SOUTH AFRICAN CORRECTIONAL CENTRES AND THE NEED TO RETHINK APPROACHES TO HIV/AIDS

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ABSTRACT

HIV/AIDS treatment inside South African correctional centres recently dominated headline discussions. Every country should take measures to ensure good health for all citizens. The right to health is a Constitutional right in South Africa. Although certain Constitutional rights may be limited, the right to health should not be exposed to limitations when the interest of society as a whole becomes affected. Therefore, there could be little doubt that the management of HIV/AIDS in correctional settings is more important today than ever before. During 2003 South African prison authorities admitted that HIV/AIDS in correctional centres is an enormous problem and that the rate of prevalence and growth is unknown. The seriousness of the issue was compounded by overcrowding, poor health facilities and violence. In this article the position of South Africa concerning HIV/AIDS as a particular health care phenomenon is investigated against the background of developments and actions inside the correctional centres of the country. Emphasis is be placed on the undeniable link between prison health and public health, which underpins the need to rethink approaches to HIV/AIDS in correctional centres.

INTRODUCTION

In recent time human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) treatment inside South African correctional centres dominated headline discussions, especially the access to such treatment by inmates. Over the years HIV/AIDS became a serious problem in prison populations. Evidence of such increases form part of this discussion and is illustrated in more detail later on. However, studies during the early 1990's have shown that HIV prevalence can vary widely, from none in a young male offender institution in Scotland, to 33.6% in an adult prison in Catalonia (Spain), and over 50% in a female correctional facility in New York (Yirrell, Robertson, Goldberg, McMenamin, Cameron & Leigh Brown, 1997).

North American states are also not immune to the phenomenon. Canada reported a high prevalence of HIV in correctional facilities which are under control of the Correctional Service of Canada in 2004. Investigators highlighted that HIV infection rates among Canadian female offenders are higher than among males (Canadian Human Rights Commission, 2004). Pongrac (2002) also stated that previous research has consistently reported higher rates among female inmates in penitentiaries.

The picture in the United States is also one of distorted proportions. Of those known to be HIV positive in all United States correctional centres at the end of 2001, 5 754 were confirmed AIDS cases, an increase from 5 696 in 2000 (as illustrated in the table below). Later statistics from the United States continued to confirm the distorted picture. By the

end of 2004, confirmed HIV positive cases in American correctional centres decreased, even though authorities reported an increase in the number of inmates. However, it is reported that 10 states have not provided statistics, which could have a significant influence on the true picture. Nonetheless, confirmed AIDS cases in the general population by the end of 2004 amounted to 0.15%, while that in the prison population was 0.50%, nearly five times higher than the general population. General HIV/AIDS statistics for the United States are set out in the table below (Maruschak, 2006:1-7):

Table 1
HIV/AIDS cases in American Federal and State correctional centres

Year	Number HIV +	% of inmate population	Reported AIDS cases*	AIDS-related deaths in prison**
1998	25 680	2.2%	6 282	350
1999	25 807	2.1%	6 642	242
2000	25 333	2.0%	5 696	185
2001	24 147	1.9%	5 754	311
2002	23 866	1.9%	4 898	283
2003	23 663	1.9%	5 227	268 + 14
2004	23 046	1.8%	5 483	185 + 18

* In 1998, 7 states have not reported statistics, 5 in 1999, 8 in 2000, 12 in 2002, 13 in 2003, and 10 in 2004.
** Statistics for 1998 - 2002 exclude Federal Correctional Centres.

In a recent study about harm reduction in Scottish correctional centres, 76.19% of participants (n = 42) in focus group interviews indicated that they knew their HIV and Hepatitis C status. The highest number of those who did not know their status came from Edinburgh prison and was cases on remand. At Glenochil, a prison for long-term inmates, all participants knew their status. Concerning the HIV status of other inmates, it was observed that in correctional centres where longer sentences are served, statuses of co-inmates were known more widely (Luyt, 2007). Concerns about HIV in Scottish correctional centres revolve mainly around needle sharing during injection drug use. Nonetheless, Power, Markova, Rowlands, McKee, & Kilfedder (1994) found that Scottish self-perceived risk of HIV infection was significantly higher prior to imprisonment than during imprisonment.

In South Africa, the Judicial Inspectorate of Prisons estimated HIV prevalence as high as 60%, based on research by the University of Natal at the Westville correctional centre (Goyer, 2003). The Department of Correctional Services disputed these estimates as unrealistic and unreliable. HIV testing inside South African correctional centres is conducted on a voluntary basis. According to Knight (2006) estimates were that 5.84% of the 110 000 sentenced inmates, or 6 400 were HIV positive, while no estimates were available for the 48 000 awaiting-trial inmates. Until 2006 South African correctional centres were not accredited to dispense anti-retroviral therapy. Therefore, inmates who were already suffering from AIDS did not have the same direct access to anti-retroviral therapy inside South African correctional centres as was the case in the general

population. Also, those who entered prison on medication had no continuation in treatment (Knight, 2006). Today, inmates receive anti-retroviral treatment, as will be elaborated on in the rest of this discussion.

