HARM REDUCTION IN CORRECTIONAL CENTRES: A SOUTH AFRICAN PERSPECTIVE BASED ON STUDIES IN GAUTENG CORRECTIONAL CENTRES

WFM Luyt[1] and GM Moshoeu[2]

ABSTRACT

Harm reduction in the South African correctional system has never been adopted as a policy. What is exercised, however, is a health policy that includes certain elements of harm reduction. Despite some expensive inclusions in the health policy approach, for example HIV testing and provision of antiretroviral medication, basic and inexpensive measures to reduce harm are still excluded. One example is the provision of sterilising facilities for tattooing equipment. Another exclusion is the denial of injection drug use inside correctional centres, contrary to evidence that this practice occurs. More complicated exclusions would include the blatant denial of rape, in particular male rape. These matters are dealt with under the umbrella of sexual assault, despite the existence of legislation that clearly makes provision for (male) rape behind bars. Although the Department of Correctional Services has a positive, commendable approach to many aspects of harm reduction, an encompassing harm reduction strategy is urgently needed. As long as matters of harm are dealt with as if they are merely matters of health, no strategy will be sufficient to address the risk inmates are exposed to. This article investigates harm reduction in the South African correctional system. The Gauteng Province (with the largest number of inmates in the country) serves as basis for the study, while national statistics are used to contextualise various harm reduction aspects. Deficiencies in reducing harm are also pointed out.

Keywords: *harm reduction; correctional environment; injection drug use; sexual abuse.*

INTRODUCTION

In February 2016, it was reported that an inmate in the remand section at the Pollsmoor Correctional Centre was denied antiretroviral treatment that was started before Mvelisi Sitokisi was incarcerated (Maregele, 2016 (a):1; Maregele, 2016 (b):1). He was charged with rape in April 2015 and allegedly also contracted tuberculosis while incarcerated. He was released after four months when charges were withdrawn. During December 2015, Sonke Gender Justice and the Lawyers for Human Rights challenged what was called the deplorable conditions for detainees and staff inside Pollsmoor in the Western Cape High Court (Maregele, 2016 (a):2). These two incidents are only two of many that sporadically reach the public domain.

On the legal front, in the case of *Lee and the Minister of Correctional Services, the Treatment Action Campaign, Wits Justice Project and Centre for Applied Legal Studies* (2012), the Constitutional Court argued that "the country's interest in the development of a sound system of incarceration, in which risk of exposure to pathogens is minimised as much as is reasonably possible, suggests there may be a need to develop the common law of causation." The Western Cape High Court (2011) declared "the respondent" (the Minister of Correctional Services) "liable for the delictual damages suffered by the applicant (Lee) because of contracting tuberculosis while in detention." The legal development brought about through the case of *Lee and the Minister of Correctional Services, the Treatment Action Campaign, Wits Justice Project and Centre for Applied Legal Studies* (2012), adds emphasis to the need for a

1. Professor. Department of Corrections Management, School of Criminal Justice, College of Law, University of South Africa. Email: WFMLuyt@unisa.ac.za.
2. Mr. South African Judicial Education Institute.

new approach to HIV and AIDS (and other communicable diseases) in correctional centres. Harm reduction is such an alternative.

Other authors (Hopkins, 2015:1; Mail & Guardian, 2015:1; Groundup, 2016; Luyt, 2003:89) have reported on inhumane conditions of health inside correctional centres. In South Africa, after a visit in April 2015 to Pollsmoor Correctional Centre in Cape Town, Constitutional Court, Judge Edwin Cameron, criticised the inhumane conditions at the correctional centre. Apart from hygienic aspects, Judge Cameron highlighted certain issues of health care that needed urgent attention, for example: HIV and tuberculosis infections. It needs mention that, in reaction to the Cameron report, the Department of Correctional Services, at Pollsmoor, has instituted some harm reduction measures. The Regional Commissioner of Correctional Services in the Western Cape, Mr Delekile Klaas, reported in Parliament that:

> "Condoms were available and placed in accessible areas in different units. Pollsmoor was in partnership with the service provider (HIV, TB Care Association) to conduct screening of inmates at reception on admission, as well as at an inmate's request. TB campaigns were conducted as preventative measures, and all remand detainees were screened for TB and HIV on admission and when released on bail. The Department of Correctional Services was focusing its efforts on hiring more staff who were adequately trained, and retaining its current skilled staff" (Parliamentary Monitoring Group, 2017).

These diseases can be managed by making use of harm reduction practices and Luyt (2003:105; 2005:87; 2008:151) has argued in favour of the introduction of these approaches in correctional environments. Each one of the more than 240 correctional centres in South Africa can benefit from harm reduction.

The researchers have investigated harm reduction inside specific correctional centres in the Gauteng province (the geographically smallest correctional region with the least number of correctional centres that houses the largest number of inmates in the country). This article will report on harm reduction in South African correctional centres in general and on these investigations in particular.

From the above outline of harm reduction in this article it is linked to correctional health, and not crime and rehabilitation as such, even though certain harmful acts constitute a crime. Harm reduction places the individual at the centre. Apart from individual efforts, harm reduction requires an enabling environment, also behind bars (McKeganey, 2005:25).

HARM REDUCTION AS PHILOSOPHY

Harm reduction represents a balanced approach to certain criminal/deviant activities somewhere between prohibition (zero tolerance) and decriminalisation. Decriminalisation embodies unrestricted access and unregulated economy, while harm reduction prioritises health, safety and individual responsibility. The question remains, how harm reduction as a concept has developed? Evidence shows that tough interventions, such as the 'war on drugs' were the preferred method of dealing with drug users, but were proven to be counter-productive. Tough interventions have been perceived as rhetorical, moralistic and lacking a meaningful outcome (Nadelmann, 1999:157). This moralist approach drives the drug market and consumption underground. Moreover, it marginalises those engaging in risky behaviour. Tough interventions focus on total prohibition, over the laissez-faire approach of decriminalisation which promoted unregulated trade and consumption. Decriminalisation has not been found to be an attractive option as it is too permissive.

Somewhere between tough interventions and decriminalisation, harm reduction is a value-neutral philosophy that promotes responsible use, while contact with those engaging in

risky behaviour is maintained. Harm reduction has a known impact on HIV infection. The World Health Organisation (2005:5), submits that HIV among drug users may increase by 40 percent in the absence of harm reduction components. The organisation reported that HIV prevalence was reduced by an average of 58 percent within a period of five years where needle and syringe exchange programmes were implemented.

Harm reduction refers to a set of pragmatic, realistic and humane approaches aimed at preventing and reducing negative harm or consequences of risk taking behaviours (World Health Organisation, 2005:5). It is therefore a public health philosophy that seeks to holistically address the adverse consequences emanating from risky behaviour (Moshoeu, 2010:46). Risk taking behaviour is part of human existence. Harm reduction aims to reduce inherent harm for those who cannot abstain (willingly or unwillingly) from risky behaviour. Harm reduction advocates a combination of solutions for risky behaviour. The main principles of harm reduction will now be discussed, namely pragmatism, humanistic values and collaboration.

Pragmatism

Harm reduction roots are embedded in pragmatism (Marlatt, 1996:785; Reinarman & Levine, 1997:356; Riley & O'Hare, 2000:2). Harm reduction measures do not condemn or punishment deviant behaviour. Instead, it fundamentally challenges penal measures, while it controls risks and reduces consequent harm emanating from behaviour (Brocato & Wagner, 2003:118). It recognises the importance of a variety of treatment options (Korf & Buning, 2000:132). Harm reduction further recognises that total abstinence from risky behaviour is not realistic. It promotes the provision of treatment and education to prevent risky behaviour, while, at the same time, measures are instituted to reduce the harm where risky behaviour cannot be prevented or avoided.

Proponents of harm reduction are of the view that those engaging in risky behaviour should use safer methods while not yet willing to refrain from the behaviour (Inciardi & Harrison, 2000:1; Brocato & Wagner, 2003:118; Hilton et al., 2001:359). Harm reduction 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 risk conscious. Brocato & Wagner (2003:111) argue that risk takers are not expected to abstain to be eligible for harm reduction, but it may be the ultimate desired result.

Humanistic values

Under humanistic values, individuals are not treated as addicts who should abstain from actions irrespective of the harmful health consequences (Prakash, 2001:1). Humanistic values bring dignity and respect to the fore. Moral and ethical judgements concerning risky behaviour are normally not made. Focus is placed on the consequences of behaviour for the individual and society at large. Harm reduction initiatives respect, for example, the use of drugs as a choice and neither condemn or condone risky behaviour (Hilton et al., 2001:358).

Collaboration

The harm reduction philosophy is collaborative and all-inclusive in nature, being user-driven and broad-based in its approach. Collaboration is essential to reintegrate persons with risky behaviour into the conforming society. It is this aspect of reintegration that encourages individuals to take responsibility for their behaviour and the consequences (Reinarman & Levine, 1997:357). Substance use policy originators have been criticised for creating solutions for harm reduction without involving communities from the inception. The Director of a California-based substance related project, maintained that harm reduction is more successful with strong collaboration between the affected community and the programme originators (Marlatt, 1996:782). Collaboration is necessitated by the fact that an enabling environment

should be created through legislation, policies and mind-set. All stakeholders should accept the model as a credible solution for improved public health (Brocato & Wagner, 2003:119; World Health Organisation, 2005:6).

