of a broader perspective. It traces the historical origin of harm reduction as a concept, discusses its philosophical underpinnings, as well as theoretical models. Harm reduction is a progressive public health construct which focuses on improving health care, reducing risks and harm associated with certain behaviours (Stevenson, 1994:101; Chitwood, Comerford, Kitner, Palacios, & Sanchez, 2001:92). The ascendancy of harm reduction philosophy is attributed to continual indulging in risk taking behaviours and consequent harm.

The philosophical roots of a harm reduction model rest on a number of principles: amongst others, pragmatism, collaboration, and humanistic values. Harm reduction accepts that individuals will always display risk taking tendencies and therefore that any intervention should simultaneously be practical and collaborative, and attempt to maintain their dignity (Hilton et al., 2001:358; Korf & Buning, 2000:132; Riley & O'Hare, 2000:6; Brocato & Wagner, 2003:118). The theories that are used in this study for the explication of the prevalence of risk taking behaviours in correctional institutions are the social learning theory, the indigenous influence theory, the cultural drift theory and the integrated theory.

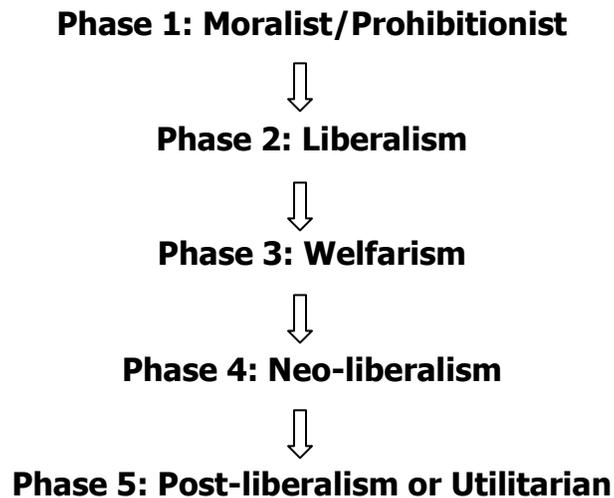
2.2. HISTORY OF HARM REDUCTION

The harm reduction concept emerged as a consequence of drug use and its inherent damage. Its genesis is rooted in the need to protect the health of those engaging in risk taking behaviours in order to avoid negative far reaching consequences (Inciardi & Harrison, 2000: viii). The fundamental objective is to reduce mortality and morbidity. Harm reduction is not the legalization of drugs, which requires legislative changes. Such a model consists of a number of components, namely, needle and syringe exchange, substitution therapy, condom provision, education, counseling, and HIV testing. This study focuses on the first four components. Although harm reduction has gained prominence as a result of drug use, it is imperative to note that it is a broad concept that may be used to address any other risk taking behaviours, such as unprotected sex and tattooing with contaminated equipment (Newman, 2005:265).

Drug use has been present in human existence throughout history and across cultures (Prakash, 2001:1; Inciardi & Harrison, 2000:x). As a result, people have devised innovative harm reduction ways of dealing with drug use although these were not formalized. In some instances a spider was placed in the bottom of the wine glasses of heavy drinkers, in an attempt to reduce alcohol consumption. Therefore, harm reduction is not a totally new phenomenon (Reinarman & Levine, 1997:356; Brocato & Wagner, 2003:118; Inciardi & Harrison, 2000:x).

Drugs are a global industry; hence illicit drug use is a worldwide problem (Wolf, 2002:20). As stated by the former British Home Secretary "drug abuse is a disease from which no country and no section of modern society seems immune" (Randall, 1990:8). Drug use permeates all levels of a society; it knows no colour, creed, or age. It has been reported to be rife in about 121 out of 195 countries (Stimson, 1998:408). Although many countries have adopted a punitive stance in response to this challenge, illicit drug use continues unabated (Korf & Buning, 2000:113).

Over a period of time, several drug combating policies have been developed, ranging from conservative to post-liberal. A schematic representation of the strategic phases follows:



[Sources: Wolf, 2002; Seddon, 2008]

During the moralist phase, drugs were regarded as a vice that had to be totally eliminated. As a result, stringent drug control measures were implemented. The main goal of the moralist approach was total abstinence. The application of strict legislation to enforce abstinence was counterproductive; it led to disastrous results. Total prohibition drove drug use and drug trade underground. It marginalized drug users and also increased their premature mortality and morbidity rates (Stevenson, 1994:104; Riley & O'Hare, 2000:3; Wolf, 2002:1).

The shortcomings of the conservative prohibitionist approach led to the emergence of the libertarian phase in the nineteenth century. The key feature of this phase was an unregulated free drug trade. Few controls were imposed on production, sale, distribution and consumption of drugs (Seddon, 2008:102). The

basic premise was that individuals could not be protected by the law from their own choices. Therefore, the use of harsh measures by government to prevent individuals from engaging in risk taking behaviour was deemed inappropriate and futile.

At the dawn of the twentieth century welfarism emerged subsequent to liberalism. Government introduced regulatory controls on the drug market. This phase was marred by many challenges. As a result, government adopted the neo-liberal approach to drug control. There was a paradigm shift towards risk based drug control measures. Demand reduction gained prominence in all efforts regarding drug control. Demand reduction refers to eliminating the desire for drug use through application of deterrent laws, education, and treatment (Bailey, 1988:11).

Notwithstanding the implementation of stringent drug prevention interventions, the problem continued unabated (Stimson, 1998:409). It is said that where a paradigm has failed there is a need to think creatively. New efforts were necessary to ameliorate harm resulting from drug use (Seddon, 2008:99). In response to the failures of neo liberalism, a new post-liberal construct namely harm reduction emerged which recognized that change begins with an individual. Harm reduction places the individual in the center and recognizes that the recovery from a risk taking existence is not instant. It is a long and arduous journey. It requires an enabling environment, as well as the courage and commitment of the individual (McKeganey, 2005:25).

A harm reduction model represents a 'middle of the road' perspective between prohibition and decriminalization. As reflected in Table 2 illustrating a comparative outlook on the three approaches to drug use, prohibition espouse the notion of zero tolerance for risk taking behaviours whereas decriminalization

calls for a laissez-faire approach to these behaviours. Due to prohibition strict sanctions are imposed thus driving the behaviour underground. Decriminalization embodies unrestricted access and unregulated economy and markets. In contrast to both perspectives, the harm reduction model prioritizes health, safety and individual responsibility. Those engaging in risk taking behaviours are regarded as rational beings who are able to alter their behaviour if provided with an opportunity.

TABLE 2: THREE APPROACHES TO DRUG USE

MIDDLE OF THE ROAD PERSPECTIVE



War on drugs

Harm Reduction

Decriminalization



- a. Tough and authoritarian.
- b. Prohibit drugs.
- c. Up - bottom approach.
- d. Marginalizes users.
- e. Fosters underground market and consumption.
- f. Unknown impact on HIV epidemic.

- a. Considerate and value-neutral.
- b. Focus on health & safety.
- c. Bottom – up approach.
- d. Promote responsible use.
- e. Controlled market.
- f. Positive impact on HIV epidemic.

- a. Laissez – faire attitude.
- b. Unrestricted access.
- c. Open markets.
- d. Use not monitored

Evidence shows that a tough stance on drug through 'war on drugs' interventions is counter-productive. It has been perceived as rhetorical and moralistic lacking a meaningful outcome (Nadelmann, 1999:157). This moralist approach drives the drug market and its consumption underground. It also marginalizes all those engaging in risk taking behaviours. The focus is on total prohibition, over against decriminalization which promoted unregulated trade and consumption. Decriminalization has not been found to be an attractive option as it is too permissive.

Harm reduction is value-neutral: it promotes responsible use and maintains contact with those engaging in risk taking behaviours. As opposed to the two perspectives cited in Table 2 above, harm reduction has a known impact on the HIV epidemic. The World Health Organization (2005:5) submits that HIV among drug users may increase by 40% if harm reduction components are not implemented. UNAIDS reported that HIV prevalence was reduced by an average of 58% within a period of five years where needle and syringe exchange programme was implemented.

Harm reduction has evolved from fuzzy and uncoordinated efforts to a mature and coherent paradigm. The first formal efforts to introduce harm reduction in the United Kingdom dates as early as the 1920s when the British Home Office raised concerns regarding the prescription of drugs to addicts. As a response, the Ministry of Health commissioned a team chaired by Sir Humphrey Rolleston to deal with this challenge (Hilton et al., 2001:359; Hedrich, Pirona & Weissing, 2008:511).

The Rolleston Committee recommended weaning users off drugs by the use of substitution therapy rather than sudden withdrawal. The prescription of narcotic drugs to addicts was subsequently authorized (Stimson, 1998:403, Seddon,

2008:99). It is this finding that laid the foundation for the introduction of a harm reduction model in the United Kingdom. Harm reduction components were first introduced in Liverpool, northwest England at the Mersey Region Drug Training and Information Centre in 1986. This harm reduction initiative is commonly referred to as the Merseyside project. Through this project, drug users were introduced to substitution therapy, a needle and syringe exchange programme, as well as to an education programme in an attempt to reduce the harmful consequences of drug use (Stimson, 1998:401; Hilton et al., 2001:360).

The Merseyside project operated from ablution facilities owing to space constraints. Despite this challenge, the project demonstrated to the world that there is a better alternative to addressing drug problems. Although Liverpool experienced high rates of heroin use and prostitution, the Merseyside initiative managed to curb the spread of HIV and also reduced crime. Liverpool was able to record the second lowest number of HIV cases in the United Kingdom (Stevenson, 1994:102; Riley & O'Hare, 2000:3). Thereafter, harm reduction components were replicated in the European Union countries, some Asian countries, Brazil, Canada, and Australia.

In the European Union countries harm reduction initiatives first emerged in the 1960s. In Sweden substitution therapy was introduced in 1967 while needle and syringe exchange was piloted in the mid-1980s. By 2001, all European Union countries but one had implemented a range of harm reduction components (Hedrich et al., 2008:506). In the Netherlands, harm reduction components emanated from the efforts of a group of concerned drug users referred to as the Junkie League based in Rotterdam. The League maintained that the views of drug users were fundamental to any harm reduction initiatives. The League's efforts contributed immensely towards the introduction of the first needle and syringe exchange programme in 1984 (Marlatt, 1996:784, Inciardi & Harrison,

2000:ix). The success of these initiatives hinged on a strong political environment supported by relevant political ideologies.

In Australia, the new government of the Labor Party revised the previous drug policy and consequently introduced a harm reduction strategy. Its purpose was to reduce the negative health consequences of drug use. The Labor government realized that HIV and drug use were closely intertwined and that prohibition was not leading to any positive outcome. The substitution therapy and needle exchange programme coupled with counseling were found to be effective in addressing HIV and drug use (Makkai, 2000:174).

Asian countries also supported the implementation of harm reduction components. Needle and syringe exchange programmes and substitution therapy were introduced to combat drug use in New Delhi and Manipur. Oral buprenorphine was provided to drug users through a Methadone Maintenance Treatment programme in New Delhi. Notwithstanding a political environment hostile to harm reduction model in Brazil, there were sporadic efforts to implement some harm reduction components. A needle and syringe exchange programme was piloted in Santos and Salvador. It was later rolled out to Rio de Janeiro which reports high rates of HIV. However, a needle and syringe exchange programme was banned by legislation in Santa Catarina and Mato Grosso do Sul (Jarlais & Friedman, 1997:55; Surrat & Telles, 2000:143).

Notwithstanding this resistance, the harm reduction model gained momentum worldwide as a response to the HIV/AIDS pandemic. Prior to the scourge of HIV, there was generally a low rate of mortality and morbidity among drug users. As a result, there was scepticism concerning harm reduction components. There was a perception that harm reduction strategies sanctioned drug use; therefore there was resistance to considering it for implementation (Stevenson, 1994:102).

Cheung (2000:1699) further states that harm reduction was misunderstood as a “Trojan horse for legalization” or as mechanism of escape from tough laws. After drug use was identified as the primary risk factors for the transmission of HIV with resultant high mortality and morbidity rates, harm reduction was accepted as a viable alternative solution. For example, in Europe drug use accounted for 60% of AIDS cases (Riley & O’Hare, 2000:2).

Correctional institutions are not immune from the adverse health challenges encountered in the general community as a result of drug use and HIV/AIDS. The inmate population, as mentioned consists of people from diverse backgrounds who would not have met had it not been for their incarceration. Thereby an opportunity is created for the transmission of blood borne viruses among inmates. Three risk taking behaviours namely: unprotected sex, drug use and tattooing that fuel the spread of viruses are also prevalent in correctional institutions (Frost & Tchertkov, 2002:7). Upon release, there is a high probability of inmates returning into the community with an infection. Goyer (2002:1) estimated that about 25,000 people in South Africa are released from correctional institutions per month thus probably transmitting HIV back into the community. This movement of inmates calls for the urgent replication of harm reduction strategies in correctional settings in order to contain the spread of HIV and other communicable diseases.

The HIV epidemic is reported to be more prevalent amongst inmates than in the general community (World Health Organization, 2005:2). Whilst general drug policies advocate for harm reduction in some countries, correctional policies generally emphasize zero tolerance and abstinence-based treatment programmes. In most countries, there is no alignment as regards health policy development between the community and correctional institutions (Levy, Treloar, McDonald, & Booker, 2007:647).

In support of the implementation of harm reduction components in correctional environments, the World Health Organization Regional Committee for Europe took the following resolution:

"to promote, enable and strengthen widespread introduction and expansion of evidence-based targeted intervention for vulnerable/high risk groups such as prevention, treatment and harm reduction programmes (e.g. expanded needle and syringe programmes, bleach and condom distribution, voluntary HIV counseling and testing, substitution drug therapy, STI diagnosis and treatment) in all affected communities, including prisons, in line with national policies"(World Health Organization, 2005:4).

UNAIDS has also joined the voices recommending the replication of harm reduction components in correctional settings. Okie (2007:106) states that various harm reduction components had been implemented in about fifty correctional institutions. These institutions are located in Canada, Spain, Belarus, Moldova, Indonesia, Germany, Switzerland and Kyrgyzstan. Despite this progressive step, needle and syringe exchange programmes are still banned in some parts of Australia and the United States. It is widely reported that the majority of the American incarcerated population has violated drug related laws. Therefore, it is obvious that there is a considerable prevalence of drug related high risk behaviours amongst inmates. Notwithstanding the situation, the federal government opposes the implementation of harm reduction components and generally adheres to prohibition practices (Riley & O'Hare, 2000:11).

In Canada, an interest group took the initiative to introduce harm reduction in correctional institutions. Substitution therapy has been operative since the 1950s in the general community. In 1992, this interest group formed an organization called Prisoners with HIV/AIDS Support Network (PASAN) as a response to HIV challenges in correctional environment. PASAN consisted of former inmates,

AIDS activists, and members of community-based groups. This organization investigated the feasibility of introducing harm reduction components in Canadian correctional institutions including needle exchange programmes, methadone maintenance treatment, bleach distribution, and safer tattooing. These components were later extended to most correctional institutions (DiCenso, 2006:1).

For a more comprehensive understanding of a harm reduction model, it is important to allude to its philosophical underpinnings.

2.3. PHILOSOPHY

Harm reduction is a public health philosophy that comprehensively seeks to address adverse consequences resulting from engaging in risk taking behaviours. The essence of harm reduction is that risk taking behaviours are part of human existence and for those who are not ready to abstain; the focus should be on reducing inherent harm. Harm reduction acknowledges that there is no single effective solution to risk taking behaviours. Different approaches to finding a suitable solution will be discussed in the next chapter. Herewith follows a brief exposition of the main principles of harm reduction, namely: pragmatism, humanistic values and collaboration.

2.3.1. PRAGMATISM

The philosophical roots of harm reduction are embedded in pragmatism (Marlatt, 1996:785; Reinarman & Levine, 1997:356; Riley & O'Hare, 2000:2). The main focus of harm reduction falls on the practical control of the risks emanating from engaging in risk taking behaviours and reducing consequent harm on the individual and society at large (Brocato & Wagner, 2003:118). Hence this model

seeks practical solutions to the harms inherent in risk taking behaviours. These measures are not based on illusions or imaginations. They concern what works rather than what is pleasant to implement. Pragmatism includes making harm reduction an integral part of the interventions whilst recognizing the importance of other treatment options (Korf & Buning, 2000:132). Harm reduction recognizes that total abstinence from risk taking behaviours is not a reality. Any society is faced with a compendium of risk taking behaviours and practical solutions should be utilized to address this challenge.

The said model is not based on a moral idealism, which condemns the behaviour and advocates the imposition of punishment. Instead, it challenges penal measures and intensifies prevention of ailments and the provision of education as well as treatment. Penal measures have not borne any positive meaningful outcomes hence the need to consider harm reduction as an alternative. Its proponents are of the view that those engaging in risk taking behaviours should be assisted to use safer methods while they are still willing to continue with the behaviour. Their competency to make choices and decisions should be recognized (Inciardi & Harrison, 2000:1; Brocato & Wagner, 2003:118; Hilton et al., 2001:359).

Risk taking behaviours emanates from a constellation of deep seated factors which cover a wide spectrum and therefore addressing these only through repressive laws will not give yield the desired results. Harm reduction is holistic and does not deal only with symptoms of risk taking behaviours. Repressive laws deal only with the risk taking behaviour and disregard the consequences thereof to the person and society at large. However, laws do not necessarily foster the desired behavioural change and prevention. Marlatt (1996:785) states that suppressing risk taking behaviours through legal means do not bring the desired results; rather it just fuels the problem by driving it underground.

Contrary to the repressive approach, harm reduction acknowledges risk taking behaviours and therefore action is supportive rather than punitive (Hilton et al., 2001:359). By means of this approach, people are made to understand the consequences of risk taking behaviours and encouraged to be health conscious. Brocato & Wagner (2003:111) further state that those who engage in risk taking behaviours “are not expected to embrace a goal of abstinence in order to be eligible to harm reduction initiatives”. Abstinence is not enforced although it is the ultimate desired result. Harm reduction components are made available to all those willing to participate and the goal of abstinence is not the qualifier for entry.

2.3.2. HUMANISTIC VALUES

The adoption of humanistic values in harm reduction brings the dignity and respect of users to the fore. No moral and ethical pronouncements are made as regards the users and their risk taking behaviour. Consumer input is deemed critical in addressing the ills of drug use (Riley & O’Hare, 2000:6; Hilton et al., 2001:359). The focus is placed on not only on behaviour but also on the consequences for the user and the society. Harm reduction initiatives respects the use of drugs as a choice and does not condemn or condone risk taking behaviours (Hilton et al., 2001:358). The users are not treated as addicts who should abstain from drug use irrespective of the harmful health consequences. They are treated with utmost respect and the resultant behavioural change facilitates healthy style of living (Prakash, 2001:1).

2.3.3. COLLABORATION

A close collaboration between those who engage in risk taking behaviours and the officials who are involved during the planning and implementation of harm reduction components affords a real voice to the risk takers. The said model does not alienate, marginalize and isolate anyone. It is collaborative and all inclusive in nature, being user-driven and broad based in its approach, and reintegrates users into the conforming society. It is this aspect of reintegration aspect which encourages users to take the responsibility for their risk taking behaviours and their consequences (Reinarman & Levine, 1997:357).

Makers of drug policy have been criticized for bringing solutions to the communities without their involvement. The director of a California-based drug related project stated that harm reduction programmes can only succeed where there is a strong collaboration between the affected community and the programme implementers. The input of all stakeholders especially users is of utmost importance, in order to achieve meaningful change (Marlatt, 1996: 782; Hilton et al., 2001:360).

Stakeholders include users, staff, politicians, correctional authorities, inmates, advocacy groups, and government representatives. They should be involved from the inception of harm reduction initiatives to implementation and evaluation, where applicable. The collaboration is necessitated by the fact that for harm reduction components to succeed, an enabling environment should be created through legislation, policies and an appropriate mindset. All stakeholders should accept such a model as a credible solution for improving public health. In addition, it is vital to move the target audience from the periphery to the centerpiece. Drug users should be pillars of harm reduction measures as they are vital in effecting radical change to the landscape of drug use (Brocato & Wagner, 2003:119; World Health Organization, 2005:6).

2.4. THEORIES

Theoretical models enable one to understand the dynamics of inmate culture, which has a tremendous influence on behaviour. The process oriented theories discussed below are the social learning theory, the indigenous influence theory and the cultural drift theory. The social learning theory and the indigenous influence theory regard a correctional institution as an environment that is different from the community setting where new learning occurs. In contrast, cultural drift theory perceives the correctional environment as an extension of society from which behavioural patterns are imported.

It is imperative to gain a clear understanding of the dynamics that have a bearing on inmates' behavioural patterns in order to come up with appropriate harm reduction measures that will be effective in addressing the formidable challenges posed by HIV/AIDS in correctional settings.

2.4.1. SOCIAL LEARNING THEORY

The basic assumption of the theory is that both conforming and non-conforming behaviours are learnt through the same learning process (Akers, 2002:13). The social context in which learning takes place and one's reaction to the resulting stimuli determines the outcome of the learning process. Given the context of this study, the ensuing discussion will focus on prisonization which is a social learning theory that refers to the adoption of norms, values, and folkways by the inmate during incarceration (Gillespie, 2003:2). This theory emanated from a seminal study conducted by Clemmer in the 1930s on inmate behavioural patterns at Menard State Prison. He defined prisonization as "the taking on in greater or

lesser degree of the folkways, mores, customs and general culture of the penitentiary" (Clemmer, 1940:299).

Consequently, Clemmer (1940:299) advocated that the process of prisonization provided a clearer insight into inmate behaviour. A correctional institution provides a unique environment in which prisonization exerts tremendous influence. Through prisonization inmates acquire behavioural patterns, values, norms, attitudes, and standards of living from other fellow inmates (John Howard Society, 1999:10). Subsequent to Clemmer's ground-breaking work on prisonization, a number of authors (Thomas, 1973; Akers, Hayner, & Gruninger, 1977; Slosar, 1978; Adams, 1992; Winfree, Newbold, & Tubb III, 2002; Krebs, 2002; Grapendaal, 1990) expressed similar views in different words. Thomas (1973:14) refers to prisonization as "a process of assimilation into the inmate subculture" while Akers, Hayner & Gruninger (1977:527) defines prisonization as "a process of adult socialization into the inmate subculture".

Slosar (1978:7) asserts that prisonization is "a given fact of incarceration, it is neither a yes nor a no matter but just it is a question of degree". He therefore regards prisonization as an integral part of incarceration. Winfree et al. (2002:214) perceives prisonization as an adaptive process to both incarcerations as well as to the inmates' code. These authors maintain that pre-incarceration and or other variables may increase or decrease the probability of prisonization.

Similarly, Grapendaal (1990: 342) posits that prisonization is "an adaptive process to the deprivation which imprisonment imposes upon inmates". Adams (1992:278) alludes to prisonization as an adjustment process to normative proscriptions of the inmate subculture" whereas Krebs (2002:23) describes prisonization as "a process of adjusting to the prison environment which has its own set of morals, laws, rules, social relations, patterns of behaviour and

problems". In sum, these authors generally also regard prisonization as the process leading to the adoption of the inmate code or subculture. This subculture is the bedrock on which inmates find solace and solidarity during incarceration.

Several views (Sykes, 2006; Grapendaal, 1990; Gillespie, 2003) have been expressed regarding the origin of such a subculture. Sykes (2006:176) posits that the inmate subculture develops as a result of the institutional environment which is characterized by the five deprivations, discussed below, that he collectively referred to as 'pains of imprisonment'. Gillespie (2003:1) states that the inmate code emanates from the inmate subculture that is replete with norms, values, and rules that are opposed to correctional regulations. The inmate subculture thrives parallel to these correctional rules and regulations. The internalization of this subculture enables inmates to survive the highly regulated correctional environment (Ramirez, 1984:424). Lastly, Grapendaal (1990:342) also asserts that such a subculture emerges as an adaptive response to the inherent deprivations.

The goals of the correctional system and that of the inmate subculture are antithetical. When a new inmate is admitted into the institution he or she is exposed to two conflicting value systems. If the values, mores and customs of the inmate subculture dominate those of the formal system, then most likely the inmate will engage in risk taking behaviours as a mode of adaptation and survival during his incarceration (Thomas, 1973:14). Bowker (1977:6) submits that inmates who engaged in risk taking behaviours such as unprotected sex were the most prisonized. He further posits that these inmates may not have engaged in such practices in the general community.

Several criticisms have been levelled against this learning theory. Alpert (1979:161) states that prisonization has lost its explanatory power and therefore

it has disappeared into oblivion. It has failed to provide compatible outcomes during the investigations. Walters (2003:401) also highlights the weaknesses of prisonization. He submits that the key aspects of the prisonization thesis have not been confirmed and therefore needs to be revisited. Despite these criticisms, prisonization as a form of social learning is still applied to the understanding of inmate behaviour and has offered some invaluable insights.

In addition to social learning theory, there are other two theories that have been historically used to explain inmates' behavioural patterns, namely; the indigenous influence theory and the cultural drift theory.

2.4.2. INDIGENOUS INFLUENCE THEORY

The indigenous influence theory regards a correctional institution as an isolated social enclave or a closed system. According to this theory, institutional environmental conditions have more impact on inmate behavioural patterns than individual characteristics. (Jiang, 2005:338; Grapendaal, 1990:342; Jiang & Fisher-Giorlando, 2002:338). Variables that are unique to the institutional environment are perceived as explanatory predictors of inmate misconduct (Hochstetler & DeLisi, 2005:258).

The correctional environment facilitates adaptation to the 'pains of imprisonment' as identified by Sykes. Adaptation to these pains translates into adherence to the normative inmate subculture that engenders involvement in amongst others, risk taking behaviours that violates the rules of the correctional institution (Jiang & Fisher-Giorlando, 2002:339). Sykes (2006:165) submits that inmates spend a considerable time of their lives deprived of freedom, goods and services, heterosexual contact, autonomy and personal safety. The five deprivations are explained as follows:

2.4.2.1. DEPRIVATION OF FREEDOM

The loss of freedom is said to be the crux of incarceration. Inmates suffer loss of freedom at two levels: they are incarcerated to the institution as well as within the institution. The inmate's contact with the general community is severely curtailed, while the physical contact with friends and relatives is subjected to institutional rules. Simultaneously, the inmate's movement within the institution is subjected to the stringent regulations of the correctional authorities. Upon admission inmates are allocated a number, and uniform and forfeit being identified by name. This loss of liberty and identity is dehumanizing and affects the ego of the individual. Inmates react to this deprivation by displaying aberrant behavioural patterns, inter alia: violence, drug use and sexual assaults (Sykes, 2006:164; John Howard Society of Alberta, 1999:6; Jewkes, 2002:2).

Through the deprivation of their freedom, inmates are constantly reminded of their rejection by society. Some of the inmates do not receive visits from loved ones. Sykes (1958:64) states that about 41% of inmates at New York State Prison had not received visits for a period of a year. This rejection has debilitating effects on the inmates. It is frustrating and leads to loneliness and boredom for the duration of the incarceration (John Howard of Alberta, 1999:6). Inmates tend to engage in risk taking behaviours as a way of adjustment to this dehumanizing environment.

2.4.2.2. DEPRIVATION OF GOODS AND SERVICES

Inmates also have restricted access to goods and services as a result of incarceration. They are only given access to basic necessities of life such as food, shelter and health care services. These necessities are very limited. For instance,

inmates receive food three times a day; a small space is shared with fellow inmates while the health care service is not like that in the general community. Inmates are deprived of their material possessions that were part of their normal daily lives prior to incarceration. Materialism is a huge part of living in the general community and being deprived in this respect represents one of the greatest losses (Sykes, 1958:287). This restriction is a major source of discontentment for inmates and is therefore perceived negatively. Inmates feel demeaned, devalued, humiliated and harbour much anger towards the correctional authorities.

Consequently, they tend to devise various illegal means ranging from bribery, bartering to smuggling in order to access goods and services (Jewkes, 2002:3). Some inmates who receive visitors obtain additional goods and use them for bartering. Others acquire goods that have been smuggled in by staff in exchange for good behaviour. Those inmates who are without possessions even engage in risky sexual activities in exchange for goods from other fellow inmates.

2.4.2.3. DEPRIVATION OF HETEROSEXUAL RELATIONSHIP

Incarceration cuts links between inmates and loved ones. Inmates are deprived of conjugal rights, which results in extreme emotional distress and frustration and leads to psychological problems (Tewsbury & West, 2000:369). These challenges are exacerbated by the fact that the inmate population consists of sexually active single-sex individuals. Inmates are figuratively castrated by the involuntary celibacy resulting from incarceration. The options available to them for the release of sexual urges are limited to masturbation, celibacy, and/or homosexuality. Masturbation is ridiculed and regarded as taboo and celibacy is impossible to maintain when the urge is uncontrollable (Sykes, 1958:70).

Therefore, options are narrowed down to situational homosexuality for the satisfaction of the sexual drive (Eigenberg, 1992:225). Homosexuality is regarded as an act of sexual deviance prompted by intolerable pressure for sexual satisfaction. Homosexual activities may be coerced or consensual, thus exposing participants to unprotected risky sex. The deprivation of a heterosexual relationship is felt mostly by long term inmates. They lure others into sex as temporary relief of the deprivation (Sykes, 1958:289).

Male inmates are shut off from the world of women. In a survey, an inmate attested to the deprivation of heterosexual relationship through the following statement:

"When I began my sanction, I was in love with a woman. The forty year sentence imposed by the Judge made it impossible for the relationship to continue. At the time in my life, losing love hurt more than the length prison term. It was more acute, more immediate, more final. When the loss of love came, prison compounded the pain [sic]"(Santos, 1995:209).

Although homosexuality is viewed with derision, contempt, and disgust, inmates do engage in it. Sexual victimization through assaults is said to be the order of the day in correctional institutions although this is mostly based on anecdotal evidence. The following excerpts illustrate how deprivation of a heterosexual relationship triggers sexual victimization. In his study of sexual predators, Lockwood (1980:127) was told the following by the participants:

"You get a letter from your girlfriend, and you think about all other girls. And it starts to build up until your head is filled with thoughts, but all you see around you is men, men, men. So you just say I have to got to get...I am going to start messing with the homos. I am going to start messing with the queens"(Lockwood, 1980:127).

Due to lack of condoms in most correctional institutions, most sexual activities are unprotected and serve as a mode of transmission of blood borne viruses (Collica, 2002:104; Gymarthy, Neagus, & Szamado, 2003:567). The deprivation model offers a more plausible explanation for the prevalence of homosexuality and HIV/AIDS in correctional institutions than any other model.