In the majority of countries HIV infection rates are much higher amongst inmates than amongst the general population. This situation is often exacerbated by high rates of Hepatitis C and tuberculosis. In most cases, high rates of HIV infection could be linked to the sharing of injection and tattoo equipment, as well as unprotected and often coerced sexual encounters (Jürgens, 2004). The lack of proper preventative measures places inmates in correctional centres at increased risk of HIV infection, while those living with HIV/AIDS are at increased risk of health decline, co-infections and even early death (Jürgens, 2004).

There can be little doubt that the management of HIV/AIDS in correctional settings is more important today than ever before. It comes as no surprise that correctional authorities in South Africa became obliged to develop improved strategies to deal with the phenomenon inside South African correctional centres. HIV in correctional centres worldwide remains part of the public health ambit and influences the wider community directly. The aim of this article is to expplore the situation of South Africa against the background of developments and actions inside the correctional centres of the country. Emphasis will be placed on the undeniable link between prison health and public health. Furthermore, measures to improve approaches to important health issues will be outlined in particular.

BACKGROUND REGARDING HIV/AIDS IN SOUTH AFRICAN CORRECTIONAL CENTRES AND THE GENERAL PUBLIC

Since 2001 the South African Department of Correctional Services followed an HIV/AIDS policy aligned to strategies of UNAIDS, the World Health Organization, and the HIV/AIDS and STD Strategic Plan for South Africa: 2000-2005 (and later to the 2007-2011 plan) (Department of Health, 2000). The increased impact of HIV/AIDS related diseases and chronic conditions remained one of the biggest challenges on health service delivery (Department of Correctional Services, 2002).

Statistics regarding HIV infection rates amongst the general population in South Africa are mostly derived from antenatal clinics. According to Goyer (2003) the prevalence of sexually transmitted infections (usually associated with HIV infection) in the general community is very high. For example, whereas the prevalence of syphilis in the United States or United Kingdom is not higher than 15 cases per 100 000 of the general population, South Africa rates between 5 000 and 15 000 cases per 100 000.

Goyer (2003) states that in rural areas of the KwaZulu-Natal province, about 25% of women have at least one sexually transmitted infection at any moment in time. Fifty percent of women who have attended antenatal clinics in the same area had at least one sexually transmitted disease, and 18% had more than one. A 2006 Department of Health study unveiled that Kwazulu-Natal antenatal clinics show the highest provincial HIV

prevalence at 39.1% (Avert, 2007:1). A significant number of the prison population is also situated in Kwazulu-Natal, with at least ten large correctional centres situated in that province (Department of Correctional Services, 2008).

While antenatal clinic statistics became an objective and reliable source of information in most respects, statistics about HIV prevalence in South African correctional centres can be described as underreported. In fact, to obtain accurate statistics is virtually impossible. Although one has to admit that the availability of accurate HIV statistics is a problem in various correctional systems around Africa, it is not an acceptable explanation for the South African context. Various factors play a role in underreporting and inaccurate statistics. Firstly, known statistics are predominantly derived from self-reported cases. Voluntary testing occur on request of the inmates. Secondly, HIV infection is still very much stigmatized and is therefore not frequently discussed, since it allows for maltreatment and labeling from correctional officials and inmates alike. Thirdly, HIV prevalence has become a challenge for prison authorities, both in terms of various aspects of harm reduction as well as the roll-out of the National Health Anti-retroviral Therapy policy (Avert, 2008). The 32 448 annual complaints (2005/06) to the independent Judicial Inspectorate of Prisons regarding health care in prison (which includes HIV/AIDS complaints) are of the highest, compared to other types of complaints and is not inclusive of the 1 458 requests for medical release (Fagan, 2006). These complaints emphasise the need for medical treatment in general and HIV-related treatment in particular.

Nonetheless, accurate HIV statistics within the South African correctional environment remains an enormous problem. There are some indicators as to the magnitude of infection. One indicator is natural deaths in custody, while another is the number of self-reported and tested cases. The Judicial Inspectorate of Prisons (Fagan, 2004) reported that since 1995 the number of natural deaths has escalated at a rate much higher than that of inmate numbers. Consider that not all natural deaths can be contributed to HIV infection but post mortem investigations from the Judicial Inspectorate of Prisons into the causes of death suggest nevertheless that in the majority of cases the illnesses that caused death are HIV/AIDS related. The figures indicate an escalation of 584% during the period 1995 to 2000, bringing the number of natural deaths in 2000 to 1 087. This trend continued and in 2003 a total of 1 683 natural deaths were recorded. Of these, 389 were awaiting-trial detainees. During 1995 the natural death rate was 1.65 deaths per 1000 inmates. This rate stood at 9.1 deaths per 1 000 inmates in 2004 (at 1 689). However, by the end of 2005 it increased to 9.2 deaths per 1 000 inmates, despite the fact that the prison population decreased by 30 000 (from 187 456 to 157 402) over the same period (Fagan, 2006).