THEORIES INFLUENCING THE HARM REDUCTION PHILOSPHY IN THE CORRECTIONAL SETTING

The correctional environment differs largely from the public environment regarding a variety of stimuli and dimensions, such as structure, privacy, support, activities, emotional support, freedom, social relations, and safety (Bradford, 2006:16). It is important to comprehend the dynamics that influence inmate culture and behaviour to introduce appropriate harm reduction measures that will address HIV and AIDS challenges in correctional settings. Theoretical models often create an understanding for the dynamics of inmate culture, which has a significant influence on individual behaviour. Social learning theory, the indigenous influence theory and the cultural drift theory are three theories that influence harm reduction. Social learning and the indigenous influence theories regard correctional institutions as a uniquely different environment from the community, approaches that are aligned to the deprivation model of coping with incarceration (Reichel, 1997:516). In contrast, the cultural drift theory perceives the correctional environment as an extension of society from which behavioural patterns are imported. The latter is aligned to the importation model (Reichel, 1997:517). These three theories will now be discussed in more detail.

Institutionalisation as process of social learning

The basic assumption of social learning theory is that both conforming and non-conforming behaviour result from the same process of learning (Akers, 2002:13). The outcome of learning is determined by the social context of learning and reaction to the stimuli. Institutionalisation (as a process of social learning) refers to the adoption of norms, values, and actions by the inmate during incarceration (Gillespie, 2003:2). It emanated from the total institution study on inmate behavioural patterns conducted by Clemmer (1940:299). Institutionalisation provided a clearer insight into inmate behaviour (Clemmer, 1940:299). Through institutionalisation, inmates acquire behavioural patterns, values, norms, attitudes, and standards of living from fellow inmates (John Howard Society, 1999:10).

Subsequent to Clemmer a number of authors (Thomas, 1973; Akers, Hayner, & Gruninger, 1977; Slosar, 1978; Adams, 1992; Grapendaal, 1990; Winfree, Newbold, & Tubb III, 2002; Krebs, 2002) express similar views about the phenomenon in different (compared to correctional) institutions. Thomas (1973:14) refers to institutionalisation as "a process of assimilation into the inmate subculture" while Akers, Hayner & Gruninger (1977:527), define it as "a process of adult socialisation into the inmate subculture." Slosar (1978:7) defined it as "a given fact of incarceration." Winfree et al (2002:214) perceive institutionalisation as an adaptive process to both incarceration and the inmate code, maintaining that pre-incarceration variables may influence the probability of institutionalisation.

The official purposes of the institutional system and the inmate subculture are anti-thecal. New inmates become exposed to these conflicting value systems. Grapendaal (1990:342), argues that the inmate subculture emerges as an adaptive response to inherent deprivations within the institution. Adams (1992:278) indicates that institutionalisation means an adjustment to normative influences of the inmate subculture. In many instances the morals, values, and influences of the inmate subculture dominate those of the institutional system and inmates start engaging in risk taking behaviour as survival strategy (Thomas, 1973:14). According to Bowker (1977:6) those inmates who engage in risky behaviour, such as unprotected sex and injection drug use, become the most institutionalised and dependent upon harm reduction strategies.

Criticism has been expressed against institutionalisation as a process of the learning theory. Alpert (1979:161) stated that it fails to account for new-generation institutional design. Walters (2003:401) argued that the key aspects of the institutionalisation thesis need to be revisited to account for modern developments. Despite criticisms, institutionalisation has offered invaluable insights and still contributes to the understanding of harm-causing inmate behaviour.

Indigenous influence theory

The indigenous influence theory regards correctional institutions as closed systems or isolated social enclaves. 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 causes deprivation that facilitates adaptation and adherence to the normative inmate subculture that coerces involvement in risky behaviour and violation of institutional rules (Jiang & Fisher-Giorlando, 2002:339).

The researchers submit that inmates, due to indigenous influence, suffer the following deprivations:

- Deprivation of freedom: Inmates react to this deprivation through deviating behavioural patterns, including violence, drug use and sexual risks (Sykes, 2006:164; John Howard Society of Alberta, 1999:6; Jewkes, 2002:2).
- Deprivation of goods and services: Materialism is part of general community living and being deprived in this area represents a great loss (Sykes, 1958:287). Consequently, they resort to various illegal means, including harmful activities, bribery and smuggling to obtain goods and services (Jewkes, 2002:3).
- Deprivation of heterosexual relationships: Inmates are deprived of conjugal rights, resulting in emotional distress (Tewsbury & West, 2000:369). As masturbation is ridiculed and regarded as taboo, institutional options are mainly narrowed down to situational homosexuality (Eigenberg, 1992:225). Due to a lack of condoms in most correctional institutions, sexual activities are mostly unprotected and serve as a mode of transmission of a variety of viruses (Collica, 2002:104; Gymarthy, Neagus, & Szamado, 2003:567). The deprivation model offers a more plausible explanation for the prevalence of homosexuality and HIV infections in correctional institutions than any other model.
- Deprivation of autonomy: Inmates forfeit autonomy and decision making is curtailed (Berman, 2004:59). They are subjected to a daily schedule managed by officials (Sykes, 1958:291).
- Deprivation of security: Donnel and Martin (2003:4) confirm that inmates are surrounded by security risks in the form of murderers, rapists and violent co-inmates. Inmates are often allocated random accommodation irrespective of their type of offence and who their cell-mates are. Security of the person becomes critically hampered.

Reisig and Lee (2000:29), tested the deprivation model at 15 Korean correctional institutions using data collected from 546 inmates. Inmates with deviant behaviour were found to be more prevalent in institutions with stringent inmate control. The results demonstrated a fair amount of support for the deprivation model. Some researchers (Seal, Belcher, Morrow, Eldrigde, Binson, Kacanek, Margolis, McAuliffe, and Simms, 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. However, according to Irwin (1980:34), the deprivation model disregards the fact that correctional institutions are constantly filled with individuals who display their own orientations, cultures, power and prestige in a free society. Grapendaal (1990:342) argues that the deprivation model is too restrictive and disregards the influences of the outside world brought into the correctional institution.

The cultural drift theory

The basic assumption of the cultural drift theory is that the development of an inmate subculture is largely influenced by individual distinctive traits and social background (Akers et al, 1977:528). It regards correctional institutions as an extension of society rather than separate entities. The inmate code forms part of the larger criminal code that exists in society. Theory proponents state that independent extraneous factors exert a major influence on inmate behavioural patterns (Irwin & Cressey, 1962; Slosar, 1978; Thomas, 1973; Wright, 1994; Gillespie, 2003).

Thomas (1973:15) observed that on admission offenders are already exposed to the socialisation process. He posited that (having been involved in crime) some elements from the community criminal subculture are imported into the correctional environment where they influence inmate subculture and behaviour. 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, previous criminal activities–and societal values, norms and attitudes. Gillespie (2003:391) 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. These attitudes influence behavioural responses during incarceration.

Empirical evidence supports the importation model concerning inmate behaviour. A Scandinavian study on the determinants of inmate behavioural patterns in 15 correctional institutions, concluded that inmate behaviour was largely influenced by pre-incarceration experiences. Additionally, the analysis of correctional rule violations shows that the importation variables predict inmate behaviour better than deprivation variables (Cao, Zhao, & Van Dine, 1997:112).

Some researchers (Thomas & Cage, 1977; Hensley, 2000; Gymarthy et al., 2003) established a direct link between the importation model and risk taking behaviour. Thomas and Cage (1977:206) evaluated the importation and deprivation models using drug use in a correctional context. A total of 255 out of 273 drug using inmates confirmed pre-incarceration drug use. The researchers concluded that inmates with a history of drug use in the community are likely to continue the behaviour during incarceration. They could not find support for a causal link between institutional deprivations and drug use.

Hensley (2000:439), established support for the importation of homosexuality perceptions from the community into correctional institutions. Homosexuality is regarded as a reflection of sexual attitudes and values held by inmates prior to incarceration. In a study on HIV related attitudes and risk behaviour history of Hungarian inmates, Gyarmathy, Neaigus, and Szamado (2003:566) found that many inmates had engaged in risky sexual practices prior to incarceration. Therefore, previous experiences of inmates formed their involvement in risk taking sexual behaviour that predisposed them to HIV infection while incarcerated.

Criticism has also been levelled against the cultural drift theory (Forsyth & Copes, 2014:224). 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 one another. Both theories independently shed light on inmate behavioural patterns and risk taking.

DEFINING HARM REDUCTION

The World Health Organisation (WHO) uses a definition that is mainly related to injecting drug use in the public health environment. It reads as follows:

> "In public health harm reduction is used to describe a concept aiming to prevent or reduce negative health consequences associated with certain behaviours. In relation to drug injecting, harm reduction components of comprehensive interventions aim to prevent transmission of HIV and other infections that occurs through sharing of non-sterile injection equipment and drug preparations" (World Health Organisation, 2005:5).

The WHO Health in Prisons Project proposes the following definition for its purposes.

> "In public health relating to prisons, harm reduction describes a concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health" (World Health Organisation, 2005:6).