2.4.2.4. DEPRIVATION OF AUTONOMY

Inmates largely forfeit their autonomy upon admission to a correctional institution. Their latitude of decision making is severely and abruptly curtailed (Berman, 2004:59). As a result, inmates are thrust into a state of mental paralysis. They are subjected to a monotonous and routine life informed by a plethora of strict rules and regulations as well as the whims of the correctional authorities. There is no room for an independent schedule for one's daily activities. All inmates are subjected to a detailed daily schedule managed by the officials (Sykes, 1958:291).

Inmates have to comply with instructions without question no matter how incomprehensible. This strict bureaucracy adversely affects inmates self concept and renders them dependent, helpless and weak (Sykes, 1958:73; John Howard Society of Alberta, 1999:6). During a survey, one inmate confirmed the deprivation of autonomy in the following statement:

"To think that authorities may arbitrarily stop me from reaching out makes me feel as if I must walk on eggshells. I don't know whether I am going to make it through this sentence"(Santos, 1995:237).

Jewkes (2002:17) is also of the view that this situation reduces inmates to a state of 'infantilisation'. They tend to become negative and rebellious disobeying rules when an opportunity presents itself. Such reaction may take the form of

engaging in prohibited risk taking behaviours that exert a far reaching influence on inmates' health and the management of correctional institutions.

2.4.2.5. DEPRIVATION OF SECURITY

Upon admission inmates are often allocated accommodation irrespective of their type of offence. The inmate population comprises violent, aggressive and non-violent individuals. Spatial considerations are generally the key to such allocation and the privacy of individuals virtually dissipates into thin air. As a result, inmates find themselves in 24-hour or 7-day proximity to other dangerous ones (Sykes, 1958:77).

Donnel and Martin (2003:4) also confirm that inmates are "in constant companionship of fellow murderers, rapists, thieves, and fraudsters". Inmates tend to be aggressive and violent at the slightest provocation as a veil of protection against falling prey to others. Therefore, there is a constant threat to their personal security. Sharing space with individuals from diverse backgrounds may be constantly nerve racking and anxiety provoking for inmates. With the reported high prevalence of HIV/AIDS in correctional institutions, there is also a continuous threat of contracting HIV during incarceration.

In a survey conducted by Santos (1995) an inmate serving a 45-year sentence said the following:

"The constant companionship of thieves, rapists, killers, aggressive homosexuals, and snitches who will say or do anything to save their own hide is far from relaxing"(Santos,1995:238).

The deprivation model has been tested by Reisig & Lee (2000:29) at 15 Korean correctional institutions using data from 546 inmates. Inmates with aberrant behaviours were found to be more prevalent in institutions characterized by stringent inmate control mechanisms. The results demonstrated a fair amount of support for the deprivation model. In addition, Seal et al. (2004:776) hold that the deprivation model has more utility for the interpretation of inmate homosexuality than the importation model. Inmate sexual behavioural patterns are significantly affected by incarceration, such as engaging in risky homosexual activities.

A number of authors (Wellford, 1967; Irwin, 1980; Raminéz, 1984; Grapendaal, 1990; Palermo, 2005) have levelled criticisms against the indigenous influence theory, asserting that it is too narrow and restrictive in scope. In their view it disregards the critical impact of key individual attributes on inmate behaviour. Wellford (1967:203) is of the view that the theory is vague, imprecise and cannot be measured. The deprivation hypothesis ignores the impact of pre-incarceration experiences.

According to Irwin (1980:34) the model disregards the fact that "prisons are constantly bombarded with individuals who arrive with their own orientations, cultures, power and prestige in the outside world". Grapendaal (1990:342) also posits that the deprivation model is too restrictive and virtually disregards the influences of the outside world brought into the correctional institution by inmates. Raminéz (1984:426) maintains that the deprivation model is conceptually flawed. Researchers who propagated this theory could have been influenced by their adherence to ethnographic tradition, cultural baggage, and functionalist orientations. Lastly, Palermo (2005:611) maintains that inmates' behaviour is not only attributable to factors intrinsic to the correctional

environment but also to that of the community in which they lived prior to incarceration.

2.4.3. CULTURAL DRIFT THEORY

The basic assumption of the cultural drift theory is that the development of an inmate subculture is largely influenced by the individual's own distinctive traits as well as his social background (Akers et al., 1977:528). Contrary to the social learning theory, this theory regards a correctional institution as an extension of society rather than as a totally separate institution. Therefore, the inmate code is perceived as part of the larger criminal code that exists in the outside community. Proponents of this theory state that extraneous factors independent of the correctional environment exert a major influence on inmates' behavioural patterns (Irwin & Cressey, 1962; Slosar, 1978; Thomas, 1973; Wright, 1994; Gillespie, 2003).

Thomas (1973:15) has pointed out that on admission offenders are already exposed to a socialization process. He further posited that having been involved in criminal activities, some elements from the criminal subculture in the community are imported into the correctional institution; hence they influence the inmate subculture and behavioural patterns. The adoption of the inmate code and the degree of assimilation into the correctional system are influenced by pre-incarceration variables such as social background, involvement in criminal activities, societal values, norms and attitudes.

In the opinion of Wright (1994:162) inmate subcultures are "composites of various criminal and conventional street identities". Therefore their behaviour is influenced by the identities acquired earlier in their life. Gillespie (2003:391) also

asserts that the inmate subculture has an external origin and that a hybrid mixture of subcultures rooted in the community is imported into the correctional environment. Offenders foster certain attitudes in the community and when they are incarcerated, these attitudes influence behavioural responses to the situation.

Empirical evidence has shown support for the importation model regarding inmate behaviour. In a study on the determinants of inmate behavioural patterns using data from 15 Scandinavian correctional institutions, it was found that inmate behaviour was largely influenced by the pre-incarceration experiences of inmates. In addition, an analysis of rule violations in a correctional institution shows that the importation variables predict inmate behaviour better than deprivation variables (Cao, Zhao, & Van Dine, 1997:112).

A direct link has been established between the importation model and risk taking behaviours (Thomas & Cage, 1977; Hensley, 2000; Gyarmathy et al., 2003). In their study, Thomas and Cage (1977:206) evaluated the importation and deprivation theoretical models using drug use in a correctional context. A total of 255 out of 273 drug using inmates confirmed pre-incarceration drug use. These authors concluded that inmates with a history of drug use in the community are likely to continue with such behaviour during incarceration. They found no support for a causal link between institutional deprivations and drug use.

Hensley (2000:439) established support for the importation of perceptions regarding homosexuality from the community into the correctional institution. Homosexuality is therefore regarded as a reflection of sexual attitudes and values held by inmates prior to incarceration. In a study on HIV/AIDS related attitudes and risk behaviour history of Hungarian inmates, Gyarmathy et al. (2003:566) found that many inmates had engaged in risky sexual practices prior

to incarceration. Therefore, previous experiences of inmates informed their involvement in risk taking sexual behaviours that predisposed them to HIV/AIDS.

Several criticisms have also been levelled against the cultural drift theory. It is regarded as methodologically wanting, too limited in scope, general and ambiguous. Despite the scathing attack on both indigenous influence and cultural theories, they remain complementary to each other. Both theories independently shed light on inmate behavioural patterns. Researchers (Grapendaal, 1990:342; Paterline & Petersen, 1999:430) have suggested that the two theories be integrated in order to enhance their explanatory value of inmate behavioural patterns. This led to the emergence of the integration model.

2.4.4. INTEGRATION MODEL

Despite the identified distinctiveness of the indigenous theory and the cultural drift theory, when employed collectively they provide a robust explanation of the prevalence of risk taking behaviours in correctional settings. Thomas (1973:19) maintains that both individual and institutional factors collectively contribute to the inmate adjustment process. Inmate population is made up of adults who have already been socialized; hence their behaviour results from both intrinsic and extrinsic variables. Thomas (1973:16) submits that that “each inmate has a past, a present, and a future. *Therefore* [GM], adaptation to the correctional environment can be nothing other than the interactive product of all influences”.

The individual application of the two theories is overly limited especially in an attempt to explain the events and behaviours that facilitate intra-institutional HIV transmission. Therefore, it is advisable to integrate both models in order to attain a valuable and sound explanation of the inmate behavioural patterns. Seal et al.

(2004:784) also found support of the explanatory utility of both importation and deprivation models as regards inmate behaviour. They looked at inmates' perceptions and experiences with drug use and sexual activities whilst serving their sentences. Out of 80 respondents, 86.3% confirmed the availability and use of drugs in a correctional institution whilst 57.5% acknowledged the prevalence of unprotected sexual activities.

In their study of structural and social psychological determinants of prisonization, Paterline and Peterson (1999:438) used the integration approach. Although their findings show that the indigenous influence variables were a better predictor of inmate behaviour than the cultural drift theory, integrating the two theories had more explanatory value. Lastly, Hochstetler and DeLisi (2005:257) also submit that inmate misconduct can be attributed to both institutional and individual variables.

2.5. SUMMARY

Harm reduction emerged as a response to drug use and has been extended to other risk taking behaviours. Harm reduction acknowledges that the culture of abstinence is counter-productive. Even with the application of strict laws, abstinence is not a given outcome; it depends wholly on the individual. Abstinence cannot be attained within a set timeframe; it is a long and arduous process. The Merseyside project in Liverpool set the tone for the implementation of harm reduction. Thereafter, other countries followed suit and later intensified their efforts as a result of the HIV/AIDS epidemic.

Harm reduction is lauded on an international level as an effective, viable and comprehensive approach to addressing risk taking behaviours. Harm reduction is

based on key principles, amongst others, being pragmatism, humanistic values, and collaboration. The basic assumption of harm reduction is that there is no society that is free from risk taking behaviours. Harm reduction proponents also notes that repressive laws have failed to resolve the problem of risk taking behaviours hence it is imperative to consider harm reduction initiatives.

According to the process theories, inmate behaviour emanates from lessons learned during and prior to incarceration. The value and norms that are indigenous to the correctional environment provides and explanation for the engagement of inmates in risk taking behaviours. Equally so, pre-incarceration experiences exert a profound influence on inmate risk taking behaviours. These two explanatory approaches found support in the research on inmate behaviour, for example, homosexuality (Thomas & Cage, 1977:197). Despite, their distinct explanatory power, there has been a call to integrate the deprivation and importation models which has given rise to the birth of the integrated model.

The next chapter provides insight into international harm reduction components that have been implemented and borne positive results in addressing risk taking behaviours. These components are needle and syringe exchange programme, substitution therapy, condom provision and education. Lastly, the chapter provides an overview of the South African approach to drug use and HIV. (Grapendaal, 1990:342; Paterline & Petersen, 1999:430).

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CHAPTER 3

INTERNATIONAL AND SOUTH AFRICAN OVERVIEW OF HARM AND RISK REDUCTION COMPONENTS

3.1. INTRODUCTION

This chapter discusses the components of harm reduction from both international and South African perspective. In addition, it provides a brief overview of the Dublin Declaration on HIV/AIDS, placing emphasis on the eight key principles. This framework serves as an international guideline on how to address HIV/AIDS within correctional institutions. Furthermore, this chapter provides a description of the harm reduction components that are internationally renowned such as needle exchange, substitution therapy, condom provision, education, and bleach distribution. These have been implemented on a large scale in Europe. Lastly, this chapter includes a list of the advantages and disadvantages of the harm reduction models.

3.2. DUBLIN DECLARATION ON HIV/AIDS IN PRISONS

As a result of serious threats posed by the HIV/AIDS epidemic and drug use in the correctional setting, organizations and governments have introduced innovations and conventions on a global scale in an attempt to address their debilitating consequences. In 2001, the General Assembly of the United Nations encouraged countries to make harm reduction measures available to drug users in order to curb drug use and the spread of HIV. On 18th June 2003, the Council of Europe adopted a recommendation that encouraged the member states to

implement harm reduction strategies in addressing drug use (Chitwood et al., 2001:92; Matic, Lazarus, Nielsen, & Laukamm-Jostens, 2007:67).

To demonstrate further commitment in implementing harm reduction initiatives, the Dublin Declaration on Partnerships to Fight HIV/AIDS in Europe and Central Asia, hereafter referred to as the Dublin Declaration, was signed in February 2004 by 53 member countries (Annexure 1). Subsequently, in 2005, UNAIDS embraced harm reduction by making it one of the key actions to addressing HIV/AIDS. The Dublin Declaration serves as a framework for addressing HIV/AIDS effectively in European and Central Asian correctional institutions (Luyt, 2005:75). It also sets out eight fundamental principles and 33 actions for countries on how to manage and prevent HIV/AIDS in the general community as well as in correctional institutions.

The eight principles of the Dublin Declaration can be summarized as follows:

1. **People in prison are part of our communities:** Inmates come from our community; they are part of our families. Inmates cannot be marginalized and cast into oblivion since they return to the community upon release. During their stint in correctional institutions they are exposed to risk and therefore may serve as conduits for HIV/AIDS between the institutions and their community.
2. **People in prison have a right to health:** The South African Constitution provides for the right to health care for everyone, including inmates under the Bill of Rights. In response to this provision, the Department of Correctional services provides for a three-tier health service comprising of primary health care, in-patient hospital service, and referral to off-site private health facilities (Luyt, 2005:77).

3. **Good prison health is good public health:** The quality of public health and inmate health care should be on par. Infected inmates return to the community after release and if they have not received good health care during incarceration any infection may be transmitted to others. It is therefore imperative to implement harm reduction models equitably in both settings.
4. **Protecting the health of prisoners, and reducing the transmission of diseases in prisons, also protects the health of prison staff:** The correctional staff members are in constant contact with inmates owing to the nature of their job. If there is an outbreak of H1N1 or tuberculosis in the correctional institution, they will almost certainly be infected. It is therefore critical for the institutions to implement robust health prevention programmes in order to improve occupational health and safety.
5. **Sex and injecting drug use occur in prison, and in many prisons are widespread:** This principle acknowledges the presence of two risk taking behaviours which are closely linked to the spread of HIV/AIDS. This policy calls for the acceptance by governments that these behaviours are a reality and therefore requires concerted preventative measures. Most governments have chosen to ignore or deny the existence of these activities due to moral and legal barriers (Luyt, 2005:79). As a result of lawsuits instituted by inmates and civic organizations, South Africa and New South Wales have introduced condoms in correctional institutions.
6. **Harm reduction, rather than zero tolerance, must represent the pragmatic policy basis for fighting HIV/AIDS in prison and in providing HIV/AIDS care:** This principles calls for a shift from the strict abstinence based approach to the harm reduction model. The former is

idealistic and futile whereas the latter is pragmatic and has contributed to curbing the spread of HIV/AIDS.

7. HIV/AIDS in prisons is a major problem in many countries, and states must act collectively and cooperatively in the fight against the epidemic:

No country is immune from the scourge of HIV/AIDS both in the community and in the correctional institutions. It is therefore imperative to develop solutions that can be put in place by all countries. The management of HIV is more costly than prevention and therefore it is critical to implement the harm reduction model especially in the developing countries.

8. Action to fight Hepatitis C in prisons is as crucial as is action to fight HIV/AIDS and must be integrated into all initiatives addressing HIV/AIDS prevention and treatment:

Hepatitis C and HIV are both blood borne diseases that result from risk taking behaviours with far reaching fatal consequences. Hepatitis is chronic and leads to liver cell damage and liver cancer. Despite its seriousness no official records of its occurrence are kept by the Department of Correctional Services (Luyt, 2005:82). Hepatitis and HIV prevention and management measures should be integrated into all health policies.

Matic et al. (2007:66) reviewed the progress on the implementation of the Declaration. They found that HIV/AIDS flourished in Western European countries (France, Italy, and Spain) that were reluctant to embrace harm reduction components as listed in the Dublin Declaration. They attributed low rates of HIV/AIDS transmission in other countries to the increased use of needle and syringe exchange programmes and substitution therapy in line with the provisions of the Dublin Declaration. Chitwood et al. (2001:92) also noted the significant behavioural changes among drug users after the implementation of

harm reduction strategies. Similarly, Hope, Judd, Hickman, Lamagni, Hunter, Stimson, Jones, Donovan, Parry, and Gill (2001:38) noted evidence of effectiveness of harm reduction components on the spread of HIV/AIDS in countries where the Dublin Declaration has been implemented.

3.3. INTERNATIONAL HARM REDUCTION COMPONENTS

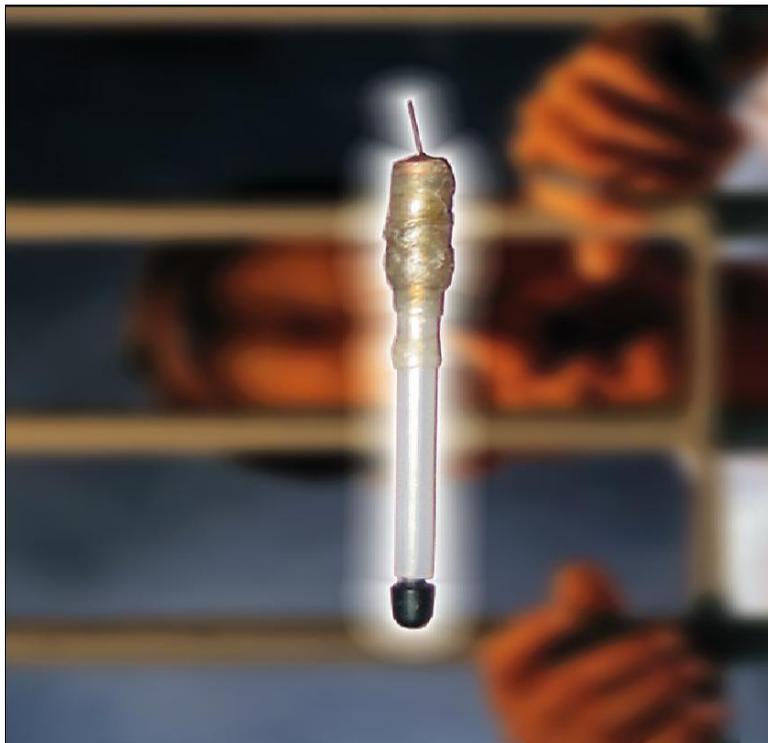
The European countries have spearheaded the incorporation of the harm reduction model in their public and correctional health policies. This is attributed to a strong political will and commitment as well as zero tolerance towards the spread of HIV/AIDS. The said model provides for a continuum of components with the possible outcome of reducing risk taking behaviours and ultimate abstinence. The lists of harm reduction components keep on growing as scientists and activists continually identify new initiatives to suit local conditions and behaviours that may be more effective than the current penal measures (Reinarman & Levine, 1997:357).

3.3.1. NEEDLE AND SYRINGE EXCHANGE PROGRAMME

A needle and syringe exchange programme enables drug users to return a contaminated needle or syringe to a service provider in exchange of a sterile one. Users are also able to gain access to sterile drug preparation equipment such as cotton wool, filters, cookers, and containers (Strike et al., 2002:128). These sterile paraphernalia ensure that users consume drugs in a healthy and protective way. It is widely argued that the use of sterile filters in syringes reduces the spread of viral infections (Hilton et al., 2001:362; Brocato & Wagner, 2003:120).

Where sterile needles and syringes are not provided, users resort to homemade needles or ersatz ones made out of pens, and or discarded syringes picked up from garbage bins during the execution of their daily chores. Such homemade equipment is a carrier of blood borne viruses. These can survive for a period of four weeks and therefore reuse of such equipment can have devastating results. Their structure, as depicted in the following homemade needle (*Figure 1*), is impossible to clean:

FIGURE 1: HOMEMADE INJECTING EQUIPMENT



Downloaded from www.ihra.net/uploads/downloads/newsitems/Lines-correlation 2007 pdf

The introduction of such a needle and syringe exchange programme has largely been attributed to the scourge of HIV/AIDS being closely linked to drug injecting behaviour (Hilton et al., 2001:359; Brocato & Wagner, 2003:119). This type of programme dates from the mid-1980s and is regarded as the cornerstone of

harm reduction. The programme is non-judgmental: it accepts the users as they are and provides them with support and advice to reduce harmful consequences. The users are therefore able to move from a state of helplessness to being confident and responsible individuals. In sum, such a programme removes barriers to safer drug use and improves the quality of life of the users (Riley & O'Hare, 2000:10; MacCoun & Reuter, 2001:268; Kerr et al., 2004:352).

The distribution of needles is effected through several operational protocols including automatic vending machines, health care personnel, counseling services, and pharmacies (Dolan, Rutter, & Wodak, 2003:153). In Portugal, pharmacies dispense sterile kits in exchange for used needles from drug users. These kits include sterilized needles, condoms, and alcohol pads (Jarlais & Friedman, 1997:53). In Swiss and German correctional institutions, needles and syringes are distributed through health care personnel and automatic distribution machines (Dolan et al., 2003:154).

Although the main objective of the programme is to exchange used needles or syringes with sterile and unused ones, it also has additional social benefits and services. It reduces health costs and facilitates constant contact with users. Generally, drug users operate in their own private and hidden spaces; hence it is ordinarily very difficult to identify and access them. Other services provided include the distribution of alcohol swabs, voluntary HIV testing, storage facilities for injecting needles, as well as aluminum containers. Needle and syringe exchange programmes are fully operational within the general community in the Netherlands, Brazil, the United Kingdom, Switzerland, Australia, New Zealand, Portugal, Spain, Iran and some parts of Canada and United States (Jarlais & Friedman, 1997:54, Surrat & Telles, 2000:140; MacCoun & Reuter 2001:268).

In Brazil, the implementation of the needle and syringe exchange programme was authorized by the Federal Narcotics Councils in 1994, despite the stringent drug laws. The programmes were supposed to be piloted at six sites but only two of them were commenced at Santos and Salvador. The Santos pilot programme was later terminated by law enforcement agencies and all property was seized. The Salvador programme continued to operate successfully providing sterile drug injecting equipment, HIV information leaflets, condoms, and referral services (Surrat & Telles, 2000:143). In Australia, the Labor Federal government authorized the implementation of harm reduction components, in particular a needle and syringe exchange as well as a methadone maintenance programme. It is reported that HIV prevalence reduced tremendously as a result of this endeavor (Makkai, 2000:182).

Needle and syringe exchange programmes commenced in the United States only in the late 1980s. There was fear of being perceived as permissive towards risk taking behaviours (Riley & O'Hare, 2000:11). On the advent of HIV/AIDS, the Clinton administration partially supported the implementation of a needle exchange programme. The Secretary for the Department of Health and Human Sciences, Don Shalala made a ruling that the responsibility for funding such a programme should not lie with the federal government but rather with the community. In this way, the federal government was being absolved from its key responsibility of providing good health care. Despite this attitude, there were about 131 needle exchange programmes in the United States by 1998 (Fitzgerald et al., 2003:114).

Initially, harm reduction measures were implemented in the general community to the exclusion of the correctional population. Later it became essential to consider the implementation of harm reduction components in the correctional setting as well, for the reasons mentioned above. Inject-able drugs are the most

sought after commodity in correctional institutions as they are not easily detectable through urinalysis. Using such drugs in correctional institutions necessarily leads to the sharing of drug paraphernalia and the risk of contracting HIV/AIDS. Therefore, refusing to provide inmates with access to sterile needles and syringes is tantamount to condoning the spread of HIV and violating their human rights (Kerr et al., 2004:353).

Spain is said to be the only country where harm reduction components are available in all correctional institutions (World Health Organization, 2005:8). In Switzerland, needle and syringe exchange programmes were formally replicated in correctional institutions from 1992. Prior to the formal introduction of the programme, it had been commenced in correctional institutions as a result of medical disobedience by Dr Franz Probst at Oberschöngrun prison in the canton of Solothurn. Dr Probst noted that inmates were injecting drugs leading to adverse health and behavioural consequences such as HIV, hepatitis, skin damage and violence. About half of the inmates shared needles and thus fuelling the spread of HIV and hepatitis. He then took the initiative of providing inmates with sterile injections, without the necessary authorization of the correctional centre management. When this was discovered, Dr Probst attributed his bold initiative to the need to curb the spread of HIV/AIDS and hepatitis amongst inmates (Lines et al., 2004a:21).

Thereafter, the Prison Director requested the necessary approval of the Cantonal authorities for the distribution of sterile needles in correctional institutions and this was granted. Later, the initiative was replicated in other correctional institutions such as Champ Dollon in Geneva at the instance of the Swiss Federal Office of Public Health. By the end of the year, 5335 syringes had been distributed in Hindelbank and Realta prisons through vending machines (Dolan et al., 2003:154). This bold initiative proved that it is possible to “advocate public

health measures in an environment where a language of discipline, security, and punishment prevails” (Nelles & Harding, 1995:1508). An evaluation of needle exchange programmes in Swiss correctional institutions showed a decrease in drug use and sharing of equipment as well as improved health conditions on inmates (Wasserfallen, Paget & Bauer, 1997:193).

By 2007, the breakdown of countries where needle exchange programmes have been implemented in correctional institutions is as follows:

TABLE 3: LIST OF COUNTRIES WITH NEEDLE EXCHANGE PROGRAMMES IN CORRECTIONAL INSTITUTIONS

Country	Year of inception	Number of Correctional institutions per country
Switzerland	1992	7
Germany	1996	1
Spain	1997	69
Moldova	1999	7
Kyrgyzstan	2002	11

Source: Lines (2007:7)

Although needle exchange programmes have been implemented in some countries of Western Europe without much fanfare or many difficulties, they remain clouded in controversy in Germany, Sweden, some parts of Australia as well as France (MacCoun & Reuter, 2001:268). Harm reduction is not accepted in Sweden and Queensland. The Swedish model of drug use is based on zero tolerance and total abstinence. Also, although the Queensland State Coroner recommended needle exchange for inmates in January 2007, it was met with strong resistance. The correctional authorities rejected the recommendation outright (Levy et al., 2007:649).

In 1996, Germany piloted needle and syringe exchange programmes in two correctional institutions (Vechta and Lingen) located in Berlin. Inmates who were on a methadone maintenance programme were provided with sterile needles. During the evaluation of the project, a substantial reduction in needle sharing was noted: it was estimated at 60% (Stark, Herrman, Ehrhardt & Beinzle, 2006:814). This indirectly contributed to curbing the spread of HIV and Hepatitis. It is reported that needle exchange programmes have also reduced quick injecting that is unhealthy, harmful and ultimately lethal. Despite the positive outcomes of the implementation of the six needle exchange programmes in Germany, the programmes were later terminated due to political interference (Levy et al., 2007:648).

Several criticisms have been advanced against the implementation of needle exchange programmes in correctional institutions. Brocato & Wagner (2003:120) assert that these needle exchange programmes aggravate illicit drug use and therefore weaken legitimate efforts in addressing the problem. They also submit that needles are not appropriate for the correctional environment which is characterized by violence. The needles may be used as weapons between inmates and against staff. For example, at Matsqui prison in Abbotsford a correctional officer was attacked by an inmate using a drug injecting needle. The officer was then put on anti-retroviral treatment which had far reaching health implications for him. There was also an incident in an Australian prison where a correctional officer contracted HIV after being stabbed by an inmate with a syringe filled with blood (Darke, Kaye & Finlay-Jones, 1998:1174).

In addition, about 167 incidents of needle pricks of officers by inmates were reported in Canada over a period of seven and half years. A correctional officer was held hostage by inmates with syringes filled allegedly with contaminated

blood. As a result the Union of Canadian Correctional Officers have rejected needle and syringe exchange programmes, fearing more attacks from inmates (Deveau, 2004:1). These incidents demonstrate that such programmes are complex and require careful planning prior to implementation. Murphy and Knowles (2000:1) further equate the provision of needles to drug users with giving matches to pyromaniacs. In sum, these critics are of the opinion that the only way to curb the spread of HIV/AIDS emanating from drug use is to eliminate drug use: this is a fallacy indeed!

Notwithstanding the criticisms, positive results have been linked to needle exchange and syringe programmes in correctional institutions. Stöver and Nelles (2003:437) carried out an evaluation of eleven programmes conducted in the correctional environment and found that the criticisms were unfounded. Leh (1999:61) states that more than 5000 syringes were distributed in a Swiss men's correctional institution over a period of 12 months by means of dispensing machines. No violent incidents were reported where needles were used as weapons and no new cases of HIV were detected. The Center for Disease Control and Prevention in the United States of America also reported that risk taking behaviours reduced by 74% where needle exchange programmes had been implemented. Furthermore, in their evaluation of the prison syringe exchange programme, Dolan et al. (2003:154) noted no syringe related violent incidents.

Hilton et al. (2001:365) also noted that where automatic syringes were provided to inmates at a Swiss female correctional institution, no new cases of HIV were reported among the participants. A cross country evaluation has been conducted in six European countries including Switzerland, Germany, Belarus, and Spain. Overall, such an exchange programme was found to be an effective intervention.

In Switzerland, a decrease was noted in the sharing of needles, drug intake, and HIV prevalence (Riley & O'Hare, 2000:11).

In sum, the advantages of a needle and syringe exchange programme can be tabulated as follows:

1. It reduces risk taking behaviours, such as sharing of drug injecting equipment.
2. It curbs the spread of HIV/ AIDS through the provision of sterile equipment.
3. It enhances individuals' control over their lives and instills a health conscious attitude towards risk taking behaviours.
4. It reduces mortality and morbidity among users.
5. It exposes users to other health referral services and ensures constant contact.
6. It does not undermine abstinence-based programmes; rather its ultimate aim is voluntary abstention (Lines et al., 1994b:vi; Darke et al., 1998:1173; Riley & O'Hare, 2000:12).

3.3.2. SUBSTITUTION THERAPY

Substitution therapy refers to a process in which a less euphoric drug is provided to a drug user as a replacement for an illicit drug. A number of prescription drugs are used in substitution therapy programmes include methadone, buprenorphine, oral palfium, lofexidine, and morphine. Buprenorphine is manufactured with the opiate antagonist naloxone in pill form, thus making it easy to take sublingually. These substitute drugs are used clinically as part of a maintenance medication programme. They maintain the drug dependency level of users at a steady level, reduce health risks and lessen the need to commit crime when users are cash-

strapped. Drug users often commit crime to support their habit (Rosen, Wallace, McMahon, Pearsall, Woods, Price, & Kosten, 1994:149; Brocato & Wagner, 2003:119; Stallwitz & Stöver, 2007:465).