A further potential indicator of HIV infection in correctional centres could be the number of terminally ill inmates released, as advanced illness due to AIDS is sufficient grounds for medical release from a South African correctional centre. One has to caution though that all medical releases could not be contributed to AIDS. Nevertheless, the causes of terminal illness could provide an indication of possible HIV infection. To be released on medical grounds is a very difficult process. Awaiting-trial detainees have to apply to the judge or magistrate, while sentenced inmates could receive medical parole. Should the

health status of people on parole show advanced improvement, they may be re-imprisoned. During 2003, a total of 117 (7%) of terminally ill prisoners were placed on medical parole. Although it has increased from the 88 inmates released in 2002, it is still much lower than the 23% of terminally ill inmates released on medical grounds during 1996 (Fagan, 2004). In 2004, 76 inmates received medical parole. This number declined to 64 in 2005 (Fagan, 2006).

During 2004 the Minister of Correctional Services, Honourable Ngconde Balfour indicated that a HIV/AIDS Prevalence and Attitude Survey is a key priority for 2004/05. There was a serious urge to get to the root of the growing HIV problem in correctional centres. With the estimated HIV/AIDS prevalence in South African correctional centres at 4.02% of the total prison population in 2006 (Knight, 2006), the number of HIV infected cases in prison grew at an alarming rate during the past decade. The 2005/06 Annual Report of the Department of Correctional Services (2006) indicated that the tender for the HIV/AIDS Prevalence and Attitude Survey was finalised in August 2005 and that results were expected in the 2006/07 financial year.

In a presentation to the Parliamentary Portfolio Committee for Correctional Services during September 2006, feedback was provided concerning the pilot study that was completed in Gauteng during May 2006. The aims of the HIV/AIDS Prevalence and Attitude Survey (announced in 2004) was broadened to include syphilis prevalence. The findings from the pilot study regarding HIV/AIDS prevalence were cause for concern. Of the seven reported findings, four findings referred to poor participation rates. The other three findings reported (1) that there was a prevalence of both HIV and syphilis, (2) that there was no correlation between HIV and syphilis, and (3) that the prevalence of the one was not significantly associated with the presence of the other (Correctional Services Portfolio Committee, 2006). Why the cause for concern? Observations were that the current study may fall pray to efforts to invalidate the study of Goyer (2003), therefore the specific incorporation of syphilis. The main motivation for such observations is that the Department of Correctional Services severely criticized the Goyer (2003) study and rejected the findings. The Office of the Inspecting Judge of Prisons (based on the Goyer study) placed the prevalence rate at 60%. The Institute for Security Studies' report ranked prevalence at 45%, with the Department of Correctional Services' own figure falling below 5% (Department of Correctional Services 2003). The re-launch of its research was presented as one of the major achievements to the portfolio committee during March 2007 (Correctional Services Portfolio Committee, 2007). Results are eagerly awaited in anticipation that more light would be shed on HIV prevalence as such.

In 1994 the Department of Correctional Services (1994) reported that confirmed HIV/AIDS cases in correctional centres suggested that one out of every 255 sentenced inmates (population 111 802) was infected with HIV, while one out of every 80 persons in the community (irrespective of age) was HIV positive. This would mean that the HIV infection rate was reported to be much lower inside correctional centres during that time.

The table below provides details of the fluctuations in the known number of HIV/AIDS cases in correctional centres since 1998 (Department of Correctional Services, 2002). The

Department of Correctional Services does not include HIV/AIDS statistics in annual reports anymore. Comparisons are therefore extremely difficult but an escalation is nevertheless evident from Table 2.

Table 2
Number of known HIV/AIDS cases in South African correctional centres

Year	Inmate Population	HIV/AIDS cases	% of Inmate Population
1998	146 435	1 865	1.27%
1999	154 574	2 536	1.64%
2000	171 462	3 397	1.98%
2001	170 959	4 720	2.76%
2002	178 998	Not published in Annual Report of DCS	
2003/04*	187 640	7 000 (rounded)	3.73%
2006**	158 858*** (110 000)	6 400	4.02% (5.84%)

*Official figures obtained from the Department of Correctional Services Annual Report for 2003/2004.
**Statistics obtained from Knight (2006).
***According to Knight (2006) the number of inmates should only be 110 000, as prevalence under the 48 000 awaiting-trial detainees is unknown.