CONCISE HISTORY OF HARM REDUCTION

Harm reduction emerged because of drug use and the subsequent health damage. The concept is rooted in health protection of those engaging in risky behaviour (Inciardi & Harrison, 2000:viii). The fundamental objective is to reduce mortality and morbidity. Harm reduction does not legalise drug use. Harm reduction consists of many components, including needle and syringe exchange, substitution therapy, condom provision, education, counselling, and HIV testing. Although harm reduction has gained prominence because of drug use, it is a broad concept that can address an array of risky behaviour not necessarily linked to drug use, such as unprotected sex and tattooing with contaminated equipment (Newman, 2005:265). International organisations warn against the spread of blood borne infection transmission through tattooing in correctional centres (Møller, Stöver, Jürgens, Gatherer & Nikogosian, 2007:44).

Illicit drug use is a worldwide problem (Wolf, 2002:20). Drug use has been present across cultures (Prakash, 2001:1; Inciardi & Harrison, 2000:x) and harm reduction is not a new phenomenon (Reinarman & Levine, 1997:356; Brocato & Wagner, 2003:118; Inciardi & Harrison, 2000:x). People have devised innovative non-formalised harm reduction methods to deal with drug use. In one instance spiders were placed in the bottom of wine glasses of heavy drinkers to reduce alcohol consumption. Drug abuse is a disease from which no section of modern society remains immune (Randall, 1990:8). 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, also in correctional regimes (Korf & Buning, 2000:113).

The dawn of harm reduction was inevitable, as drug use grew through various phases. During the moralist phase, drugs were regarded as a vice that should be eliminated. Stringent drug control measures were implemented. The aim of the moralist approach was total abstinence. The application of strict legislation to enforce abstinence was counterproductive. Total prohibition drove the drug trade underground, also in correctional settings, while it marginalised drug users and increased mortality and morbidity rates (Stevenson, 1994:104; Riley & O'Hare, 2000:3; Wolf, 2002:1).

The shortcomings of the moralist phase gave origin to the nineteenth century libertarian phase. 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 from liberalism. Government introduced regulatory controls on the drug market. There was a paradigm shift towards risk based drug control measures. Demand reduction as a policy to reduce drug use gained prominence in drug control efforts. Demand reduction refers to eliminating the desire for drug use through the application of deterrent laws, education, and treatment (Bailey, 1988:11). Regardless of stringent drug prevention interventions the problem continued (Stimson, 1998:409). New efforts were necessary to reduce drug related and other forms of harm (Seddon, 2008:99). In response to the failures of neo-liberal welfarism, the post-liberal construct of harm reduction emerged.

The foundation for harm reduction in the United Kingdom was laid by the Rolleston Committee who recommended substitution therapy rather than sudden withdrawal, as is normally prudent in correctional environments. The prescription of narcotic drugs to addicts was subsequently authorised (Stimson, 1998:403, Seddon, 2008:99). Harm reduction components were first introduced in 1986 at the Mersey Region Drug Training and Information Centre, Liverpool. Commonly referred to as the Merseyside project, drug users were introduced to substitution therapy, needle and syringe exchange-and education programmes to reduce the harmful consequences of drug use (Stimson, 1998:401; Hilton et al., 2001:360). Harm reduction components were replicated in European Union countries, some Asian countries, Brazil, Canada, and Australia. The harm reduction model as a response to the HIV pandemic then gained momentum worldwide.

HARM REDUCTION AND CORRECTIONS

Inmate populations from diverse backgrounds form the correctional microcosm that (sometimes closely) reflects society. Correctional institutions are not immune from the adverse health effects encountered in society. Three risky behaviours that fuel the spread of viruses are particularly prevalent in correctional institutions, namely unprotected sex, drug use and tattooing (Frost & Tchertkov, 2002:7). Malati (2015:30) reported that the Judicial Inspectorate for Correctional Services regards correctional centres as breeding grounds for communicable diseases. Upon release, there is a high probability of inmates returning into the community with an infection. In March 2014, 27 980 inmates were on record as being HIV positive in South African correctional centres (Mahlati, 2015:31). Johnstone-Robertson, Lawn, Welte, Bekker, and Wood (2011:101) with reference to an overcrowded Pollsmoor Correctional Centre, for example, concluded that current conditions of detention are highly conducive for the spread of drug-sensitive and drug-resistant tuberculosis. Overcrowding, however, is one of the biggest challenges in all correctional centres (Department of Correctional Services, 2013a:13).

Goyer (2002:1) estimated that about 25 000 people return each month from correctional institutions to the South African community, all of whom can potentially transmit HIV. This number was reported to have dropped and during the 2012/13 financial year, a total of 65 931 inmates were released back into the community (Department of Correctional Services, 2013a:26). Such massive movement of inmates calls for the urgent replication of harm reduction strategies in correctional settings to potentially reduce the spread of HIV and other communicable diseases.

HIV infection 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 emphasise zero tolerance and abstinence-based treatment programmes. In most countries there is no alignment between health policy development for general communities and correctional institutions (Levy, Treloar, McDonald, & Booker, 2007:647).

The World Health Organisation Regional Committee for Europe decided to support the implementation of harm reduction in correctional environments with the aim to promote, enable and strengthen evidence-based targeted intervention for vulnerable/high risk groups. Measures such as prevention, treatment and harm reduction programmes (e.g. expanded needle and syringe, bleach and condom distribution, voluntary HIV counselling and testing, substitution drug therapy, STI diagnosis and treatment) in all affected communities, including corrections, were then aligned to national policies (World Health Organisation, 2005:4).

UNAIDS supports the replication of harm reduction in correctional settings. Research (Stöver, & Nelles, 2003:440; Okie, 2007:106) confirms the introduction of various harm reduction components in fifty correctional institutions in Canada, Spain, Belarus, Moldova, Indonesia, Germany, Switzerland and Kyrgyzstan. Needle and syringe exchange programmes are still banned in some parts of Australia and the United States (where many American inmates have violated drug laws). Despite a considerable prevalence of drug related high risk behaviour amongst inmates, the US Federal government opposes harm reduction in favour of prohibition practices (Riley & O'Hare, 2000:11).

In Canada, substitution therapy has been operative since the 1950s in the general community. In 1992, an organisation called Prisoners with HIV/AIDS Support Network 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).

In countries where harm reduction practices are implemented in the correctional environment, the rationale is based on public health principles and human rights. As part of the human rights of inmates, free access to health care at least equivalent to what is available to those in free society should be available. The same approach should be protocol for harm reduction programmes in correctional environments (World Health Organisation, 2005:6).

What is the status quo concerning harm reduction in South African correctional centres?

From the discussion it becomes evident that the Department of Correctional Services do not have an official integrated harm reduction policy. This does not mean that nothing is done concerning the phenomenon. Many individual actions address harm reduction, but they are approached as medical issues. The official policy position of the Department of Correctional Services on health is summarised with the following statement:

> "Health care delivery in the Department of Correctional Services is rendered in accordance with international guidelines and national health legislation, policies and guidelines in an effort to contribute to the key outputs which are consistent with the Millennium Development Goals and National Development Plan with a focus on increasing life expectancy by addressing HIV and tuberculosis" (Department of Correctional Services, 2014:1).

South African correctional facilities have high rates of HIV and tuberculosis. The Department of Correctional Services argues that they must ensure the provision of appropriate prevention and treatment services concerning sexually transmittable infections and tuberculosis. Prompt treatment of all inmates and correctional staff within a continuum of care through proper referrals is also included. Enforcement of laws and policies to prevent sexual violence in correctional settings, including the use of newly developed guidelines to identify inmates who are vulnerable to sexual violence, is said to take preference (Department of Correctional Services, 2014:14).

The Portfolio Committee on Correctional Services, in a handover report, informed the incoming committee that (Parliamentary Monitoring Group, 2014):

> "The DCS had ignored previous recommendations that assaults should be disaggregated to differentiate between general cases of assault and sexual assault. The DCS did not deny that sexual assaults took place in correctional centres, but stated that such incidents were under-reported. At the time of reporting the DCS had not yet given any indication of efforts to create awareness of sexual assault in correctional centres so as to address the stigma associated with it and thereby hopefully encourage victims to report such incidents."

It was further reported to the new Portfolio Committee (Parliamentary Monitoring Group, 2014) that:

> "The DCS had reported that it had, in partnership with stakeholders, developed a policy framework for creating awareness of, and managing sexual assaults. At the time of reporting the policy was in the final stages of approval. Although the policy had not been referred to in planning documents, it is hoped that the strategy, to be implemented with the assistance of stakeholders, will result in victims increased reporting of sexual assaults, the DCS improved monitoring and reporting on the prevalence of sexual assaults, and ultimately, in a reduction in sexual assaults. The incoming Committee may wish to receive a briefing on its finalisation, content and implementation."

Over the years the Department of Correctional Services has implemented a range of harm reduction related health measures, albeit that harm reduction itself does not feature independently as a component of the correctional health strategy. For example, the system provides condoms for a very long time now, which forms part of harm reduction strategies. Luyt (2008:149) reported that access to condoms was questionable as dispensers were not freely accessible or properly maintained in all correctional centres. Private correctional centres dispensed condoms through nursing staff in the hospital section only, thus compromising anonymity and exposure. The status quo, therefore, is that inmates are afforded improved health care services, but harm reduction as a separate entity is still lacking, albeit that some components of harm reduction is present within the broad correctional health care services. More recent developments in this regard will now be discussed.

