

CHAPTER 3

HIV/AIDS POLICY IN SOUTH AFRICAN PRISONS

The first policy to address HIV/AIDS in the South African prison system was formulated in 1992 and has been described as based on “fear, lack of knowledge, and prejudice”.¹⁷¹ The DCS approach was to segregate HIV positive prisoners, a policy which was not officially implemented until 1995. The procedure consisted of interviewing new prisoners to determine if they were involved in high risk behaviour, testing those who were considered at high risk for being HIV positive, and then segregating HIV positive prisoners in a separate facility from the general prison population.

Prisoners considered high risk were those who were illegal immigrants, those convicted of sexual crimes, intravenous drug users, or those “who have had sexual contact whilst abroad, specifically in those countries where HIV-infection is present in 10% or more of the population.”¹⁷² The Department’s definition of high risk populations is indicative of a lack of appropriate information.

There is no evidence to suggest that illegal immigrants or sexual offenders in South Africa are more likely to be HIV positive. Inclusion of IV drug users as high risk is theoretically valid although realistically not useful given the low incidence of IV drug use in South Africa. Finally, the specific reference to countries with greater than 10% HIV prevalence would not be useful in South Africa today, as the current prevalence rate is more than 14%.¹⁷³

If a prisoner was determined to be high risk, he or she was segregated from the general prison population as well as from the HIV/AIDS section until an HIV antibody test was administered.¹⁷⁴ The policy, as it was written, also required that all high risk prisoners be referred to a medical officer, where they were given pre-test counselling, asked for their informed consent to the test, and then given post-test counselling.¹⁷⁵

According to the policy paper, test results were to be kept confidential, but were required to be reported to the head of the prison.¹⁷⁶ Interestingly, most policies which violate the fundamental principles of confidentiality regarding

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

By the mid-nineties's, the DCS policy came under scrutiny in light of the WHO Guidelines on HIV Infection and AIDS in Prison which condemned segregation policies. The primary changes to be considered included the desegregation of HIV positive and high risk inmates and the distribution of condoms to prisoners on the same basis as they are available in the general community.

The issue of condom distribution provides an excellent context for examining the denialist tendencies of the South African government with regard to HIV/AIDS policies. The former Minister of Correctional Services, Siphon Mzimela "led the chorus of denials" when he said that condoms would not be distributed in the prisons until he was presented with irrefutable evidence that sexual activity took place.¹⁷⁷ In 1994, the DCS produced a White Paper which declared that "sex, in whatever form, cannot be condoned and authorised for prisoners in South Africa."¹⁷⁸ The paper went on to specifically dismiss any suggestions for condom distribution within the prison, citing that sexual activity in prisons is neither permitted nor tolerated.¹⁷⁹

Current policy

During the second half of 1996, a policy amendment paper was distributed to prison officials which ended the practice of segregating HIV positive prisoners. Instead of recommending prisoners for HIV testing upon admission, prisoners were only to be tested when they requested a test or were tested upon recommendation by the district surgeon. In either case, the prisoner's written consent was required before the test could be administered.

In order to try to prevent HIV transmission in the prison, the revised policy advocated extensive AIDS education and counselling for the inmates and staff, and encouraged all prison staff to practice "universal precautions."¹⁸⁰ The concept of universal precautions is that all potentially contaminated fluids are to be treated as if they are HIV positive, and the appropriate safety measures to prevent infection should be followed in every instance.

In addition to reversing the earlier policy of segregation, the amendment also introduced a number of specific programmes to be implemented at the provincial as well as the prison level. The first of these was the provision of STI clinics at all prison hospitals. These clinics would be run by the nursing staff, and would provide testing, treatment, counselling, and information regarding STI's for prisoners.¹⁸¹ Nurses were also instructed to monitor the condition of patients with HIV/AIDS, arrange diet supplements and consultations with psychologists, social workers, medical specialists and other professionals.¹⁸²

As well as the policy amendment paper, a separate policy document was circulated to the provincial commissioners relating to the distribution of condoms to prisoners. The new policy allowed for condoms to be "provided to the prison population on the same basis as condoms provided in the community."¹⁸³ Part of the implementation required that a prisoner would not receive condoms, "before having undergone education/counselling regarding AIDS, the use of condoms and the dangers of 'high risk behaviour.'"¹⁸⁴ Condoms could be supplied to prisoners only on request and only by a nurse trained as an AIDS counsellor.¹⁸⁵ The condoms would be supplied and paid for by the Department of Health (DOH), and therefore the DCS was not to purchase condoms with its own departmental funds.¹⁸⁶