IMPORTANT LINKS BETWEEN PUBLIC AND CORRECTIONAL HEALTH

During 2003 South African correctional authorities admitted that HIV/AIDS in correctional centres is an enormous problem and that the rate of prevalence and growth is unknown. The seriousness of the issue was compounded by overcrowding, poor health facilities and violence (Department of Correctional Services, 2004). With the latter in mind a range of links between public and prison health will now be investigated, contextualized and aligned to existing realities and practices from a South African perspective.

People in corrections are part of our communities

Inmates come from our communities and the vast majority returns to the same communities. Fagan (2006) indicates that there is a high turnover rate of offenders admitted to and released from prison. In 2003, during any month, more than 25 000 inmates were released from corrections. Nearly the same number of inmates was admitted from the courts and the South African Police Services (SAPS) (Fagan, 2004).

HIV/AIDS in correctional centres remain part of public health and influences the wider community directly. Governments have a moral and ethical obligation to prevent the spread of HIV/AIDS in society, including amongst the inmate prison society. When inmates are protected, broader communities will also be protected. The figures below were combined from annual reports of the Judicial Inspectorate of Prisons (Fagan, 2004, 2005, 2006) and illustrate releases from correctional centres over a period of three years. Particular emphasis is placed on the group "*Awaiting-trial to court not returned from*

court." These detainees were exposed to the detrimental effects of imprisonment without substantial evidence that they have committed an offence. The larger number of releases of sentenced inmates in 2005/06 resulted from special remission in June to August 2005.

Table 3
Type of release

	2003/04	2004/05	2005/06
Medical	117	76	64
Bail pending appeal	345	311	361
Deportation/repatriation	1 827	2 543	3 508
Detainees*	2 873	2 888	1 995
Warrant of Liberation	4 617	4 952	4 550
Awaiting-trial transferred to SAPS	5 917	1 221	5 011
Parole Board prisoners	11 304	10 211	16 673
Fine paid	12 423	15 391	15 440
Parole Non-Board prisoners	13 148	10 834	6 673
Sentenced prisoners on sentence expiry date	18 980	20 607	35 726
Awaiting-trial bail paid	44 174	64 029	62 932
Awaiting-trial to court not returned from court	199 058	225 373	246 912
Total	314 783	358 436	399 845

* Detainees refer to prisoners incarcerated on authority other than a court

Some inmates spent a short time in correctional facilities, such as cases where a fine is paid and those who paid bail (about 1 300 and 5 250 per month respectively). Other inmates spent on average 3-5 months in correctional facilities such as the "Awaiting-trial to court, not returned from court" category (about 20 600 per month). Sentenced inmates released on sentence expiry date, might have spent years in a correctional facility and were released at a rate of about 3 000 per month (2006). Those inmates who were sentenced to two years and more of imprisonment were released at a rate of nearly 1 400 per month (2006). Inmates with a sentence of less than two years were released at a rate of more than 560 per month. During 2006, releases from correctional facilities increased to nearly 31 000 per month.

Nearly 250 000 innocent citizens revolved through the criminal justice system in 2006. In the previous two years the total was nearly 425 000. At an average of 225 000 people per year over three years, this would mean that roughly 2.7 million people were exposed to imprisonment during the period of democracy alone, without substantial evidence that they have committed an offence. These innocent people "served" an average "sentence" of three months in a criminal justice system where one is supposedly "innocent until proven guilty."

Potential exposure to the harm originating from the correctional environment may include as many as 800 000 persons per year, taking into account that almost 400 000 (399 845) released persons may have families, wives and partners in the community.

Current tendencies show that the incarceration rate in South Africa is growing at a "healthy" pace, irrespective of efforts to reduce it. Luyt (2003b) previously pointed out that South Africa resorts under the ten most aggressive incarcerators in the world (housing more than 100 000 people) and Fagan (2006) confirmed this. Therefore, one could accept that public exposure to various forms of correctional harm will also increase. The increase in the confirmed HIV positive cases in correctional facilities could already be an indication of this trend.

DiClemente and Peterson (1994) claimed that sexual abstinence is the most obvious method of preventing sexual transmission of HIV. Incidentally, a substantial proportion of adults fail to adopt abstinence. At the same time, the expectation to adopt abstinence as a measure of HIV prevention is unrealistic. This statement is of value to all communities. The partners of imprisoned people may be in a position to abstain from sexual activity. However, some may engage in sexual activity with other people while their regular partners are imprisoned. When this happens the opportunities for HIV infection in communities would increase. This increased risk may be due to the indirect effects of imprisonment.