Developments in harm reduction inside South African correctional centres

In terms of the Correctional Services Act 111 of 1998 correctional authorities provide primary health care services and refer patients to external health facilities (primarily the Department of Health managed hospitals, unless the inmate decides differently and accepts responsibility for costs of alternative private referrals) for secondary and tertiary levels of health care. In an effort to contribute to the Millennium Development Goals, correctional health care is rendered in accordance with legislation, policies and guidelines applicable to the Department of Health (Department of Correctional Services, 2013:1).

Corrections in South Africa benefitted from the Global Fund against HIV, AIDS, Tuberculosis and Malaria when US$53.8 million over three years was awarded to the country (around 2012/13) for the benefit of three sub-populations, namely people living with multi-drug resistant tuberculosis, inmates in correctional facilities, and miners (Department of Correctional Services, 2014:44). Corrections received 36 percent of this amount (Department of Correctional Services, 2014:44). The Global Fund was founded in 2002 and is designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics (The Global Fund, 2016:1). This grant has changed the approach to HIV management amongst South African inmates in a

positive way. From the National Strategic Plan for HIV, STIs and TB: 2012-2016, four objectives stood out as having a direct impact on correctional services, namely:

- Addressing the social and structural barriers to HIV, STI and tuberculosis prevention, care and impact;
- Preventing new HIV, STI and tuberculosis infections;
- Sustaining health and wellness, and;
- Promoting and supporting human rights protection (Department of Correctional Services, 2014:9-14)

South African correctional authorities accepted that correctional facilities have high rates of tuberculosis and HIV infection (Department of Correctional Services, 2013:2) and that appropriate prevention and treatment services must be provided (including HIV, STI and TB screening, prompt treatment of all inmates and correctional staff, ensuring continuum of care through proper referrals and enforcement of laws and policies to prevent sexual violence in correctional settings, including the use of newly developed screening guidelines to identify inmates who are vulnerable to sexual violence). All correctional management areas became clinics that should offer an integrated chronic care package (Department of Correctional Services, 2014:14). There is at least one primary health care facility per correctional centre and one in-patient facility per management area (Department of Correctional Services, 2013:2).

Operational guidelines were developed, while the Minister of Correctional Services and Minister of Health launched the guidelines on World Tuberculosis Day in 2013. These guidelines included screening, diagnosis and treatment in correctional centres for tuberculosis and STIs on admission, on self-reporting during interaction with a nurse, screening every six months and screening on release from correctional centres. Voluntary HIV counselling and testing must be offered to all inmates at entry, during incarceration, as per request by inmates, as part of routine screening campaigns, as part of integrated primary health care services and on release of the inmate. All HIV-positive inmates must be referred for assessment, X-ray and tuberculosis culture tests (Department of Correctional Services, 2014:16).

On admission, all adult inmates with suspected tuberculosis must provide sputum samples. If the smear or GeneXpert® MTB/RIF results are positive, tuberculosis treatment is commenced. If both specimens are negative in either test, HIV-negative inmates receive antibiotic treatment for five days and are then reassessed after completion of treatment. HIV-positive inmates are referred for assessment, X-ray and TB culture (Republic of South Africa, 2012(a):10).

HIV prevention in correctional centres is to be achieved through information sharing, peer education, provision of isoniazid preventive therapy on HIV positive inmates that are not receiving tuberculosis treatment, implementation of environmental and administrative controls and personal protection, access to (male and female) condoms and water-based lubricants, reducing rape vulnerability, provision of post-exposure prophylaxis with established drug regimens, monitoring of drug safety and potential seroconversion and harm reduction programmes to reduce the risk of HIV-transmission related to substance abuse (Department of Correctional Services, 2014:17). Other measures include education on risk behaviour, preventive measures for men having sex with men, the provision of male medical circumcision with adequate counselling on risk reduction after the intervention–and treatment aligned to Department of Health clinical guidelines in correctional centres (Department of Correctional Services, 2014:18).

The Department maintains that HIV and tuberculosis management is rendered in accordance with the National Strategic Plan for HIV, Sexually Transmitted Infections and

Tuberculosis 2012 – 2016. Ensuring access to voluntary medical male circumcision completes the list of actions available to inmates.

These actions are indeed commendable. However, certain harm reduction areas remain critical to address. The use of needles (in whatever format) is one of them. The core of transmission prevention tools for tattooing, piercing and skin penetration practices is the provision of education on the dangers of sharing shaving, tattooing and piercing instruments and other skin penetration items. Inmates are also encouraged to report coerced participation in such activities. (Department of Correctional Services, 2014:35). Although it is conceded that there is a need to strengthen health education programmes, there are no efforts to sterilise any equipment. Also, reported coerced participation in these activities does not contribute to infection prevention, as the action comes after infection may have taken place.

HARM REDUCTION ACTIONS AND RELATED STATISTICS FOR CORRECTIONS IN SOUTH AFRICA

Statistics present a certain reality, irrespective of the phenomenon investigated. In the past various investigations (Goyer, 2002; Jali, 2005; Luyt, 2008) have criticised the unavailability of reliable HIV and other harm reduction related statistics for the Department of Correctional Services. In the last decade more transparent statistics became available. One example is the DCS HIV Prevalence Survey 2006. Before 2006 the Department of Correctional Services could not provide accurate statistics concerning HIV infection amongst inmates. The Department of Correctional Service commissioned an 'Unlinked, Anonymous HIV and Syphilis Surveillance Study' among staff employed by DCS and offenders in the custody of the Department (Anon, 2006:1). The sample of both personnel and offenders for the study was stratified according to the following demographics:

- Urban / rural correctional centres;
- Gender;
- Age groups;
- Work rank levels (for personnel only); and
- Regions according to the Department's geographical divisions.

Other statistics also became available, such as the number of condoms distributed, the amount of HIV tests conducted inside correctional centres, the number of inmates receiving HIV treatment and sexual incidences inside correctional facilities.

The DCS HIV Prevalence Survey 2006

The first official HIV prevalence survey was done in 2006 when the Department of Correctional Services commissioned the 'Unlinked, Anonymous HIV and Syphilis Surveillance Study' amongst staff and sentenced offenders. In the pilot study in Gauteng, 786 staff members and 2 770 sentenced inmates were targeted that resulted in participation rates of 8.72 percent and 26.93 percent respectively. In the main study, ten percent of both the staff and sentenced inmate populations was targeted for participation, which resulted in a sample size of 3 024 staff members (N=38 268) and 8 649 sentenced offenders (N=113 567). The actual participation in the national survey (including the pilot study) was 29 percent for staff and 46.4 percent for sentenced offenders (Sakawuli, 2006:1; Muntingh, 2008:2). Significant resistance was observed from correctional officials to participate in the survey (Muntingh, 2008:3).

From the 1 098 correctional officials who participated (n=3 024), 109 (9.9%) tested HIV positive. The report concluded that the national HIV infection rate amongst staff varied between 6.7 percent and 13.9 percent. The majority of HIV positive persons (87%) were aged between 26-45 years (Sakawuli, 2006:2; Muntingh, 2008:2). According to Tapscott (2008:2) the HIV Prevalence Survey found that the national HIV infection rate amongst all staff

members was 9.8 percent, lower than the national estimated prevalence rate of 16.25 percent. It further found that 93.6 percent of HIV positive staff members were involved either in the direct management of offenders or in providing support services.

A total of 5 299 sentenced inmates (n=8 649) participated in the HIV Prevalence Survey. Of these, 1 047 (19.8%) tested positive for HIV, a rate higher than the South African Department of Health national prevalence rate (in society) of 16.25 percent. It was concluded that the national sentenced inmate infection rate was between 18.4 percent and 22.6 percent. The survey also showed that HIV positive sentenced inmates were mostly younger (58.4% were aged 18-35; 21.4% were aged 36-45) (Sakawuli, 2006:3; Muntingh, 2008:2).

HIV testing inside correctional centres

Since the importance of HIV testing was realised in all earnest after the 2006 HIV Prevalence Survey, testing inside correctional centres has increased. In the 2006 survey, a total of 8 649 sentenced offenders were tested. After that, the increased rate of HIV testing is expressed in table 4 below. From the statistics it is evident that during 2014/15 nearly double the number of inmates was tested in six months, compared to the number for the whole of the 2008/09 statistical year.

Table 4: HIV testing in the South African correctional system

Statistical period*	**Number[1] of inmates tested****	**Number[2] tested positively*****	**Number[3] on ARV******	**Inmate population[4] *******
2008/09	36 549 (-%)	15 446 (42%)	5 708 (37%)	Not available
2009/10	45 887 (28%)	22 304 (49%)	7 640 (34%)	163 793
2010/11	59 717 (38%)	19 147 (32%)	6 691(35%)	157 508
2011/12	67 409 (43%)	23 006 (34%)	6 095 (26%)	155 177
2012/13	76 202 (51%)	34 278 (45%)	11 814 (35%)	150 608
2013/14	107 415 (72%)	28 829 (27%)	15 417 (53%)	149 058
2014/15	68 207 (45%)	35 489 (52%)	15 760 (44%)	153 226

*Statistical period commences on 1 April each year
** Department of Correctional Services (DCS), (2014:21)
*** DCS, 2014:22.
**** DCS, 2014:23.
***** DCS, 2010:68 & 2015:28.
[1;2;3, 4] All percentages are derived from comparison with the previous column ([2] from [1]; [3] from [2]), but the number of inmates tested are derived from comparison with the total inmate population for the period under discussion ([1] from [4]). All figures are rounded upward or downward.