In order to help with implementation of these new policies, DCS directed that each province appoint a member of the nursing staff to act as Provincial HIV/AIDS Co-ordinator. The duties of the co-ordinator include training inmates and staff on "universal precautions" practices, monitoring STI clinics, arranging information sessions for both staff and inmates on the policy change, and organising the distribution of condoms.¹⁸⁷ The provincial co-ordinator is also expected to liaise with AIDS counsellors at each of the prisons in the province, and identify and train AIDS counsellors for those prisons which do not have one.¹⁸⁸

The policies outlined in the two documents circulated in 1996 remain the official position of the DCS regarding HIV/AIDS in prison. The issue is consistently mentioned in the DCS Annual Reports, parliamentary discussions, and press releases although never in great detail and usually with vague promises but no specific actions described.

In the 1995 Annual Report, the section on "AIDS and HIV cases" consisted of one paragraph and was not accompanied by any statistics. Official statistics regarding HIV and AIDS have been included in the Annual Report since 1996, although the report still only contains a few paragraphs on the issue. The 1999

Annual Report discusses several projects and strategies, and even mentions a video-conference between South Africa and the US on the issue, but makes no reference to either the design or implementation of new policies.

Implementation

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

Testing

According to the 1996 policy document, "testing for the HI-virus must only be done on medical grounds on recommendation of the District Surgeon or by request of the prisoner and with his/her written consent."¹⁸⁹ However, prisoners at WMB are not able to receive a test upon request because of cost constraints.¹⁹⁰ This appears to be an example of implementation deficit due to insufficient resources.

The Health Economics and HIV/AIDS Research Division (HEARD) at the University of Natal conducted anonymous unlinked HIV testing at WMB in January 2001, and more than half of the prisoners who voluntarily participated asked to be informed of their HIV status. When a proposal was submitted to the Department of Correctional Services Provincial Commissioner to offer testing and counselling for these prisoners *at no cost to the Department*, the request was denied on the grounds of security issues.

Arguably, informing a prisoner of his HIV status while appropriate medical treatment (ARV, better nutrition) is not available could cause considerable unrest, particularly in light of the high number of prisoners expected to be infected. However, denying prisoner requests to learn their HIV status not only contravenes DCS policy but also violates the equivalence principle as prescribed by WHO guidelines.

Although prisoners are not able to be tested for HIV upon request, HIV testing is conducted at the recommendation of the prison doctor at WMB. A doctor visits WMB for two hours in the morning and two hours in the afternoon, Monday through Friday. During each two hour session, the doctor will see an average of 60 prisoners. Of these, the doctor will recommend an HIV test for an average of five prisoners. Every prisoner who has or displays symptoms of TB is recommended for an HIV test. Prisoners who have significant weight loss, persistent skin infections, chronic diarrhoea, oral thrush, or an STI are also recommended for an HIV test.¹⁹¹

Once a prison doctor recommends an HIV test for a prisoner, he is first referred to a member of the nursing staff to receive pre-test counselling. The counselling session covers a variety of HIV-related issues including the explanation of the prisoner's rights to privacy and dignity and that the prisoner can refuse to take the test. If the prisoner agrees to have the HIV test, he will sign an informed consent form. Out of every ten prisoners who are recommended to be tested for HIV at WMB, one or two will refuse. For those who give their informed consent, the test is conducted on a blood sample and sent to a private lab and the results are usually available in two weeks.¹⁹²

The nurse responsible for HIV counselling will submit a list of all the prisoners whose results have arrived, whether they are positive or negative. The wardens will then bring those prisoners to see the nurse for their post-test counselling session. One reason given for arranging a post-test counselling session with all tested prisoners regardless of whether the test was positive or not is to protect confidentiality.

As one nurse explained, most prisoners know that she is the one who gives prisoners their HIV results and so if she only meets with those who test positive for HIV, then anyone who is called out from his cell to be sent to see her will be labelled as HIV positive. Only the nurse knows the results of a prisoner's HIV test and she does not inform anyone except the prisoner himself, although a prisoner's HIV status will be recorded in his medical file. This reflects a very in-depth understanding of the crucial issues of privacy and confidentiality which actually exceeds that provided by DCS policy.