The discourse regarding the use of substitution therapy to address drug use dates as far back as the 1920s. In its report, the Rollerston Committee stated that "morphine and heroin addiction...must be regarded as a manifestation of disease and not as a mere form of vicious indulgence" (Stears, 1997:123). The disease model regards addiction as a genetic pathology (Marlatt, 1996:785) and calls for demand reduction through several interventions including substitution therapy. In 1994, multilateral agencies also unanimously supported the implementation of substitution therapy as the most effective way of addressing drug use (Stallwitz & Stöver, 2007:467). As suggested, methadone is widely used as a substitute pharmacotherapy in a maintenance regimen for drug users that is commonly known as Methadone Maintenance Treatment (MMT) programme.

3.3.2.1. METHADONE MAINTENANCE TREATMENT PROGRAMME

Methadone is a synthetic opioid with properties similar to those of heroin and morphine. Methadone as an opioid agonist is prescribed to drug users for detoxification, prevention of withdrawals and reduction of craving. It is known to be effective in reducing mortality, and morbidity as well as opium and heroin intake among drug users (Langendam, Van Brussel, Coutinho, & Van Ameijden, 2001:774; Hilton et al. 2001:361; Brocato & Wagner, 2003:119). Methadone maintains addiction at a steady level to prevent deeper dependency and stabilizes drugs users pharmacologically (Stevenson, 1994:107; Riley & O'Hare, 2000:9).

The use of methadone as a principal modality for treatment of drug use has gained momentum in Western Europe, although it was developed in the United States. The increased use of methadone was reinforced by the onset of HIV/AIDS (MacCoun & Reuter, 2001:269). Generally, methadone is administered in several dosages ranging from 20-100 milligrams (mg). During the first two weeks of entry into the programme, dosage range from 20-40mg (Hughes, 1999:458). It is said to be effective when dispensed at dosages between 60-100mg per day. Langendam et al. (2001:774) submits that dosage is determined by the threshold level of a user. These levels rank from low, medium to high. Methadone is prescribed at low or medium threshold levels for users who have regulated their consumption. For those who are on a detoxification programme, methadone is prescribed at a high threshold level.

Methadone Maintenance Treatment has been used as a key strategy to address drug use and HIV since the early 1960s within the general Canadian community but not in correctional institutions. It was only introduced in Canadian federal correctional institutions during the 1990s (DiCenso, 2006:3) to bridge the disparity of health services between the general community and the correctional population. This is in line with the principle of equivalence, mentioned earlier, that dictates consistent uninterrupted provision of health treatment services between the community and correctional institutions.

The World Health Organization (WHO) also endorsed the roll out of Methadone Maintenance Treatment from the community to correctional institutions for continuity of care. Such continuity is immediately of great value and benefit to short term inmates as they return quickly to the community upon release. They do not face an interruption of services that may trigger a relapse to irresponsible drug using behaviour (Kerr et al., 2004:351; Luyt, 2007:218; Stallwitz & Stöver, 2007:446). Methadone Maintenance Treatment programmes has been

introduced in several countries such as Australia, Poland, Iran and Switzerland as a response to the mounting problem of drug use and HIV/AIDS.

In Australia, the first prison based methadone maintenance programme was implemented in New South Wales in 1986. It was followed by South Australia in 1990 and Poland in 1992 (Levy et al., 2007:648; Moskalewicz, Barrett, Bujalski, Dabrowska, Klingemann, Klingemann, Malczewski, & Struzik, 2007:505). By 2001, eight countries were identified as having implemented the methadone maintenance programmes in correctional institutions (Darke et al., 1998:1169; Butler & Milner, 2003:125). In his study on harm reduction in Scottish correctional institutions, Luyt (2007:220) reported that Methadone Maintenance Treatment had been introduced to Scottish correctional institutions in 2002. Within a period of two years, numbers of participants in the programme had been increased by about 66%.

Moskalewicz et al. (2007:504) point out that Iran has launched one of the biggest methadone maintenance treatment programmes in the correctional setting with more than sixty clinics and about 8200 participating clients. The Iranian programme has been lauded as successful in reducing the spread of infectious diseases, mortality and recidivism (Heimer, Catania, Newman, Zambrano, Vrunet & Ortiz, 2006:123). To date, prison based Methadone Maintenance Treatment is common in Scotland, Belgium, France, Spain, Austria, Germany, Italy, Australia, New Zealand, Switzerland, as well as some American and Asian countries, excluding Greece and Sweden (Darke et al.,1998:1169; Luyt, 2007:218; Stallwitz & Stöver, 2007:466).

It is important to have the political will and support in order to implement the Methadone Maintenance Treatment in the correctional institutions. In Switzerland there was this commitment to the Methadone Maintenance Treatment

programmes in the clinics which were approved by the Swiss President and the Heads of the Cantonal governments. No negative results were reported rather it was said that this programme enabled users to improve their health, social and economic functioning (MacCoun & Reuter, 2001:289).

The outcomes of making Methadone Maintenance Treatment available to drug users are positive and encouraging. An evaluation of it shows that it is an effective strategy that has tremendous impact on the reduction of the illegal drug trade, and in curbing taking behaviours (Stevenson, 1994:107). An evaluation of a randomized controlled trial of methadone maintenance treatment in an Australian correctional institution yielded positive results showing a tremendous reduction of such behaviours (Kerr et al., 2004:351). The results of other two independent evaluations of the Methadone Maintenance Treatment programme for heroin users showed that methadone was effective in reducing mortality, the spread of HIV and heroin dependence. The Puerto Rican inmates also expressed similar opinions about this programme during an evaluation (Langendam et al., 2001:778; Heimer et al., 2006:127).

Despite the successes of substitution therapy programmes, several shortcomings have also been identified. Amongst others, key challenges relate to treatment modalities, lack of standardization of regulations, duration of the treatment, methods of detoxification, provision of information to users, anonymity of the participants and post incarceration treatment. Upon the release of inmates who have participated in the programme, they usually face long waiting lists at drug treatment community centre and thereby hampering progress already made (Kerr et al., 2004:351). In addition, deprecatory attitudes are often held by staff and management towards substitution therapy programmes. Methadone has been alluded to as another mood altering drug that retards efforts in getting rid of a drug habit (Kerr et al., 2004:351).

Korf & Buning (2000:127) also assert that Methadone Maintenance Treatment replaces one drug of dependence with another. It worsens drug use by prolonging the user's drug career. It is further submitted that some inmates are even reluctant to participate in a Methadone Maintenance Treatment programme because of its addictive nature and useless detoxification process. Hughes (1999:460) reports that one inmate refused to participate in the Methadone Maintenance Treatment programme as she had already experienced withdrawal symptoms whilst detained in the police cells and was afraid that methadone might worsen her situation.

3.3.3. CONDOM PROVISION

A condom is a barrier device made of latex or polyurethane designed to be used during a sexual act as protection. Its purpose is to reduce the transmission of the virus found in the semen. The combination of semen and HIV accelerates the transmission of the virus at a rate five times higher than where there is no semen, hence the need for protection (Boloji.com, 2008:1). Condoms are therefore an important harm reduction component that plays a critical role.

Unprotected sex has been identified as the main route of HIV transmission and therefore as one of the riskiest behaviours (Dolan, Lowe, & Shearer, 2004:124). Despite the well documented evidence of unprotected sexual activities in correctional institutions, the distribution of condoms in correctional institutions is still perceived as a controversial issue (May & Williams Jr., 2002:89; Winkelman, 2006:82). Condoms are generally regarded as contraband in correctional institutions despite their known utility owing to legal and or moral barriers (Estébanez et al., 2002:102; Collica, 2002:104; Hammet, 2006:974; Senok & Botta, 2006:483). As a result, the distribution of condoms in correctional

institutions has been met with mixed reactions; hence they are only available to inmates in some countries (Dolan et al., 2004:124; Krebs, 2006:251; Hammet, 2006:974).

In 1991, the World Health Organization noted that condoms were available in 23 out of 52 correctional systems. In the United States, condoms had been made available only in 1% of the correctional institutions and jails by 2002. They were available in Mississippi, New York City, Philadelphia, San Francisco, Washington DC and Vermont (Spaulding, Lubelczyk & Flanigan, 2001:1177; May & Williams, 2002:85). In Vermont, condoms have been made available to inmates since 1992 even though the correctional regulations prohibit sexual activity (Stöver & Weilandt, 2007:91).

In all Canadian federal correctional institutions, as well as ten out of thirteen provincial institutions condoms are made available to inmates. In the European Union condoms are distributed in two-thirds of the correctional institutions. It is also reported that condoms are available in Thai prisons but their distribution is poor due to the negative attitudes of staff (Wolfe, Xu, Patel, O'Cain, Schillinger, St Louis & Finelli, 2001:1224; Betteridge, 2005:2; Medecins Sans Frontier, 2007:1).

There are several ways of distributing condoms to inmates including vending machines, containers placed at strategic locations for privacy, at health care seminars, and via medical personnel during a consultation. At Washington DC jail, inmates had access to condoms during HIV counselling, weekly health education and counselling sessions as well as from open containers. These containers were discontinued as a result of the personnel taking more condoms than the inmates (May & Williams, 2002:87). In New South Wales, condom packs were distributed by means of vending machines. These packs consisted of

a condom, sealable disposable bag, lubricant, and information leaflet. The leaflet provided instructions for use and disposal to those who received them. It is reported that a total of 294,853 condoms were distributed within eleven months after they had been introduced (Butler & Milner, 2003:132; Dolan et al., 2004:125).

The inmates prefer discreet methods of distribution due to prevalent homophobia and HIV related violence in correctional institutions (Mahon, 1996:1213). In Norway, the Prison Board approved condom distribution to inmates. Scherdin (1994:15) found that inmates were embarrassed to obtain condoms as they were made available in a way that exposed these people. Betteridge (2005:9) also cited lack of privacy as one of the main weakness of condom distribution. In contrast, an evaluation of the distribution of condoms to inmates in New South Wales showed that only 15% of the participants reported ridicule from fellow inmates when accessing condoms, whilst 68% reported no harassment (Dolan et al., 2004:126).

Critics of condom distribution in correctional institutions present several negative allegations. Overall, this is perceived by critics as unethical, immoral and contrary to the grain of corrections. They further assert that in terms of the correctional policies and legislation, sex is prohibited amongst inmates; therefore, distributing condoms in a correctional setting is tantamount to sanctioning the behaviour. In addition, the core business of corrections is to rehabilitate inmates, and not to create conditions conducive conducive to risk taking behaviours, like homosexuality (May & Williams, 2002:124).

It is also reported that condoms encourage sexual assault amongst inmates and also enable sexual predators to dispose of critical DNA evidence required during prosecution. These predators tend to dispose of semen in the condoms. It is also

reported that inmates may use condoms as a repository for contrabands such as drugs (Wolfe et al., 2001:117; Spaulding et al., 2001:1177; Dolan et al., 2004:125). Some correctional authorities in the United States are of the view that since inmates have broken the law and therefore do not deserve protection against HIV through the provision of condoms (Okie, 2007:106).

In contrast, proponents of condom provision assert that condoms prevent the spread of HIV; depriving inmates of condoms does not prevent them from engaging in unprotected sexual activities. Instead providing condoms to inmates facilitates a healthy lifestyle and preservation of their human rights (Blumberg, 1989:8; Arriola, 2006:140). Despite the preventative nature of condoms, there are several challenges relating to condom usage, which may be adversely affected by misuse, lack of know-how, drug use, as well as negative attitudes towards them.

Corsi et al. (2006:650) state that using condoms occurs in an intimate setting and that even when there is increased access; inmates may not necessarily use them for the intended purpose. The misuse of the contents of condom packs by inmates was reported in a New South Wales study. Condom wrappers were used as storage for drugs, lubricants as hair gels, and condoms turned into liquid bombs with urine and or water to serve as weapons during violent incidents (Butler & Milner, 2003:132).

Inmates may not know how to use condoms. The instruction leaflets that are available with condom packs in New South Wales are not commonly supplied. For example, in South Africa condoms are provided in wrappers with no accompanying instructions. The general assumption is that everyone who has access to condoms knows how to use them properly, which is not necessarily true. There may also be slippage and or breakage during the sexual act. Such

breakages if they occur in oral or anal mucosa may expose users to contracting blood borne viruses (King, Brooner, Bigelow, Schmidt, Felch, & Gazaway, 1994:237; Pagliaro & Pagliaro, 1992:207).

Furthermore, sexual victims in correctional institutions do not have any control over the decision of whether to use condoms or not. Such a decision lies with the perpetrator or initiator who may be under the influence of drugs. It has been widely reported that drugs impede condom use during a sexual act. Unprotected sexual activities and drug use are co-morbid. Drugs are said to relax the nerves, removes inhibitions and in some cases improve sexual performance. In a study investigating drug use and sexually risky behaviours in three major South African cities, Parry et al. (2007:105) reported that drug users confirmed unprotected sexual activities when under the influence of drugs. King et al. (1994:231) also notes that there is a low rate of condom use among drug users.

Lastly, negative attitudes about condom usage may be imported into the correctional setting. Generally, men in the general community are unwilling to use condoms in sexual activities due to ego-related factors, stigma, and prevailing negative attitudes. Some men tend to regard condoms as a "sex let-down" (Parry et al., 2007:101). Wojcicki & Malala (2001:149) stated that Southern African men detest using condoms as they view them to be negatively affecting their masculinity and performance during the act. Such masculinity is linked to direct contact with genitalia during the sexual act thus requiring unprotected sex. Given the fact that local correctional institutions are mostly inhabited by males, one may assume that such preconceived attitudes are imported into the institutions. It is therefore critical to implement robust condom provision programmes and awareness programmes in correctional institutions in order to inculcate a totally new paradigm shift.

3.3.4. EDUCATION

Education is the most widely employed method of information dissemination and capacity building both in the general community and the correctional institutions (World Health Organization, 2005:8; Levy et al., 2007:648). Education facilitates provision of information that appeals to the morals of people and instills fear about engaging in risk taking behaviour. Fear arousal messages provide details on adverse consequences emanating from risk taking behaviours, whereas a moral appeal focuses on the wrongfulness of such behaviour. These strategies have varied effects on the target group (Walker, 1994:266). Incarceration presents an opportunity to educate inmates about health care interventions (Lubelczyk, Friedman, Demon, Stein, & Gerstein, 2002:123).

Education assists in developing and improving personal and social skills that enable people to develop resistance to engaging in risk taking behaviours. The purpose of drug education materials with a focus on harm reduction is to enlighten users regarding the risks of drug use as well as to curb the spread of HIV and other blood-borne pathogens. It is not meant to encourage drug use as alleged by critics. Upon the advent of HIV, the thrust of several education programmes was fear arousal. It is said that people changed some of their behaviours but still engaged in risk taking behaviours such as needle exchange and unprotected sexual activities. Informing people about the danger of engaging in risk taking behaviour and the need to consider harm reduction measures without necessarily providing the means is a futile exercise. Levy et al. (2007:648) state that although inmates are informed about the danger of engaging in such behaviours, they are often not provided with the means of applying such knowledge.

In addition, the provision of harm reduction measures like condoms and or syringe kits without the know-how to use them effectively is counterproductive. Therefore, lessons should be offered about how to use them correctly (Leh, 1999:57). In addition, it is a futile exercise to provide education without supplying condoms or sterile injecting equipment (Kerr et al., 2004).

The method of disseminating the information to the target audience is very important. This may be via direct instruction by lecturers, seminars by subject experts, and or focused training by officials or peers (Luyt, 2003:100). The peer education approach is mostly used for health education training. Peer education refers to "as the sharing of information in small groups or one to one by a peer matched, either demographically or through risk behaviour to the target population" (Medley, Kennedy, O'Reilly, & Sweat, 2009:182). Kerr et al. (2004:349) suggest that peer educators are able to speak candidly to their fellow colleagues in a language that is easily understood. Peers command a level of trust and exert a tremendous influence on behavioural change; more than the professionals.

Professionals may experience the difficulty of addressing issues of a personal nature such as sex and drugs, in more details. Furthermore, those engaging in risk taking behaviours may not trust professionals. In contrast, peer educators are on an equal footing with the target audience and they share similar experiences; hence the information is processed easier and quicker. They are able to encourage behavioural changes through their prevention messages (Strike et al., 2002:136). Brook et al. (2006: 270) investigated risky sexual behaviour amongst South African adolescents, focusing on inconsistent condom use and multiple sexual partners. They held that peer driven programmes were the most effective in changing the attitudes of the adolescents.

In most correctional settings, the staff finds it awkward to offer educational programmes with a harm reduction perspective as they have been trained to advocate total abstinence from risk taking behaviours. They need a radical paradigm shift in order to deliver harm reduction services effectively. Hence peer educators are the preferred conveyors of educational messages. The content of the programmes as well as language used is also of utmost importance. The target group should be involved in the design and developing of the curriculum to ensure the relevance of the content (World Health Organization, 2005:8). In seeking behavioural change amongst the affected, their input in programme development cannot be over emphasized. Users' experiences based on factual information can be very powerful (Luyt, 2003:100).

It is vital that the information content should be nonjudgmental and factual for the programme to be successful (Stevenson, 1994:105). Mass advertising with a blanket condemnation such as "Say No to Drugs" has not borne any positive results. Some users or inmates may find such approaches condescending and insulting their intelligence. The language should nonetheless be easily understood in order to be well received. Drug users are largely underprivileged and have received no or little education; therefore bombarding them with complicated drug education programmes is inappropriate and time wasting.

3.3.5. BLEACH DISTRIBUTION

Bleach is a disinfectant used to sterilize drug injecting equipment. It is dispensed in both liquid and tablet form as a harm reduction measure. Its distribution to drug users is common in Europe, Australia, Canada and Scotland. Disinfectants in the form of tablets have been available in New South Wales correctional institutions since January 1990, whereas liquid bleach has been distributed from October 1992. They were obtained from staff and some designated inmates on

request (Dolan et al., 2004:6; Kerr et al., 2004:349; Butler & Milner, 2003:123). In 1991, it was reported that bleach distribution had been implemented in sixteen out of fifty-two European correctional systems. In 1995, the policy as regards the distribution of bleach with instructions for how to use it in Canadian correctional institutions was formally approved. In the Scottish correctional institutions bleach tablets were also distributed for sterilization of the equipment (Luyt, 2007:219).

Bleach is said to be effective as a harm reduction measure, if prescribed cleaning procedures are strictly followed. In New South Wales, a specific cleaning method called 2x2x2 was recommended to inmates. The method prescribes flushing twice with water, twice with bleach, and again twice with water (Dolan et al., 2004:4). The efficacy of bleach as a decontaminating agent has been questioned. It is said that despite repeatedly rinsing with bleach and water, blood still remains in the injecting equipment, thereby exposing users to blood borne virus (Riley & O'Hare, 2000:10).

In their study, Dolan, Wodak, & Hall (1998a:838) found that the bleach programme was adversely affected by operational issues in the correctional institutions. Inmates who requested the bleach were viewed with suspicion and subjected to unnecessary searches by correctional authorities. Also, despite the implementation of the bleach distribution policy, access is still scant. Butler and Milner (2003:124) noted that some of the New South Wales inmates were not aware of the bleach distribution policy. As a result of these challenges, inmates tend to resort to certain other ineffective and dangerous means of cleaning the drug paraphernalia, thus fuelling the spread of infectious communicable diseases.

According to Kerr et al. (2004:350) despite the effectiveness of bleach, several limitations have been identified, inter alia, users forgetting instructions, the time consuming cleaning procedure, reluctance of inmates to use bleach openly for fear of victimization by correctional staff as well as negative attitudes of authorities towards its distribution. Improper use of the disinfectant was a major concern expressed by correctional authorities in New South Wales. As noted, inmates tend to forget the cleaning instructions or do not follow the time consuming 2x2x2 cleaning method. As a result, they do not sterilize equipment properly due to the inherent haste in drug use (Butler & Milner, 2003:124).

The distribution of bleach as a harm reduction component has also been criticized. Critics allege that this is tantamount to condoning illegal drug use, bleach may be used as weapon against staff, and it encourages non-users to experiment with injection drug use. In addition, bleach is said to create a false sense of security between inmates sharing drug equipment. Dolan et al. (1996:157) noted that despite the availability of bleach, evidence showed that it was "an imperfect decontaminant".

3.4. SOUTH AFRICAN OVERVIEW

Africa as a continent is affected equally by rampant drug use and high rate of HIV/AIDS. Africa serves as a pathway for drug trafficking to North America and Europe (Gonsalves, 2006:1). South Africa in particular serves as one of the key conveyor belts : it has been alluded to as the "supplier, receiver, and conduit for drugs". It is reported that after the democratic elections in 1994, South Africa became the drug trafficking transit point for international drug kingpins (Parry & Pithey, 2006:144; Dewing, Plüddemann, Myers, & Parry, 2006:122; Singh & Van Zyl, 2007:123). The drug inflow is attributed to porous borders, lax security at

customs, weak criminal justice processes and law enforcement (Needle, Kroeger, Belani, & Hegle, 2006:85).

The drugs that are commonly used in South Africa are cannabis, mandrax, ecstasy, heroin, dipipanone hydrochloride, methamphetamine, and crack cocaine. Cannabis, mandrax and dipipanone hydrochloride are the primary drugs which are consumed by means of smoking. In contrast, heroin, cocaine hydrochloride and ecstasy can be ingested through smoking, snorting, injecting and or anal insertion (Parry, Carney, Peterson, and Dewing, 2007:4; Carney & Parry, 2008:3). Injection drug use was not common in South Africa, until after 1994 when there was a proliferation of other inject-able drugs. As a result of the continuous drug inflow in South Africa, there has been a steady increase in the use of such drugs.

This now represents a newly acquired culture in South Africa (Ratsaka-Mothokoa, 2003: 2; Legget, 2001:102; Parry et al., 2007:11; United Nations Integrated Regional Information Network, 2007:1). Parry et al. (2007:12) further point out that an affordable inject-able drug commonly known as "nyaope or sugars" which is a mixture of cannabis and heroin is easily available in South Africa, especially in the Gauteng and Kwa-Zulu Natal provinces. At the request of the International Harm Reduction Association the Medical Research Council conducted an assessment of drug use, injection drug use, HIV, and harm reduction in ten Southern African countries including South Africa.

The Council found that injecting drug use was prevalent in Gauteng (40%), Mpumalanga (18%) and Western Cape (9%). There was no evidence of needle and syringe exchange programmes although injecting equipment is available for sale in pharmacies, at a price of between R5 and R10 depending on location (Carney & Parry, 2008:2; Parry et al., 2007:38). Despite this situation, drug use

is highly criminalized and the responses focus on reducing demand and supply rather than harm reduction (Needle et al., 2006:84; Parry & Pithey, 2006:151).

In addition to drug use, HIV in South Africa has reached unprecedented levels. It is estimated that about 5.54 million people in South Africa had already been infected with HIV/AIDS in 2005. To date, it is reported that the epidemic has multiplied at an alarming rate in this country (Legget, 2001:4; Parry & Pithey, 2006:140). Currently, it is submitted that "between 4.9 million and 6.1 million" South Africans are infected with HIV (Luseno & Wechsberg, 2009:178). It is further stated that HIV prevalence amongst injection drug users in South Africa is between 5% and 20% (Carney & Parry, 2008:2). Despite this bleak scenario, the South African response has been plagued with reluctance, denial and failing interventions.

In 1992, there were efforts to develop the National Strategy on HIV/AIDS by the National AIDS Coordinating Committee of South Africa (NACOSA). After the review of the strategy in 1999, a National Strategic Plan (NSP 2000-2005) was developed through a consultative process with stakeholders. The aim of this plan was to improve the response to the HIV that was continuing to ravage the nation. Health policies, charters, and guidelines for addressing HIV were developed as a result of the plan (HIV and AIDS Strategic Plan, 2007-2011:20).

In 2005, the South African National AIDS Council (SANAC) requested the Department of Health to develop a new National Strategic Plan for 2007-2011. This was preceded by the assessment of the National Strategic Plan 2000-2005. The weaknesses identified via the assessment included, amongst others; poor coordination and monitoring, unclear targets as well as vertical programming. There have also been discourses dominated by AIDS denials including those uttered by government platforms. In sum, South Africa's response to HIV/AIDS

has been found to be fragmented and piecemeal despite the well documented prevalence of risk taking behaviours. Different structures in the public and private sector are addressing HIV/AIDS in ways that appeal and are affordable, to them. Hence no synergy exists between private and public agencies working on HIV/AIDS and drug issues (Brook, Morojele, Zhang, & Brook, 2006:259).

Furthermore, there is no effective and coordinated guidance and leadership from government agencies on dealing with the HIV epidemic. Knight (2006:3) stated that "South Africa is the only country in Africa whose government continues to propound HIV theories more worthy of a lunatic fringe than a concerned and compassionate state". Although correctional institutions are a microcosm of the general community, no specific reference is made to inmates in the local National Strategic Plans. They are, to an extent, treated as a marginalized segment of our community. The country is therefore failing in fulfilling its legal and ethical obligations towards inmates.

On the African continent, condoms are banned in most correctional settings due to total prohibition of homosexuality and unwillingness to promote promiscuity amongst inmates. For example, inmates are not accorded access to condoms in Tanzanian and Botswana correctional institutions. The Botswana correctional management is of the opinion that providing condoms to inmates is tantamount to sanctioning homosexuality which is regarded as a "proscribed conduct" (Moloi, 2008:1). This position militates against the World Health Organization's recommendation on HIV in correctional institutions that calls for condoms to be made available to all inmates. Their unavailability of condoms is not a deterrent for unsafe sex (Wolfe et al., 2001:1224).

South Africa is the leading country on the African continent as regards the provision of condoms to inmates, followed by Lesotho. The distribution of

condoms commenced in 1996 after the introduction of the condom policy. The policy was developed inter alia as a response to a lawsuit by an inmate and pressure from the civic organizations (Goyer, 2003:4). It is estimated that the Department of Correctional Services has distributed about 676 621 condoms to inmates between 2006 and 2007 (Carney & Parry, 2008:4). Despite this progress, the method of distribution has been severely criticized.

The local condom distribution policy provides for condom to be made available to inmates after counselling and education on HIV and risk taking behaviours. This indiscreet method of access hampers the supplies of condoms to inmates who are afraid of revealing themselves to correctional authorities as individuals who engage in homosexual activities. They fear stigmatization and intimidation from staff and fellow inmates (Ohaeri, 2000:133; Xinhua News Agency, 2002; Moloji, 2008:1).

In a study conducted on condom distribution at Westville Medium B correctional institution, Goyer (2003:4) found that out of 274 participants only one inmate had accessed condoms through the prescribed route. The AIDS Law Project (2004:1) has called for the introduction of the discreet methods of distribution in order to prevent stigmatization and victimization. In contrast, a survey at a New South Wales correctional institution revealed, that 86% of the inmates reported easy access to condoms (Butler & Milner, 2003: 132). New South Wales is one of the most progressive correctional systems worldwide; therefore it is advisable to consider replicating its practices.

In this study, respondents concede that there is access to condoms at the Leeuwkop Correctional Centre but on a varied scale. In Table 4, it is evident that a total of 63.90% of the inmate respondents agree that it is easy to acquire condoms. In contrast, 78.67% of the staff respondents concede that access to

condoms is unhindered, as reflected in Table 5. There is a margin of difference of 14.77%; consequently one may assume that condom dispensers are placed at locations that are generally not easy for inmates to obtain condoms, as compared to staff. A total of 36.10% inmates, report that condoms are not freely accessible at the Leeuwkop Correctional Centre. The overall findings relating to condom access suggest that it is necessary to improve availability in order to encourage inmates to engage in safe sexual activities.

TABLE 4: CONDOM ACCESS AT LEEUWKOP CORRECTIONAL CENTRE (INMATES, N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	It is easy to get condoms in prison.	30.24	33.66	20.00	16.10

TABLE 5: CONDOM ACCESS AT LEEUWKOP CORRECTIONAL CENTRE (STAFF, N=79)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	It is easy to get condoms in prison.	44.00	34.67	9.33	12.00

Despite the overwhelming evidence of drug use and HIV on the African continent, internationally renowned harm reduction components such as needle and syringe exchange and substitution therapy are not implemented in African correctional institutions, except in Mauritius (Gonsalves, 2006:2). In South Africa, cursory reference is made to the harm reduction measures in the National Drug Master Plan which is managed by the Department of Social Development as well as to the National Strategic Plan for HIV and AIDS.

In section 2.4.4 of the National Drug Master Plan it is provided as follows: "primary prevention and treatment programmes should also include harm reduction, which implies efforts to reduce and prevent the harmful effects of the

use of alcohol and other drugs". The recommendations of internationally renowned organizations as regards implementing harm reduction components in the community and correctional institutions have been largely ignored in South Africa. This reluctance may be attributed to a number of competing priorities such as the overcrowding, violence, under-staffing, corruption, and poor morale prevalent in our correctional institutions.

To date, there is still no firm commitment to implement internationally acclaimed harm reduction strategies such as needle and syringe exchange in addressing drug use. This is generally viewed as an individual problem that should be addressed through abstinence or alternatively law enforcement. Non-governmental organizations are skeptical about references to harm reduction in plans and strategies, as they are of the opinion that government has not clarified its understanding of the concept (UN Integrated Regional Information Network, 2007:2). Furthermore, government has not created an enabling environment for the large scale implementation of the harm reduction components through the development of appropriate policies and legislation.

Locally, inequitable distribution of the limited drug treatment services is evident. These services are offered at the South African National Council on Alcoholism and Drug Dependence (SANCA), Alcoholics and Narcotics Anonymous and rehabilitation centres. These facilities are located in a few urban areas and services are not available in correctional institutions. Private treatment facilities for drug use are also scattered, unaffordable and therefore inaccessible to the general public. As a result, only those with funds enjoy access to these private services (Needle et al. 2006:89; Dewing et al., 2006:131; Carney & Parry, 2008:2).

Health professionals are also not willing to prescribe methadone for detoxification as this is not sanctioned by legislation. In some instances, the expensive drug Subutex is prescribed to users who have the necessary means to afford such a service, although it is illegal. Also, opioid substitution therapy is prescribed on a very limited scale for the detoxification of heroin users (Carney & Parry, 2008:3). In a local study, service providers were asked their opinions on a needle and syringe exchange programme: they provided two conflicting responses. Some were supportive of the programme whilst others were totally opposed to it. More emphasis was laid on education by means of awareness campaigns, information dissemination, and capacity building (Parry et al., 2007:195). It is evident that knowledge regarding harm reduction components is very limited; hence there is a need to extend international networks that will assist in establishing their footprints in the country and in ensuring greater visibility of the components in drug use and HIV strategic and planning initiatives.

