

CHAPTER 1

HIV/AIDS IN SOUTH AFRICAN PRISONS

The South African Department of Correctional Services (DCS) includes statistics on HIV/AIDS infection in the prisons in its Annual Report. However, these statistics reflect only the reported cases from the health services of each prison and are not considered reliable. The DCS statistics underestimate the extent of HIV infection because reporting is inconsistent and often AIDS-related deaths are recorded only as TB or pneumonia. According to the DCS Annual Report, there were 2,600 registered HIV positive cases, 136 prisoners with AIDS, and 2,897 new cases of TB as of 31 December 1999.⁷¹ This translates to an HIV prevalence rate of 1.6% and AIDS prevalence of .08%. According to UNAIDS, HIV/AIDS seroprevalence for adults in the general population in South Africa in 1999 was estimated at 19.9%.⁷² Clearly, the DCS statistics significantly underestimate HIV/AIDS prevalence in South African prisons.

The data on the number of natural deaths in prisons is more useful for understanding the real impact of HIV/AIDS on the prison population. There were 1,087 natural deaths in prison during 2000; an increase of 584% from 1995.⁷³ The increase in the prisoner population was 38% over the same period. Table 1 shows the increasing number of natural deaths in prison per 1,000 prisoners.

Table 1: Natural deaths in South African prisons per 1,000 prisoners

Year	Per 1,000
1995	1.65
1996	1.68
1997	2.30
1998	3.65
1999	4.53
2000	6.38

Source: Office of the Judicial Inspectorate, 2001

It is difficult to determine how many of these deaths can be attributed to AIDS, because some records list only TB or pneumonia as the cause of death. However, it can be assumed that the dramatic increase in natural deaths in prison is a result of the same disease which is causing an increase in deaths outside of prison. The logical conclusion is that prisoners, like their counterparts in the community, are dying of AIDS.

Alarmed by the increasing number of natural deaths reported in prisons and aware of the limitations of DCS statistics, the Judicial Inspectorate conducted its own study in 1999. Examining post-mortem reports, the study determined that 90% of deaths in custody are from AIDS-related causes. Using figures from the previous five years and assuming the escalation would continue, the study projected that by 2010 nearly 45,000 prisoners will die whilst incarcerated. The study predicted that natural deaths in prison would increase 43% from 737 in 1999 to 1,056 natural deaths in custody in 2000. The actual figure was even higher than expected, as natural deaths in prison actually increased 48% to 1,087 during 2000.⁷⁴

HIV prevalence in South Africa's prisons: who knows?

The Department of Correctional Services does not know the HIV prevalence rate in prison. The Annual Report does not disclose how the current estimate, about 3%, is determined, but the Department has acknowledged that this figure is "unrealistically low".⁷⁵ However, when the Inspecting Judge of Prisons, Judge Johannes Fagan, estimated that as many as 60% of prisoners could be HIV positive, the Department disputed this figure as well as being "unrealistic and unreliable".⁷⁶

Judge Fagan based his estimate on a report which was presented at a DCS research workshop in May 2002. The report presents the findings of a study conducted on the nature and extent of HIV prevalence at Westville Medium B, a men's maximum security prison in KwaZulu-Natal. From January through April 2001, a team of researchers led by the Health Economics & HIV/AIDS Research Division (HEARD) at the University of Natal, Durban in conjunction with the Medical Research Council (MRC) collected urine samples from 274 prisoners for anonymous, unlinked HIV tests. The samples were connected to a survey questionnaire which included questions on age, race, income, education and criminal activity, as well as high risk behaviour both prior to and during incarceration. In addition to this data collected from prisoners, semi-structured interviews were conducted with prison

management and staff as well as DCS officials and relevant NGOs and academics.

Prior to commencing the research, DCS required the study co-ordinator (who is also the author of this monograph) to sign a contract agreeing not to release the results without prior approval from DCS. During the latter half of 2001, with the assistance of funding from the Ford Foundation, the findings of the study were compiled in a report entitled, "HIV/AIDS at Westville Medium B: An Analysis of Prevalence and Policy". The research team was invited to present the findings at a research workshop, attended by the DCS National Commissioner Linda Mti and approximately 30 other high level DCS officials, in Pretoria on May 14 2002.