People in correctional facilities have a right to health care

Section 27 of the Bill of Rights in the Constitution of South Africa (Republic of South Africa, 1996:13) allows all citizens the right to health and medical treatment. The Constitution also secures the right of individuals who are detained to obtain their own medical practitioner in terms of Section 35 (2) (f) (iv) (Republic of South Africa, 1996:16). In addition, various aspects regarding health care of inmates are included in the Correctional Services Act 111 of 1998 (Republic of South Africa, 1998).

Health care in South African correctional centres are divided into three levels of care. The first is primary health care clinic services at small centres. The second entails primary health care services at large centres, combined with in-patient care facilities and stand-by services after hours. Thirdly, there are provincial correctional hospitals for more serious cases from where access to public hospitals is facilitated. In some instances inmates may be admitted to private hospitals, although this is not a general practice anymore (Department of Correctional Services, 2002:77). The Department of Correctional Services reported facing various medical challenges, including insufficient access to medical and dental practitioners, a chronic shortage of professional nursing staff, inferior salaries to attract and retain professional staff, chronic overpopulation, and the increased impact of HIV/AIDS related diseases and chronic conditions (Department of Correctional Services, 2002:77). These factors impedes on the health care standards inmates are exposed to, thus also affecting their right to health care in a negative way.

Good prison health is good public health

Diseases contracted in prison, or any illnesses made worse by the conditions of confinement, become issues of public health when people are released. According to Abeyta-Phelps (1993:147) a prison nurse with six years of experience once wrote:

> *I believe the standards for quality and professionalism in correctional medicine are the same as those for care delivered and expected in the free world. Contrary to public opinion, however, medical care in a prison environment requires a specific mental attitude, a special fortitude, a special understanding from the medical provider. Health care for inmates should be tempered with a great deal of diplomacy and compassion. It disturbs me to see medical care providers with the attitude that inmates are lucky to receive care of any kind.*

Burdon (1999) stated that released HIV positive inmates would seek help from friends or peers more often than from professionals. They would also seek assistance more from professionals than from families. In other words, inmates would keep their HIV status a secret to those close to them for as long as possible. For this reason there should be more integration between correctional and societal health care. Inmates should know upon release where to go to continue any form of treatment that was initiated inside the correctional facility.

It was mentioned earlier that South African correctional centres were not accredited to dispense anti-retroviral therapy during 2006. Good prison health as stated in the principle above could therefore not be delivered regarding HIV treatment. The inevitable outcome regarding HIV in corrections was that it contributed to bad public health. During June 2006 the Durban High court ordered correctional authorities to treat 15 HIV positive inmates at the Westville prison (Treatment Action Campaign and Others v Government of the Republic of South Africa and Others (76/06/01) [2006] ZAKZHC 9). This only realised after inmates obtained a court order that instructed the Department to comply, followed also by an unsuccessful appeal from the Department of Correctional Services together with a contempt of court order against the Department (Business Day, 2006:1). All the inmates involved showed a CD4 count of less than 200. A CD4 count indicates the strength of the immune system in humans. Normal counts in adults range from 500 to 1500 cells per cubic millimeter of blood. The American based Centre for Disease Control regards HIV positive persons to have AIDS once CD4 counts go below 200, regardless whether the person is sick or not. Policies of the South African Department of Health provide for free antiretroviral (ARV) treatment once the CD4 count measures below 200 (Department of Health, 2006).

However, it required the initiative of 242 inmates to begin with a hunger strike in March 2006 as well as filing a court application to obtain the right to good health in prison. Since the court ruling, four correctional centres, namely Grootvlei in Bloemfontein, Pietermaritzburg, Qalakabusha in Empangeni and St Albans outside Port Elizabeth were accredited as ARV treatment sites. Efforts to increase the number are still continuing. The Mangaung maximum prison outside Bloemfontein, for example, is a private correctional facility but ARV treatment is also available there.

Protecting the health of inmates, and reducing the transmission of disease in correctional centres, also protect the health of prison staff

Improving health care and prevention programmes for inmates is suppose to be an integral part of enhancing workplace health and safety for correctionsal. Nearly 41 500 staff members (41 393 on 30 April 2007) were employed in corrections (Department of Correctional Services, 2007). The majority of them are in daily contact with the inmate population. The very nature of their occupation entails an increased risk of exposure to HIV infection due to searching (when needle pricking or cuts from tattoo equipment may occur) and intervening in cases of interpersonal violence. Assaults mounted to 2 973 during the statistical year 2001/2002 (Department of Correctional Services, 2002). During the year 2005 the Judicial Inspectorate received 4 755 complaints regarding assaults (inmate on inmate) and 2 494 regarding assaults of staff on inmates (Fagan, 2006). Although the risk of exposure to infections is lower for staff members than for inmates, it is nevertheless a risk that may be increasing in line with prison overcrowding and the growing number of HIV positive cases.