3.5. ADVANTAGES AND DISADVANTAGES OF HARM REDUCTION MODELS

3.5.1. ADVANTAGES OF HARM REDUCTION MODELS

- a. Such a model is a cost effective measure to curb the spread of HIV/AIDS. The cost of providing needle and syringe exchange, condoms, substitution therapy, and education is far less than the human and economic costs of HIV/AIDS management. HIV/AIDS has no cure and it is fatal, while AIDS management requires a cocktail of medication which is costly.
- b. Harm reduction components reduces the morbidity and mortality of those engaging in risk taking behaviours.

- c. The said components facilitate constant contact with those who engage in behaviours of this kind. Without the existence of these components it is impossible to determine the extent of risk taking behaviours.
- d. Participation in harm reduction components in the community reduces the likelihood of being incarcerated. Therefore they contribute to the reduction of the inflow of offenders through the criminal justice chain, especially of the overcrowding in correctional institutions, which is currently a major insurmountable problem facing the Department of Correctional Services.
- e. The harm reduction model may contribute to the recent rehabilitative ideal espoused in the amended Correctional Services Act. The core element of the model is that of treating the risk taking behavior, with the ultimate intention of encouraging abstention depending of the individual. Therefore there is a likelihood that, through participating in the harm reduction model one may abstain from risk taking behaviours and exit a life of crime.
- f. The said components encourage consultation with the user and also promote ownership, and decision making amongst participants. The components instill responsibility and restores sense of self-worth.
- g. The implementation of the harm reduction model in correctional institutions protects government from lawsuits. As mentioned, a former inmate has instituted a lawsuit against the Department of Correctional Services as regards contracting HIV/AIDS during incarceration. The argument was that the Department failed to provide protective measures such as condoms despite its knowledge of rampant sexual activities. The matter was resolved by an out-of-court financial settlement.

3.5.2. DISADVANTAGES OF THE HARM REDUCTION MODEL

- a. Harm reduction components may convey the wrong message to participants, as well as the public, that the risk taking behaviours are authorized and condoned.
- b. The components may exert an adverse impact on other deterrent mechanisms. There may be continued drug use and sexual assault in correctional institutions.
- c. Harm reduction models are perceived as morally unacceptable and as militating against well entrenched values and principles. This perception adversely affects the implementation of the models even where they are authorized.

3.6. SUMMARY

Drug use and HIV/AIDS pose a serious challenge to countries on a global scale. Since this challenge has emerged, initiatives have been introduced to address it. The most well known effective strategies that have been implemented in other countries to address risk taking behaviours are user treatment and management (substitution therapy), education, and hygienic innovations to minimize harm (condoms provision, bleach distribution, needle and syringe exchange).

From the above discussion, it is evident that harm reduction models display both advantages and disadvantages. Despite the overwhelming evidence of positive spin-offs, some countries are still reluctant or resistant to implement the models. This emanates inter alia from: lack of political will, legislation, conflicting

perceptions of the authorities as well as from competing national priorities such as poverty, poor health systems, and crime. The emotionally charged commitments to penal measures that demonize the risk taking behaviours have not borne any positive outcomes. It has been argued that HIV transmission has far reaching consequences for both public and correctional health and therefore that programmes should be replicated in the correctional environment (Dolan & Wodak, 1999:14).

The Sub-Saharan approach to drug use and HIV/AIDS is the most archaic and outdated in the world. South Africa criminalizes drug use and yet fails to address fundamental problems. Although there is a commitment to comply with international conventions, not much has been put into practice. In order to understand the need for the implementation of harm reduction measures, the next chapter offers an overview of the prevalent risk taking behaviours, which as mentioned are: unprotected sex, drug use, and tattooing in the correctional institutions. All three of these risk taking behaviours have a direct link to the scourge of HIV/AIDS.

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CHAPTER 4

RISK TAKING BEHAVIOURS IN CORRECTIONAL INSTITUTIONS

4.1. INTRODUCTION

This chapter provides a discussion of three risk taking behaviours prevalent in a correctional environment that fosters HIV/AIDS transmission: as mentioned, these are unprotected sexual activities, drug use (including sharing of contaminated needles and or syringes) and tattooing (Korte, Pykalainen & Seppala, 1998:171; Leh, 1999:54; Estébanez, Zunzunegui, Aguilar, Russel, Cifuentes, & Hankins, 2002:102; Goyer, 2003). This chapter commences with a description of the sample and demographic profile of the respondents as well as a brief overview of the findings regarding the extent of risk taking behaviours at Leeuwkop Correctional Centre. The biographical information of inmates and staff at the Leeuwkop Correctional Centre is contained in Tables 6 and 7.

TABLE 6: INMATE BIOGRAPHICAL INFORMATION (N=209)

Factor	Frequency	Percent
Race		
Black	183	92.89
White	5	2.54
Indian	1	0.51
Colored	8	4.06
Age		
0-23	79	37.80
24-30	60	28.71
31-40	51	24.40
41-50	19	9.09

Marital status		
Married	26	12.62
Single	162	78.64
Remarried	4	1.94
Widow	3	1.46
Divorced once	10	4.85
Divorced twice	1	0.49
Education		
No schooling	2	1.03
Grade 1-7	50	25.77
Grade 8-10	73	37.63
Grade 11-12	47	24.23
Tertiary	22	11.34

The age distribution of the inmates in Table 6 indicates that 37.80% were aged 0-23 years, 28.71% were aged 24-30 years, and the least number (9.09%) were aged 41-50 years. In 2007, out of the total inmate population of 160 712 in South Africa, 38% were aged between 14 and 25 years (Mbeki, 2007:59). Out of a total of 209 inmate respondents in this study, 79 were juveniles and 42 of them were housed at the juvenile section of the Leeuwkop Correctional Centre, whereas 37 juveniles were accommodated with adult inmates in Medium A and Maximum security section. Accommodating juvenile inmates with adult inmates expose them to exploitation.

TABLE 7: STAFF BIOGRAPHICAL INFORMATION (N=79)

Factor	Frequency	Percent
Race		
Black	67	84.81
White	9	11.39
Coloured	3	3.80

Age		
24-30	14	17.72
31-40	47	59.49
41-50	15	18.99
50+	3	3.80
Marital status		
Married	45	57.69
Single	31	39.74
Remarried	1	1.28
Divorced once	1	1.28
Education		
Grade 8-10	11	14.10
Grade 11-12	32	41.03
Diploma/degree student	12	15.38
Completed diploma/degree	18	23.08
Post-grad student	5	6.41

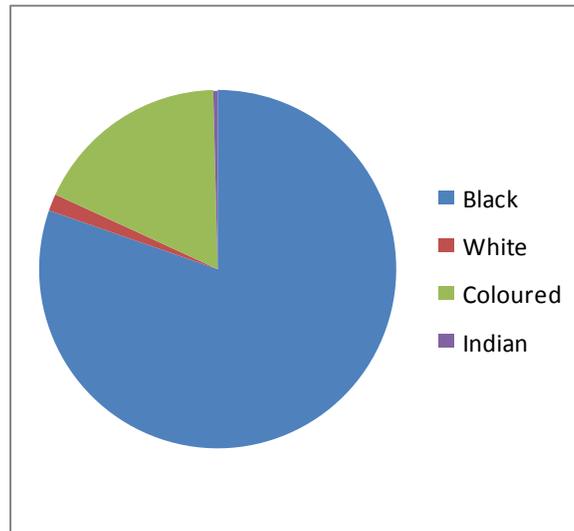
As reflected in Table 7, the majority of the staff fell in the age category between 31 years to 40 years as against the inmates who were largely between 24 years and 40 years. The ethnic breakdown of staff was Black (84.81%), Whites (11.39%) and Colored (3.80%). Similarly, the majority of the inmates were Blacks (92.89%), Whites (2.54%), Colored (8.9%) and Indians (0.51%). The inmate population breakdown also follows the same trend as the general population statistics, with Blacks in the majority (Knight, 2006:1). The inmates' racial breakdown closely resembles that of the correctional population in Table 8 and Graph 2. In comparison with the Gauteng demographics of the general population in Graph 2, the Colored racial group is larger than Whites in correctional institutions.

TABLE 8: SOUTH AFRICAN INMATES RACIAL BREAKDOWN

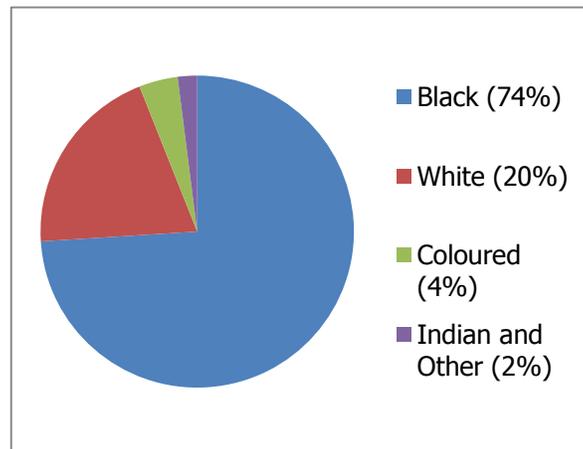
#	Race	Number
i.	Black	129 172
ii.	White	2 471
iii.	Coloured	28 517
iv.	Indian	636

Source: Department of Correctional Services (October, 2008)

GRAPH 1: SOUTH AFRICAN INMATES RACIAL BREAKDOWN

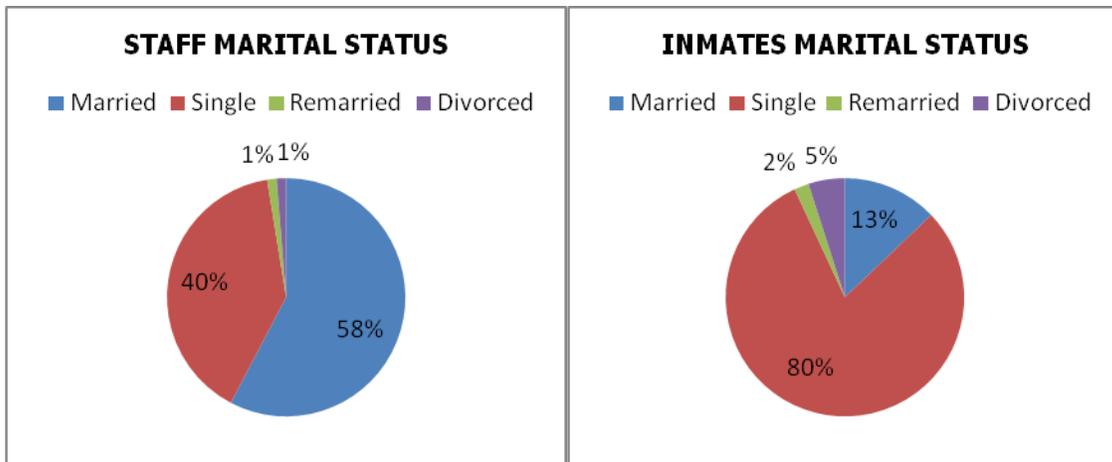


GRAPH 2: GAUTENG DEMOGRAPHICS OF GENERAL POPULATION



The inmate respondents were drawn largely from the school going cohort in order to enable them to read and complete the questionnaire independently. The education level of them was between grade 8 and grade 10. It is imperative to note that there was also a small number (1.03%) of inmates who were not school going. They found their way surreptitiously into the hall where questionnaires were administered. In comparison to inmates, most staff members had a grade 12 qualification, which is the entry requirement for employment of correctional officers. Only 6.4% of the staff had post-graduate qualification indicating the low participation in continuing education after attaining debut degrees. Lastly, as regards the marital status, Graph 3 reflect that 57.69% of staff are married as compared to inmates (78.64%) who are largely single.

GRAPH 3: MARITAL STATUS OF STAFF AND INMATES AT LEEUWKOP CORRECTIONAL CENTRE



NB: The percentages have been rounded off

The concept 'risk' is multi dimensional; there are risks of different types and extent, receiving varied attention (Hay & Sparks, 1992:304). Jones (1976:4) defines risk as "the per capita frequency (rate) at which the occurrence of any kind of harm can be observed, estimated or predicted among a group of persons

over a certain interval of time". In this study, risk refers to harm inherent in incarceration to which inmates are, with specific emphasis on risk taking behaviours. It is important to note that such behaviors represent not only a correctional service challenge but also a volatile phenomenon for public health. The following discussion of the key risk taking behaviours provides a basis for the need to consider and implement harm reduction components in order to curb the spread of blood borne viruses in correctional settings.

4.2. SEXUAL ACTIVITIES

Sexual activities are a reality among inmates, whether consensual or coercive in nature (Saum, Surrat, Inciardi, and Bennet, 1995:414; Valette, 2006:89; Leh, 1999:59). Sex is part of a normal pattern; it is both a biological and a psychological need. Inmates are human beings with the full range of feelings, emotions, and needs. Therefore, sex is as important a need for the inmate as it is for the general community. The inmate population is a single sex fraternity comprising of sexually active individuals whose sexual outlet has been abruptly interfered with because of confinement (Caldwell, 1971:81; Luyt, 2003:96). As stated by Solursh et al. (1993:50) "heterosexuals still need to have sex whether they are incarcerated or not". Therefore, it is unrealistic for one to expect inmates to function within a framework of sexual denial.

Notwithstanding the available evidence, the subject of sex behind bars has been shrouded in secrecy from time immemorial (Solursh et al., 1993:439; Struckman-Johnson et al., 1996:67). Fishman (1934:5) also observes that there has been a "dreaded silence" about the prevalent sexual activities in correctional institutions. The correctional authorities are reluctant to publicly acknowledge sex amongst inmates as it reflects poor management and lack of inmate control (Goyer, 2003:18). In addition, the correctional authorities rarely acknowledge the serious

extent of sexual activities behind bars; hence the public remain ignorant of and oblivious to the serious plight of inmates (Booyens, Hesselink-Louw, & Mashabela, 2004:1).

In addition, sexual activities in correctional institutions are criminalized which further fosters secrecy. Both consensual and coercive sexual activities are prohibited in correctional institutions so that anyone found engaging in such activities runs the risk of being subjected to stringent disciplinary measures (Eigenberg, 2000:416; Bick, 2007:112). For example, in Malawi same sex activities are prohibited by legislation and punishable (Booyens et al., 2004:6). Saum et al. (1995:427) state that this restriction ensures that the staff maintains safety and security; indeed, this is a fallacy which distorts the realities of incarceration.

As a result of this approach, the statistics recorded should be treated with extreme care and regarded as conservative as they are only indicative of the problem (Cotton & Groth, 1982:48; Dumond, 2000:408). Booyens et al. (2004:5) state that "victims of sexual abuse do not report, thus leading to a dark figure". Any investigation of the prevalence of sexual activities in correctional institutions is largely dependent upon inmates' self reports. The results may be jeopardized by unwillingness to provide the required details (Cory, 1971:92; May & Williams, 2002:86). Inmates are reluctant to report sexual abuse due to fear of reprisal, stigmatization of the victims, and the lackadaisical attitude of the correctional staff (Struckman-Johnson & Struckman-Johnson, 2000:380; Butler & Milner, 2003:133; Goyer, 2003:18). It is therefore difficult to quantify the frequency of sexual activities among inmates with precision (Kantor, 2003:4; Weinbaum, Sabin, & Santibanez, 2005:42).

Struckman-Johnson & Struckman-Johnson (2000:379) regard the prevalence of sexual activities amongst inmates as one of the most elusive statistics in correctional history. Generally, correctional authorities do not keep statistics of sexual activities that come to their attention; they usually dismiss or shrug off such reports. Also, although rape is said to be prevalent in South African correctional institutions, the Department of Correctional Services does not keep statistics (Booyens, Hesselink-Louw, & Mashabela, 2004:2). It is evident that correctional authorities are faced with dealing with a monster of unknown dimensions.

Saum et al. (1995:429) also questions the veracity of the reports on sexual activities in such a setting. They allege that these reports are exaggerated, informed by anecdotes and sensational reports. Saum et al. (1995:417) further state that "overall analyses of sexual activity in prisons have been inconsistent and inconclusive". But despite these challenges, there have been numerous attempts to quantify homosexuality behind bars.

A social worker at a local correctional institution in Kwa-Zulu Natal province confirmed that homosexuality is rife amongst inmates Booyens et al. (2004:5). Furthermore, inmates and staff at the Zomba, Blantyre, and Lilongwe correctional institutions in Malawi revealed that homosexuality takes place despite its prohibition (Jolofani & DeGabriele, 1999:7; Goyer, 2003:19). Homosexuality may be the result of consensual relationships, prostitution, and or promiscuity (Caldwell, 1971:81). Homosexuality is therefore a significant behavioural pattern in correctional institutions despite its denial by the correctional authorities and prevailing repressive laws (Jürgens, 1994:116).

No inmate is immune from homosexual attacks, but some are more vulnerable than others. The most vulnerable inmates include newly admitted young,

inexperience and frail looking individuals, non-gang members and those who have already been sexually victimized by fellow inmates. The newly admitted inmates are usually unfamiliar with the correctional terrain and its uniquely demanding lifestyles and are therefore prone to being exploited (Dumond, 2000:408; Gear, 2005:1; Wolff, Shi, Blitz, & Siegel, 2007:538).

The vulnerable inmates engage in coercive homosexual activities with bullies in order to secure protection from being abused by other aggressive inmates. Goyer (2003:33) reports that a 15-year old juvenile attested to being a sex slave of a gang member in return for protection from other bullies. Once vulnerable inmates give in during the first sexual attack, they find it difficult thereafter to get out of the 'fraternity of homosexuality' or sex slavery owing to fear (Caldwell, 1971:82; Inciardi, 1987:566; Gear, 2005:2).

It is also reported that young inmates are often offered to adult inmates by correctional staff for good behaviour. A former young inmate reported the following experience during a survey:

"He was presented to an entire wing of the prison as a bonus to the convicts for their good behaviour...In this wing any prisoner who wanted his services at any time for any purposes was given it, the guards opening doors, passing him from one cell to another, providing lubricants, permitting two convicts to have simultaneous sexuality (oral and anal) when desired and arranging, for those requiring some privacy"(Scacco, 1975:31).

The above incident may result from collusion between corrupt staff and powerful inmates with the aim of appeasing inmates who are incorrigible. Weaker inmates are turned into 'wyfies' (prison wives) in exchange for tender loving care from 'husbands' (Gear, 2005:3). The abuse of vulnerable inmates is pervasive in most

correctional systems. Table 9 shows that Leeuwkop Correctional Centre is not an exception.

TABLE 9: ABUSE OF VULNERABLE INMATES AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	If you are weak you will become a wyfie (prison wife).	45.69	36.04	11.17	7.11
ii.	Prisoners can buy food and goods with sex in prison.	32.66	43.72	11.56	12.06

In this study, abuse of vulnerable inmates was assessed via the items reflected in Table 9. A total of 81.73% out of 209 inmate respondents conceded that vulnerable inmates are forced to be sexual slaves in the form of 'wyfies' (prison wives), with 45.69% of the respondents affirming this strongly. In addition, sex is used as a prime currency; with 76.38% of the respondents confirming that it does occur. Similarly, Dissel (1996:8) conducted a study on prison conditions in two local institutions, Leeuwkop Correctional Centre and Modderbee Correctional Centre. She found that vulnerable, young inmates were coerced into sex by gang members. In some instances, bribes were utilized to coerce the victim into sex.

Most inmates stem from economically challenged families; hence they cannot be adequately provided for during their incarceration. They therefore resort to any means of survival, including being sexual slaves or prostitutes in exchange for food and goods. The same sex correctional facilities create an environment conducive to vulnerable inmates being sexually exploited. Those found vulnerable are either manipulated or coerced into becoming objects of sexual malpractices.

A number of studies estimate that the proportion of sexual activities in international correctional institutions amongst inmates ranges between 4% and 90% (Horsburgh, Jarvis, McArthur, Ignacio, & Stock, 1990; Olivero, 1992; Bick, 2007; Dunn, Loranjeira & Marins, 2000; Krebs, 2002; May & Williams Jr, 2002; Seal et al., 2004; Weinbaum, et al., 2005). Weinbaum et al. (2005:42) estimated that oral or anal sexual activities among inmates ranged from 4% to 30%. In a study conducted in a large Brazilian prison, it was found that 10% of 917 inmates reported having had sex with fellow inmates (Dunn et al., 2000:48). Furthermore, about 15.6% of the 80 participants confirmed engaging in sexual activities whilst serving sentence during an investigation into inmate sexual behaviour (Seal et al., 2004:782).

In addition, in a Tennessee-based study 17% of former inmates reported having engaged in sexual activities during their incarceration (Horsburgh et al., 1990:210). At Oklahoma maximum security prison, about 25% of inmates confirmed that they had engaged in sexual activities (May & Williams, 2002:86). Similarly, the reports of the Federal Bureau of Prisons indicate that 28% of inmates in federal custody engaged in sexual activities (Olivero, 1992:39). Krebs (2002:31) estimated that about 44% (n=121) of inmates engaged in sexual activities, based on a survey conducted in a South Eastern correctional facility.

Similarly, several studies and anecdotal evidence have confirmed the prevalence of sexual activities in local correctional institutions (Parry et al., 2004:100; Booyens, 2008:225; Judicial Inspectorate of Prisons Annual Report, 2007/2008). Commenting on the prevalence of sexual activities in correctional institutions, the former President of the South African Prisoners Organization for Human Rights (SAPOHR), who is also a former inmate, reported that "inmates are sodomized everyday and every night" (Lazarus, 2002:82). In the Annual Report of the

Judicial Inspectorate of Prisons (2007/2008:32) it is reflected that approximately 60% of inmates confirmed that sexual abuse is prevalent amongst inmates, albeit at different levels. Table 10 demonstrates that sexual activities do also take place at Leeuwkop Correctional Centre.

TABLE 10: PREVALENCE OF SEXUAL ACTIVITIES AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	Some prisoners have sex in prison.	43.07	47.52	4.95	4.46
ii.	Prisoners ask each other all the time for sex.	22.11	33.67	28.14	16.08
iii.	People in prison have sex every night of the week.	13.64	25.25	29.80	31.31
iv.	I know prisoners who have been approached to have sex with another prisoner	8.46	16.92	20.90	53.73
v.	You can buy food and goods with sex in prison	32.66	43.72	11.56	12.06

As illustrated in Table 10 above, four items were used to assess the prevalence of sexual activities. Although 90.59% of the respondents reported that certain inmates do engage in sex at the correctional centre, a total of 61.11% disagreed that inmates do so on a frequent basis. In addition, 55.78% stated that inmates ask each other all the time for sex whereas in contrary, 74.63% deny knowledge of fellow inmates being approached to have sex. As stated earlier, it is generally difficult to obtain accurate and honest responses from inmate respondents on questions of intrusive personal nature relating to risk taking behaviours. A contradiction is evident here.

Also, 76.38% of the inmates in this study confirmed that inmates engage in commercial sex commonly known as 'survival sex' (Erickson, Bastani, Maxwell, Marcus, Capell, & Yan, 1995:478). 'Survival sex' refers to the exchange of sexual favors for food, cigarettes and other scarce items in the correctional institutions. This is consistent with other studies where it is reported that inmates regularly trade sexual favors for food and goods (Zacharia, Harries, Chantulo, Yadidi, Nkhuma & Maganga, 2002:618). Inmates come from diverse background mostly punctuated by poverty and homelessness (Gaiter & Doll, 1996:1201), a factor that contributes to participation in sexual acts. As a result, not all inmates receive visitors and they tend to rely on those who are adequately cared for by their loved ones. In 'commercial or survival sex' the power relations are not balanced between the initiators of sex and victims. Invariably, the indigent inmates who are offered or asking for goods and food from others cannot negotiate the use of condoms during sexual activities.

The dichotomy between consensual and coercive sex amongst inmates is difficult to discern (Gear, 2005:5). It is reported that correctional staff also find the difference between these two types of sex blurred and confusing (Sisco & Becker, 2007:581). Inmates tend to use both overt and covert ways of luring others into sexual activities. In some instances, newly admitted inmates are offered basic necessities by experienced inmates before being coerced into sexual acts as payment for 'debt' created unknowingly (Gear, 2005:1). Booyens (2008:218) states that a 21-year old inmate reported that he was sexually assaulted during the night after being lured with food and cigarettes. Other inmates prostitute themselves owing to poverty, in order to gain access to basic necessities, and therefore expose themselves to risky sexual activities (May & Williams, 2002:86).

Some inmates may appear to be in a consensual relationship when in actual fact they have submitted to advances because they are afraid of the consequences of not doing so, such as gang rape or incessant sexual victimization (Eigenberg, 2000:421). Intimidation by predators prevents the victims from reporting such incidents to the correctional authorities (Banbury, 2004:125). Out of six inmate sexual assaults mentioned during research in a local correctional institution, three incidents were not reported to the authorities (Booyens, 2008:218).

Several studies provide evidence of the prevalence of consensual sexual activities in correctional institutions (Chen, Callahan, Kerndt, 2002; Gyamarthy, Neaigus, & Szamado, 2003). In their investigation of syphilis and HIV at a Los Angeles male facility, Chen et al. (2002:1474) noted that there was consensual high risk sex among inmates. Gyamarthy et al. (2003:561) also reported that many Hungarian inmates engaged in consensual risky sexual activities. Also, there is a general practice amongst South African inmates to create temporary enclosures with blankets called 'mkhuku' in which consensual sex mostly takes place (Prison sex....2005:1).

Most sexual activities in correctional institutions are said to be with multiple partners. Teplin, Mericle, MacClelland, & Abraham (2003:906) studied the behavioural patterns of detainees in relation to the HIV epidemic and found that more than 90% were sexually active, while about 60.8% engaged in sex with multiple partners. Turnbull et al., (1991:26) also reported that inmates who engaged in homosexual activities had multiple partners with a mean average of 2.8 partners. This enhanced the transmission of communicable diseases such as hepatitis and HIV/AIDS. During a survey on group sexual assaults, one of the respondents reported the following:

"...two inmates came into my room (prison cell) and told me to give it up. When I refused they started hitting me. When I still refused they pulled a knife and

threatened to kill me. They made me perform fellatio on one of them while the other sodomized me. They then switched. Then one of them performed fellatio and told me I would die. It happened a few times so I checked into protective custody”(Struckman-Johnson et al., 1996:72).

Sexual assault of both an oral and anal nature by more than one predator exposes the victim to communicable diseases.

The occurrence of sexual activities in correctional institutions is said to be quick and opportunistic. Inmates select certain hidden places and certain time slots for sexual interaction to evade the attention of the correctional authorities (Solursh et al., 1993:441). Sexual activities take place when an opportunity presents itself in the cells, ablution facilities, showers, work areas, during periods of low supervision or when lenient or lazy officers are on duty. In a local study, inmates confirmed that sexual activities took place in showers adjoining the cells. Also, most sexual activities usually take place during the night between fellow inmates. Predators attack victims in their sleep (Seal et al., 2004:781; Banbury, 2004:124; Booyens, 2008:218).

Sexual activities among male inmates are mostly of an oral and /or anal nature (Struckman-Johnson et al., 1996; Inciardi, 1987:567). Out of six European correctional institutions investigated in one study, anal sex was reported in four facilities (Rotily et al., 2001:247). Anal intercourse is very risky and has been recognized as one of the key modes of HIV transmission (Pagliaro & Pagliaro, 1992:204). The mucous lining of the rectum is susceptible to rupturing and any tearing during the sexual act facilitates quick transmission of blood borne viruses. Struckman-Johnson et al. (1996:75) conducted a study on sexual assaults in correctional institutions and found that 52% involved anal sex whereas only 8% were of an oral nature. An inmate asserted the following during an interview:

"I had a roommate who told me he would kill me if I didn't let him have anal sex. He pinned me to his bed and put all his weight on my legs with them in the air"
(Struckman et al., 1996:75).

The above excerpt illustrates that victims are unwillingly subjected to anal penetration during sexual assaults and therefore run the risk of contracting HIV/AIDS and Hepatitis. Table 11 reflects that most inmates at Leeuwkop Correctional Centre engage in sex of an anal nature.

TABLE 11: TYPES OF SEXUAL ACTIVITIES AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	Prisoners prefer to have anal sex with one another.	32.50	43.00	14.50	10.00

This finding from the study shows that anal sex is the preferred form of intercourse. From the above table it is evident that a total of 75.50% of the respondents reported that inmates prefer anal sex. This is in line with the results of international studies on the types of sex amongst male inmates (Seal et al., 2004; Turnbull et al., 1991; Singh & Verma, 2004). In a survey conducted by Seal et al. (2004:781) participants reported 75% anal sex and 68.8% oral sex. Turnbull et al. (1991:25) interviewed former inmates on risk taking behaviours during incarceration. They found that 26 men reported having engaged in sex during their incarceration while 22 had had anal intercourse. Singh and Verma (2004:181) studied sexual behaviour and condom usage in high risk groups including inmates. They found that 20.69% of the inmates engaged in anal sex. Sexual activities of an anal nature are common occurrences during rape.

Rape is a fairly common occurrence in correctional institutions perpetrated mainly by gang members. Gang activities are largely violent and contribute largely to the prevalence of risk taking behaviours in correctional settings (Goyer, 2003:5). Gang members use rape as punishment and /or a control mechanism. Several authors (Struckman-Johnson, Struckman-Johnson, Rucker & Bumby, 1996) have reported the prevalence of coercive sexual activities amongst inmates, albeit on a different scale. In an anonymous survey conducted at Nebraska prison, Struckman-Johnson et al. (1996:74) found that 22% of inmates had been sexually assaulted. In addition, an officer in a Nigerian correctional facility confirmed that rape is a common occurrence (Ikuteyiyo & Agunbiade, 2008:286).

TABLE 12: COERCIVE SEXUAL ACTIVITIES AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	Some gangs will rape people to punish them.	19.40	40.80	18.91	20.90
ii.	Gang leaders choose who they want to have sex with.	24.75	36.63	16.34	22.28
iii.	Some prisoners will force you to have sex with them.	16.58	22.11	25.13	36.18
iv.	Prisoners get raped in the cells at night.	14.93	30.85	27.86	26.37

Gangsterism is one of the key features of correctional life, particularly in South Africa. Gang members are known to be engaging in risk taking behaviours, inter alia sexual assault, in furtherance of their gang activity. It is evident in this study that Leeuwkop Correctional Centre is not an exception. According to Table 12 about 60.20% of the respondents admit that gang members commit sexual assaults against fellow inmates. Also, 61.38% of respondents indicate that gang

members bully others into sexual activities. Gang members have the liberty to choose their victims. It is during such acts that victims are prone to contracting communicable diseases. In developing harm reduction measures, a specific focus should be placed on gang members in order to salvage the lives of other inmates.