The following week, Judge Fagan referred to the findings in the Westville report in his presentation to the Parliamentary Portfolio Committee for Correctional Services. When newspapers ran headlines with the Judge's estimate that HIV prevalence could be as high as 60% in prisons, DCS immediately distanced itself from the estimated figure and the Judge was called to report back to the committee to provide further explanation. On the same day that a copy of the Westville report was given to committee chairman Ntshikiwane Mashimbye, the primary author received a fax from Commissioner Mti prohibiting release of the report into the public domain until seven "concerns" were resolved. The following week, on May 28 2002, Judge Fagan apologised to the portfolio committee, explaining that his 60% HIV prevalence statistic was "a guesstimate, which was not intended to be taken as a scientific fact".⁷⁷

In a press conference later that day, Commissioner Mti said the report from the Westville study was confidential, and that much of its content was being seriously questioned by the Department. "The judge found himself vulnerable to an unscrupulous NGO with a particular agenda (to obtain more funding). Let us forgive him," Mti said.⁷⁸ A few days earlier DCS Communications Director Luzuko Jacobs released an official statement which criticised the Judge for disclosing such information and also told the press that there had never been a prevalence survey conducted in prisons.⁷⁹

The researchers of the Westville study wrote a detailed response to the seven concerns presented in Commissioner Mti's fax, but received no further communication from the Commissioner or the Department regarding publication of the findings. The research team also requested an opportunity to present,

and defend, the findings of the report to the parliamentary committee but this request was flatly refused. ANC MP and chairman Mr Mashimbye explained that the report was intended for the Commissioner and thus presentation to the committee would be “inappropriate.”

A few weeks after the Commissioner specifically prohibited the release of the report, SABC TV's Special Assignment programme aired an expose of corruption at Grootvlei prison in Bloemfontein. Less than a week later, Commissioner Mti declared a three month moratorium on all prison research. The findings of the Westville report, the only study ever conducted on HIV prevalence in a South African prison, remain under embargo by the Department of Correctional Services and thus have not been included in the research presented in this monograph.

The prison hospital at Westville Medium B (WMB) is the only prison hospital in KwaZulu-Natal. This means that prisoners from anywhere in KwaZulu-Natal are sent to the hospital at WMB if they require in-patient care. Therefore, information on AIDS-related deaths at this prison is useful for understanding the number of AIDS-related deaths amongst prisoners in the entire province. The number of deaths in the WMB prison hospital has been increasing at a faster rate than natural deaths in prisons nationwide. In 1993, there were 11 deaths at WMB Hospital. By 2000, this number had increased more than ten-fold to 122 deaths. Of these, 95% were from AIDS-related causes. During the first 15 days of 2002, five deaths were recorded and AIDS was listed as the cause of death for four of them; the cause of death for the fifth was unspecified.⁸⁰

The most common way in which HIV/AIDS presents itself in South Africa is through TB.⁸¹ Data obtained from one hospital in Gauteng showed that as many as 80% of newly admitted TB patients were also HIV positive.⁸² In South Africa overall, about half of the new cases of TB are attributable to HIV.⁸³ Among deaths at Westville Medium B in 2001, pulmonary tuberculosis was listed as cause of death for 47%.⁸⁴

Prisoners are a high risk population not just for HIV but also for other STIs and there is a significant correlation between STIs and HIV.⁸⁵ Ulcerative STIs, such as syphilis, exhibit symptoms of genital sores and ulcers which increase the risk of HIV transmission. High levels of STIs have been referred to by one author as “the most significant bio-medical factor driving the [HIV/AIDS] epidemic in South Africa.”⁸⁶

In South Africa, the prevalence of sexually transmitted infections (STIs) in the general community is very high. For example, whereas the prevalence of syphilis in the USA or UK is no higher than 15 cases per 100,000 population, in South Africa there are between 5,000 to 15,000 cases per 100,000. Studies conducted in rural KwaZulu-Natal have shown that about 25% of rural women will have at least one STI at any moment in time, 50% of women attending antenatal clinics in the same area have at least one STI, and 18% have more than one.