The National Commissioner for Correctional Services reported that 91.2 percent of all inmates were tested for HIV by December 2015, a number that has increased to 91 percent by April 2016 (Shange, 2016:1). This increase in the number of inmates who are tested for HIV is indeed encouraging from a harm reduction point of view.

Inmates receiving antiretroviral treatment

HIV testing and antiretroviral treatment goes hand in hand. As the Department of Health has secured funding from the Global Fund for various sexually transmittable diseases, the strategic objectives are to provide inmates with HIV, AIDS and tuberculosis treatment, appropriate nutrition and appropriate hygiene services during incarceration (South African Government News Agency, 2016:1). There was a steady increase in the number of inmates who receive antiretroviral treatment since 2008, as expressed in ŧTable 4 above.

The Minister of Justice and Correctional Services reported on 3 May 2016 that 97 percent of more than 19 000 inmates who tested positively for HIV received antiretroviral treatment. Only those with a CD4 count below 600 were reported to be deserving cases for ARV treatment (Ministry of Justice and Correctional Services, 2016:7), compared to a CD4 count below 350 for other South African citizens before they were offered free treatment (Geffen, 2015:1). The percentage of inmates on antiretroviral therapy stood at 97.95 percent at the end of December 2015 (South African Government News Agency, 2016:1).

In strengthening the fight against the HIV epidemic, the Department of Correctional Services managed to put on treatment 98 percent (24 506/25 042) of those who tested HIV positive during 2015/16 (Department of Correctional Services, 2017:9). Compared to the statistics in Table 4, there is a dramatic increase in access to treatment for HIV positive inmates from 2014 to 2016. By 2017, as the Department managed to put on treatment 98 percent (24 506/25 042) of those who tested positive against the set target of 98 percent (Department of Correctional Services, 2017:8). The reason for the vast increase in numbers that received treatment is uncertain and more research needs to be done, but the funding secured from the Global Fund for treatment of various sexually transmittable diseases may play a significant role in the large number of inmates who received treatment.

Condom distribution

In the more recent past the Department of Correctional Services (2014:17) has improved condom provision and provide access to water-based lubricants. Today, both male and female condoms are provided. There is improved provision of condoms, but there is no evidence that condoms are effectively distributed to and used by inmates. In fact, there are some doubts that condoms reach inmates at all. There is also evidence of misuse of condoms, as Mabena (Sapa, 2013:1) reported that male inmates fill condoms with water and hang it on cell bars, while female condoms are filled with soap and used as dildos. Although there are evidence of condom distribution and reports of misuse in some correctional centres, the utilisation rate and impact on health has not been determined (Department of Correctional Services, 2014:32). National statistics for condom distribution is as follows (Department of Correctional Services, 2014:27):

Table 5: Condom distribution in the South African correctional system

Statistical period*	Male condoms	Female condoms	Inmate population
2009/10	1 241 519	15 649	163 793
2010/11	1 341 429	20 123	157 508
2011/12	1 166 381	22 759	155 177
2012/13	1 511 264	39 297	150 608
2013/14	1 333 073	44 802	149 058
2014/15	484 510	13 042	153 226
*Statistical period commences on 1 April each year.			

(Source: Department of Correctional Services (DCS), 2010:68 & 2015:28).

The statistics in Table 5, individualised, means that on average, for the period 2009-2015, each inmate could have received 11 condoms each year. Concerning condom distribution in correctional centres, Fullilove (2008:110) argued that the high HIV infection rate in the American correctional systems has focused attention on the role that these institutions play as drivers of the domestic epidemic. The first dilemma concerning condom distribution is to determine how much HIV transmission takes place inside correctional facilities, something that is not happening in South Africa.

For the 2014/15 statistical year the annual report makes no mention of condom distribution to inmates, but the number of condoms distributed to personnel is monitored (Department of Correctional Services, 2015:98). Although the researchers concede that not all information is publishable in (annual) reports, the above report creates the impression that staff wellness takes preference over that of inmates. This occurs while inmates and not staff, are the exposed ones who need protection from the system through harm reduction measures. Questions also arise about the condom distribution figures mentioned in Table 4, as those figures do not distinguish between the number distributed to staff and to inmates. The lower the number of condoms available for distribution to inmates, the greater the risk of exposure to harm becomes.

Distribution of condoms inside the system is not only motivated by the number of HIV positive people entering the system, but is more directly linked to sexual behaviour while incarcerated. For South Africa, the enormous amount of condoms distributed to inmates must be applauded, but more research is needed into a variety of factors, including the transmission rate and sexual assault incidences during incarceration to better comprehend the influence of condom distribution on harm reduction and HIV transmission prevention. The Department of Correctional Services (2014:33) has conceded that the utilisation rate of condoms and its impact must be determined.

Sexual incidences

The relevance of assessment as per Section 38 regarding sexual incidences does not seem to be relevant. The Section has a particular meaning in terms of the overall sentence plan for each inmate – also known as case management. The reference to health needs in terms of Sect 38(1) (b) is not linked to sexual incidences. The meaning here is relevant to incidences related to the Criminal Law (Sexual Offences and related matters) Amendment Act 32 of 2007. Section 38 of the Correctional Services Act and implementing policy.

Luyt (2013:31) mentioned that "the phenomenon of sexual activities in a single gender environment is not fully and openly acknowledged by correctional authorities." Luyt (2013:31) further observed that "with inmate rape one is confronted by a unique ethical dilemma where the victim of a crime is also a convicted offender." Gear (2016:1) remarked that different kinds of sexual interactions take place between men in South African correctional centres, of which the majority are abusive, exploitative and involve rape and coercion. Consensual sexual relations reportedly exist, but in a skewed format. Oppressive notions of gender are at the centre of much of these sexual interactions. To be naive, trusting, poor and not prepared to use violence, are qualities associated with inferiority that are classified as female traits to become a sexual victim (Gear, 2016:2).

Booyens, Hesselink-Louw and Mashabela (2004:5) stated that victims of sexual abuse in the correctional environment do not report such, thus leading to a dark figure. It was also noted that South African correctional officials are not trained to reduce rape or to treat victims inside correctional centres (Booyens et al., 2004:10). Luyt (2013:57) reported that strong leadership at correctional centre level was needed to implement and maintain anti-rape strategies and to bring about a correctional culture change. Luyt (2013:59) argued that condom provision to inmates could not compensate for the scars caused by rape while incarcerated.

The Department of Correctional Services in recent times not only has more accurate statistics of inmate sexual incidences available, but is also providing post exposure prophylaxis (PEP) (Department of Correctional Services, 2014:35). The statistics presented in Table 6 are applicable to cases of sexual assaults and injuries where there is a suspicion that victims may have had contact with body fluids. In the statistics no mention is made of male rape, even though South African legislation explicitly provides for such crime (Republic of South Africa, 2007) and reports show that male rape occurs (Luyt, 2013:35; 44).

Table 6: Sexual assaults and post exposure prophylaxis (PEP) provision

Statistical period*	Sexual assault incidences	PEP provision
2008/09	166	120
2009/10	154	126
2010/11	121	101
2011/12	98	91
2012/13	110	77
2013/14	213	205
2014/15	18	18
*Statistical period commences on 1 April each year.		

(Source: (DCS, 2014:24).

It is extremely likely that we are faced with underreporting here. These numbers only reflect the number of victims who came forward (very few considering the policing role played by gangs) or if there are severe obvious injuries. To obtain a better picture of the situation, the authors could compare this data to the number of complaints recorded by ICCVs, the number of HIV infected inmates (which in turn should be compared to the national HIV infection rate to have an indication of the in-prison infection rate).

It was mentioned in the previous paragraph that this figure is a dark figure and is indeed underreported. It was not the aim of the article to compare different sets of statistics, as it was found that it will make the article too bulky in length, posing its own problems with the journal requirements per article. The numbers were mentioned from a harm reduction perspective and the included numbers were regarded as accurate enough from official sources to make the point without labouring it. Although other statistics are available on the side of complaints, they are less explanatory in terms of harm reduction actions taken. Therefore, they contribute to the HIV infection debate, but they do not contribute to the harm reduction debate and the aim of this article. PEP provision was per sexual assault (rape) incident, therefore a direct harm reduction action.

The nature of sexual assault incidences mentioned above are not given, but it can safely be deducted that the potential of HIV and other infections existed in each case where PEP provision occurred. PEP provision for all incidences of sexual assault only occurred in the 2014/15 statistical year (the period April –June). In 2012/13, 70 percent of reported cases received PEP. In 2013/14 the number of incidences nearly doubled, but four percent of victims had not received PEP. The so-called "suspicion that victims may have had contact with body fluids" (Department of Correctional Services, 2014:34) is peculiar, because suspicions may not be accurate, while the potential of exposure remains. In the untreated cases the risk of HIV and other infections are not completely addressed, which may increase the risk of infection and accompanying harm.