From the findings reflected in Table 12, it is evident that 61.31% of the respondents refute the view that force is used during sexual activities. Similarly, about 54.23% disagree that inmates are subjected to coercive sexual activities at night. In contrast, about 60.20% of the respondents agree that fellow inmates are raped by gangs as a penal measure. This is an anomaly as force is used in rape situations; therefore the respondents have contradicted themselves. The argument that inmates are unreliable sources when it comes to information of a personal intrusive nature is therefore supported.

Overwhelming evidence exists with regards to the prevalence of HIV/AIDS in correctional institutions largely due to risk taking behaviours. It is reported that the rate of HIV/AIDS in the United States of America is higher among inmates as compared to the general community (Seal et al., 2004:775). Similarly, it is noted that in South Africa HIV/AIDS prevalence in correctional institutions is twice as high as in the community. In a study conducted in a local correctional institution on HIV/AIDS, it was found that 30% (n=271) of inmates were HIV positive (Gear, 2005:4).

The unprotected sexual activities and illicit drug use are closely related (Goyer, 2003:13). Generally, drugs impair one's judgment; therefore one is more likely to engage in risky sexual activities after taking drugs. Also, vulnerable inmates may resort to drugs as a coping mechanism for repeated sexual abuse. The debates on risk taking behaviour behind bars began with a specific focus on

homosexuality and gradually slanted towards intravenous drug use. For example, in the late 1980s, the prevalent behavioural risk factor associated with HIV/AIDS in New York gradually shifted from homosexuality to intravenous drug use (Gido, 1989:27). In addition, this type of drug use is alluded to as the key risk factor and main route of HIV transmission, primarily due to the sharing of contaminated equipment (Blumberg, 1989:3; Backmund, Meyer, Schuetz, & Rainer, 2006:154). The following discussion provides a concise analysis of drug use among inmates.

4.3. DRUG USE

This is a well-known problem within the criminal justice system, especially in correctional institutions (Korte et al., 1998:171; Berman, 2004:38; World Health Organization, 2005:3). One's access to drugs and consumption does not stop as soon as one enters the gates of a correctional facility (Leh, 1999:54; Heimer et al., 2006:123). Correctional institutions are at the end of the criminal justice value chain (Senok & Botta, 2006:1); hence they are not immune from the flow of drugs. These institutions accommodate awaiting-trial offenders and sentenced inmates after they have been handled by law enforcement and the courts (Luyt, 2008:176). Offenders and inmates generally find a way of bringing drugs into the institutions.

There is ample evidence that drug use is widespread in correctional institutions (Jürgens, 2000; Einat, 2005; Snacken, 2005; Heimer, Newman, Zambrano, Brunet, & Ortiz, 2006; Berman, 2004). Jürgens (2000:3) cites studies where it was found that the use of drugs among inmates ranged from 11% to 75% of them. It is also submitted that drug use among Israeli inmates is so common to an extent that it is alluded to as "the backbone of the inmate subculture" (Einat, 2005:294). Similarly, the Belgian correctional institutions were found to be

replete with illicit drugs. It is estimated that about 50% of the inmates engage in drug use while approximately 15% of inmates were intravenous drug users (Snacken, 2005:325).

Furthermore, about 71.4% out of 12659 Puerto Rican inmates reported continued use of drugs during incarceration (Heimer et al., 2006:123). Also, drug use was estimated to be within the range of 5% to 54% in European correctional institutions (Berman, 2004:37). Access to drugs in a correctional institution is deemed to be fairly easy. Despite tight security measures at correctional institutions, drugs still find their way inside. During an inmate survey conducted in New South Wales, 78% of male participants confirmed that access to drugs was very easy (Butler & Milner, 2003:122). This inflow of drugs can be attributed to several courier agents.

According to Jürgens (1994:114) and Inciardi et al. (1993:126) drugs enter correctional institutions on a daily basis via several agents including visitors, correctional personnel, newly admitted inmates, and awaiting trial inmates from court appearances. Sarang et al. (2006:1789) also state that drugs change hands between inmates and legal representatives during consultations. During an interview, the former Chairman of the local Parliamentary Portfolio Committee on Correctional Services, Mr Bloem, said that "prison warders and the public often smuggled drugs...and other illegal substances into prison" (Mati, 2006:6). In some instances, correctional staff provide drugs to inmates as a sign of appreciation or when seeking favours from them.

The methods of smuggling drugs into the correctional institutions are varied. Drugs are smuggled through any item brought into a correctional institution whether edible or inedible. For example, drug couriers hide drugs in bread, garment linings and in balloons kept in the mouth and exchanged through bodily

contact with an inmate. In an attempt to combat the inflow of drugs, some correctional institutions prohibit an exchange of items or bodily touch between inmates and visitors (Snacken, 2005:325).

The proliferation of drugs in correctional institutions is a mirror of the situation in the general community. For example, South Africa is experiencing a dramatic increase in drug availability and use. Goyer (2003:30) attributes increased drug inflow to the Nigerian drug syndicates operating in the country. The situation became worse due to borders and ports that are replete with weak security controls that fail to detect the inflow of drugs into South Africa (Dewing et al., 2006:122). Lastly, Interpol reports show that out of the cannabis seized in the world, the largest consignment was from Southern Africa (Saah, 2005:1).

Inmates tend to start using drugs during incarceration in order to relieve anxiety, boredom, and helplessness and reduce insomnia (Kevin, 2005:15; Stöver & Weilandt, 2007:88). During a study at an Irish correctional institution, inmates reported that they used drugs to relieve boredom and affiliate themselves to a certain group (Long et al., 2004:143). Inmates also import drug use patterns from the community into the correctional setting (Blumberg, 1989; Shewan, Gemmel & Davies, 1994; Dolan, Wodak, Hall, Gaughwin, & Rae, 1996; Keene, 1997; Korte, Pykalainen, and Seppala, 1998; Luekfeld, 2002). Shewan et al. (1994:203) investigated the drug using behaviour of inmates at four Scottish adult prisons. They found that out of 234 inmates, 32% had a history of intravenous drug use prior to incarceration. In addition, almost half of the inmates surveyed in New South Wales reported a history of drug use (Dolan et al., 1996:152).

Keene (1997:343) investigated custodial and non-custodial drug use in a Welsh correctional facility using 134 male inmates. The findings show that 74% of the

respondents utilised drugs prior to imprisonment. Korte et al. (1998:171) conducted another study on the prevalence of drug use at four Finnish prisons. Out of a total of 354 respondents, 136 inmates confirmed drug use at some point in their lives. In a survey conducted under the auspices of the United States Department of Justice, Luekfled et al. (2002:715) found that 57% of the Kentucky male inmates reported using drugs prior to incarceration. Lastly, Stohr et al. (2009:296) report that in 1998, 70% of the inmates were found to have regularly used drugs prior to incarceration.

Despite the challenges, anecdotal evidence and several studies (Plourde & Brochu, 2002; Small et al., 2005) provide evidence that drug use is a feature of incarceration. Canadian inmates from ten federal correctional institutions confirmed using cannabis and heroin during their incarceration (Plourde & Brochu, 2002:48). The following excerpt from an interview with an inmate during a survey on drug use attest to the abundance of drugs in a correctional institution:

"Its [drug use] part of the lifestyle. I mean if you're an addict, and you are in prison- especially in BC. It's part of the environment. There is always dope in prison in BC, always. I've always chipped [injected] when I've been inside".....In prison any day you want heroin, you can get it" (Small et al., 2005:834).

TABLE 13: DRUG USE AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i	Prisoners use drugs in prison	33.17	38.05	12.68	16.10

The majority of the respondents (71.22%) confirm that drug use is rife within the Leeuwkop Correctional Centre, as reflected in Table 13 above. Inmates use

different types of drugs during their incarceration. Their drug of preference is informed by availability, access and cost. The drugs that are generally available in correctional institutions are cannabis, heroin, and cocaine, which may be consumed through smoking, snorting, and injection. Empirical evidence shows that cannabis is the recreational drug most widely used by offenders and inmates (Korte et al., 1998; Plourde & Brochu, 2002; Butler & Miller, 2003:121; Goyer, 2003; Stöver & Weilandt, 2007:171). Bennet & Holloway (2007:40) conducted a urinalysis of offenders and detected that 48% of them used cannabis as compared to methadone (7%). The proportion of smoking cannabis amongst the South African offenders was found to be more than 40%: it is the most widely used drug in South Africa (Legget, Louw, Parry, & Pluddermann, 2004:155).

At the local Durban Westville Medium B correctional facility, 72% of the inmates reported using cannabis as against only 5% of them who asserted they used mandrax (Goyer, 2003:31). Korte et al. (1998:171) also reported that 68% of the Finnish inmates used cannabis, 37% heroin and 20% cocaine during their incarceration. In their study, Plourde and Brochu (2002:53) found that 91% of the inmates reported using cannabis as against 6% heroin during their incarceration. The drug use patterns of the New South Wales inmates have likewise been recorded as 68.7% cannabis and 15.3% cocaine (Kevin, 2005:1).

Table 14 depicts a breakdown of the type of drugs used by inmates in Netherlands, the United States of America, and Scotland. Cannabis ranks very high in all three countries as a preferred drug of choice for inmates. In comparison with the Netherlands (55%), the level of its use by inmates in Scotland (71%) and the United States of America (71%) is very marked. Of note, is that the levels of cannabis use in Finland (68%), South Africa (72%), Scotland (71%) and the United States (71%) are almost similar, with a very small margin of difference. The degree of reporting on the extensive use of cannabis can be

attributed to the fact that it is easily detectable through urinalysis even after a month, unlike heroin which lasts for only a very short period in the user's system (Luyt, 2007:215).

TABLE 14: PATTERNS OF DRUG USE AMONG INMATES: AN INTERNATIONAL PERSPECTIVE

Country	Level of use	Type of drug
Netherlands	55%	Cannabis
Netherlands	37%	Heroin
Scotland	71%	Cannabis
Scotland	14%	Cocaine
United States of America(California, Missisipi, Rhode Island, & Wisconsin)	71%	Cannabis
	35.0%	Cocaine
	18.8%	Heroin

Sources: Korte, Pykalainen, & Seppala (1998), Seal et al., (2004), Luyt (2007)

Injection drug use is speedily gaining momentum in Africa. It is reported that the mostly commonly employed injecting drug used around the world is heroin the use of which presence is increasing tremendously in Africa (Luyt, 2007:206; Dewing et al. (2006:122). Heroin is not of African origin and therefore its availability can only be due to weak customs and lax border controls. Equally, injecting drug use is imported into local correctional institutions from the community, as reflected in the following table:

TABLE 15: INJECTING DRUG USE AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
ii.	Some prisoners inject themselves with	12.44	31.84	26.37	29.35

drugs in prison.				
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A total of 44% of inmates answered this question in the affirmative. As illustrated in Table 15, a significant majority (56%, n=209) did not agree that inmates inject themselves. The presence of a degree injecting drug use at the Centre serves as testimony to the new drug culture which has also been transferred from the community. Although intravenous drugs are too pricy and therefore out of reach for the indigent segment of society that is populating the correctional institutions, the intractable habit still permeates the correctional environment (Goyer, 2003:31).

The sharing of injecting drug equipment is a social activity which is part of the drug culture. This is normative, common and signifies a stronger bond among drug users (Sarang et al, 2006:1791). Des Jarlais, Friedman, & Strug (1986:120) also argue that the sharing of the injecting needles symbolizes a “close, caring, and family relationship”. The sharing of the equipment is a significant drug related risky behavior (Dewing et al., 2006:121; Bennet & Holloway, 2007:64).

It is important to note that sharing is not a risky behaviour per se but that it is the sharing of non-sterilized injecting or drug preparation equipment that is highly problematic. The compulsion or urge to use drugs usually supersedes the need to protect oneself. The method of injection employed by intravenous drug users predisposes them to contracting HIV. An intravenous drug user draws blood into the injecting equipment in order to mix it with the drug. Thereafter, the drug is injected back into one’s vein. Therefore, during needle exchange there is direct blood to blood contact which facilitates the transmission of HIV. As Olivero (1992:38) states, drug users tend to use instruments that are not sanitized to inject drugs into the veins. Also, it is unlikely that the equipment will be sanitized before sharing as the cleaning ingredients are also contraband in

most correctional institutions (Swartz, Lurigio, & Weiner, 2004:487). Therefore, the likelihood of the spread of HIV is very high.

There is an increased rate of sharing non-sterilized drug injecting equipment among inmates, as compared to the general community (Darke, Kaye, & Finaly-Jones, 1998:1170). Empirical evidence support that needle sharing is rife in correctional institutions (Carvell & Hart, 1990; Dolan et al., 1996; Butler & Milner, 2003; Small et al., 2005; Stephens, Braithwaite, & Conerly, 2005; Sarang et al., 2006). Carvell & Hart (1990:1384) conducted a study on risk taking behaviours among incarcerated drug users. They found that out of 50 respondents 26 inmates reported having shared the injecting equipment. Dolan et al. (1996:152) also established that ten out of eleven HIV infected inmates who were injecting drug users shared injections during incarceration.

In New South Wales, Butler and Milner (2003:121) reported that 67% of 154 male inmate drug injectors shared the injecting equipment. Furthermore, Stephens et al. (2005:68) report that more than 80% of the drug injecting inmates in a Georgia correctional institution reported having shared the drug injecting equipment. In addition, a survey of inmate drug use in New South Wales, showed that 80.0% (n=36) of injecting drug users shared the equipment. Also, out of 15% of the first time users, more than three quarters had done so (Kevin, 2005:15). Looking at HIV infection and risk behaviours among Bangkok inmates, Thaisri et al. (2003:4) found that 333 out of 351 inmates shared drug injecting equipment with other users.

Lastly, in a study conducted by Sarang et al. (2006:1788) on drug use of 1000 Russian inmates it was reported that of the 26% injection drug users, 65% shared injecting equipment. The following anecdote from an 18-year old male

inmate provides evidence of sharing contaminated injecting equipment and transmission of HIV and Hepatitis:

"With drugs it is possible to hide them, somehow, somewhere, but well, how do you hide a syringe? So, if someone somehow got hold of a syringe-maybe they brought it in or stole it from medical centre - then it was just super achievement. Then that syringe would do the rounds and rounds and rounds of the whole camp. And then you get loads of syphilis, AIDS and....Someone would shoot up once and then in the course of the next 2 months about 20 people would be in the isolation ward with viral hepatitis" (Sarang et al., 2006:1790).

As indicated, inmates who are drug users belong to injecting groups where the sharing of contaminated injecting equipment invariably occurs. Any refusal by the member of the group to share the equipment with others may cause him to be ostracized by fellow users. During a study conducted by Small et al. (2005) one inmate stated the following regarding needle sharing:

"It's a nightmare. Equipment like syringes is in very, very short supply. You see syringes that have literally been around for months and months, if not years...patched and repaired, used over and over and over and over again. I am sure that many, many cases of HIV were transmitted because of those practices....sharing. Everybody shares" (Small et al., 2005:835).

In sum, the sharing of such equipment amongst inmates can be largely attributed to the scarcity of sanitized needles and maintenance of camaraderie amongst users. The scarcity fosters the sharing and contributes to the spread of blood borne viruses (Jürgens, 1994:114; Long et al., 2004:139).

TABLE 16: SHARING OF INJECTING EQUIPMENT AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
iii.	Those who inject drugs in prison share needles with other prisoners.	17.09	35.18	26.63	21.11

The above finding in Table 16 depicts that 52.27% of the respondents agree that there is sharing among fellow inmates. This is also an indication that there a certain amount of injecting drug use at the facility. Since a cleaning solution is not available in the local correctional institutions, transmission of blood borne viruses is likely. Evidence demonstrates that the sharing of drug injecting equipment may also be imported from the community. In their study, Dewing et al. (2006: 131) found that sharing was common among heroine users in Cape Town community.

The inmates use needles or any equipment to inject drugs into their body. Despite the known presence of drugs in correctional institutions, all needles including sterile needles are regarded as contraband in most institutions, especially in Africa and the United States. Most correctional policies outlaw distribution as well as possession of injecting equipment by inmates. As a result, inmates tend to be creative and innovative especially where access cannot be gained through smuggling from outside. They manufacture handmade needles from any available material, be it hollow pens, eye droppers, soda cans, and used toothpaste tubes (Inciardi, Lockwood, & Quinlan, 1993:126; Small et al., 2005:836).

The structure of the handmade injecting needle makes it difficult to clean. It tends to have dull and narrow points and hence it is impossible to get rid of all the blood before passing it to the next user (Stöver & Weilandt, 2007:104). It is thus easier to transmit HIV from one user to another through contact with other

users' blood residue. In addition, the sharing is not only limited to the drug injecting equipment, it but also extends to the paraphernalia used to prepare the drug solution such as the drug cookers, containers and filtration cottons. In Miami, the HIV virus was found in filtration cottons and drug cookers. This finding confirms the potential for viral transmission via drug preparation equipment (Hagan, Thiede, Weiss, Hopkins, Duchin, & Alexander, 2001:34).

In a survey conducted by Seal et al. (2004) on drug use, inmates stated the following about their attitude to needle sharing and HIV transmission:

You don't have time to sterilize needles in the joint.... A majority of the people that do that [inject drugs] may have life without parole. They ain't got nothing to lose.... Shoot up. I am going to die anyway. They [injection drug users] know they got HIV. They don't care. They don't give a fuck...How you gonna give everybody needles in prison to use drugs when you are not supposed to use drugs in jail?"(Seal et al., 2004:780).

The above excerpt confirms that the consumption of drugs is a hasty activity done in secrecy. There is also an element of a lackadaisical attitude amongst inmates which predisposes users to engaging in risk taking practices. Generally, drug users engage in unprotected sex and risky injection-related behaviours (Corsi, Kwiatkowski, & Booth, 2006:656). Drug use and the sharing of drug injecting equipment are categorized as the second set of HIV risk factors to incarceration after unprotected sex (Rivers, 1993:233). The link is confirmed in several studies (Fitzgerald, Purington, Davis, Ferguson, Lundgren, 2003; Andia, Deren, Robles, Kang, Colon, & Finlinson, 2005; Marquat, Merianos, Cuvelier & Carrol, 2009).

As a result of the 'war on drugs' approach used in the United States of America, intravenous drug users constitute the majority of inmates with HIV/AIDS in all

states. In 1989, the HIV prevalence amongst inmates was estimated at 362 per 100,000 as compared to 18 per 100,000 in the community (Marquat et al., 2009:748). Andia et al. (2005:330) state that “of all the AIDS cases diagnosed in 1999 in New York State Department of Corrections, 84% were reported to have acquired HIV infection through injection drug use”. Fitzgerald et al. (2003:108) also report that injection drug use is closely linked to HIV.

Clarke, Stein, Hanna, Sobota, & Rich (2001:209) further contend that incarcerating drug users contributes to the increasing number of people living with HIV behind bars. In their study of drug use and HIV infection among inmates, Beyrer et al. (2003:154) found that having been incarcerated is an important independent risk for HIV infection among Thai male drug users, especially intravenous drug users and men engaging in sex with men (MSM). They state that Bangkok intravenous drug users who have been incarcerated were more likely to be HIV positive than those who have not been incarcerated.

Lastly, in addition to unprotected sexual activities and drug use in correctional institutions, inmates also engage in tattooing, which poses an additional health risk for contracting HIV and or any blood borne disease (Berman, 2004:38; Manuel & Retzlaff, 2002:522; Kevin, 2005:20; Medecins Sans Frontieres, 2007:1).

4.4. TATTOOING

Tattooing refer to the act of inserting a colouring substance into the layers of the skin with a sharp object in order to make a mark (tattoo) for decorative or other reasons (Wikipedia.org/wiki/tattooing). The mark is usually of a permanent nature performing a certain symbolic function. In this study, tattoos refer to

marks of affiliation with a group used by inmates. Tattooing in correctional institutions is part of a strong inmate subculture (Estébanez et al., 2002:102). A cross sectional survey of six European prisons as regards risk behaviours showed that tattooing proportions ranged between 6% and 43% among inmates (Rotily et al., 2001:247).

Amongst inmates tattoos carry out a complex symbolic function. They may be a sign of toughness; and masculinity or indicate the affiliation of an individual to a particular group or a gang. In South Africa, gangs are named after numbers with prominent ones being 26, 27, and 28. The gang members wear insignia that links them to a particular gang (Luyt, 2003:94). The insignia is mostly inscribed on the visible parts of the body such as arms, chest and legs. The 26-gang specializes in obtaining goods through unscrupulous means whereas the 28-gang focuses on sexual exploitation and abuse of vulnerable inmates (Goyer, 2003:36; The Problem of AIDS...1998:15).

The tattooing culture is either imported into the correctional environment or acquired during incarceration. Krebs (2006:115) estimated that about 45% of inmates in Canada acquired a tattoo during incarceration. Likewise, in a national survey of inmates in England and Wales with respect to prison tattooing, Strang, Heusten, Whiteley, Baccus, Maden, Gossop, & Green (2006:60) found that 21% of 1009 participants acquired tattoos whilst serving a sentence. Furthermore, Khan et al. (2005:1797) looked at Hepatitis B prevalence among inmates and established that almost half of the participants had been tattooed during their incarceration. Out of 58% (n=747) inmates wearing tattoos in New South Wales study, 42% reported having acquired tattoos in the correctional institution (Butler & Milner, 2003:114). Lastly, Goyer (2003:32) also submits that about 50% of 3 100 inmates at a local institution were tattooed during incarceration.

TABLE 17: TATTOOING ACTIVITIES AMONGST INMATES AT LEEUWKOP CORRECTIONAL CENTRE (N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
ii.	Most prisoners I know had tattoos before they came to prison	20.59	41.67	22.06	15.69

Table 17 reflects that 62.26% of the respondents report that most tattoos were acquired prior to incarceration. This may be true as the South African community is replete with gang activities. Krebs (2006:255) also submits that tattooing is part of the pre-incarceration life of the inmates. Generally, inmates belong to street gangs prior to incarceration where they acquire tattoos. For example, at the Cape flats in the Western Cape there is a gang called the 'Americans' which is similar to the 26s gang operating in correctional institutions (Eggington, 2009:13). Therefore, the tattoos that the 'Americans' wear in the community also serve as their identity insignia of their membership of the 26s during their incarceration. However, certain tattoos are explicitly linked to incarceration (Luyt, 1994:49). This would mean that although some tattoos had been acquired when this study was conducted, they may have resulted from a former period of incarceration. In such instances the potential for harm increases even more.

Primitive and unprofessional tattooing is said to be an integral part of the inmate subculture (Kantor, 2003:5; Goyer, 2003:16; Laticevschi, 2007:46). Generally, there are no professional tattooists or approved tattooing equipment in correctional institutions. As a result, inmates tend to use make-shift equipment or needles for making tattoos (Olivero, 1992:39). The needles are usually smuggled from health care centers and or vocational workshops. Where access is impossible, inmates obtain other items and use innovative ways to manufacture make shift drug injecting equipment.

Generally, inmates use paper clips, staples, pen barrels, sewing needles, toothbrush handles, guitar strings or even any sharp instrument picked up during gardening chores to manufacture make-shift tattooing equipment. These items are turned into tattoo guns through various methods, for example, a pen barrel which holds the pigment is connected to a needle or its substitute used to make a mark on the skin. It is reported that inmates in Scottish correctional institutions used guitar strings for doing so (Luyt, 2007:213). The pigments used in tattooing include soot, dirt, and charcoal, ash from burnt rubber bands, shoe polish and ballpoint ink (Kantor, 2003:5; Butler & Milner, 2003:114; Goyer, 2005:32; Laticevschi, 2007:46; Medecins Sans Frontieres, 2007:1; Luyt, 2003:94).

Tattooing in correctional institutions is a potential source of HIV transmission. Unsafe tattooing practices are rife amongst inmates (Estébanez et al., 2002:102). Via tattooing, inmates experience percutaneous exposures to blood borne virus thus facilitating contracting it (Bick, 2007:112; Arriola, 2006:140; Strang et al., 2006:60). In correctional institutions, tattooing is carried out mostly with contaminated needle substitutes that are often shared. This again increases the possibility of transmitting blood borne infectious ailments like HIV and Hepatitis (Braithwaite, Braithwaite, & Poulson, 1998:108; Beyrer et al., 2003:154; Butler & Milner, 2003:114).

4.5. Summary

The risk taking behaviours are closely linked to a range of health related challenges. This chapter has provided an exposition of the three most prevalent such behaviours. Incarceration per se exposes inmates to the harm, emanating from these deleterious activities. Risk and harm reduction is central to the responsibilities of the correctional authorities. It is therefore critical to assess the risk as well as devise effective and appropriate harm reduction measures.

One may reasonably glean from the findings on risk taking behaviours at Leeuwkop Correctional Centre, that it is equally faced with the prevalence of these behaviours. The correctional institution provides a unique opportunity to deal with these behaviours through comprehensive harm reduction components. Such intervention will benefit both the correctional environment and the general community, especially since many inmates do return home after serving their sentences. Notwithstanding the recommendations of the international agencies such as UNAIDS and the World Health Organization (WHO) to implement harm reduction components in correctional institutions, countries are still reluctant to do so, and this is a sad state of affairs.

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CHAPTER 5

KNOWLEDGE LEVELS OF INMATES AND STAFF AS REGARDS HIV/AIDS

5.1. INTRODUCTION

HIV/AIDS as an epidemic has occupied the centre stage in public health and many political discourses. It has also presented several challenges to the correctional community. AIDS has been reported as the leading cause of mortality in correctional institutions (Long, 1998:28). As a result, there are vigorous debates on the utility of the harm reduction components with regards to curbing the spread of HIV in the correctional environment. The vulnerability to being HIV infected during the incarceration largely depends on the person's knowledge of HIV/AIDS and the prevalent risk taking behaviours (Akhtar, Luby, Rahbar & Azam, 2001:351).

Education is perceived as the primary form of HIV prevention, as argued below. Given the absence of a cure, education plays a pivotal role in fighting the AIDS epidemic. Without concerted efforts regarding education in this respect, the epidemic will continue to increase to unprecedented levels (Long, 1998:2; Katjavivi & Otaala, 2003:1). Currently, education is widely used to disseminate information with regards to HIV/AIDS both in the public and correctional settings. The education of inmates in this respect, HIV/AIDS enhances their knowledge, exposes them to possible behavioural modifications, and reduces fear of being infected, thus contributing towards curbing the prevalent risk taking behaviours associated with HIV/AIDS in correctional institutions (Hogan,1994:221; Martin, Long & West, 1995:6; Collica, 2002:103; Kourelakis, Power, Gnardellis & Agrafiotis, 2003:105; Oyewale, 2008:16; Katjavivi & Otaala, 2003:5).

This chapter provides an outline of HIV/AIDS related knowledge levels of inmates and staff. The specific knowledge domains covered herein include; the meaning of HIV/AIDS, general awareness of this syndrome, modes of HIV transmission, HIV prevention methods, sources of HIV/AIDS knowledge and attitudes towards the pandemic. The knowledge assessment section of the questionnaire is modelled on the AIDS Knowledge and Attitudes Questionnaire (AKQA) previously used by Long (1998) on inmate populations in the Pennsylvania correctional system. The knowledge scale in this study consists of a total of 26 items; with 23 items measuring HIV/AIDS covering the above mentioned knowledge domains and three items gauging the attitudes towards HIV/AIDS.

A total of 22 items offer choices between two responses, 'true' or 'false'. The correct responses are calculated to produce a knowledge score while incorrect responses are indicative of a 'knowledge gap' score. A single item deals with sources of HIV/AIDS and offers a choice of six subsets from which respondents have to select any applicable response. The three items dealing with attitude towards HIV/AIDS were based on the Likert scale with the four response categories being 'strongly agree', 'agree', 'strongly disagree', and 'disagree'. For the analysis, the 'agree' and 'strongly agree' responses are collapsed into affirmative answers whereas the 'disagree' and 'strongly disagree' responses collectively represent negative answers.

The concept 'knowledge' is defined in various ways. According to Hornby (2000:658) knowledge may be defined as "understanding and skills acquired through education and experience". Furthermore, Houaiss and Salles (2001:802) as cited in Ernesto (2007:19) define knowledge as "the theoretical and practical mastery of a subject". In addition, Oyewale (2008:37) states that there are two forms of knowledge namely; conceptual and procedural.

The conceptual knowledge refers to a “connected web of knowledge (a network) in which linking relationships of the discrete bits of information about a phenomenon are made”. Procedural knowledge is defined as “the knowledge exercised in the performance of some task” (Oyewale, 2008:38). In sum, knowledge can be referred to as the acquisition of factual information regarding a subject by means of education with the ability to apply it intelligently to make a difference. In this study, knowledge refers to a general understanding of HIV/AIDS and the ability to use such information for specific purposes: the prevention and management of HIV/AIDS. It is critical for persons to possess a basic understanding of HIV/AIDS in order to survive the scourge.

HIV/AIDS is a very formidable major public health problem ravaging all populations on a global scale. Approximately 25 million people worldwide have died as a result of HIV related diseases since 1981, with about 66% stemming from Sub-Saharan Africa. As a result, this region is alluded to as the epicentre of the HIV pandemic (Ntombela, Stillwell & Leach, 2008:73; Dijkstra, Kangawaza, Martens, Boer & Rasker, 2007:636). According to the prevalence studies in the Sub-Saharan countries, South Africa houses the highest number of HIV infected people. (Katjavivi & Otaala, 2003:2; Condon & Sinha, 2008:37).

AIDS first became apparent in South Africa around 1983. To date, it is estimated that one in 8 to 10 adults is HIV positive (*City Press*, 2008: 14; Moosa, 2009:16). It is further estimated that approximately 5.7 million South Africans were HIV positive as at the end of 2007, and of these approximately 18.1% were 15 to 49 year old individuals. This is the cohort which forms the core of the inmate population. This is a devastating situation that requires urgent attention (Mwamburi, Dladla, Qwana & Lurie, 2005:518; Delva, Pretorius, Temmerman,

2009:639; Matjila, Hoosen, Stolz & Cameron, 2009:91; Buys, 2009:143; Grundlingh, 2009:239).