Tuberculosis has always been present in South African correctional centres and many inmates receive treatment (Luyt, 1994). The South African Department of Correctional Services (2002:19) is on record confirming: "A disturbing increase in the number of new tuberculosis cases has been noted." According to Stead (1993) the resurgence of tuberculosis caused a new and extremely serious health threat in the United States. Stead (1993:13) stated that HIV changed tuberculosis from a disease in decline into a developing explosion because HIV infected individuals are at least 100 fold more vulnerable to tuberculosis than HIV negative people. With large overcrowding in South African correctional centres, the spreading of tuberculosis in the infectious stage places each person in those spaces at risk. Due to overcrowding more and more inmates are detained in the same space. According to Fagan (2004) more than 4 out of every 1 000 South Africans are imprisoned. The ten highest populations in individual South African correctional centres range from 219% to 388% of design capacity at the end of March 2006 (Fagan, 2006). Being an airborne disease and closely associated with HIV infections, these conditions of density could allow tuberculosis to spread at an alarming rate. As tuberculosis is an airborne disease, staff members are also in daily contact with inmates and are therefore at a higher risk of contracting tuberculosis than outside populations.

A new threat to the health of inmates and staff alike originated when people with extremely drug resistant tuberculosis were admitted at prison hospitals in the Western Cape. These persons were neither sentenced inmates nor awaiting-trial detainees. It was reported that "*most patients with XDR-TB were admitted as quickly as possible to Brooklyn. At times, patients do have to wait for an (isolation) bed at Brooklyn Chest Hospital. Some patients were treated in side wards, while the rest were in isolation at correctional centres in the province*" (Stuijt, 2007:1). In response to this, Maxime Lunga, Carol Nyirenda, Steve Amolo and others wrote a letter to the Minister of Health, which stated: "*Pills not prison – our only crime was breathing. Yours may be violating human rights*" (Af-aids, 2007).

This particular action (admitting non-offenders to correctional centres for medical isolation from the general public) undermines any effort that may have been aimed at protecting the health of inmates. Correctional centre hospitals are frequently occupied by inmates, who all have contact with the broad inmate and staff population, thereby creating opportunities to transfer the risk of infection back to the community.

In a proactive step leaders at the Mangaung private maximum security correctional centre have decided to provide all inmates with a high protein diet. The benefit lies in an increased immune system. During a visit by the researcher they argued that the expenses of a long-term high protein diet, compared to a long-term medical treatment bill, are much lower, while inmates enjoy better health at the same time. According to Fagan (2006:34) the death rate in the two private correctional centres in South Africa is the highest per 1 000 inmates, namely 14.3. Fagan (2006) contributed this to the health conditions of these inmates when they are transferred to private correctional centres. Private correctional centres only receive maximum security inmates from the Department of Correctional Services. Contractual penalties exist for confirmed maltreatment of inmates, escapes, suicides and various other breaches. To a large extend inmates with a high (security) risk profile are transferred to private correctional centres. A senior staff member of the Department of Correctional Services explained in an interview with the researcher that the Department of Correctional Services transfer those inmates with the highest risk profile to private prisons. From the above observation by Fagan, it appears as if the "highest risk profile" is not limited to security, but may include medical conditions. However, correctional centres in the provinces of Kwazulu-Natal (13.6), Gauteng and Mpumalanga (10.9), and Free State (10.5) are all above the national average of 9.2/1 000.

Sex, injecting drug use and tattooing are widespread in many correctional centres

Sexual activity and injecting drug use occur in correctional centres and are widespread practices across different countries. The prevalence of sex in South African correctional centres was denied for a long time. Denial was mostly based on arguments that policy does not allow sexual contact. It was also argued that the provision of condoms to inmates would result in giving them permission to engage in sexual activities. However, this point of view has changed over years. At the 2003 gathering of Central, Eastern and Southern Heads of Corrections in Africa (CESCA) correctional leaders from 17 African countries still maintained that the provision of condoms is equal to granting permission to have sex inside correctional centres, regardless of the fact that sexual acts are occurring in any event (Luyt, 2003a).

Presently, South Africa is the only country in the Southern African Development Community (SADC) who provides inmates with condoms. Accessibility to these condoms may be questioned, but cannot be dealt with properly within the scope of this discussion. While condom availability is a theoretical reality, personal experience during visits to various South African correctional centres over time showed the opposite in practice. Condom dispensers are neither freely accessible, nor properly maintained to ensure smooth dispensing. In some cases it is completely absent. Inquiries revealed that the materials condom dispensers are made of, pose a threat to inmates as it could be used for weapons. In some South African private correctional centres condoms could only be

obtained from medical staff. Thus necessitating a visit to the medical section that is in the unit, but outside the general living area of inmates. By providing condoms to inmates, South Africa once again became a leader in Africa.