There is still concern about the so-called dark figure, i.e. the cases that are not reported to authorities. The Judicial Inspectorate for Correctional Services (Van der Westhuizen, 2016:82), for example, reported 63 cases of sexual assault complaints for the 2015/16 period, but no rape cases were reported. If the annual number of distributed condoms is considered, this concern is even greater. More than a million condoms have been distributed every year since (at least) 2009/10 (see table 4). The above figures should also be viewed against the backdrop of the large number of sexual offenders in the correctional system. In 2013/14 a total of 18 percent (n = 19 262) of the sentenced inmate population were sexual offenders (qualified as indecent assault, intercourse with a minor, rape, attempted rape, and other sexual crimes), while 17.91 percent (n = 20 608) of the 2014/15 sentenced inmate population were sexual offenders (Department of Correctional Services, 2015:30).

Furthermore, concerning terminology, there is a tendency to prevent the use of rape as per legislative definition. All reports refer to sexual assault, which is outdated for most of the sexual actions occurring inside correctional centres. There is also no indication of efforts to determine to what extent consensual sex is practiced, compared to rape.

Male circumcision

Male circumcision is reported to reduce heterosexual HIV transmission by 60 percent. Nearly 9.1 million voluntary medical male circumcisions for HIV prevention have been performed in East and Southern Africa (three million in 2014 alone) (World Health Organisation, 2016:1). Medical male circumcision provides permanent partial protection against HIV and other sexually transmitted infections. It should be considered as part of comprehensive HIV prevention services in conjunction with other prevention methods, such as condoms (Avert, 2016; World Health Organisation, 2012:1). Since circumcision received prominence, the correctional system has introduced it as a medical procedure to prevent relevant infections. Statistics for male circumcision are as follows (Department of Correctional Services, 2014:26):

Table 7: Voluntary male medical circumcision

Statistical period*	**Number**
2012/13	2 991
2013/14	15 320
2014/15	3 309
*Statistical period commences on 1 April each year	

Isoniazid Preventive Therapy

Tuberculosis is the most common cause of mortality among HIV-infected persons in South Africa and has been shown to accelerate the onset of AIDS (The Aurum Institute, 2012:4). On the other hand, HIV infection has contributed significantly to an increase in tuberculosis incidences (Luetkemeyer, 2013:1). In the presence of HIV, tuberculosis may become drug resistant and patients require more intensive therapy. There are substantial overlapping toxicities and interactions that must be considered when co-treating HIV and tuberculosis (Luetkemeyer, 2013:4).

According to Hamilton (2014:1), HIV infection is the strongest risk factor for a person to develop tuberculosis. Correctional centres experience high levels of co-infection with HIV and tuberculosis. Telisinghe, Fielding, Malden, Hanifa, Churchyard, Grant and Charalambous (2014) concluded from their research that undiagnosed tuberculosis and HIV prevalence was high in the South African correctional environment, justifying routine screening for tuberculosis during admission and intensified case finding among existing inmates. Treatment of latent tuberculosis infection with a drug called isoniazid is an inexpensive, effective prevention method. The Department of Correctional Services provides this treatment to inmates, as set out in Table 8 below (Department of Correctional Services, 2014:25).

Table 8: Inmate patients receiving isoniazid preventive therapy

Year	2010/11	2011/12	2012/13	2013/14	2014/15*
Number of inmate patients	1 276	2 308	1 990	2 771	6 166
*April-June 2014					

Estimations are that 70 percent of new tuberculosis amongst adults (in the general population) in South Africa is co-infected with HIV (Department of Health, 2010:2). This (public population) tendency will most definitely influence the inmate population in times to come and place more pressure on resources. The increase in the number of inmates who receive isoniazid preventive therapy means an increase in the number of inmates with tuberculosis and HIV co-infection. This is an alarming development, even though the Department claimed to experience a 68.8 percent tuberculosis cure rate from January to September 2014, increasing from 39 percent in 2011 (Department of Correctional Services, 2014:28). The Department of Correctional Services achieved a tuberculosis cure rate of 83 percent (1 034/1 250) for offenders by March 2016, which is lower than the set target of 85 percent (Department of Correctional Services, 2017:9), but represents a significant increase in the tuberculosis cure rate since 2011.

HARM REDUCTION RESEARCH IN SOUTH AFRICAN CORRECTIONAL CENTRES

General remarks about the research

In many countries, injection drug use is the major concern for HIV infection, while violence and sex are low on the list of concerns. South Africa is different. In fact, the Department of Correctional Services (2014:33) report that not one injection drug user has been identified up to 2014. At the same time, it was reported that (concerning injection drug use) "there is a need for the Department to develop relevant programmes for implementation should a need arise" (Department of Correctional Services, 2014:33), meaning that there is no need for injection drug use measures in particular. The major harm reduction concerns in the South African system come from violence (including sexual violence), tattooing, and consensual sex, while injection drug use hardly features. Booyens (2008:87) reported that inmate gangs, overcrowding, and vulnerable categories of inmates contribute most to rape in South African correctional centres, while long hours of idleness in overcrowded correctional centres also play a contributing role in deviant behaviour (Luyt, 2008(a):182).

Research in selected Gauteng correctional centres

The researchers conducted harm reduction research amongst the sentenced population in selected correctional centres in Gauteng. The selection of these centres for Gauteng for the research originated for a number of reasons, including the following:

- A doctoral study on the topic by one of the researchers in this article was undertaken in selected Gauteng correctional centres, which created the ideal opportunity to expand the research to additional Gauteng correctional centres
- Gauteng incarcerates a representative number of inmates in South Africa with the sentenced inmate diversity ranging from C-max to maximum, medium, minimum, females and youth. It remains the region with the highest number of sentenced offenders (25 729/117 255), making up nearly 22 percent of all sentenced inmates in South Africa (Department of Correctional Services, 2017:24). At the same time Gauteng is the second largest region where remand detainees are incarcerated (10 555/43 799) (24.17%), resulting in Gauteng being the largest region for all incarcerated inmates (36 284/161 054), or 22.53 percent of all inmates in South Africa (Department of Correctional Services, 2017:25). It needs mentioning (again) that the research only included sentenced inmates, but the overall numbers certainly do have a dynamic influence on service delivery, and therefore also the delivery of harm reduction services).

- High incidences of harm-related deaths are reported from Gauteng correctional centres. For example, suicides and medicinal overdose as the most common cause of unnatural deaths was the highest in Gauteng, while natural deaths were also the highest (Van der Westhuizen, 2016:70;72)
- Overcrowding is more typical in Gauteng (largely made up of urban correctional centres), undermining the ability to uphold humane conditions (Van der Westhuizen, 2016:47;49). Correctional centres in urban areas have the worst overcrowding rates, impacting negatively on all services and programmes. In the 2015/16 financial year, Johannesburg Correctional Centre's Medium B was populated at 233 percent, translating into a shortage of 1 736 beds (Africa Check, 2017).
- Financial dictates forced the researchers, who are based in Gauteng, to limit research to the province/correctional region.

The aims of the study

The study set out to:

- investigate risk taking behaviour prevalence among inmates;
- discuss harm reduction components that may be implemented to manage inmate risk taking behaviour;
- assess the HIV and AIDS knowledge levels of staff and inmates at the identified correctional centres (staff data is to be used for a separate research report and it will not receive attention here); and
- provide impetus for new and revised programmes to manage inmate risk taking behaviour and harm reduction practices.

The study (2010 – 2015) investigated (*inter alia*) the extent of risk taking behaviour amongst sentenced male inmates at three different correctional centres in the Leeuwkop Management Area, the Krugersdorp Correctional Centre and amongst sentenced females at the Johannesburg Female Correctional Centre. Three (security) types of correctional centres were included at the Leeuwkop Management Area, namely a maximum, a medium, and a section incarcerating sentenced youth (ages 18 to 21). Although the views of staff were also included in the research project and collected data, this discussion will only deal with findings from data for inmates. The staff data will be the topic of a different discussion.

Data collection

Data collection was done by means of a survey. Selected respondents volunteered to participate in the research and granted informed consent. In minimal cases additional interviews were conducted, using the questionnaire as guideline (in cases of illiteracy and foreign language barriers) to clarify responses. Two groups of eight respondents per male correctional centre (N=64) and two groups of eight respondents in the female correctional centre (N=16) were selected for focus group interviews to obtain additional information regarding aspects which were included in the questionnaires. Data gathered through the empirical stage of the research was utilised to address the following broad themes:

- Views about sex; and
- High risk behaviour.

Views about sex were adapted from a questionnaire by Koopman, Rotheram-Borus, Henderson, Bradley, & Hunter (1990). This questionnaire comprises a self-report measure by means of a four-point Likert scale. It contains questions concerning the offenders' personal view of and preference about sex, prevalence of sexual activities and coercive sexual activities.

The questionnaire on high risk behaviour in correctional centres was adapted from Torabi and Yarber (1992). Responses were also measured against a four-point Likert scale. Respondents were selected through systematic random sampling. Table 9 gives an exposition of the participants per correctional centre.