It is worth noting that there is significant under-reporting, owing to a number of reasons, *inter alia*, stigmatization and fear of victimization. On the African continent, being HIV positive carries a stigma; hence the prevalent fear of being victimized (Okonkwo, Reich, Alabi, Umeike & Nachman, 2007:252); consequently the level of HIV/AIDS might be greater than the above mentioned statistics. South Africa contains a population of 47.9 million with the number of incarcerated inmates and awaiting trial detainees estimated at 162095 as at the end of October 2009 (Ncana, 2009:13). The site of this study is in the Gauteng province, which is the most densely populated province with an estimated population of 9.6 million. There are 26 correctional centres in Gauteng with a capacity of 26709 and an inmate population of 44 833 as at 2004 (Luyt, 2008:5).

Generally, it is estimated that the rate of infection amongst inmates is six times higher than in the general community (Keeton & Swanson, 1998:119; West, 2001:20). However, in the South African correctional centres the precise extent of the HIV prevalence is illusive. This is owing to the lack of mandatory testing, and scanty records on HIV cases. Earlier attempts to quantify HIV/AIDS rates amongst inmates have been met with resistance from the Department of Correctional Services (Luyt, 2008:148). Despite the resistance, there have been attempts to do so. Lanier (2009:63) estimated that approximately 41% of the inmates are living with HIV.

The HIV/AIDS knowledge levels of South Africans have been found to be varied. The Human Sciences Research Council (HSRC) noted the HIV/AIDS knowledge gaps amongst the less educated people. In some instances, the awareness of HIV/AIDS was high yet respondents exhibited inadequate knowledge regarding

prevention methods and whether AIDS is curable. In another study, high school learners knew the basics of HIV/AIDS but lacked knowledge of the modes of transmission and preventive strategies (Grundlingh, 2009:244).

AIDS has no cure; hence HIV is the most difficult retrovirus to deal with. It appears in one's immune system in various forms. Also, the virus constantly mutates and multiplies itself; as a result it is impossible to treat the syndrome with a single drug or a vaccine (Hammet, 1988:17). Since there is no cure for AIDS, education has been alluded to as one of the most important harm reduction strategies that can be employed to address this epidemic (Nyamathi, Bennet, Leake, Lewis & Flaskerud, 1993:65; Collica, 2002: 103; Koulierakis et al., 2003:103). Feucht, Stephens & Gibbs (1991:10) submit that "in any health crisis, the reduction of risk depends greatly upon the level of knowledge among those at risk'.

However, Martin et al. (1995:26) cautions that providing HIV information per se cannot be expected to bring change. They suggest that inmates should be taught risk reduction skills, provided with the opportunity to practice such skills, and lastly, be accorded access to risk reduction resources, in order for the acquired knowledge to make a significant difference. Therefore, individuals need in-depth knowledge of HIV with accompanying practical and access to harm reduction components in order to effectively deal with the prevention and management of HIV/AIDS (Reader, Carter & Crawford, 1988:125; Al-Owaish, Moussa, Anwar, Al-Shoumer & Sharma, 1999:172).

In sum, adequate HIV/AIDS knowledge is critical as it enhances better management of the disease and care for the infected. The amelioration of risk taking behaviours and the curbing of consequent HIV affliction to a greater extent depends on the knowledge acquired by those at risk as well as their

application thereof. The following discussion provides a description of these knowledge content areas: the meaning of HIV/AIDS, basic knowledge about it, HIV transmission routes, and HIV prevention methods. Lastly, the chapter delineates sources of information and the attitudes of inmates and staff towards HIV/AIDS. It is important to score the AIDS knowledge questions according to content areas in order to identify issues that require intensive efforts to improve knowledge (Keeton & Swanson, 1998:121).

5.2. THE MEANING OF HIV/AIDS

It is essential for persons to know the meaning of the acronyms as this serves as a foundation of HIV/AIDS knowledge. A brief explanation is as follows:

- a. HIV:** It is a virus (V) that attacks the immune (I) system of a human (H) being and makes it weak, that is, Human Immunodeficiency Virus.

- b. AIDS:** It is an acquired (A) virus that makes the immune (I) system deficient (D) and presents itself as a syndrome (S). The virus renders the body incapable of fighting a set of opportunistic infections (Whiteside & Sunter, 2000:1).

Tables 18 and 19 consist of two items to check whether the respondents have a basic understanding of the acronyms. The questions require affirmative responses to indicate sound knowledge levels in this respect. Negative responses are the indicator of a knowledge deficit.

TABLE 18: MEANING OF HIV/AIDS (INMATES, N=209)

No.	Items	Correct Response	True	False
i.	HIV means Human Immunodeficiency Virus	True	86.70	13.30
ii.	AIDS means Acquired Immunodeficiency Syndrome	True	89.55	10.45

TABLE 19: MEANING OF HIV/AIDS (STAFF, N=79)

No.	Items	Correct Response	True	False
i.	HIV means Human Immunodeficiency Virus	True	85.90	14.10
ii.	AIDS means Acquired Immuodeficiency Syndrome	True	89.61	10.39

From Tables 18 and 19, all the respondents show a basic understanding of the meaning of both acronyms, although minimal knowledge deficits are still evident. The incorrect responses with regards to the meaning of both abbreviations range between 10.39% (inmates) and 14.10% (staff). The two items were mostly answered correctly. The level of correct understanding of the concept HIV/AIDS ranges from 85.90% to 89.61% for all the respondents. The correctional staff should be purveyors of correct information and represent a major source of knowledge; therefore the deficits noted therefore call for intensive efforts to bring all correctional staff to the desired level of knowledge.

It is generally expected that some inmates would indicate a knowledge deficit in this regard owing to their social background. Inmates largely stem from groups of out-of-school youths who have missed out on HIV programmes that are part of the structured learning environment in the community. Inmates drop out of school for various reasons, including poverty, loss of interest, and failure to meet academic requirements (Haigler, Harlow, O'Connor, & Campbell, 2004:41; Francis & Rimmansberger, 2009:604). In this study, findings on the education

levels of the inmate respondents reveal that 64.43% have studied up to grade 10. It is highly likely that they mostly started studying after their incarceration.

5.3. BASIC KNOWLEDGE OF HIV/AIDS

It is widely reported that HIV causes AIDS. HIV is a viral agent that attacks the white blood cells (T4 cells), weakens the immune system, and progresses into full blown AIDS over a number of years (Hammet, 1988:3). Adequate knowledge on HIV/AIDS enables one to invoke preventive strategies and manage the condition effectively if infected. The nine items in Tables 20 and 21 measure basic HIV/AIDS knowledge of inmates and staff at the Leeuwkop Correctional Centre, respectively. The range of responses requires either affirmative or negative responses depending on the content. Items (ii), (iv),(vi),(vii), and (viii) require 'false' as an answer to be considered correct whereas items (i), (iii), (v) and (ix) require 'true' as a response to indicate an acceptable level of knowledge.

TABLE 20: BASIC KNOWLEDGE OF HIV/AIDS (INMATES, N=209)

No.	Items	Correct responses	True	False
i.	AIDS is caused by HIV virus	True	91.30	8.70
ii.	AIDS is a condition you were born with	False	8.29	91.71
iii.	AIDS is a medical condition in which your body cannot fight off diseases	True	75.13	24.87
iv.	All people who have HIV are sick with AIDS	False	35.29	64.71
v.	AIDS weakens the ability of the body to fight off disease	True	80.20	19.80
vi.	AIDS can be cured and people recover from it	False	21.67	78.33
vii.	AIDS can be cured by having sex with a virgin	False	12.20	87.80
viii.	All gay people have AIDS	False	4.58	95.42
ix.	HIV is carried in men's semen	True	45.45	54.55

TABLE 21: BASIC KNOWLEDGE OF HIV/AIDS (STAFF, N=79)

No.	Items	Correct responses	True	False
i.	AIDS is caused by HIV virus	True	92.41	7.59
ii.	AIDS is a condition you are born with	False	6.58	93.42
iii.	AIDS is a medical condition in which your body cannot fight off diseases	True	80.77	19.23
iv.	All people who have HIV are sick with AIDS	False	22.08	77.92
v.	AIDS weakens the ability of the body to fight off disease	True	89.87	10.13
vi.	AIDS can be cured and people recover from it	False	16.67	83.33
vii.	AIDS can be cured by having sex with a virgin	False	7.59	92.41
viii.	All gay people have AIDS	False	2.53	97.47
ix.	HIV is carried in men's semen	True	61.84	38.16

Overall, the majority of all the respondents answered all the items correctly. The scores of all the respondents show that they are knowledgeable regarding the aetiological agent of AIDS. As indicated in Tables 20 and 21, most of the respondents (91.30%-inmates to 92.41%-staff) know that AIDS is caused by the HIV virus. Only 7.59% (staff) to 8.70% (inmates) responded incorrectly to the statement regarding whether AIDS is caused by HIV. Generally, this knowledge deficit may be attributed to the misinformation that was transmitted by government agencies after the onset of AIDS. For example, the initial government response to the HIV/AIDS epidemic in the country perpetuated flawed and dangerous myths.

It has been widely reported that the former State President, Honourable Thabo Mbeki publicly denounced the link between AIDS and HIV at the World Conference on AIDS in 1999 (Condon & Sinha, 2008:35; Lanier, 2009:61). Therefore, this statement may have caused a ripple effect with regards to the general misunderstanding of HIV/AIDS. Equally in other African states, the response to the HIV pandemic in the early 1980s was that of denial which

exerted an adverse effect on the level of HIV knowledge. For example, as a consequence of the denial the HIV knowledge level of the correctional staff in Nigeria was found wanting. They were found to display the same knowledge deficit as the inmates (Ikuteyijo & Agunbiade, 2008:287).

Another knowledge deficit concerning the aetiology of HIV was also noted in a study conducted on AIDS and prostitution at a city jail for women, where 83% of 23 respondents knew that AIDS is caused by a virus (Beatty, 2005:73). Sweat and Levin (1995:357) investigated knowledge about AIDS in detail among the US population. They found that although most respondents (62.9%) knew that AIDS was caused by the HIV, about 11% still did not know this. Ikuteyijo and Agunbiade (2008:282) conducted a study on HIV institutional policies, HIV knowledge levels, and risk taking behaviours in two Nigerian correctional institutions. They established that 67.6% (n=341) revealed a deficit of knowledge regarding basic AIDS issues.

No one is born with AIDS: it is an acquired virus. There has to be an exchange of bodily fluids for one to contract HIV. For example, there has to be contact with infected blood, semen, vaginal secretion, and breast milk (Whiteside & Sunter, 2000:3). The responses to the question regarding whether 'AIDS is a medical condition you were born with' as reflected in Tables 20 and 21 above indicate that the majority of the respondents exhibit a high level of knowledge that AIDS is an acquired disease. A total of 91.71% of the inmates and 93.42% of staff refuted that AIDS is a congenital condition.

In addition, there is a distinct difference between having AIDS and being HIV positive. HIV positive individuals do not necessarily develop AIDS, which is entirely dependent on one's immune system. HIV can be dormant in one's system for a period of approximately 10 years before there is progression to full

blown AIDS status. The process of HIV infection is that the virus enters one's body and attaches itself to the CD T-cells which are normally 1200 per micro litre of blood and at this stage the person becomes HIV positive. It is only after the virus has depleted the cells to approximately 200 per micro litre when it is said that one has AIDS (Whiteside & Sunter, 2008:8).

It is at this stage, the infection has to be closely monitored through repeated medical checkups, as failure to do so may result into morbidity and mortality. The responses in Tables 20 and 21 show that there are recognizable knowledge gaps amongst inmates and staff in terms of the question that 'all people who have HIV are sick with AIDS'. The inmates (64.71%) indicated a slightly lower percentage of correct responses than that of the staff (77.92%). It is of concern that more than 20% of the staff reflects a knowledge deficit relating to the difference between HIV and AIDS.

In contrast, a study conducted on HIV knowledge amongst Scottish inmates indicated that the majority 82.5% (n=559) revealed a clear understanding that 'having AIDS and being HIV infected are not the same', as compared to 64.71% (n=209) in this study (Power et al., 1993:15). In addition, it is reported that some inmates regarded HIV and AIDS as being synonymous, a testimony that they do not know the difference (Gunter, Snach-Alridge & Moss, 1993:14). It is therefore vital to improve knowledge of both local inmates and staff regarding the stages of HIV and the inherent differences between HIV and AIDS.

There is no cure or vaccine for HIV and its sequelae (Martin et al., 1995:6; Al-Owaish et al., 1999:163; Grundlingh, 2009:239). In this study some respondents believe that AIDS is curable. The affirmative responses to the question 'AIDS can be cured and people recover from it' were 16.67 % (staff) to 21.67% (inmates). These responses are incorrect and given the inherent fatality attributed to AIDS,

the knowledge deficit requires urgent intervention. Similarly, in a comprehensive study on HIV knowledge, attitudes, beliefs and practices in Kuwait, 11.5% (n=2219) reported that there was a vaccine for AIDS.

The responses of all the respondents to the question of whether 'AIDS can be cured by having sex with a virgin' show that the majority are knowledgeable in this regard. Nevertheless, a knowledge deficit is still evident in that 7.59% (staff) and 12.20% (inmates) responded affirmatively, which may result from the myth prevalent among African men that having sexual contact with a virgin cures AIDS. This myth is largely blamed for the reported infant sexual abuse perpetrated by adults in South Africa.

It is widely reported that the first cases of AIDS were found among gay people; the virus was acquired through male-to-male sexual transmission. Those who had been infected developed rare types of pneumonia (*pneumocystis carini*) and cancer (Kaposi's sarcoma). Later, information became available that heterosexuals had also been infected. Notwithstanding this additional information, myths that AIDS only affects gay people prevailed (Hammet, 1988:3; Tewksbury, Vito, & Cummings, 2006:230). In this study, a larger percentage both inmates (95.42%) and staff (97.47%) exhibited accurate knowledge regarding the statement that 'All gay people have AIDS'; that is, they responded negatively to the statement. This clearly indicates that myths previously held about gay people and AIDS have been successfully dispelled.

Furthermore, it is common knowledge that HIV is transmitted through sexual contact (Whiteside & Sunter, 2000:10; Williamson & Martin, 2005:115) since the semen also carries the virus. The responses to the statement on whether 'HIV is carried in men's semen' indicate that there is a serious knowledge deficit in this respect among both the inmates and the staff. As compared to the staff

(61.84%) who responded correctly to this statement, only 45.45% of the inmates did so, which suggests that more education on this aspect is required for both the inmates and the staff. Such knowledge is important in order to employ preventive measures such as consistent use of condoms.

Finally, it is imperative for persons to know that once infected, medical attention is required. As stated earlier, HIV weakens the immune system hence the need for prompt medical intervention. Most of the responses to the statement as to whether 'AIDS is a medical condition that cannot be fought off by one's body' were correct. The responses, 75.13% (inmates) and 80.77% (staff), indicate that most of them would seek medical attention once infected. Such knowledge would, amongst others, enable them to invoke measures that prevent the transmission of HIV.

5.4. KNOWLEDGE OF HIV TRANSMISSION MODES

HIV is transmitted through the exchange of bodily fluids of seropositive individuals. The virus has to enter the body through a mucous membrane into the blood of another person (Long, 1998:10; Whiteside & Sunter, 2000:10). The likely routes of HIV transmission include unprotected sexual intercourse, perinatal (intrauterine and peripartum) functions, and blood inoculation. Unprotected sex is the key mode of transmission as the virus is carried in the semen. It has been widely reported that HIV transmission through unprotected sex is rampant amongst inmates (Jolofani & DeGabriele, 1999:7; Krebs & Simmons, 2002:60). The probability of being infected sexually is even higher in the presence of sexually transmitted diseases (STDs) which causes inflammation of the genital tract (Coetzee & Johnson, 2005:193).

Perinatal HIV transmission takes place from a pregnant HIV positive mother to baby towards the second trimester. It is estimated that the rate of transmission during pregnancy ranges from 5% to 10%. Also, after birth the transmission may occur from the infected mother to a baby through breastfeeding. It is therefore prudent for an HIV infected mother to resort to formula feeding (Martin et al., 1995:29; Coovadia, 2005:185).

Blood transfusion introduces the virus directly into the blood stream of another person. Although there are measures in place to reduce the risk of infection, there is still a minimal chance of being infected even when the blood has been screened. According to the World Health Organization (WHO) approximately 80,000 to 160,000 cases of HIV occur through blood products (Whiteside & Sunter, 2000:13). The risk of contracting HIV through the routes alluded to ranges from high to low. For example, the risk of transmission through open wounds and cuts is lower than via blood transfusion and the sharing contaminated equipment.

There is ample evidence that HIV cannot be transmitted through casual contact, be it hugging, kissing, handshaking, sharing personal belongings or using same toilet seat (Hammet, 1988:8-15; Long, 1998:10). Despite this, there are prevailing misconceptions regarding casual contagion. In a study on HIV transmission among Iranian inmates at the Rajaei-Shahr correctional institution, the respondents exhibited a high knowledge of HIV yet 95% (n=100) identified kissing and shaking hands as modes of transmission (Eshrati, Asi, Dell, Afshar, Millson, Ismaili, & Wilkes, 2008:4).

Tables 22 and 23 indicate the level of knowledge on HIV transmission modes amongst inmates and staff at the Leeuwkop Correctional Centre.

TABLE 22: HIV TRANSMISSION MODES (INMATES, N=209)

No.	Items	Correct response	True	False
i.	If a pregnant woman has AIDS, it may affect her baby	True	73.40	26.60
ii.	Infected blood can give a person AIDS during blood transfusion	True	92.61	7.39
iii.	You can get AIDS by sharing injection equipment with other drug users	True	93.07	6.93
iv.	Sharing tattoo equipment can cause HIV infection	True	84.95	15.05
v.	You can get HIV from a toilet seats and touching urine	False	9.31	90.69
vi.	You can get HIV from kissing on infected person	False	12.25	87.75
vii.	You can get HIV from hugging or touching infected persons	False	4.39	95.61
viii.	You can get AIDS by using someone's personal belongings	False	10.78	89.22
ix.	You can get HIV infected through open cuts and wounds	True	83.33	16.67

TABLE 23: HIV TRANSMISSION MODES (STAFF, N=79)

No.	Items	Correct response	True	False
i.	If a pregnant woman has AIDS, it may affect her baby	True	88.61	11.39
ii.	Infected blood can give a person AIDS during blood transfusion	True	91.14	8.86
iii.	You can get AIDS by sharing injection equipment with other drug users	True	93.67	6.33
iv.	Sharing tattoo equipment can cause HIV infection	True	91.03	8.97
v.	You can get HIV from a toilet seats and touching urine	False	7.59	92.41
vi.	You can get HIV from kissing on infected person	False	11.39	88.61
vii.	You can get HIV from hugging or touching infected persons	False	6.33	93.67
viii.	You can get AIDS by using someone's personal belongings	False	10.13	89.87
ix.	You can get HIV infected through open cuts and wounds	True	96.20	3.80

In this study, the scale of knowledge regarding HIV transmission modes as reflected in the above tables consists of 9 items, each with a choice of 'true' or 'false' responses. A sound knowledge of the modes of transmission is collectively

represented by 'true' responses to five items (i-iv & ix) and 'false' responses to four items (v-viii). Table 22 it shows that inmates are generally knowledgeable about likely and unlikely modes of transmission. Blood transfusion and the sharing of equipment were mostly correctly identified as the routes of HIV transmission.

Most inmates knew that AIDS can be contracted through blood transfusion (92.61%), open cuts and wounds (83.33%), sharing drug injecting equipment (93.07%) as well as tattooing equipment (84.95%). As regards the knowledge of the staff, Table 23 indicates that they also possess a high level of knowledge of the likely modes of HIV transmission. The correct responses were as follows; blood transfusion (91.14%), open cut and wounds (96.20%), sharing injecting equipment (93.67%) and tattooing (91.03%). Only a negligible number of both inmates and staff indicated a deficit of knowledge regarding the direct transmission modes.

The perceived vulnerability to HIV was assessed by means of questions on casual contagion. Tables 22 and 23 indicate that the majority of both the staff and inmate respondents appear to be knowledgeable about this issue. The inmate respondents also confirmed that they mostly believe that no transmission occurs from engaging in casual behavioural activities with infected persons, such as kissing (87.75%), hugging and touching (95.61%), as well as sharing personal belongings (89.22%). However, a negligible number of the responses show a knowledge gap with regards to contagion. This consequently calls for concerted efforts at addressing the knowledge gaps through the provision of comprehensive programmes.

Similarly in a study conducted by Power et al. (1993:16), Scottish inmates exhibited a very high knowledge level on the likely and unlikely transmission

modes. They confirmed that there is transmission through bodily fluids (93.5%, n=559), sharing of the drug injecting equipment (91.6%) and unlikely transmission by sharing toilets seats with infected persons (84.5%). The more inmates are knowledgeable about the modes of transmission, the less the stigmatization of their fellow infected inmates will be.

Furthermore, the European Network on HIV/AIDS and Hepatitis commissioned a study on the status of HIV/AIDS/Hepatitis in five correctional institutions (Greece, Italy, France, Belgium, & Portugal). Amongst others it investigated the knowledge, attitudes, behaviour of the correctional staff towards AIDS and Hepatitis. It was found that between 20-30% of staff were not willing to share cigarettes, drink and clothes with HIV positive people fearing possible transmission (Weilandt & Rotily, 2001:216), indicating that there are knowledge gaps relating to casual contagion. Furthermore, in a study conducted by Kouliekaris et al. (2003:113) the inmates indicated that kissing, and urine thrown at them transmitted HIV.

Empirical evidence also reveals that there are knowledge gaps relating to modes of transmission even within the larger community. Eaton and Flisher (2000:97) assessed the HIV/AIDS knowledge of the South African youth. They found that there were moderate to high levels of misconceptions concerning the risk of unlikely HIV transmission. Ford et al. (2001:555) conducted a study on AIDS knowledge of Latino adolescent and adult migrant workers using 17 statements with eight questions addressing viral transmission. Most respondents were knowledgeable about sexual transmission but held misconceptions about casual transmission. About 62% of the respondents reported that one may be infected through kissing whereas 30% believed that casual contact may transmit the virus. It is imperative for one to have a clear understanding of both likely and unlikely modes of HIV transmission in order to be able to prevent contagion.

5.5. KNOWLEDGE OF HIV/AIDS PREVENTION METHODS

The prevention of the communicable diseases should receive priority in both public and correctional sectors, given the reported rapid spread of HIV/AIDS. Historically, HIV prevention methods used in the correctional environment like HIV antibody testing have been affected by fear, stigma, and legislation. Generally, HIV is regarded as indictment of one's morals and values. Thus people are reluctant to undergo HIV test due to a fear of having their status revealed and the stigma attached to being HIV positive. Stigma has been identified as the major barrier to HIV testing in South Africa (Muller, 1999:29; Mwamburi et al., 2005:518; Buys, 2009:146).

Also, within most correctional settings, HIV testing of inmates is only voluntary due to legislative restrictions. Correctional authorities are unable to conduct mandatory testing of inmates. As a result, the HIV prevention methods implemented within correctional institutions largely 'shoot in the dark'. There is no concrete quantification of the extent of HIV positive inmates and therefore the prevention strategies are addressing a problem of unknown dimension.

TABLE 24: KNOWLEDGE OF HIV PREVENTION METHODS (INMATES, N=209)

#	Item	Correct response	True	False
i.	Having sex with someone looking healthy is an effective way of protecting oneself	False	12.75	87.25
ii.	Using condoms during sex can lower the risk of getting AIDS	True	87.62	12.38

TABLE 25: KNOWLEDGE OF HIV PREVENTION METHODS (STAFF, N=79)

#	Item	Correct	True	False
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		response		
i.	Having sex with someone looking healthy is an effective way of protecting oneself	False	12.66	87.34
ii.	Using condoms during sex can lower the risk of getting AIDS	True	97.47	2.53

Only two items are used to measure the respondents' knowledge on HIV prevention methods. With reference to Tables 24 and 25 the respondents show a generally adequate knowledge level of HIV prevention methods. Inmates (87.25%) and staff (87.34%) believed that having sex with someone looking healthy is not an effective way of protecting oneself from being infected with HIV. The virus can lay dormant for a number of years before symptoms show; consequently it is disastrous for one to assume that not looking sick indicates that the person is not HIV infected.

Also, both inmates (87.62%) and staff (97.47%) recognize that the use of condoms is effective in reducing the risk of being HIV infected as reflected in Tables 24 and 25. In comparison with the staff (2.53%) there is a recognizable number of inmates (12.38%) who do not view the use of condoms as effective. This erroneous belief need to be dealt with through intensive and context specific educational intervention measures. Similarly, in another study on risks in custodial care, 64% (n=284) of the former inmates identified the use of condoms as a possible means of reducing the spread of HIV (Turnbull, Dolan & Stimson, 1991:46).

Inmates are exposed to risky sexual practices on a daily basis and therefore it is essential that they are convinced about using the condoms, as a prevention method. Condom use as an HIV prophylactic is known to be effective (Blumberg, 1989:7; Crosby, 1998:548). This is therefore central to education programmes

aimed at preventing the spread of HIV. The content of the programme should also include detailed descriptions of risk taking behaviours as well as how to use condoms appropriately (Catania, Coates, Golden, Dolcini, Peterson, Kegeles, Siegel, & Fullilove, 1994:24).

5.6. SOURCES OF HIV/AIDS KNOWLEDGE

Generally, the commonly used sources of HIV/AIDS information are mass media, institutional and interpersonal sources. Mass media refers to television, radio, magazines and newspapers, whilst institutional sources include school and churches. Lastly, interpersonal sources refer to parents, friends, and relatives. Tables 26 and 27 provide a breakdown of the responses on sources from which the HIV information was acquired by inmates and staff, respectively.

TABLE 26: SOURCES OF HIV/AIDS KNOWLEDGE (INMATES, N=209)

#	Item	Frequency
i.	HIV/AIDS brochure	49
ii.	Newspaper/Magazines	84
iii.	Television	79
iv.	Community course or School	36
v.	Course presented in prison	108
vi.	Friends or Family	59

TABLE 27: SOURCES OF HIV/AIDS KNOWLEDGE (STAFF, N=79)

#	Item	Frequency
i.	HIV/AIDS brochure	44
ii.	Newspaper/Magazines	44
iii.	Television	41
iv.	Community course or School	16
v.	Course presented in prison	22
vi.	Friends or Family	22

In this study, inmate respondents reported that they obtained information about HIV/AIDS from multiple sources, with the prison course being the most obvious one amongst them as reflected in Table 26. This implies that there are HIV programmes available to inmates at the Leeuwkop correctional centre. In contrast, in Table 27 the staff respondents indicated that print media in the form of HIV/AIDS brochures (44%) and newspaper/magazines (44%) were the most frequently used sources of HIV information.

In sum, for the staff, mass media (print and television) ranked higher than institutional (courses) and interpersonal (friends or family) sources of HIV information. Whereas, for the inmates, prison course (institutional), Newspaper/Magazine (print media) and television (audio media) were reported as the main sources of HIV information. The scores with regards to friends and family as a source of HIV information are comparatively very low. This may be attributed to the prevailing intergenerational conservatism about issues of sexual behaviour as well as the shame and stigma attached to HIV (Visser, 2007:775; Buys, 2009:147).

The findings herein are consistent with most studies (Ntombela et al., 2008; Grundlingh, 2009). The television is cited as a key source of HIV information, always ranking higher than other sources. In South Africa the commonly used sources of HIV information are television, radio, magazines, newspapers, theatre, friends, family, workshops, and lectures. The first four mass media sources are regarded as the most powerful tools of for communicating messages regarding HIV/AIDS. They raise awareness, change attitudes and trigger behavioural modification. In addition, in a survey conducted amongst students at the University of Natal, they reported that the most commonly used sources for HIV

information were television (84%), radio (83.1%), and friends (61%). It was also found that the information provided by friends was mostly inaccurate (Ntombela et al., 2008:78).

Furthermore, in a study conducted by Parry et al. (2004:108) participants indicated that television and advertisement were their main source of HIV information. Other sources cited were seminars, prison courses, health care centers, friends, family and print media. During the investigation on challenges and obstacles experienced in HIV education in South Africa, Grundlingh (2009:255) also noted that television and radio were mostly identified as sources of HIV information. There have been additional efforts to accommodate those of a lower literacy level through edutainment and photo-comics in order to convey the HIV/AIDS messages (Grundlingh, 2009:255).

In addition, Muller (1990:72) noted in her study of female inmates that television represented the major source of HIV information. Amongst Nigerian inmates, radio was found to be the major source of HIV knowledge. About 76.3% (n=341) confirmed that they mostly received HIV related information through listening to the radio, whereas television (50.7%) and newspaper/magazine (42.5%) ranked lower as a source (Ikuteyijo & Angunbaide, 2008:282).

In a study assessing HIV/AIDS knowledge of female offenders in the Texas criminal justice system, Keathly (1997:133) found that the information on HIV/AIDS was more readily obtained from print media rather than from courses. An investigation in correctional institutions situated in five European countries, revealed that television and radio are the major sources of HIV/AIDS information there (Weilandt & Rotily, 2001:218). Lastly, Chinese students also identified television, newspapers and magazines are major sources of HIV information (Huang, Bova, Fennie, Rogers & Williams, 2005:775). From the above cited

studies, it is clear that television is a strong and effective medium of communicating information regarding HIV/AIDS. It may also be contributing towards changing the prevailing negative attitudes towards HIV positive individuals.

5.7. ATTITUDES TOWARDS HIV/AIDS

The knowledge of HIV/AIDS, its transmission modes and prevention methods as well as appropriate attitude towards HIV are a prerequisite for behavioural change. Individuals can be greatly knowledgeable about the first three aspects, but if their attitude towards HIV/AIDS is negative, then the impact on behavioural patterns may be minimal. The appropriate use of the HIV information is largely influenced by one's attitude (Reader, Carter & Crawford, 1988:126). Therefore, in HIV education programmes, it is critical to address the baseless opinions and thoughts that individuals hold about HIV/AIDS. In Tables 28 and 29 below, the questions gauged the opinion of the inmates and staff at Leeuwkop Correctional Centre regarding people living with HIV and their willingness to engage in discussions on AIDS with their partners.