The Jali Commission (Republic of South Africa, 2006a) recently pointed out that the very system that should protect, is causing harm. The Jali Commission criticised in the strongest terms practices at Grootvlei correctional centre where staff members facilitated prison sex trade through the provision of young and vulnerable inmates to older, more predatory inmates. The Jali Commission found that in some cases the officials themselves engaged in these single-gender sexual acts with inmates. In a country where legislation allows for liberal approaches such as same sex marriages, one can no longer turn a blind eye to prison sex. What requires serious consideration, are new approaches, not only aimed at the correctional environment itself, but also with reference to proper conjugal visits. The latter is proven to reduce sexual tension and in doing so, create a safer correctional environment in the long run. Conjugal visits also contribute to family stability. Allowing conjugal visits is not new, but a practice that dates back to 1918 (Rodgers, 2007). The first conjugal visit programme was introduced as an incentive for inmates to work harder by James Parchmann, the warden at the Mississippi State Penitentiary in the United States.

As far as drug use in correctional centres is concerned, the Department of Correctional Services in South Africa does not disclose any figures in official reports. There is also no evidence of drug or alcohol testing. Despite these shortcomings, some time ago social workers claimed to have conducted 5 194 individual interviews with inmates concerning alcohol dependence and 3 611 interviews regarding drug dependence. For youth offenders the numbers were 979 for alcohol dependence and 1 025 for drug dependence (Department of Correctional Services, 2002). In contrast, two private correctional centres in South Africa made use of mandatory testing to confirm the prevalence of drugs. From an interview in 2004, at one private correctional centre it became evident that positive results for at least one of a variety of drugs were found in 38 percent of the inmates admitted. Taking into account that the majority of inmates transferred to private maximum security correctional centres are not new admissions, but individuals who have spend profound periods in government correctional centres, the prevalence of (at least some) illicit drugs in South African correctional centres could be described as widespread. Very little is known about injection drug use in South African correctional centres. Goyer (2003) reported that the inclusion of injection drug users as high risk is theoretically valid, although realistically not useful given the low incidence of injection drug use in South Africa. Irrespective of this, the use of more potent drugs is on the increase in South Africa in general (Luyt, 2003a).

Gang activities are an integral part of life in correctional facilities. Gang members are identified through various means of which tattooing is one of the most obvious. Equipment used for this purpose is seen as contraband and tattooing as such, is not allowed. Nevertheless, it happens on large scale and on a continuous basis as gang members are recruited and promoted within the various gang structures. Equipment to sterilise tattooing equipment is not provided officially. Therefore, inmates are placed at

risk when tattooing takes place - in many cases coerced - with the use of illegal and unsterilised equipment (Luyt, 2003a).

Harm reduction as policy basis for fighting HIV/AIDS in correctional centres

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 and 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 treatments including substitution treatment. Harm reduction accepts (for better and for worse that licit and illicit drug use is part of our world) chooses to work to minimise its harmful effects rather than simply ignore or condemn them. Harm reduction approaches substance use/abuse as a complex, multifaceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence, acknowledging that some ways of administrating 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 to assist them in reducing attendant harm. International evidence has shown that HIV/drug related transmission can occur in correctional facilities. Drug users do not cease using drugs simply because they are imprisoned. Many inmates continue to inject during their incarceration. Therefore, in order to effectively reduce HIV/AIDS in correctional centres, prison and health policy must be based on the philosophy of harm reduction.

According to Luyt (2005) harm reduction in the prison environment should be defined broader than merely HIV infection due to drug-use. It should include all forms of harm that may lead to HIV infection. The underlying assumptions of harm reduction include the following:

- Some illicit drug use, tattooing and sexual encounters are inevitable in most prison societies;
- Drug use, tattooing and dangerous sexual encounters will inevitably cause harm to the concerned communities, both inside and outside prison;
- Prevention of infection with HIV will benefit whole communities;
- Keeping in mind that it is desired to have a drug free and healthy society, it is possible to reduce the potential harm caused by drugs, tattooing and sexual acts; without necessarily reducing the actual levels of incidences that lead to harm or even HIV infection; and
- As some perpetrators of harmful acts inside prison are unable or unwilling to abstain from their acts, achievable alternative goals that reduce the potential harm should be available.

The HIV/AIDS epidemic has prompted a fundamental re-examination of various perspectives and correctional policies. It includes fundamental changes in perceptions of prison managers and politicians, policy revisions, and the introduction of measures that are deemed fit to address infection. One such a measure is harm reduction. Stopping sexual activities and drug use in correctional centres, for example, is not possible. This is

where the introduction of harm reduction measures becomes centrally important. Some harm reduction measures already exists in South African correctional centres, for example, condom availability. Although there is still room for improvement in the way condoms are dispensed in single correctional centres, the United Nations (1999) indicates that access to condoms in itself becomes an encouragement to practice safer sex. South Africa should seriously consider increasing harm reduction practices. Examples of such practicescurrently implemented other correctional systems elsewhere refer to bleach distribution, provision of dental dam, drug substitution programmes, revised education programmes and treatment for drug and alcohol dependencies (Luyt, 2003).