During the first half of 2001, a study on HIV prevalence and the relationship with STIs and other factors, was conducted by the Health Economics & HIV/AIDS Research Division (HEARD) at the University of Natal, Durban, in conjunction with the Medical Research Council. The results of this study were presented to the Department of Correctional Services in May 2002, but the National Commissioner has prohibited the public release of the findings. To date, this study represents the only prevalence data from a prison in South Africa. However, both the general public and even other relevant decision-makers in the criminal justice system, have been denied access to the report.

HIV prevalence amongst prisoners in South Africa can only be estimated using demographic data provided by the Department of Correctional Services and applying it to projections from antenatal clinic data in the general community. The Actuarial Science Society of South Africa has published a detailed projection of HIV/AIDS infection and death rates, commonly referred to as the ASSA 2000 model. According to DCS, 88% of female prisoners and 84% of male prisoners are between the ages of 20 and 65.⁸⁷ Table 2 shows the ASSA Model projections for these age groups in South Africa.⁸⁸

	2000	2001	2002	2003	2004
Antenatal clinics	25%	27%	29%	30%	31%
Women aged 15–49	22%	24%	26%	27%	29%
Adult women (ages 20–65)	20%	22%	24%	25%	26%
Adult men (ages 20–65)	21%	23%	25%	26%	27%
Adults (ages 20–65)	20%	22%	24%	25%	26%
Total population	12%	13%	14%	15%	16%
Source: ASSA, 2000					

Table 3: Projected HIV prevalence in the South African prison population

	2000	2001	2002	2003	2004
Prisoners male	34.3%	38.2%	41.4%	43.5%	45.2%
Prisoners female	34.4%	38.3%	41.3%	43.8%	45.3%
Total prison population	34.3%	38.2%	41.4%	43.5%	45.2%
Source: Author's projections					

Given what is known about the high risk behaviour of prisoners prior to their incarceration, the high risk profile of the prisoner demographic, and the risk of transmission inside prison, most researchers agree that HIV prevalence in South African prisons is expected to be twice that of the prevalence amongst the same age and gender in the general population. Therefore, a conservative estimate of HIV prevalence amongst South African prisoners is approximately 41% for the year 2002. Table 3 presents the projected HIV prevalence in South African prisons, assuming the age and gender proportions of the prison population remain constant.

Contaminated needles

Intravenous drug use is not common in South Africa. Until the early nineties, the primary injected drug was a pink prescription pill which was dissolved in water and then injected for an energising rush. Referred to as 'pinks', the drug gradually declined in popularity because of unpredictable fatalities. Unlike deaths from overdoses, people died from taking pinks quite unexpectedly and with no particular pattern. Some would die after only using a few times, others would remain addicts for years and then suddenly die after taking the usual dose. Because of this reputation, pinks declined in popularity and was eventually looked down upon as a drug only for the most hopeless junkies.⁸⁹

Since South Africa's transformation, illegal drugs are obtained to a large extent from Nigerian drug syndicates. Heroin, the most commonly injected drug in the United States, is provided in South Africa by Nigerian syndicates.⁹⁰ Heroin has not found the same popularity in South Africa, and those who do use it tend to smoke it rather than take it by injection. This seeming aversion to injecting drugs could be related to previous negative associations or bad experiences with

pinks. However, an increasing number of younger people have taken to smoking heroin who were perhaps not involved with drugs when pinks were popular. Once a person is a heroin addict, it is not entirely unlikely that they will take to injecting in addition to, or perhaps instead of, smoking their drug of choice. Given that the Nigerian syndicates control an estimated 40% of the United States heroin market, it is likely that the supply will become available should the demand increase in South Africa.⁹¹

Intravenous drug use is not common in South African prisons, perhaps because these types of substances are far too expensive and are normally used by socio-economic segments of the population that are typically not sent to prison.⁹² A recent study on AIDS and human development has confirmed that, "drug use through injections appears to be limited and sharing of needles does not, at this stage, appear to be a very significant mode of HIV transmission [in South Africa]."⁹³ However, a survey of incarcerated juveniles in Western Cape found that 5% reported using IV drugs.⁹⁴ While this amount is not high, it is also not negligible and the potential for growth is compounded by the fact that those interviewed were all between the ages of 12 and 18.