TABLE 28: ATTITUDES TOWARDS HIV/AIDS (INMATES, N=209)

No.	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	I would feel very uncomfortable around someone with AIDS.	8.00	16.50	31.00	44.50
ii.	You have to talk to your partner about AIDS.	67.34	26.13	2.01	4.52
iii.	I would support a person with HIV/AIDS.	62.56	29.74	2.05	5.64

TABLE 29: ATTITUDES TOWARDS HIV/AIDS (STAFF, N=79)

#	Items	Agree strongly	Agree	Disagree	Disagree strongly
i.	I would feel very uncomfortable around someone with AIDS.	10.53	13.16	30.26	46.05
ii.	You have to talk to your partner about AIDS.	72.60	17.81	2.74	6.85
iii.	I would support a person with HIV/AIDS.	66.23	25.97	1.30	6.49

The questions listed in Tables 28 and 29 address empathy (two items: i & ii) for the infected persons, and a general attitude towards HIV/AIDS (one item: iii). Both inmates (92.30%) and staff (92.20%) comprehensively scored very high on their support for HIV positive persons. In addition, both inmates (24.50%) and staff (23.69%) scored almost the same on feeling discomfort when around infected persons. Generally, the willingness to support HIV infected persons and the absence of discomfort around them indicates that inmates and staff have empathy towards HIV positive people and they generally understand their plight.

The scores on the general attitude items are from 90.41% to 93.47% for inmates and staff respectively, as reflected in Table 28 and 29 respectively. These items deal with whether one is willing to openly discuss sex with a partner. Most of the inmates and staff provided affirmative responses. This is very impressive as certain cultural practices and intergenerational silence generally affect open discussion about sex. The responses indicate that there is an acceptable level of HIV knowledge amongst inmates and staff that has influenced their attitudes and behavioural patterns. Negative attitudes adversely affect the quality of care of infected inmates and the management thereof.

5.8. SUMMARY

Overall, the findings of this study indicate that both inmates and staff at Leeuwkop Correctional Centre possess a considerable amount of accurate information about HIV/AIDS, with minor knowledge deficits with regards to some aspects. As far as basic HIV knowledge is concerned there are small knowledge gaps relating to the meaning of HIV and AIDS, the curability of AIDS, and whether one's body is able to fight off AIDS. Furthermore, inmates and staff appear to possess high levels of knowledge concerning the transmission modes of HIV/AIDS.

Amongst inmates, there is a knowledge gap only relating to prenatal HIV transmission. A total of 26.60% of the inmates do not know that a pregnant infected mother can infect the baby. Furthermore, it is necessary to mention that there are debates as to when actual transmission occur in correctional institutions. This is largely due to several factors such as a lack of HIV testing of inmates on admission as well as the length of the viral incubation period. It is submitted that the length of viral incubation is between 8 and 10 years (Dusenbury, Botvin, Baker & Laurence, 1991:367). These factors make it difficult to state with precision that inmates are infected during the incarceration.

In this study, interpersonal HIV sources rank lower than the mass media and institutional sources from which inmates and staff obtained the HIV/AIDS information. Therefore, interventions for improving the communication between family members on sensitive topics are necessary. Consistent with other studies (Keathly, 1997; Ntombela et al., 2008), mass media is the main source of HIV information for inmates.

Lastly, both the inmates and staff who participated in this study largely exhibit a positive attitude towards HIV positive people. For those who express discomfort

around the latter, there should be intensified ongoing education interventions in order to address the negative attitudes. Whether education changes the attitudes and behavioural patterns, is a question for further research. In sum, HIV transmission is an ongoing concern for the correctional community and therefore there is a dire need to expand the knowledge of inmates and staff with regards to the meaning of HIV/AIDS, general HIV issues, HIV transmission modes and prevention methods. Any attempts to improve the knowledge levels of inmates and staff must be targeted and context specific.

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CHAPTER 6

FINDINGS, RECOMMENDATIONS AND CONCLUSION

6.1. INTRODUCTION

The goal of this study was to investigate and describe the risk taking behaviours amongst inmates at the Leeuwkop Correctional Centre, assess the HIV/AIDS knowledge of staff and inmates, as well as to highlight the value of harm reduction components that have been successfully implemented in the international correctional setting. This study has provided baseline information about such behaviours and the level of HIV knowledge amongst staff and inmates at the Leeuwkop Correctional Centre.

From the findings it is clear that, most inmates have confirmed the prevalence of sexual activities and drug use at Leeuwkop Correctional Centre. Also, the findings indicate that a higher percentage of tattoos are imported from the community. Lastly, the analysis of the AIDS Knowledge and Attitude Questionnaire (AKAQ) items shows that inmates and staff possess a significantly high level of knowledge with regards to HIV/AIDS. The findings, recommendations and concluding remarks are presented in this chapter.

6.2. FINDINGS

6.2.1. FINDING 1: PREVALENCE OF SEXUAL ACTIVITIES

Generally, inmates experience sexual deprivation as a direct result of their incarceration. They turn into voyeurs, masturbate and/or engage in unprotected

sex with fellow inmates. Voyeurs are people who obtain sexual gratification from looking at sexual objects or acts. In this study, the majority of inmates (90.59%) and staff (85.53%) confirmed that sexual activities among the inmates are prevalent at the Leeuwkop Correctional Centre, although they do not agree on the frequency thereof.

Furthermore, the findings demonstrate that there is a high level of risky sexual practices such as anal sex at the Centre. The inmates (75.50%) and staff (78.30%) conceded that inmates prefer engaging in anal sex with each other. Generally, anal sex is risky and has the highest potential of spreading HIV. In most cases, anal sex involves the tearing of the rectal membrane during the act and thus enhances the spread of blood borne pathogens (Goyer, 2003:17).

Lastly, over 50% of the inmates submit that there are coercive sexual activities which are used as a penal measure by the gang leaders. Generally, such activities are very risky and thus contribute to the transmission of HIV.

6.2.2. FINDING 2: SEX IN EXCHANGE OF GOODS AND FOOD

A significant number of inmates (76.38%) in this study have responded that trading sexual favours in exchange for goods and food is prevalent. This practice is commonly alluded to as 'survival sex' (Erickson et al., 1995:478). During such sexual practices, the victims are unable to negotiate the use of protection and therefore there is a high likelihood of the transmission of HIV.

6.2.3. FINDING 3: CONDOM ACCESS

In this study, more staff members (78.67%) confirm easy access to condoms at Leeuwkop Correctional Centre than the inmates (63.90%) do. The condom distribution policy of the Department of Correctional Services requires inmates to receive counselling prior to being afforded access to condoms (Goyer, 2003:6). This face-to-face access may hinder inmates from accessing condoms. In a previous study, only one out of 274 inmates confirmed access to condoms at Durban Westville Correctional Centre. Although an improvement regarding condom access at Leeuwkop Correctional Centre is recorded as compared to Durban Westville Correctional Centre, it is still not adequate given the risk of contracting HIV in correctional institutions.

6.2.4. FINDING 4: DRUG USE

A high proportion of the inmates (71.63) and staff (72.73%) reported that drug use takes place at Leeuwkop Correctional Centre. This finding is corroborated by a previous exposé at Grootvlei Correctional Centre in the Free State province where drug dealing was confirmed by a widely publicised video allegedly recorded by inmates (Judicial Inspectorate of Prisons Annual Report 2002/2003:3).

Drug use is a risk taking behaviour that is closely linked to unprotected sex and HIV (Adjei, Armah, Gbagbo, Ampofo, Quaye, Hesse, & Mensah, 2006:594; Parry, Carney, Petersen & Dewing, 2007:105). When users are under the influence of drugs, they inevitably tend to engage in unprotected sex and other risk taking behaviours. Therefore, drug use directly contributes to the spread of HIV.

6.2.5. FINDING 5: INJECTION DRUG USE

In this study, 44% of the inmates reported drug use by means of injection at Leeuwkop Correctional Centre. The finding is in contrast with the results of the study conducted at Westville Medium B Correctional Centre in Kwa-Zulu Natal where drug use by injection was confirmed by only a small number (16.44%, n=274) of the respondents. This finding indicates that drug use by injection is gaining momentum, although cannabis has been reported as the most widely used recreational drug amongst inmates and offenders in South Africa (Goyer, 2003:31; Legget, Louw, Parry & Pluddermann, 2004:155).

6.2.6. FINDING 6: SHARING OF DRUG INJECTING EQUIPMENT

Invariably where there is injection of drugs as stated in Findings 6.2.5, there will be sharing of the injecting equipment. In this study, a total of 52.27% of the inmate respondents reported that this does occur amongst drug users at Leeuwkop Correctional Centre. Such practices are common among inmate drug users, as reflected in other studies (Carvell & Hart, 1990:1384; Butler & Milner, 2003:121; Stephens, Braithwaite, & Conerly, 2005:68). There is a high likelihood of the spread of blood borne diseases during the sharing of the equipment as the injecting equipment is unsanitized and used repeatedly.

6.2.7: FINDING 7: TATTOOING AT LEEUWKOP CORRECTIONAL CENTRE

Tattoos have become an integral part of the inmate subculture (Luyt, 2008:1). The tattoos are either imported into the correctional institution or acquired by inmates whilst serving their sentences. In this study, most inmates (62.26%) reported that the tattoos are imported into the institution. This finding is supported by the fact that in most cases the insignia of the gangs operating in the community and the correctional institutions are similar. For example, the

'Americans' gang found in the Cape Flats in Cape Town, use the insignia of the rising sun which is similar to that of the 26 gang (Eggington, 2009:13). The most prominent gangs that operate in the South African correctional environment are the 26s, 27s, and 28s (Goyer, 2003:65).

6.2.8. FINDING 8: BASIC KNOWLEDGE ON HIV/AIDS

Basic information on HIV/AIDS is the bedrock of any HIV related intervention. Generally, it is possible to influence people and alter their perception once there is understanding of the basic information. In this study, nine items were used to assess the basic HIV/AIDS knowledge of both inmates and staff, as reflected in Chapter 5. Although the overall HIV knowledge of staff and inmates is significantly high, there are deficits relating to the following items listed under 6.2.8.1. and 6.2.8.2. The percentages in brackets indicate the range of incorrect answers.

6.2.8.1. INMATES

- a. All people who have HIV are sick with AIDS (35.29%).
- b. HIV is carried in men's semen (54.55%).
- d. AIDS can be cured and people recover from it (21.67%).

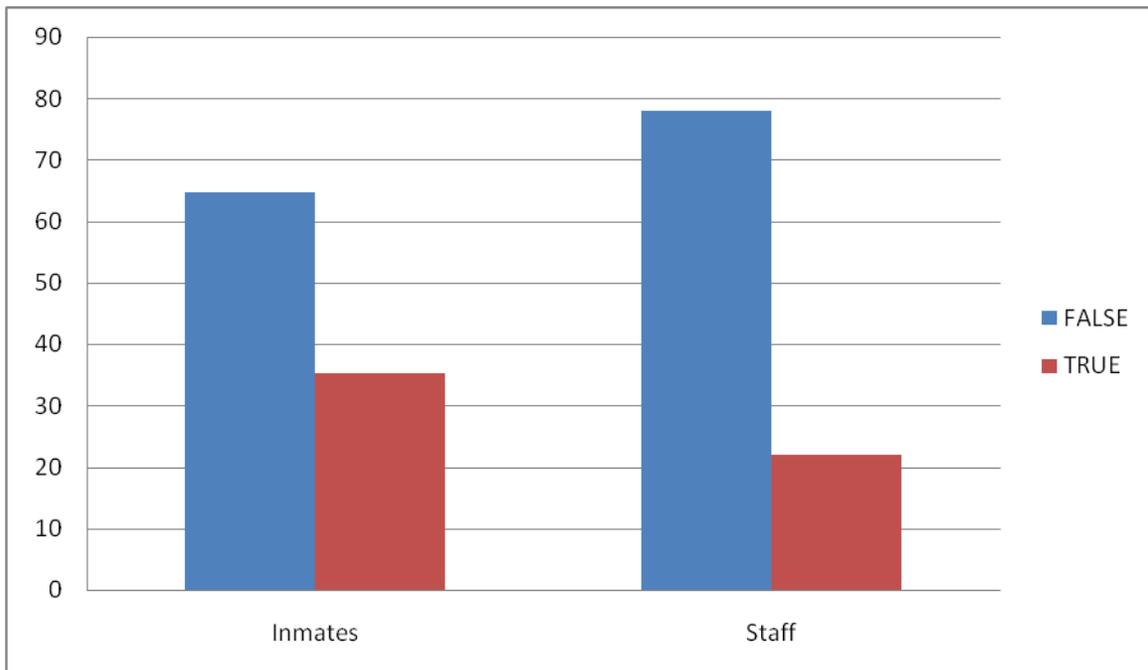
6.2.8.2. STAFF

- a. All people who have HIV are sick with AIDS (22.08%).
- b. HIV is carried in men's semen (38.16%).
- c. AIDS can be cured and people recover from it (16.67%).

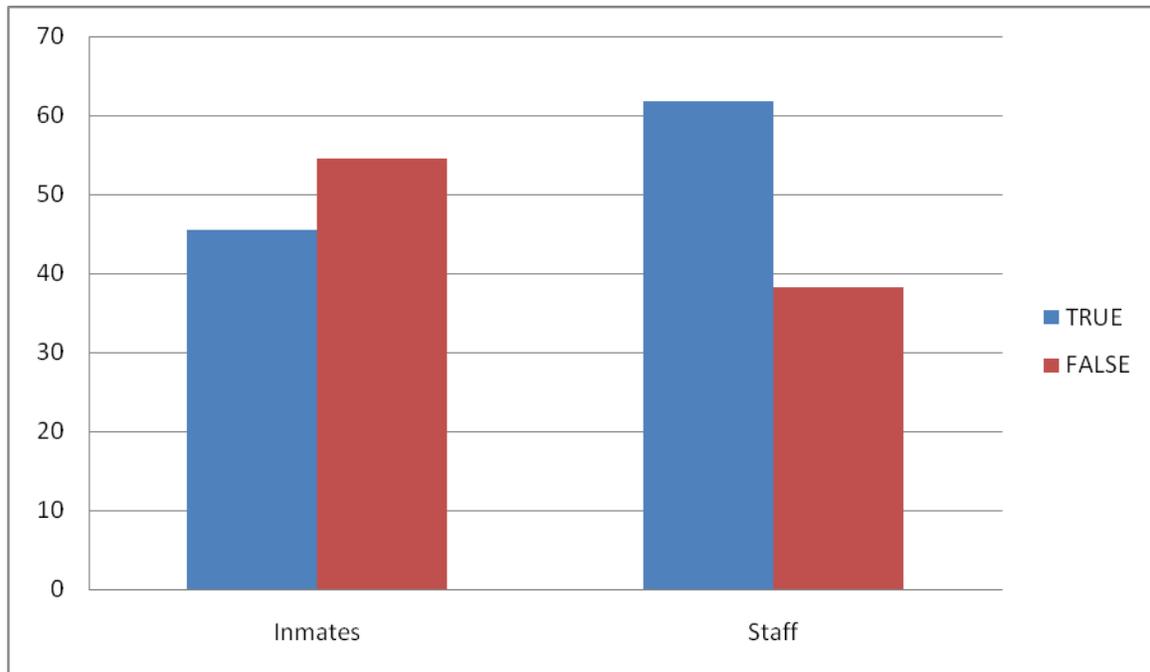
A sizeable number of both inmates and staff do not know that there is a difference between being HIV positive and having AIDS. Also, over 50% of the inmates do not know that HIV is carried in men's semen. Such a low perception of the inherent risks as regards men's semen may prompt inmates not to use protection during sex which is largely risky.

Furthermore, AIDS has no cure nor is there a vaccine for HIV yet there is a knowledge gap regarding this aspect (Al-Owaish, Moussa, Anwar, Al-Shoumer, & Sharma, 1999:163; Grundlingh, 2009:239). A total of 21.67% of the inmates and 16.67% of the staff in this study believe that AIDS is curable. This is quite disturbing and requires intensive intervention methods. The primary reason for the disparity of the responses of the staff and inmates to these questions could be attributed to the fact that inmates stem largely from a marginalised segment of the community who generally do not have access to HIV/AIDS materials and programmes.

GRAPH 4: ALL PEOPLE WHO HAVE HIV ARE SICK WITH AIDS



GRAPH 5: HIV IS CARRIED IN MEN'S SEMEN



6.2.9. FINDING 9: KNOWLEDGE OF HIV TRANSMISSION MODES

The knowledge of the respondents regarding HIV transmission was assessed through the use of nine items covering likely and unlikely modes. Both inmates and staff exhibited a high degree of knowledge of the HIV transmission modes although minimal knowledge gaps are evident. A significant number of the inmates confirmed that AIDS can be contracted through blood transfusion (92.61%), open cuts and wounds (83.33%), as well as by sharing drug injecting equipment (93.07%). As regards the staff, their correct responses for the three questions ranged from 91.03% to 96.20%, similarly indicating a high level of knowledge of the HIV transmission modes.

Also, although a large number of inmates and staff showed that they know that HIV is not transmitted through casual contagion, there was a noticeable knowledge deficit relating to transmission through kissing and using someone's

belongings. Inmates (12.25%) and staff (11.39%) believe that one can contract HIV from kissing an infected person. Furthermore, a total of 10.78% of inmates and 10.13% of staff conceded that HIV can be transmitted through using someone's belongings. These myths tend to engender the stigmatization of and discrimination against infected persons.

6.2.10. FINDING 10: KNOWLEDGE OF HIV PREVENTION METHODS

The known effective method of HIV prevention during sexual activity is the use of condoms (Blumberg, 1989:7; Crosby, 1998:548). As reflected in Table 24, in this study, a majority of inmates (87.62%) and staff (97.47%) know that using condoms during sex reduces the risk of HIV transmission. The ideal situation is for all inmates to perceive condoms as the main protective measure against contracting HIV in order to curb its spread.

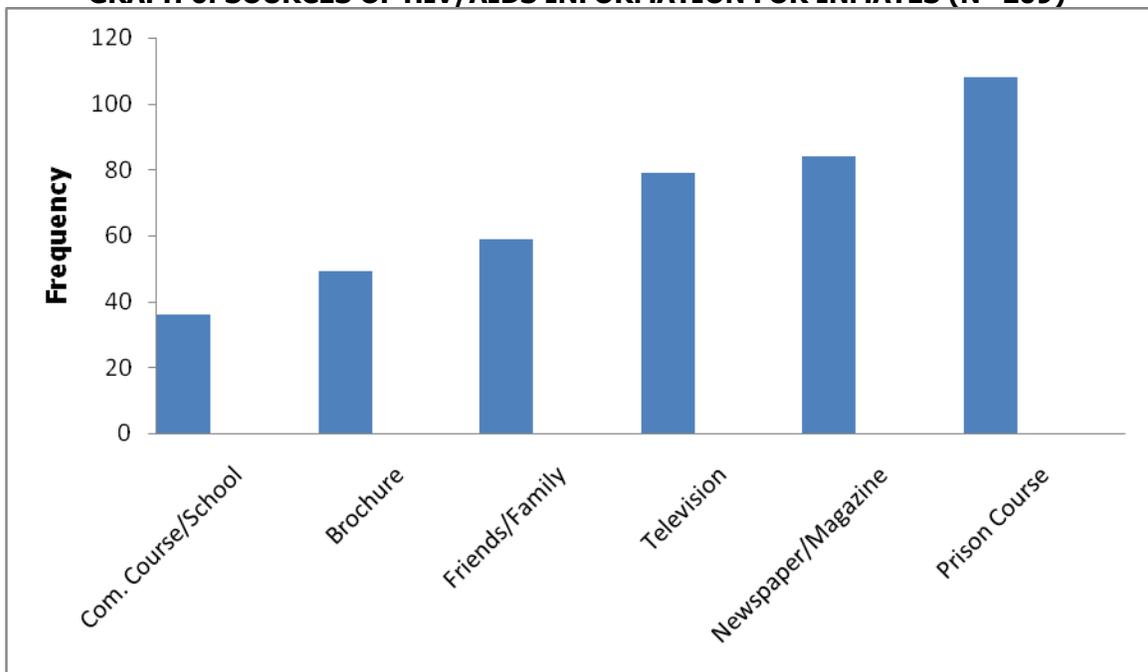
6.2.11. FINDING 11: SOURCES OF HIV INFORMATION

The findings reveal that there are differences and similarities regarding the primary sources from which the inmates and the staff obtain the information on HIV. For inmates at the Leeuwkop Correctional Centre, as reflected in Graph 6, the most common source of HIV information is the prison course. In contrast, the reported key source of HIV information for staff in Graph 7 is the HIV brochure. Inmates are generally difficult to reach whilst in the community but since they are a captive audience it is possible to expose them to a prison-based HIV course.

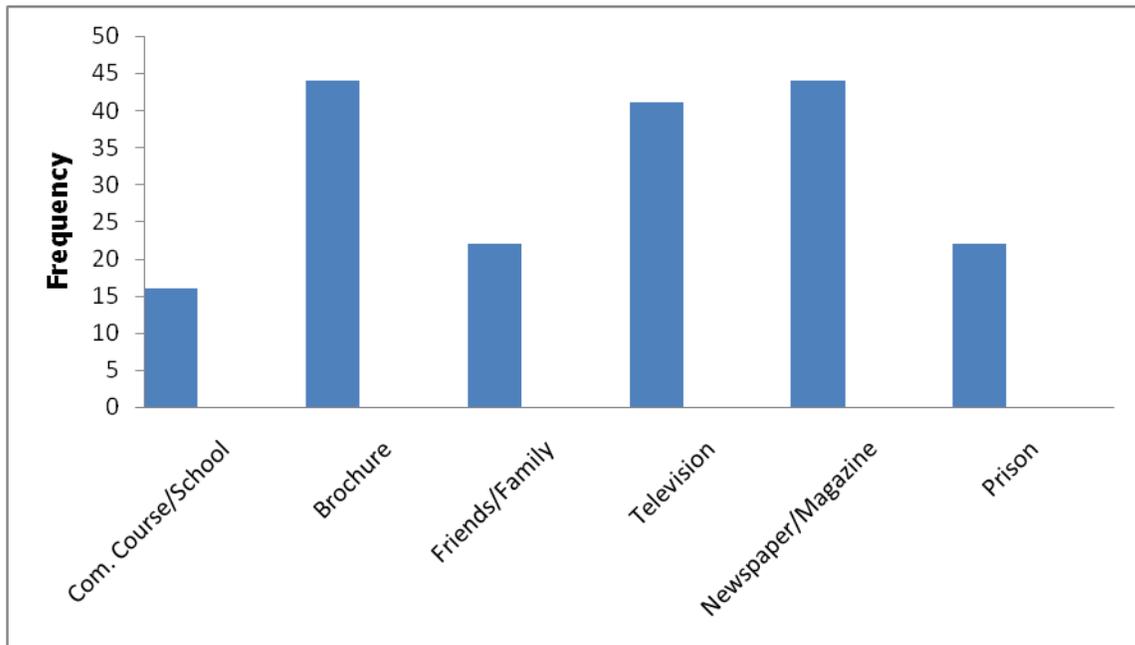
Furthermore, both inmates and staff reported that television is the other main source of HIV information. This finding is consistent with the previous studies

conducted in South Africa, where television was identified as a common source of HIV information (Ntombela et al., 2008:78; Grundlingh, 2009:255). Graph 7 also indicates that the course offered at schools is the source of the least HIV information for the staff. Most of the staff (62%) who participated in the study fell within the age cohort of 31-50 years, therefore at the time they were of school going age; information regarding HIV/AIDS had not yet been included in the school curriculum.

GRAPH 6: SOURCES OF HIV/AIDS INFORMATION FOR INMATES (N=209)



**GRAPH 7: SOURCES OF HIV/AIDS INFORMATION FOR STAFF
(N=79)**



Lastly, the findings reveal that friends or family are also one of the least sources of HIV/AIDS information for both inmates and staff. This is unexpected since basic information on safe sex is regarded as falling in the primary domain of family and friends (Zambrana, Cornelius, Boykin & Lopez, 2004:1154). This finding suggests that there is poor dialogue in familial settings with regards sex issues.

6.3. RECOMMENDATIONS

The recommendations below flow from the findings discussed above. They relate to the prevalent risk taking behaviours at the Leeuwkop Correctional Centre, the HIV knowledge levels of the inmates and staff as well as the harm reduction components that may be appropriate in the South African Correctional Services environment.

6.3.1. RECOMMENDATION 1: PREVALENCE OF SEXUAL ACTIVITIES

In order to curb the prevalence of the sexual activities, there is a need for the Department of Correctional Services to conduct continuous information sessions regarding risky sexual practices and the potential of spreading HIV/AIDS. The content of the messages should be explicit and unreservedly highlight the fatal consequences resulting from such risky and coercive sexual practices. In conjunction with the information sessions, the Department of Correctional Services should provide inmates with packs suitable for anal sex including condoms, lubricant, and HIV information and an instruction leaflet. The lubricant will reduce the chances of the tearing of the condoms during anal sex and the instruction leaflet will provide information on how to use condoms properly.

6.3.2. RECOMMENDATION 2: SEX IN EXCHANGE FOR GOODS AND FOOD

The prevalence of 'survival sex' requires a review of certain policies; inter alia, those dealing with visits and meal times. The visiting policy will control what items visitors may bring for the inmates, with the aim of barring any that facilitates abuse of inmates. Simultaneously, the Department of Correctional Services should ensure that inmates are adequately provided for as regards the basic necessities. The current departmental meal times for inmates provides for dinner to be served at 15h00 to allow staff to leave by 16h00. As a result, other inmates keep extra food in their cells received from visitors and then use such food to trade for sex with indigent fellow inmates. The Department of Correctional Services should review the meal times to 18h00 in order to reduce the vulnerability of the indigent inmates. Inmates should also be reminded through HIV briefings that they should at all times insist on condom use when engaging in sexual activities. Inmates should be made to view themselves as HIV

change agents, because the power to prevent the spread of HIV lies with each individual.

6.3.3. RECOMMENDATION 3: CONDOM ACCESS

The condom distribution policy should be reviewed in order to remove the mandatory face-to-face interaction between inmates and staff that precedes condom access. The condom packs should be placed at strategic places where inmates can freely access them without fear. Such places may include showers, the library and the toilets at the Health Centre. For those inmates who cannot read, there should be trained inmate HIV champions who can explain the HIV information in the condom packs. These champions would be able to use easily understandable language that can be translated into action.

6.3.4. RECOMMENDATION 4: DRUG USE

Drug use is an intractable habit that has permeated correctional institutions. The correctional authorities should establish the type of drugs used at the Leeuwkop Correctional Centre by means of an in-depth investigation in order to develop appropriate harm reduction measures. The current repressive measures of searching inmate cells, confiscating the drugs and subjecting culprits to penal measures have not persuaded the inmates to cease drug use activities.

6.3.5. RECOMMENDATION 5: INJECTION DRUG USE

Despite the reported lower level of the injection drug use at the Leeuwkop Correctional Centre, it should not be left to become endemic before implementing harm reduction measures. The correctional authorities should pilot

substitution therapy with the aim of reducing drug dependency, minimizing health risks and curbing the spread of HIV.

6.3.6. RECOMMENDATION 6: SHARING OF DRUG INJECTING EQUIPMENT

In order to reduce the sharing of such equipment, the following interventions should be implemented:

6.2.6.1. Educate inmates regarding the dangers of sharing contaminated injecting equipment.

6.2.6.2. Provide inmates with bleach to serve as a cleaning solution for the injecting equipment. Generally, bleach is already used in the correctional institutions for housekeeping purposes; therefore extending its use for sanitizing the injecting drug equipment will not trigger cost implications.

6.3.7: RECOMMENDATION 7: TATTOOING

Finding 7 shows that inmates import tattoos from the community. Tattoos are permanent marks and therefore it is critical to clearly understand the implications before opting for them. There should be public awareness campaigns educating the community as regards tattooing. Furthermore, the correctional authorities should consider establishing safer tattooing outlets in the current hair salons operating in the correctional centres so as to cater for other tattooing activities that take place during incarceration. These outlets will be similar to the commercial tattooing outlets available in the community.

6.3.8. RECOMMENDATION 8: BASIC KNOWLEDGE ON HIV/AIDS

There should be HIV education programmes that address context specific issues of inmates such as risky anal sex. The use of such programmes for inmates that are prevalent in the community is not advisable. Since risk reduction programmes do not cater for all situations, each segment of the population should receive relevant educational programmes. The objective of such programmes should be to change the mindset of the group and initiate behavioural modification.

Furthermore, there should be ongoing training of staff in order to improve their knowledge regarding risk taking behaviours, HIV/AIDS and treatment of the HIV positive inmates. Until 2007, the focus of the Department of Correctional Services was to provide security and control. With the introduction of the concept of rehabilitation in the Correctional Services Amendment Act as the core of the incarceration, there is a need for a renewed approach to the training of staff to ensure a paradigm shift.

It is reported that the correctional staff have historically been reluctant to provide inmates with the tools that prevent the transmission of HIV. Amongst others, the reluctance has been attributed to the prevailing negative attitudes and social determinants that negatively influence their opinions (Godin, Gagnon, Alary, Noël & Morissette, 2001:469). The training of staff may possibly create an environment conducive to the implementation of the harm reduction model.

6.3.9. RECOMMENDATION 9: HIV TRANSMISSION MODES

Constant HIV messages that place emphasis on both the likely and the unlikely transmission modes should be disseminated through all available media in correctional institutions. The education programmes should specifically aim to dispel the myths concerning HIV.

6.3.10. RECOMMENDATION 10: HIV PREVENTION METHODS

Since 12.38% of the inmates do not perceive condoms as protective measures against HIV, it is critical for the HIV brochures and programmes to emphasize the value of condoms in HIV prevention. Lastly, condoms should be promoted as measures that prevent mortality and morbidity.

6.3.11. RECOMMENDATION 11: SOURCES OF HIV INFORMATION

The distribution of HIV brochures to inmates will assist in improving their knowledge. Such brochures could be read during their own leisure time during the day as well as after lock-up. Inmates are locked up at about 16h00 and therefore there is plenty of time on their hands that could be used productively. The distribution of the HIV brochures can be coupled with the appointment of inmate HIV champions in each cell who can facilitate dialogues during the evening. Also, televisions should be used as a key medium for communicating HIV information to inmates on a daily basis.