Government must act collectively in the fight against HIV/AIDS

Preventing HIV transmission in correctional centres and providing treatment for inmates living with HIV/AIDS can be costly. In this struggle, wealthier countries have a moral obligation to assist countries that are less wealthy. South Africa managed to secure a grant from the US President Emergency Fund. This is now utilised for the HIV and syphilis survey, a survey that has already drawn mixed reactions. The South African Aids Law Project already indicated that they could not see how the survey would identify individual persons who needed treatment, merely because of the particular approach of the survey. Resources are available elsewhere, for example from the Bill Gates Foundation, the South African AIDS Law Project and South African universities. Government should utilise these resources to the benefit of inmates, their families and communities.

Hepatitis in correctional centres is as crucial as HIV/AIDS

In the correctional centres of many countries, rates of Hepatitis C infection are higher than in the outside community, and numerous inmates living with HIV/AIDS are also co-infected with Hepatitis C. Therefore, the struggle against Hepatitis C in correctional centres is integrally linked to the fight against HIV/AIDS. A number of studies (Farrell, M. Singleton, N. & Strang, J. 2000; Gaughwin & Ali, 1995) identified correctional centres *per se* as an independent high risk factor for the transmission of blood-borne viruses like HIV and Hepatitis C.

With injection drug use reported to be low in South Africa, the emphasis in correctional centres should be on Hepatitis B. Hepatitis B is a contagious blood-borne virus that mainly spreads through contact with contaminated blood and causes inflammation in the liver. It could lead to chronic hepatitis B, liver cell damage and liver cancer, also known as cirrhosis (Centre for Disease Control, 2002). The virus can be transmitted under the following conditions:

- Having sex with an infected person or having contact with seminal fluid and vaginal secretions;
- From mother to child;
- Sharing personal items like razors, earrings and toothbrushes with infected People;
- Using drugs and sharing needles;
- Sharing tattoo and body-piercing instruments;

- Cuts and scrapes during contact sports; and
- Exposure to infected blood, particularly as a health care worker.

Hepatitis is not included in the intended HIV prevalence survey to be completed in South African correctional centres. Yet, according to Hesse and Mensah (2006) similar studies that included HIV, hepatitis and syphilis have been conducted in other African states. In contrast to their Scottish counter-part, inmates in South Africa are furthermore, not acutely aware of their Hepatitis C status in particular (Luyt, 2007). Unlike in the case of HIV and tuberculosis, correctional centres in South Africa also do not keep official records of any variant of this disease. More research is urgently needed in this area (Senok & Botta, 2006).

CONCLUSION

Every country should take all relevant measures to ensure good health for all of its citizens. The right to health is indeed a Constitutional right in South Africa. Of all known harm reduction measures available in many correctional centres across the world today, South Africa only attempts to provide condoms to inmates. South Africa is in the process of a complete roll-out of HIV treatment to the public. The same service is provided on a limited scale inside prison. The latter only benefits a small portion of the potentially infected. Determining the extent of HIV prevalence in correctional centres is unfortunately still not a matter of absolute urgency. The equality and parity that should exist between public and prison health can not be emphasised enough. Prevalence figures need to be established so that actions can meet real needs.

AIDS-phobia among inmates is also a cause of concern. During a seminar on prison reform organised by Lawyers for Human Rights (2004), a representative of the judicial inspectorate of correctional centres reported a new form of a death sentence reportedly inflicted by prison gangs. A non-conforming inmate will be punished by being raped by a HIV positive inmate. The sentence is called the “slow puncture” as it will gradually cause death. This practice was confirmed by the research of Brody and Potterat (2003). The potential of such an occurrence is not only an ideal catalysis for AIDS-phobia, but also a confirmation of how irresponsible individuals may become in the absence of harm reduction practices. To effectively deal with the escalation rate of HIV/AIDS amongst inmates and communities in general, together with the rise in incarceration rates, the South African Government in general, and the Department of Correctional Services in particular, need to urgently intensify measures to reduce harm. Greater co-operation with private prison role-players in the country also needs to be advocated. Also, opportunities to benefit from international resources should be harnessed more effectively.

In her address on World Aids Day in 2006, the Deputy Minister of Correctional Services, Ms Loretta Jacobus (2006) called correctional centres a microcosm of society. It is exactly that, small towns, however, with medieval characteristics due to the walls around but in HIV/AIDS terms, the walls are not protecting those inside it.

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