Table 9: Participants per correctional centre

Leeuwkop	Krugersdorp	Johannesburg	Total (N)
209	79	36	324

Table 10 shows some demographic information of the respondents in the research. The respondents were mostly black, reflecting the general make-up of the inmate population, while most respondents were younger than 40 years of age.

Table 10: Some demographic information about the respondents

Race	Frequency	Percentage
Black	298	91.97%
White	5	1.54%
Indian	1	0.30%
Coloured	20	6.17%
Age		
18-23	122	37.65%
24-30	93	28.70%
31-40	79	24.38%
41-50	30	9.25%9
Gender		
Male	288	88.88%
Female	36	11.12%

FINDINGS

The findings revealed that risk taking behaviour and incidences are prevalent at all the included correctional centres. It was established that a huge need existed to improve current harm reduction initiatives in these correctional institutions. More details will be provided later. The context about specific aspects of the research will first be provided. Inmate views about sex will be dealt with first, followed by a discussion on high risk behaviour.

Views about sex

The summary below represents feedback from the respondents concerning the following areas:

- Abuse of vulnerable inmates;
- Prevalence of sexual activities in correctional centres;
- Types of sexual activity, and
- Coercion and sexual activities.

Abuse of vulnerable inmates

In Table 11, the results for the two items that were used to test abuse of vulnerable inmates are listed.

Table 11:[1] Views about sex: Abuse of vulnerable inmates (N = 324)

Items	Strongly agree	Agree	Disagree	Strongly disagree	Total responses (n)
If you are weak you will become a *wyfie* (wife)	129	105	52	38	324
Inmates can buy food and goods with sex	106	122	43	51	322

Inmate respondents were overwhelmingly in agreement that vulnerable inmates are abused. Respondents indicated that weak inmates are prone to sexual abuse inside Gauteng correctional centres. The weaker ones are normally subdued into taking on female roles. It is also indicated that those who have less possessions due to their deprived situation, are persuaded into abusive situations, because they cannot 'pay their way' with goods, but present themselves as payment for protection, extra food and other goods. Looking back upon the theories discussed earlier, it transpires that both institutionalisation and deprivation play a role in inmate abuse. This area of abuse is not associated with coercion, but with persuasion and the fulfilment of need for commercial goods.

Prevalence of sexual activities in correctional centres

Statistics recorded regarding sex amongst inmates 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). Table 12 sheds light on the prevalence of sexual activities in the correctional centres in this study. The items do not test personal involvement, but refer to how inmates view the prevalence of sex by observing others in the correctional environment.

Table 12: Views about sex: Prevalence of sexual activities in correctional centres (N = 324)

Items	Strongly agree	Agree	Disagree	Strongly disagree	Total responses (n)
Inmates have sex in here	120	153	15	12	300
Inmates ask each other for sex	61	100	107	56	324
Inmates in here have sex every night of the week	40	76	103	78	297
I know inmates who have been approached to have sex with another inmate	33	69	68	130	300
You can buy food and goods with sex	99	125	38	37	299

Responses give a strong positive indication of the prevalence of sex between inmates. Although there is disagreement that inmates ask for sex all the time and the regularity with which it takes place, indications are very strong that sex is used as a commodity. Yet, responses show that there is around 60 percent disagreement about knowing others who have been approached for sex. The reasons are not clear, but there is a secrecy regarding how inmates are

approached for sex. The latter may be declared in terms of the dictates of the inmate code, expecting inmates not to speak truthful about certain topics. According to the cultural drift theory, the inmate code forms part of the larger criminal code that exists in society where secrecy is also expected. According to Moshoeu (2010:138) it is generally difficult to obtain accurate and honest responses from inmate respondents on questions of intrusive personal nature relating to risk taking behaviours.

Another possible explanation is the fact that sex remains a taboo topic, giving rise to the indigenous influence theory that regards correctional institutions as closed systems or isolated social enclaves. In addition, concerning South African correctional systems, Goyer, 2003:18) reports that the correctional authorities are reluctant to publicly acknowledge sex amongst inmates or the serious extent of sexual activities behind bars, as it reflects on poor management and shows a lack of inmate control. A lack of response will ultimately lead to a lack in reporting incidences.

Types of sexual activity

In Table 13, the respondents indicated the type of sexual activities that are most frequent. The researchers analysed the responses in Table 13 along gender lines. Male respondents were mainly of the opinion that any type of sexual interaction was acceptable, but males mainly resorted to anal sex. Women on the other hand, preferred oral sex and other interaction. Focus group participants indicated that incarcerated women 'would accept anything' when the opportunity for sexual interaction with men arises, including anal sex. Such opportunities originate between inmates and male staff, contract workers and during visitation. Occasional sexual interaction between male and female inmates were also reported.

Male inmates frequently use the term '*matanyola*' for sex between men. It is reported to have originated among migrant mine workers who would be away from home for long periods (Motswapong, 2010:104). From focus group discussions with inmates it transpired that there is division on whether *matanyola* refers to any form of penetration or not. At each of the four male correctional centres follow-up focus group interviews that were held with eight groups of eight respondents (N=64) to clarify sexual preferences, a reasonable number of persons (n=47) described *matanyola* as a form of 'thigh sex'. The majority (n=56) were of the opinion that many male inmates 'want the real thing' and *matanyola* is used between 'men who are not *wyfies*' [men who act as women/'wives'] This means that sexual interaction is not limited to the blood line (men acting as soldiers and leaders in gang structures) and *wyfies*, but sometimes soldiers will also have sexual encounters with each other. The 'real thing' increases exposure to risky behaviour and the need for harm reduction. Both *matanyola* and anal sex are regarded as an adaptive response to inherent deprivations within the institution with its origin in the institutionalisation theory.

Table 13: Views about sex: Types of sexual activity (N = 324)[2]

Items	Strongly agree	Agree	Disagree	Strongly disagree	Total responses (n)
Inmates prefer to have oral sex with one another	99	135	52	38	324
Inmates prefer to have anal sex with one another	103	123	47	49	322
Inmates prefer to have other forms of sex	23	147	69	83	322

Regarding female respondents, it is important to note that Pardue, Arrigo and Murphy (2011:279) indicate that the literature on sexuality in women's correctional facilities has identified a variety of sexual behaviour in which female inmates amongst each other and with correctional staff members participate. No single taxonomy has been developed that adequately describes the range of sexual behaviour found within the confines of women's correctional centres, but prison sexuality is shaped by multiple levels of social life that are determined by mainstream culture and amplified by the idiosyncratic subculture of correctional confinement. Research emphasises masturbation, homosexual relationships, and custodial sexual abuse (Pardue, et al., 2011:282). Many women in prison are desensitised to sexual violence (Pardue, et al., 2011:292).

Struckman-Johnson and Struckman-Johnson (2002) surveyed 263 female inmates and 100 staff members in three female correctional facilities to quantify their attitudes and experiences concerning sexual coercion during incarceration. In one of the facilities, the investigators found that 27 percent of female inmates (N = 148) reported experiencing sexual coercion at some point during their incarceration. One half of the assaults were perpetrated by women and one half perpetrated by men (correctional officials). One fourth of those who reported sexual coercion survived either oral, anal, or vaginal rapes.

Coercion and sexual activities

Participants were questioned about coercive sexual activities. Results are reflected in Table 14. In South Africa, gangsterism is a key aspect of inmate life. Sex forms part of the risky behaviour used in gang activities. Gangsterism is more active among males, but group formation is reported to be prevalent among females.

Table 14: Views about sex: Coercion and sexual activities (N = 324)

Items	Strongly agree	Agree	Disagree	Strongly disagree	Total responses (n)
Some gangs rape inmates as punishment	69	68	65	76	278
Gang leaders choose their sexual partners	87	108	56	73	324
Some inmates will force others into having sex	58	71	81	114	324
Inmates get raped in cells at night	55	84	84	101	324

The results for sexual coercion were interesting. There is large public support for the idea that inmates prey off others through coercion. Gear and Ngubeni (2002:3), for example, remarked about the "reportedly high incidence of sexual violence behind prison walls" and that subordination is "associated with inferiority, stigma, and a loss of status" (Gear & Ngubeni, 2002:14). Rape is a fairly common occurrence in correctional institutions perpetrated mainly by gang members. Gang sexual activities are largely violent and contribute to the prevalence of risk taking behaviours in correctional settings (Goyer, 2003:5)

Respondents in this survey were divided on being forced to have sex. More than 60 percent denied that it is the case. Also, 57 percent denied that inmates are raped and 50.72 percent denied that inmates are raped for punishment (missing value = 46). Although 60 percent were of the opinion that gang leaders select their sexual partners, the statement failed to measure the amount of coercion involved. The high missing value may have influenced result accuracy. Nonetheless, an indication from between 40-50 percent that inmates are raped or raped for punishment is indeed cumbersome.

The vulnerable inmates engage in coercive homosexual activities with bullies to avoid abuse by other aggressive inmates. Goyer (2003:33), reported that a 15-year old juvenile attested to being a sex slave of a gang member in return for protection from other inmates. 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 (Gear, 2005:2).