Both prisoners and staff interviewed from WMB confirmed that IV drug use does not happen at all in that particular prison. From interviews with 274 prisoners at Westville Medium B, only six had ever tried intravenous drugs, only three had used IV drugs in the 12 months prior to incarceration, and none had used IV drugs since entering prison. Although IV drug use did not occur in this prison, use of mandrax and marijuana (dagga) is more common inside prison than outside.⁹⁵ Of the prisoners surveyed at Westville Medium B, 72% reported smoking marijuana and 5% reported taking mandrax while in prison.⁹⁶ It is difficult to predict whether IV drug use will increase in South Africa, but if an injection culture develops outside of prison it can be expected to erupt inside prison as well.

An integral part of the prison sub-culture is the incidence of rudimentary tattooing by inmates on other prisoners.⁹⁷ One of the many health and safety hazards associated with this is the transmission of HIV. The risk of transmission is higher if a tool is used to puncture the skin, becomes contaminated with HIV positive blood, and is then immediately used on another prisoner. Less likely means for transmitting HIV include sharing razor blades or use of sharp implements in prison violence or self-mutilation. Owing to the relatively secure nature of the prison, cutting instruments are in short supply and are thus more likely to be shared. The risk for HIV transmission from use of contaminated cutting instruments will depend on the amount of blood involved

and the time elapsed between uses, as well as the viral load of the infected person and certain biological attributes of the non-infected person.⁹⁸

In South Africa, tattooing is part of the extremely powerful gang structure within the prisons. Because everyone's clothing is standard issue, identifying tattoos become the medium for communicating who belongs to which gang. A social worker at Westville Medium B Prison estimated that about half of the 3,100 or so prisoners there had been tattooed while in prison.⁹⁹ The inmates use home-made tools for the procedure, either a bit of metal, or even a spoon, that has been sharpened to a point which is able to cut the skin. The prisoners do not have access to any materials to clean these implements, such as bleach or disinfectant.¹⁰⁰ For ink, prisoners burn rubber bands or will use shoe polish.¹⁰¹

Tattooing is against the regulations in prison, so a prisoner is not likely to seek medical attention for an infected wound resulting from a tattoo. A representative at the South African Prisoners' Organisation for Human Rights (SAPOHR) confirmed this information, explaining that sometimes the prison staff will supply needles or in other ways promote tattooing within the prison. The prison guards are often involved in the gang power structures themselves as they are easily bribed into complicity or bought into association with a specific gang.¹⁰²

High risk sex

Lawyers for Human Rights estimates that 65% of inmates in South African prisons participate in homosexual activity.¹⁰³ Among prisoners awaiting trial, many of whom are held in the same cells as convicted prisoners, an estimated 80% are robbed and raped by other prisoners before they are officially charged.¹⁰⁴ At Westville Medium B Prison, social workers reported that prisoners commonly participate in sexual activity either voluntarily or through threats and coercion. A social worker at Westville Medium B commented that while many prisoners and prison guards will not admit it or discuss it, homosexual intercourse and rape are "rife".¹⁰⁵

One former prisoner, when asked to estimate or quantify the amount of sex which takes place in South African prisons, simply stated that it is an "every night, every day occurrence." Of particular interest was the interviewee's explanation of sex as currency in prison. If a prisoner is poor and does not have any money, he will not be able to buy influence or protection within the powerful prison gang system. Often his only option is to agree to be the passive partner of another prisoner with power or money in order to obtain his

protection and influence. The *Mail & Guardian* carried the story of a 15 year old boy who, "in exchange for protection in the lethal environment of the prison gang network...eventually became the *tronkmaat* (sex slave) of a bigger, stronger gang member."¹⁰⁶

The impact of this gang regulated sex trade is so far reaching as to be inescapable. According to one former prisoner, if a prisoner with money and/or influence wishes to acquire a certain prisoner as his passive partner, the chosen prisoner may not have a choice as the gang system is powerful enough to engineer changes in cell assignments with the assistance of the prison guards and officials.