6.4. OTHER RECOMMENDATION

6.4.1. HIV TESTING

Implementing mandatory HIV testing for inmates on admission and on a six-monthly basis thereafter is strongly recommended. Currently, the Department is dealing with a problem of unknown dimensions due to the respect for inmate's human rights which militates against enforced testing. Mandatory HIV testing for inmates was terminated in 1994 (O'Haeri, 2000:133). Testing prompts immediate access to medical care that will ultimately reduce direct and indirect costs of HIV (Klein, Gieryic, O'Connell, Hall & Klopff, 2002:71).

The direct costs consist of personal and non-personal costs whereas the indirect costs include lost economic production resulting from morbidity, mortality and disability. It is estimated that direct HIV costs in South Africa ranged from R686 million to R1, 26 billion in 2005. The estimated ratio between direct and indirect cost was 3.2:1 with the total government HIV/AIDS expenditure being approximately R3.3 billion excluding the costs incurred by the business sector and civil society (Broomberg, Steinberg, Masobe, & Behr, 1991:65; Chetty & Michel, 2005:17).

The inmate population is a particular segment of the population which requires special interventions. Generally, voluntary HIV testing in South Africa is very minimal. It is being conducted in the public health facilities but it has been reported that a significant number of the South African youth have never been tested (MacPhail, Pettifor, Moya & Rees, 2009:456). This may be due to a poor perception of the risk of HIV infection, cultural barriers, HIV-related stigma and discrimination (Luseno & Wechberg, 2009:178). Given this dismal situation, it would be foolhardy for anyone to think that all inmates will voluntarily request being tested for HIV. It is therefore imperative to revisit the implementation of mandatory HIV testing and replicate practices that are in place in other countries such as the United States of America in particular, Nebraska and South Carolina (Luyt, 2003:98).

The initial suggested step is to seek the amendment of Section 12(4b) of the Correctional Services Amendment Act 111 of 1998 to allow the Department to compel inmates to undergo medical attention after counseling, with the specific aim of determining their HIV status on admission and preventing the spread of HIV.

7. CONCLUSION

There is the potential for underreporting regarding the risk taking behaviours. It is a sensitive matter to study inmates and correctional staff. Inmates are generally reluctant to divulge details of risk taking behaviours for fear of reprisals (Wohl, Johnson, Jordan, Lu, Beall, Currier & Kerndt, 2000:387) and, equally, the staff do not reveal the exact details of such behaviours as these may have negative connotations with regards to their management capabilities. Furthermore, inmates are generally distrustful of researchers (Arriola, 2006:138). For further research, the use of interview as a data collection tool could enhance the validity and reliability of the research results.

The harm reduction components are known to reduce the harm emanating from risk taking behaviours whilst inmates are continuing with such behaviours. The Scottish correctional system serves as a valuable example of a situation where harm reduction components have been successfully implemented (Single, 1995:288; Seal et al., 2004:787; Luyt, 2007:226). The harm reduction model is also necessary for the developing countries. The model has been implemented in Morocco and Egypt although they command limited resources (Moskalewicz, Barret, Bujalski, Dabrowska, Klingemann, Malczewski & Struzik, 2007:8). South Africa as the political and economic powerhouse on the African continent has to take the lead in considering the harm reduction components. The

implementation of the harm reduction model does not mean approval of the risk taking behaviours but demonstrates a commitment to improving inmate health and avoiding turning inmate cells into death chambers.

Incarceration provides a window of opportunity to effectively reduce risk taking behaviours yet if this opportunity is not utilized, HIV will continue to skyrocket in the correctional institutions. An estimated ratio of 1:217 adults in South Africa is incarcerated. Failure to implement harm reduction urgently will expose the general community to additional risk as the inmates are released back into the society. Harm reduction strategies have been hailed as the most effective means of reducing the spread of blood-borne diseases in the correctional setting (Zack & Kramer, 2009:2).

The suggested steps for the implementation of the harm reduction model are as follows:

- a. Environmental analysis:
 1. Conduct an in-depth analysis of the prevailing risk taking behaviours in correctional institutions.
 2. Review current legislation and policies relating to HIV/AIDS and risk taking behaviours in the correctional institutions. The legislation and policies will provide a framework in which harm reduction can develop to its full potential.
- b. Policy Development: Improve and /or develop robust, appropriate policies.
- c. Advocacy and Stakeholder Liaison:
 1. Obtain political and community support: This is critical as their resistance may make it impossible to implement the harm reduction programmes (Tewksbury, et al., 2003:232). The collaboration and

linkages with all the stakeholders should ensure seamless continued service between the community and the correctional institutions.

2. Conduct awareness campaigns in order to ensure that all stakeholders know the pros and con's of the harm reduction model.

d. Pilot the following harm reduction programmes at the Correctional Centres of Excellence:

1. Condom provision: The inmates should be provided with condoms, as well as the lubricant that are suitable for anal sex together with instructions for use. The generic condoms that are provided to inmates are not suitable for this type of sex. Failure to provide these condoms whilst being fully aware of the risky sexual practices amongst inmates facilitates the spread of HIV: thus the Department is falling short of providing adequate health care as provided for in section 12(1) of the Correctional Services Act 111 of 1998.
2. Bleach solution and smoking pipes: The inmates should be provided with this solution to sterilize the drug injecting and tattooing equipment. Although it has been reported in chapter 4 that injecting drug use is not endemic in the local correctional institutions, safety methods should be implemented before such use becomes out of proportion. Currently, inmates use broken bottlenecks to smoke drugs in particular cannabis, mandrax and crack cocaine (Legget, Louw & Parry, 2004:160). Hence it is recommended that pipes be furnished.

3. Safer tattooing outlets: The correctional authorities should consider establishing safer tattooing outlets in the hair salons currently supplied. Tattooing should be preceded by counselling in order for inmates to make informed decision, since the marks are permanent.
- e. Conduct evaluation of outcome.
- f. Improve the programmes based on the results of the evaluation.
- g. Incremental roll-out to other correctional institutions.

It is imperative for the researcher to mention the following challenges that may impact on the implementation of the harm reduction model in South Africa:

- a. Crime rate: Owing to the prevailing high crime rate in our country, inmates continue to suffer stigma and discrimination at the hands of the community. The government and civil society are faced with reducing the crime rate prior to considering a humane approach to inmate problems which will be acceptable to all.
- b. Cultural and religious values: Culture and values can present obstacles to implementing any new innovations. Although gay relationships are recognized in South Africa, sexual relations amongst same sex inmates and drug use in correctional institutions are still frowned upon and perceived as being immoral. Therefore, allowing the implementation of the harm reduction components may be viewed as being tantamount to condoning these risk taking behaviours.

Despite these challenges, the Department of Correctional Services has to consider implementing the harm reduction components. Failure to do so is indefensible; it amounts to abdicating the responsibility of providing inmates with

adequate health care and can be viewed as imposing additional 'de facto' punishment on the inmates for engaging in risk taking behaviours.

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ANNEXURES

HARM REDUCTION IN STATE PRISONS

QUESTIONNAIRE (INMATES)

FINANCIALLY SUPPORTED BY THE NATIONAL RESEARCH FOUNDATION

RESEARCHER: MS GOMOLEMO MOSHOEU

2. No
10. Information that I know about HIV/AIDS was gained in the following ways. Please circle all that apply.
- | | |
|----------------------------|-------------------------------|
| 1. HIV/AIDS brochure | 4. Friends or family |
| 2. Community course/school | 5. Television |
| 3. Newspaper/magazine | 6. Course presented in prison |
11. Please circle your selection: I know what my own HIV status is. You are not requested to unveil your status.
- | | |
|--------|--|
| 1. Yes | 3. Not prepared to answer the question |
| 2. No | |

QUESTIONNAIRE: GENERAL HIV/AIDS INFORMATION

Please read each question or statement carefully, and then answer by marking either true or false in the relevant block below. There is no correct or wrong answer.

- | | | | |
|------|-------|----|--|
| True | False | 1 | AIDS is a medical condition in which your body cannot fight off the disease. |
| True | False | 2 | AIDS is caused by the HIV virus. |
| True | False | 3 | AIDS is a condition that you were born with. |
| True | False | 4 | AIDS means Acquired Immunodeficiency Syndrome. |
| True | False | 5 | AIDS can be cured and people recover from it. |
| True | False | 6 | HIV means Human Immunodeficiency Virus. |
| True | False | 7 | If a pregnant woman has AIDS, it may infect the baby. |
| True | False | 8 | HIV is carried in the blood of infected people. |
| True | False | 9 | All people who have HIV are sick with AIDS. |
| True | False | 10 | All gay men have AIDS. |
| True | False | 12 | It is safe to have sex without a condom if someone does not look sick. |
| True | False | 13 | Using a condom during sex lowers the risk of getting AIDS. |
| True | False | 14 | Infected blood can give a person AIDS during a blood transfusion. |
| True | False | 15 | You can get AIDS by sharing injecting equipment with other drug users. |
| True | False | 16 | HIV is carried in men's semen. |

- True False 17 Sharing tattoo equipment can cause HIV infection.
- True False 18 You can get HIV from toilet seats or touching urine.
- True False 19 You can get HIV from kissing an infected person.
- True False 20 You can get HIV from hugging or touching infected persons.
- True False 21 You can get AIDS by using someone's personal belongings.
- True False 22 You can get HIV through open cuts and wounds.
- True False 23 AIDS can be cured by having sex with a virgin.
- True False 24 AIDS weakens the ability of the body to fight off the disease.
- True False 25 I know if I am HIV+ or if I have AIDS.

QUESTIONNAIRE: PERSONAL VIEWS ABOUT SEX

Please read each statement carefully and indicate your agreement or disagreement by circling one number to the right of each statement.

- For example, circle 4 if you disagree strongly
- 3 if you disagree
- 2 if you agree
- 1 if you agree strongly
- 1 I would feel uncomfortable buying condoms. 4 3 2 1
- 2 I would feel uncomfortable asking for
condoms in prison. 4 3 2 1
- 3 Most of my friends practice safe sex 4 3 2 1
- 4 I would be too embarrassed to carry a condom
with me. 4 3 2 1
- 5 I prefer to have sex without a condom. 4 3 2 1
- 6 My body is too healthy to get AIDS. 4 3 2 1
- 7 I have changed the way I have sex since I know
about AIDS. 4 3 2 1

8	I would very uncomfortable around someone with HIV/AIDS.	4	3	2	1
9	There is a good chance that I will get AIDS in the next five years.	4	3	2	1
10	My friends feel that it is too much trouble to use condoms.	4	3	2	1
11	Even if my sex partner insisted, I would not use a condom.	4	3	2	1
12	I do not know how to use a condom.	4	3	2	1
13	Trying to have safe sex gets in the way of fun.	4	3	2	1
14	You have to talk to your partner about AIDS.	4	3	2	1
15	I would support a person with HIV/AIDS.	4	3	2	1
16	If I use drugs you will not get HIV/AIDS.	4	3	2	1
17	Tattoos cannot give you HIV/AIDS.	4	3	2	1

QUESTIONNAIRE: HIGH RISK BEHAVIOUR IN PRISON

Please read each statement carefully and indicate your agreement or disagreement by circling one number to the right of each statement.

For example, circle 4 if you disagree strongly
 3 if you disagree
 2 if you agree
 1 if you agree strongly

1	You are forced to get tattoos in prison.	4	3	2	1
2	Most prisoners I know had tattoos before they came to prison.	4	3	2	1
3	Prisoners use drugs in prison.	4	3	2	1
4	Some prisoners inject themselves with drugs in prison.	4	3	2	1

5	Those who injected drugs in prison share needles with other prisoners.	4	3	2	1
6	Prisoners prefer to have anal sex with one another.	4	3	2	1
7	Prisoners prefer to use condoms when they have anal sex in prison.	4	3	2	1
8	It is easy to get condoms in prison.	4	3	2	1
9	Some prisoners force you to have sex with them.	4	3	2	1
10	People get raped in the cells at night.	4	3	2	1
11	Some prisoners pay to have sex with other.	4	3	2	1
12	There is no sex between prisoners and correctional officials.	4	3	2	1
13	I can ask to be tested for HIV/AIDS here in prison.	4	3	2	1
14	Some gangs will rape people to punish them.	4	3	2	1
15	People in prison have sex every night of the week.	4	3	2	1
16	You can buy food and goods with sex in prison.	4	3	2	1
17	Prisoners will not rape someone who has HIV.	4	3	2	1
18	I know people in prison who have HIV/AIDS.	4	3	2	1
19	Some prisoners have sex in prison.	4	3	2	1
20	Prisoners ask each other all the time for sex.	4	3	2	1
21	If you are weak you will become a wyfie (prison wife).	4	3	2	1
22	I have been approached to have sex with another prisoner during my sentence.	4	3	2	1
23	Gang leaders choose who they want to have sex with.	4	3	2	1
24	Prisoners fight a lot with each other.	4	3	2	1
25	There are many weapons in prison to defend you				

	with.	4	3	2	1
26	Prisoners often think about killing themselves (suicide).	4	3	2	1
27	People will hurt themselves to draw attention to problems.	4	3	2	1
28	I know about people who have committed suicide in prison.	4	3	2	1
29	Staff members always protect prisoners .	4	3	2	1
30	I know prisoners who considered suicide at some stage during my sentence.	4	3	2	1

HARM REDUCTION IN STATE PRISONS

QUESTIONNAIRE (STAFF)

FINANCIALLY SUPPORTED BY THE NATIONAL RESEARCH FOUNDATION

RESEARCHER: MS GOMOLEMO MOSHOEU

8	I would very uncomfortable around someone with HIV/AIDS.	4	3	2	1
9	There is a good chance that I will get AIDS in the next five years.	4	3	2	1
10	My friends feel that it is too much trouble to use condoms.	4	3	2	1
11	Even if my sex partner insisted, I would not use a condom.	4	3	2	1
12	I do not know how to use a condom.	4	3	2	1
13	Trying to have safe sex gets in the way of fun.	4	3	2	1
14	You have to talk to your partner about AIDS.	4	3	2	1
15	I would support a person with HIV/AIDS .	4	3	2	1
16	If one uses drugs you will not get HIV/AIDS.	4	3	2	1
17	Tattoos cannot give you HIV/AIDS.	4	3	2	1

QUESTIONNAIRE: HIGH RISK BEHAVIOUR IN PRISON

Please read each statement carefully and indicate your agreement or disagreement by circling one number to the right of each statement.

For example, circle

4	if you disagree strongly
3	if you disagree
2	if you agree
1	if you agree strongly

1	People are forced to get tattoos in prison.	4	3	2	1
2	Most prisoners I know had tattoos before they came to prison.	4	3	2	1
3	Prisoners use drugs in prison.	4	3	2	1
4	Some prisoners inject themselves with drugs in prison.	4	3	2	1

5	Those who injected drugs in prison share needles with other prisoners.	4	3	2	1
6	Prisoners prefer to have anal sex with one another.	4	3	2	1
7	Prisoners prefer to use condoms when they have anal sex in prison.	4	3	2	1
8	It is easy to get condoms in prison.	4	3	2	1
9	Some prisoners will force you to have sex with them.	4	3	2	1
10	People get raped in the cells at night.	4	3	2	1
11	Some prisoners pay to have sex with other.	4	3	2	1
12	There is no sex between prisoners and correctional officials.	4	3	2	1
13	People can ask to be tested for HIV/AIDS here in prison.	4	3	2	1
14	Some gangs will rape people to punish them.	4	3	2	1
15	People in prison have sex every night of the week.	4	3	2	1
16	People can buy food and goods with sex in prison.	4	3	2	1
17	Prisoners will not rape someone who has HIV.	4	3	2	1
18	I know people in prison who have HIV/AIDS.	4	3	2	1
19	Some prisoners have sex in prison.	4	3	2	1
20	Prisoners ask each other all the time for sex.	4	3	2	1
21	If you are weak you will become a wyfie (prison wife).	4	3	2	1
22	I know prisoners who have been approached to have sex with another prisoner.	4	3	2	1
23	Gang leaders choose who they want to have sex with.	4	3	2	1
24	Prisoners fight a lot with each other.	4	3	2	1
25	There are many weapons in prison to defend you				

	with.	4	3	2	1
26	Prisoners often think about killing themselves (suicide).	4	3	2	1
27	People will hurt themselves to draw attention to problems.	4	3	2	1
28	I know about people who have committed suicide in prison.	4	3	2	1
29	Staff members always protect prisoners .	4	3	2	1
30	I know prisoners who considered suicide at some stage during their sentence.	4	3	2	1

**DUBLIN DECLARATION
ON HIV/AIDS IN PRISONS
IN EUROPE AND CENTRAL ASIA**

Good Prison Health is Good Public Health

Dublin, Ireland
February 23, 2004

The Dublin Declaration on HIV/AIDS in Prisons
in Europe and Central Asia was prepared by

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Released in Dublin, Ireland
February 23, 2004

During the conference
*Breaking the barriers: Partnership in the fight against
HIV/AIDS in Europe and Central Asia*

Dublin Castle
Dublin, Ireland
23—24 February 2004

PREAMBLE

HIV/AIDS is a serious problem for prison populations across Europe and Central Asia.

In most countries, rates of HIV infection are many times higher amongst prisoners than amongst the population outside prisons.* This situation is often exacerbated by high rates of Hepatitis C and/or (multi-drug resistant) Tuberculosis in many countries. In most cases, high rates of HIV infection are linked to the sharing of injecting equipment both inside and outside prison walls and to unprotected sexual encounters in prison. In a majority of countries, adequate preventive measures have not been introduced in prisons, although they have been successfully introduced in other prison systems and shown to be effective. As a result, people in prison are placed at increased risk of HIV infection, and prisoners living with HIV/AIDS are placed at increased risk of health decline, of co-infection with Hepatitis C and/or TB, and of early death.

The failure to implement comprehensive programmes that are known to reduce the risk of HIV transmission in prisons and to promote the health of prisoners living with HIV/AIDS is often due to lack of political will or to policies that prioritize zero-tolerance to drug use over zero-tolerance to HIV/AIDS. In some cases, it is the result of a lack of state resources and technology to meet the overwhelming need. In some cases it is both.

This public health crisis requires urgent attention and action from all governments.

Under national and international law, governments have a moral and ethical obligation to prevent the spread of HIV/AIDS in prisons, and to provide proper and compassionate care, treatment, and support for those infected. What needs to be done is clear: policies and programmes that effectively reduce the spread of HIV in prisons and provide care, treatment and support for prisoners living with HIV/AIDS already exist in several countries and should be replicated elsewhere.

People in prison have the same right to health as people outside, and the lives and health of people in prison are connected to those of people outside prison in many ways. If we protect them, we also protect our broader communities. Protecting prisoners will also protect prison staff, who also have a right to be protected against HIV/AIDS, Hepatitis C, and TB in prisons, and whose needs are entirely compatible to those of the prisoners in this respect.

As the representatives of 55 governments from Europe and Central Asia gather in Dublin this week to discuss "Breaking the Barriers" in the fight against HIV/AIDS, we call upon them to begin by breaking down the barriers over which they have total control – the barriers that have thus far prevented comprehensive HIV/AIDS services from being implemented in prisons.

* Studies in various countries in Western Europe, Eastern Europe and Central Asia have found rates of HIV infection between 0–17% among prisoners.

PURPOSE

This Declaration provides a framework for mounting an effective response to HIV/AIDS in the prisons of Europe and Central Asia. The Principles and Articles outlined herein are based upon recognized international best practice, scientific evidence, and the fundamental human rights of people in prison and the obligations of States to fulfil those rights.

STATEMENT OF FUNDAMENTAL PRINCIPLES

Principle 1: People in prison are part of our communities.

People in prison are fathers and mothers, brothers and sisters, sons and daughters, grandfathers and grandmothers, husbands and wives, lovers, partners and friends. The fact that they are incarcerated for a period of time does not change this fact. Prisoners come from our communities and the vast majority return to our communities.

Principle 2: People in prison have a right to health.

This right is guaranteed in international law, as well as in international rules, guidelines, and covenants including the *Universal Declaration of Human Rights*, the *International Covenant on Economic, Social and Cultural Rights* (Article 12), the *International Covenant on Civil and Political Rights* (Article 10.1), the United Nation's *Basic Principles for the Treatment of Prisoners* (Principles 5 and 9), and the Council of Europe's *Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison* (Recommendation 10). This includes the right to medical treatment and to preventive measures, and to standards of health care equivalent to that available in the community. States are obligated to uphold this principle. Those that do not are in violation of both international law and international guidelines on the treatment of prisoners.

Principle 3: Good prison health is good public health.

The vast majority of people sent to prison eventually return to the community. Therefore any diseases contracted in prison, or any illnesses made worse by the conditions of confinement, become issues of public health when people are released. Governments cannot ignore prison health issues, as they are fundamentally a component of public health. Reducing the transmission of HIV and Hepatitis C in prisons is an important element in reducing the spread of these diseases in the broader population. Implementing effective TB treatment programmes in prisons will prevent the spread of (multi drug resistant) Tuberculosis inside and outside prison.

Principle 4: Protecting the health of prisoners, and reducing the transmission of disease in prisons, also protects the health of prison staff

Prison staff benefits from enhancing the health status of prisoners, and reducing the incidence of disease in penal institutions. Therefore, improving health care and prevention programmes for prisoners is an integral part of enhancing workplace health and safety for prison staff.

Principle 5: Sex and injecting drug use occur in prison, and in many prisons are widespread.

Experience in many countries in Europe and Central Asia (as in other parts of the world) has shown that sexual activity and injecting drug use occur in prisons, and are often widespread. Governments must publicly recognise this situation and act to implement appropriate health interventions. Denial of this reality by governments inhibits the fight against HIV/AIDS in prisons.

Principle 6: Harm reduction, rather than zero-tolerance, must be the pragmatic policy basis for fighting HIV/AIDS in prisons and in providing HIV/AIDS care.

International evidence has shown that HIV transmission can occur in prison, sometimes with alarming speed. Zero-tolerance policies towards drug use can create barriers to the fight against HIV/AIDS in prisons. The criminalization of drug use has ensured that drug users comprise a disproportionate part of prison populations. Many drug users do not cease using drugs simply because they are imprisoned. Many prisoners continue to inject on a regular or occasional basis during their incarceration. Zero-tolerance approaches towards drug use that ignore this reality result in prison policies that increase the likelihood that these injecting practices will be unsafe, and heighten the risk of HIV transmission. Therefore, in order to effectively fight HIV/AIDS in prisons, prison and health policy must be based on the philosophy of harm reduction.*

* Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. This includes discouraging the sharing of contaminated injecting equipment by providing sterile injecting equipment and disinfectant materials to users, and providing a range of drug dependence treatment including substitution treatment. Harm reduction accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them. Rather, harm reduction understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself, and calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm. (Definition adapted from the Harm Reduction Coalition, www.harmreduction.org)

Principle 7: HIV/AIDS in prisons is a major problem in many countries, and States must act collectively and cooperatively in the fight against the epidemic.

HIV/AIDS is an international problem that demands international solutions. Preventing HIV transmission in prisons and providing treatment for prisoners living with HIV/AIDS can be costly. In this fight, wealthier countries have a moral obligation to assist countries that are less wealthy.

Principle 8: Action to fight Hepatitis C in prisons is as crucial as is action to fight HIV/AIDS, and must be integrated into all initiatives addressing HIV/AIDS prevention and treatment.

Hepatitis C is an infection driven largely by unsafe injecting practices. In the prisons of many countries, rates of Hepatitis C infection are also many times higher than in the outside community, and many prisoners living with HIV/AIDS are also co-infected with Hepatitis C. Therefore, the fight against Hepatitis C in prisons is integrally linked to the fight against HIV/AIDS. The rights and principles outlined in this Declaration apply equally to the issue of Hepatitis C, and government strategies to combat the transmission of HIV and to care for those living with the illness must be integrated with those of Hepatitis C.

FRAMEWORK FOR ACTION

Article 1: Prisoners have a right to protect themselves against HIV infection. Prisoners living with HIV/AIDS have a right to protect themselves from re-infection and/or co-infection with Hepatitis C and/or TB.

Therefore, States have a responsibility to

- Ensure that HIV prevention measures available in the outside community are also available in prisons. This includes providing prisoners with free access to HIV prevention and harm reduction measures including, but not limited to, sterile syringes and injecting paraphernalia; condoms and other safer sex materials; bleach and disinfectants; safer tattooing equipment.
- Provide free access to methadone and other substitution treatments to prisoners in those countries where these treatments are provided in the community. This must include both the ability of people who are already on such a treatment to continue it when incarcerated, and the ability to initiate substitution programmes during incarceration. Countries that have not legalized or implemented substitution treatments should do so.
- Provide access to harm reduction measures in a confidential and non-discriminatory fashion.

- Provide accurate and easily understood information on the proper use of harm reduction measures using an effective means of delivery.
- Offer effective and timely treatment of Tuberculosis inside prison walls and ensure proper follow up when released in society.

Article 2: Prisoners living with HIV/AIDS have a right to maintain and promote their health.

Therefore, States have a responsibility to

- Provide free access to HIV/AIDS treatment and care that is equivalent to that available to people outside prison. This should include antiretroviral treatment, proper diet, health promotion options, and pain management medications.
- Provide prisoners with the same access to non-approved, investigational, and non-conventional and alternative therapies that people outside prison have.
- Provide quality gynecological and obstetrical care for HIV positive pregnant women in prison, including antiretroviral therapy on a continuous basis, and prophylaxis for the infant during and post-delivery to ensure that vertical transmission of the infection is interrupted.
- Provide sufficient levels of qualified medical personnel in prisons.
- Include treatment of STIs as a key component of a comprehensive HIV care.
- Improve conditions of confinement (overcrowding, poor prison conditions, poor sanitation, poor lighting and ventilation) that can negatively affect people with weakened immune systems.
- Provide access for non-governmental organizations and other external health professionals to assist in the provision of care, treatment, and support services.

Article 3: Prisoners have a right to keep their HIV status confidential.

Therefore, States have a responsibility to

- Ensure that the security and confidentiality of prisoners' medical information is guaranteed.
- Ensure that prisoners are not housed, categorized, or treated in such a fashion as to disclose their HIV status, and that prison records are not marked or labelled in such a manner as to disclose HIV status.

Article 4: Prisoners have a right to informed consent in accessing HIV treatments and therapies, including the right to refuse treatment.

Therefore, States have a responsibility to

- Prohibit mandatory treatment of prisoners living with HIV/AIDS.
- Ensure that prisoners are provided with information on HIV treatments and therapies sufficient to enable them to make an informed choice about their treatment options.

Article 5: Prisoners have a right to access voluntary, confidential HIV testing, with pre- and post-test counselling. Prisoners have a right to informed consent before being tested for HIV infection, including the right to refuse testing.

Therefore, States have a responsibility to

- Prohibit mandatory HIV testing of prisoners.
- Provide access to voluntary, confidential HIV testing for prisoners.
- Ensure that proper pre- and post-test counselling is a mandatory component of HIV testing protocols and practice.
- Provide access to anonymous HIV testing to prisoners in countries where such testing is available in the community.

Article 6: Prisoners living with HIV/AIDS have a right to live free from stigma, discrimination, and violence.

Therefore, States have a responsibility to

- Ensure that prisoners living with HIV/AIDS are not involuntarily segregated or isolated from the general prison population because of their HIV status.
- Ensure that prisoners living with HIV/AIDS are not prohibited from participation in prison programming, work, or recreational activities because of their HIV status.
- Provide education on HIV/AIDS for all prisoners and prison staff.
- Combat AIDS-phobia among prisoners and prison staff.
- Provide regular training on communicable diseases and drug use for all prison staff, and to update this training on a regular basis.

Article 7: Prisoners have a right to accurate, non-judgemental, and accessible education on HIV/AIDS.

Therefore, States have a responsibility to

- Provide free access to such educational information in various formats on an ongoing basis.

Article 4: Prisoners have a right to informed consent in accessing HIV treatments and therapies, including the right to refuse treatment.

Therefore, States have a responsibility to

- Prohibit mandatory treatment of prisoners living with HIV/AIDS.
- Ensure that prisoners are provided with information on HIV treatments and therapies sufficient to enable them to make an informed choice about their treatment options.

Article 5: Prisoners have a right to access voluntary, confidential HIV testing, with pre- and post-test counselling. Prisoners have a right to informed consent before being tested for HIV infection, including the right to refuse testing.

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- Prohibit mandatory HIV testing of prisoners.
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- Provide education on HIV/AIDS for all prisoners and prison staff.
- Combat AIDS-phobia among prisoners and prison staff.
- Provide regular training on communicable diseases and drug use for all prison staff, and to update this training on a regular basis.

Article 7: Prisoners have a right to accurate, non-judgemental, and accessible education on HIV/AIDS.

Therefore, States have a responsibility to

- Provide free access to such educational information in various formats on an ongoing basis.

- Address HIV prevention as one component within a comprehensive programme of STI prevention.
- Provide access for non-governmental organizations and other external health professionals to assist in the provision of educational interventions.
- Provide support for peer education initiatives by prisoners themselves.

Article 8: Prison populations have a right to have their diversity acknowledged and respected in the design and provision of HIV/AIDS services.

Therefore, States have a responsibility to

- Provide HIV/AIDS interventions and services that address and respect differences in gender, age, race, ethnicity, language, sexual orientation, and gender identity.

Article 9: Prisoners, prison staff, and non-governmental organizations should be consulted in the design and implementation of prison HIV/AIDS programmes.

Therefore, States have a responsibility to

- Create mechanisms that allow for meaningful input from prisoners, prison staff, and non-governmental organizations in the content, design, and delivery of HIV/AIDS programmes.
- Encourage and support peer-led educational and support interventions by prisoners themselves.
- Ensure the sustainability of short-term NGO interventions by embedding them within prison programming.

Article 10: Prisoners living with HIV/AIDS have a right to a continuity of post-release healthcare services.

Therefore, States have a responsibility to

- Create systems of referral between prisons and community healthcare, social services, substitution treatment, and harm reduction services.
- Ensure that community health and social services receive sufficient resources and other supports to enable them to provide post-release care for ex-prisoners.

Article 11: Wealthier states have an obligation to assist and support less-wealthy states in providing HIV prevention and treatment options to prisoners.

Therefore, wealthier States have a responsibility to

- Provide affordable access to HIV treatments and therapies, harm reduction measures, and technical expertise to countries with fewer resources and medical/pharmaceutical infrastructure. This must include allowing for the development of generic HIV drugs.

• SIGNATORIES



We therefore request an appointment to arrange further actions for the finalization of the research project.

Warmest regards


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