For high risk behaviour the researchers, *inter alia*, looked into injection drug use and tattooing. Injection drug use is a growing problem, even though Dada (2013:8) reported that research in this area remains limited. Around 69 percent of heroin users inject on a daily basis and 89 percent of injectors share needles according to Dada, (2013:10; 20). Injecting drug use is associated with health problems such as hepatitis and HIV. People who inject drugs tend to engage in sexual and other risk behaviour, including having more than one sexual partner. The HIV prevalence among injection drug users in South Africa is estimated at 19.4 percent (Dada, 2013:19). Table 3 provides a profile of injection drug users at South African treatment centres (Dada, 2013:12) and show upward trends in injection drug use.

Table 15: High risk behaviour: Drugs injected - South African drug treatment centre cases

Statistical period & number treated	**2010 (N = 17 501)**		**2011 (N = 16 864)**		**2012 (N = 19 230)**	
Drug	**N**	**%**	**n**	**%**	**N**	**%**
Heroin	2 721	15.5%	3 032	17.9%	3 268	16.9%
Methamphetamine (Tik)	3 155	18%	3 356	19.9%	4 247	22.1%
Methcathinone (CAT)	360	2.1%	840	4.9%	1 073	5.6%
Cocaine	1 860	10.6%	1 970	11.7%	1 860	9.7%
Other over-the-counter drugs	378	2.2%	848	5%	626	3.3%

Dada (2013:21) reported that there are little injection drug use interventions, also inside correctional centres. At Leeuwkop, in a study by Moshoeu (2010), 44 percent of inmates participating in harm reduction research (N = 209) agreed that inmates inject themselves, confirming that injecting drug use (as a growing new culture) has been transferred from the community into the correctional system (Moshoeu, 2010:150). Furthermore, 52.27 percent of the respondents agreed that there is a sharing of injection equipment among inmates (Moshoeu, 2010:153), confirming that the need for injection drug use, harm reduction measures are much higher than previously thought. As already mentioned, the Department of Correctional Services (2014:33) reported that the existence of injection drug use could not be confirmed. Also, it indicated that relevant programmes will be developed should a need arise. This need is already there and will increase in future, taking the national figures outside correctional centres given above into consideration.

More than 60 percent of participants (N = 324) indicated that tattooing takes place by using the same equipment over and over, even though many inmates have tattoos on arrival. Luyt (1994:49) observed that certain tattoos are (for generations) explicitly linked to incarceration. Primitive and unprofessional tattooing is reportedly an integral part of the inmate subculture (Goyer, 2003:16). There is no approved tattooing equipment in correctional institutions and inmates use make-shift equipment. There is no evidence that tattoo equipment is officially sterilised, even though authorities know that tattooing have existed for decades (Republic of South Africa, 2012(a):14). Inmates reported that equipment is heated to sterilise it.

The need for a full range of harm reduction measures

Successful harm reduction is based on policies, legislation and positive social environments to reduce problematic drug use. A comprehensive, multi-sector involvement that includes health services, the legal system, law enforcement and the cultural, social and economic environments is necessary. For South Africa, harm reduction should fit a wider definition, because the exposure to certain pathogens and virus infections such as HIV, have different influences than may be the case in other correctional systems. For example, tuberculosis as an airborne disease is particularly troublesome in the presence of HIV infection in South African correctional centres. Similarly, tattooing may be the South African version of infection exposure caused by needle sharing in other parts of the world (Luyt, 2008:149).

One could argue that, because of an apparent lower level of needle sharing, harm reduction in South African correctional centres (per definition) may not be an important issue. However, intravenous heroin use increased on the Cape Flats. For example, at Mitchells Plain heroin injection increased from four percent of all drugs used in 2000 to 11 percent in 2007 and 18 percent in 2012 (Prince, 2012:1). Constitutional Court Justice Johann van der Westhuizen visited Pollsmoor on 18 December 2012 and reported that "structured health programmes cannot be run in the (correctional) centre" (Van der Westhuizen, 2012:3), referring to a range of health services wider than harm reduction. Justice Van der Westhuizen (2012:5) further observed that:

> "It is clear that the realities inside the (correctional) centre are informed by the gang culture in the Western Cape as well as the high rate of drug dependency. Considering the long amount of time inmates are awaiting trial more programmes should be set up to deal with these issues."

It will only be a matter of time before the practise of intravenous drug use inside correctional centres can no longer be ignored by DCS, at least not in the Western Cape Province with its proven high rate of drug dependency (as pointed out by Judge Van der Westhuizen above). These factors (the gang culture, the high rate of drug dependency, and more programmes to be set up to deal with these issues) are not limited to one correctional centre or one province. These are the reasons why the system urgently requires the introduction of a full range of harm reduction measures and the availability of a full range of harm reduction measures must be addressed as soon as possible.

CONCLUSION

For more than a decade now, researchers have been pointing out a variety of deficiencies concerning harm reduction in the correctional system. These reports were not in vain. There are many positive developments around harm reduction in the correctional system. However, more actions still need to be implemented, while areas for continued research also exist.

There are a number of important achievements in recent years that benefitted inmate health. Political commitment regarding HIV treatment is the first that needs mentioning. After many court actions on a variety of HIV related issues, correctional leadership is now more committed to provide antiretroviral treatment. The renewed commitment is inspired by financial support from the Global Fund. In addition, the Department has received a donation of 12 GeneXpert machines for the diagnosis of tuberculosis, which has resulted in the reduced turnaround time of sputa results (Department of Correctional Services, 2014:42).

However, there is a disturbing increasing trend in isoniazid preventive therapy, in the number of condoms distributed, in the number of HIV positive inmates, the increased number of inmates on antiretroviral treatment and more inmates receiving post exposure prophylaxis. It is not the increased measures of harm reduction that is alarming, but the fact that so many cases are prevalent in the different categories within the inmate population. One could argue

that the availability of funding from the Global Fund may contribute to increased testing and treatment, but more research is needed regarding these increases.

The Department of Correctional Services employed 834 full-time professional nurses in 242 correctional centres (May 2016) (Maistry, 2016:1). Logically, there is tremendous pressure on this group of personnel to reduce harm while optimal medical services are rendered. The reality is that this select group of professionals are not the only ones responsible for harm reduction. It is at grassroots-level, in the very sections of our correctional centres, where harm can be best prevented. The question is how much commitment regarding harm reduction can be found here?

In general, the Department can do more to enhance harm reduction, including the following:

- Stop avoiding the question of male rape by only referring to sexual assault;
- Start sterilising tattooing equipment;
- Start administering ARV treatment to all HIV positive inmates and not only those with a CD4 count below 600;
- Research the effects of condom distribution in more detail, and;
- Investigate consensual sex inside correctional centres in detail to better understand the complete 'sex behind bars' phenomenon.

The Minister reported in the 2016 budget vote speech (Ministry of Justice and Correctional Services, 2016:2) that "We identified and prioritised the Sex Offender Treatment Programme and Substance Abuse Treatment Programme for research and further development in order to raise the effectiveness bar." This was decided after research that was reportedly completed in 18 correctional centres. It is imperative to share the findings from these research studies with the public. In doing so, more can be achieved to prevent harm amongst inmates.

One of the biggest concerns about harm reduction in correctional centres today (in addition to the reactive approach to various forms of harm, which is evident of not embracing harm reduction as a strategy) is the very source of the positive development in this area in South Africa, namely the Global Fund contribution. What will happen to these initiatives once the funding is not available anymore? To what extend are the harm reduction initiatives (as a complete strategy) integrated into the broad correctional budget over time? The lack of resources should not negate the positive developments we are experiencing now. Harm reduction is not a leisure activity, but it is fundamental to health and human rights. It was ignored for years and received an impressive boost through the Global Fund. Once the benefits are realised, for example the improved tuberculosis cure rate (Department of Correctional Services, 2014:28-29), one cannot return to the old ways of doing business.

The impetus needed is a harm reduction strategy, not a number of harm reduction functions. Once a correctional system cements its approach under one umbrella, more effort goes into such a strategy. Only with a consolidated harm reduction strategy will the provision of bleach prevent infected tattoo equipment to continue infection, or rape will be dealt with in terms of the created legal framework and will not be called sexual assault. With a consolidated harm reduction strategy, the correctional system will acknowledge the need for injection drug use services and replacement therapy policies. Although the harm caused by risky behaviour remains high, much progress had been made in the South African system. However, a separate, independent harm reduction strategy should remain a future priority.

ENDNOTES

1. Table 11 measures persuasion, i.e. subtle abuse, whereas Table 12 measures coercion which refers directly to the use of forceful activities. One of the questions asked was whether vulnerable inmates are abused by means of food and goods. Another question dealt with all inmates in general. The differences are in fact small, meaning that inmates can both be **abused** with money and goods, while others will **consent** to sex for money and goods without any threats. In essence all participants were of the view that **vulnerable** ones are **abused**, while the other is just a positive **indication of the prevalence** of **sex between inmates**.
2. The inclusion of women in the pool of respondents in a question on anal sex is motivated by the fact that some female inmates do engage in anal sex. The issue is not so much about what type of sex, but whether the actions call for harm reduction measures. Harm through natural sex may be addressed through female condoms for females, but for anal sex in female populations, male condoms would be a better option. Therefore, in this study there was not a need to implement data cleansing concerning gender of respondents.

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