Impact of prison conditions

The conditions inside prison can contribute, in varying degrees, to the risk for HIV transmission, the progression of HIV, and the deterioration in health of a person with full-blown AIDS. According to one author, "Incarceration cuts in half the life expectancy of those with HIV seropositivity."¹⁰⁷ In the US, AIDS inmates are dying an average of eight months earlier than AIDS patients in the general population.¹⁰⁸

Although definitive data from South African prisons is not available, it appears that the finding in the US remains applicable, that "Incarceration speeds the progress of the disease from infectious stage into the full-blown malady."¹⁰⁹ Several factors contribute to this phenomenon, with stress and malnutrition leading the list. While overcrowding, gangs, drugs, and violence are realities of prison life in every country, specific aspects of these issues as they are manifested in South African prisons will have different impacts on prisoners already infected or at risk for contracting HIV/AIDS.

Overcrowding

Overcrowding can impede efforts to deal with HIV/AIDS in that it exacerbates the health problems of those who are already ill, and also leads to increased high risk behaviours. Conditions of overcrowding in prisons are linked to the spread of TB. Because it is an airborne communicable disease, TB is easily spread wherever conditions combine a large number of people and low sanitary standards. In the United States, prisons have become an incubator for TB due to overcrowding and poor ventilation.¹¹⁰

The prison doctor at Westville Medium B cited TB as one of the most commonly treated illnesses for prisoners. One nurse is assigned as the TB co-ordinator, and an entire cell block is reserved for prisoners who have tested positive for TB. In Westville Medium B, communal cells originally intended for 18 are crammed with an average of 50 prisoners, but can contain up to 62 prisoners.¹¹¹ Prisoners are unlocked for breakfast at around 7 a.m. and are locked up again at 3 p.m. This means that a typical cell contains 50 people who spend 18 hours each day in close proximity to each other with no ventilation or air circulation. There are no statistics available on the full extent of TB in South African prisons, but given the conditions of overcrowding there is every reason to believe that the disease affects the prison population to an alarming degree.

Prison overcrowding has a direct bearing on many aspects of a prisoner's life in that it inevitably leads to a deterioration of hygiene, care, and supervision.¹¹² In addition to the basic health and sanitation risks, the incidence of rape within a prison varies with the intensity of overcrowding.¹¹³ The risks for violence as well as sickness are obvious. Plainly stated, "...the more crowded is the prison, the greater is the likelihood of acts of rape and homosexuality."¹¹⁴ And the dangerous corollary to this is that increased homosexual activity means more prisoners more often are participating in high risk behaviour for transmitting HIV.¹¹⁵

In South African prisons, overcrowding can lead to high risk behaviour in that the increasing scarcity of simple items such as blankets and shoes are then used as commodities which can be exchanged for sexual acts. One former prisoner explained that in the particularly crowded cells there are fewer beds than there are people. It is not surprising that sharing a bed with another prisoner can lead to homosexual activity, sometimes in exchange for the privilege of having a bed to sleep in. The only other options for some prisoners is to sleep in the shower or toilet as sometimes even floor space is not available.¹¹⁶

Even if enough beds are available, the practical reality of fitting 50 beds in a space intended for 18 means that beds are not only triple or even quadruple bunked, but placed right next to each other so that they are touching other beds on almost all sides. In a typical South African prison cell, the prisoners fortunate enough to have beds are literally sleeping side by side and toe to toe. It is not hard to imagine the implications of this lack of defined or sufficient personal space on the incidence of high risk sexual behaviour.

Nutrition

One of the most common complaints raised by prisoners is about the food. At Westville Medium B, inmates are fed twice a day. At breakfast, they receive porridge with one teaspoon of sugar, two slices of bread and tea. In mid-afternoon, they receive their only other meal of the day and are then locked up until the following morning. The mid-afternoon meal normally consists of samp, *mielie pap*, or minced fish which still contains bones and is more reminiscent of cat food than of anything fit for human consumption. This meal is accompanied by five slices of bread, and no butter or condiments of any kind are provided.¹¹⁷ The kitchen at WMB is in need of new equipment; in order to prepare breakfast the outmoded ovens must start cooking at 3 a.m.¹¹⁸ Meals are often served cold, and might not even be cooked at all. A former prisoner explained that dinner would sometimes be raw *pap*; simply the powdered *mielie* meal mixed with water.¹¹⁹

More than one staff member at the Westville Medium B prison cited the incidence of smuggling and theft in the prison kitchen, by both prisoners and staff alike, as a primary cause for the lack of decent meals.¹²⁰ The problem is not even alleviated by those prisoners lucky enough to receive visitors who wish to bring them food. Many of these items are confiscated or disallowed because of the risk of containing contraband. Even fresh fruit and vegetables are not permitted, as these could potentially be injected with drugs.¹²¹ Limiting access to such things as fruits and vegetables or other much desired foods increases demand, and thus the profit to be had from selling these items inside the prison increases, creating additional incentive to steal and smuggle. The resulting restricted access to adequate nutrition has an impact on health concerns of all kinds. In particular, prisoners living with HIV are affected because proper nutrition and vitamins may postpone the development of HIV into AIDS.¹²²

Stress

The staff at WMB who provide counselling to HIV positive prisoners unanimously agreed that a prisoner's mental state has a significant impact on the prisoner's health. Social workers and psychologists attested that those who lost hope and resigned themselves to die were those for whom the disease progressed most rapidly.¹²³ Being imprisoned carries with it a number of stresses, including being separated from family and other support structures, frustration of goals or plans for the future, interruption of familiar activities, and intimidation and fear resulting from bullying or victimisation from other prisoners.¹²⁴

The otherwise heavy psychological burden of imprisonment is then further intensified by the knowledge that one is infected with HIV. Few people would doubt that life in prison is unpleasant and is likely to be stressful at the very least, thus the negative effects of prison life on HIV/AIDS prisoners are understandable given that, "stress enhances depression of the immune system, thereby hastening the progress of the disease."¹²⁵

Gang activity

The power of the 26s and 28s gangs inside South African prisons pervades nearly every issue related to HIV/AIDS in prison. Many high risk behaviours are directly related to gang activity. Membership in both gangs frequently includes tattooing, and it is not uncommon for more than one inmate to be tattooed at a time using the same needle.¹²⁶ Violence between prisoners which leads to bleeding is also a product of gang activity. Prisoners may be required to attack another prisoner and draw blood in order to be initiated into a gang.¹²⁷ For members of the 26s, the practice of stabbing another person, usually a non-gang member, is referred to as *phakama* and allows the gang member to move up in rank depending on the severity of the attack and the situation of the person who is attacked.¹²⁸

While the 26s engage in stabbings, the primary activity of the 28s is sex and prostitution.¹²⁹ In 1906, the 28s gang began to take shape as two loosely connected associations, one inside prison and the other in the mining compounds. Both structures warehoused young men away from their families with minimal opportunities for diversion or normal social interaction. When the gang leader, Nongoloza, was imprisoned in 1908 he consolidated his criminal empire from his prison base in Pretoria. The prison environment, then and now, provides the ideal location to recruit new members and train them in the tight discipline necessary to maintain gang hierarchical structures. Although stories vary about the split of the 27s from the 28s, one reason given is the 27s' refusal to accept the custom of homosexuality which had become an accepted feature of Nongoloza's gang by that stage.¹³⁰

The 28s' hierarchy consists of two lines: one is the 'men' and the other is their 'wives'. The men do the fighting and protecting, and the wives are the sexual partners of the fighters, or 'men'. In addition to being the receptive sexual partner, the wives perform many traditionally considered feminine roles, including washing and other domestic chores.¹³¹ Although the 26s and 27s may claim to eschew homosexual activity, and are reportedly forbidden by

the gang's official code from taking a wife, staff at Westville Medium B noted that homosexual activity has become common amongst all gangsters. When asked about the impact of the 28s gang on the incidence of sexual activity at Westville, one interviewee responded that the 26s are also taking 'wives' even though they claim it is something only the 28s do.¹³²

According to one former prisoner, prison wardens are also involved in gang activities, and gang members will actively recruit prison wardens as a means of increasing their power. For example, if a member of the 28s wishes to obtain a specific prisoner as a wife, he may be able to gain the complicity of a warden in transferring the targeted prisoner to the gangster's own cell. The former prisoner claimed that the wardens are also known to not only facilitate but also engage in sexual activities as part of their membership in a gang.¹³³ The wardens involvement with either the 26s or 28s can also extend to the smuggling in of food, weapons, cigarettes, drugs, and other items as well as the prostitution of juveniles to other prisoners.