The 1996 policy document provides that, "The diagnosis of HIV/AIDS must be kept absolutely confidential and must only be communicated to disciplinary staff on a 'need-to-know' basis."¹⁹³ Examples given of those who "need to know" include a prison guard who is injured by an HIV positive prisoner and psychological or welfare counsellors.¹⁹⁴ Amongst organisations devoted

to defending the rights of people living with HIV/AIDS, the phrase 'need to know' is considered antithetical to the principles of confidentiality; the only person who actually needs to know is the HIV positive individual himself.

Although the HIV nurse insists on seeing all HIV tested prisoners for post-test counselling irrespective of a positive or negative result, the reality is that 80 to 90% of those tested are actually HIV positive.¹⁹⁵ Aware of the psychological distress of learning that he has tested positive for HIV, the nurse has implemented her own policy of always informing prisoners of their results first thing in the morning so that she can monitor them throughout the day.

She emphasises the importance of a prisoner's mental health and believes it is an important part of her duties to check on her patients' psychological condition before leaving for the day. The nurse elaborated, saying that she will never give a prisoner his HIV test results just before lock-up in the afternoon because of the emotional stress involved and the need for support as an important part of caring for a prisoner's health and well-being.¹⁹⁶

Condoms

The DCS policy to distribute condoms was the result of a hard fought battle, waged by several pressure groups including Lawyers for Human Rights and the South African Prisoners Organisation for Human Rights. Unfortunately, the policy does not achieve its objectives because of both poor design and implementation. The policy document states that condoms are to be provided to the prisoners, "on the same basis as condoms are provided in the community."¹⁹⁷ This seems an appropriate policy, were it not for the very next paragraph which effectively prevents condom availability in the prison from bearing any resemblance at all to the manner in which condoms are available in the community:

A prisoner may not receive condoms before having undergone education/counselling regarding AIDS, the use of condoms and the dangers of "high risk behaviour." The fact that a prisoner received counselling must be recorded on his/her medical file.¹⁹⁸

In effect, a prisoner who wishes to obtain a condom must endure a face to face interaction with a member of the health staff to make his request and then receive a lecture regarding his sexual behaviour. In the general community, condoms are available discreetly and free of charge at universities and

clinics and are even provided by some employers. Clearly, the DCS policy on condom distribution is poorly designed to the point that even with perfect implementation it is not likely to be effective.

Interviews with prisoners and health staff at WMB confirmed the ineffectiveness of the condom distribution policy as it was determined that prisoners very rarely request condoms. Of the 274 prisoners interviewed, only one reported requesting a condom while in prison. This may or may not be a result of the flawed design of the condom distribution policy, as some would argue that sex in prison is at a minimum coerced under threat, when it is not forcible rape, and the perpetrators would not agree to using a condom anyway. Furthermore, more than three-quarters of the prisoners interviewed reported that they never used a condom prior to their incarceration.¹⁹⁹ One can scarcely be surprised that the same behaviour regarding condom usage outside of prison would persist inside the prison.

However, even assuming that the condom distribution policy was appropriately designed and that prisoners were genuinely interested in practising safer sex and avoiding high risk behaviour, the DCS condom distribution policy would still fail because the actual condoms issued are not strong enough for anal intercourse. According to health staff at WMB, the condoms provided break during anal intercourse thus negating any effort to reduce HIV transmission.²⁰⁰ The condoms are issued by the Department of Health (DOH) and are the same as those provided in the general community. However, this is one instance where the standard which applies for the general community is not appropriate in the prison environment.

Liability and legal issues

Many countries have seen legal battles arising from HIV transmission in prison. Prisoners in two Australian states have taken legal action against their prison systems for failing to provide measures to prevent the spread of HIV.²⁰¹ In the United States, non HIV-infected inmates have filed cases against the prison system for failing to test and segregate HIV positive inmates, correctional staff have filed against facilities for failure to warn, and families of HIV positive inmates have filed against the prison system for failure to inform.²⁰² If a prisoner is infected with HIV as a result of negligence on the part of the corrections system, then it is not farfetched to imagine that the Department can be held liable for failure to provide safe custody. However, keeping in mind that HIV transmission is not a criminal

offence in South Africa, DCS would not be charged with attempted murder as some might assume. Rather, a court case is more likely to be associated with the failure of the state to provide a prison environment which is consistent with conditions of humane detention.

One such case, *PW vs Minister of Correctional Services*, is currently pending regarding a prisoner who contracted HIV while incarcerated. PW was a prisoner at Pollsmoor from November 1993 through December 1994, and repeatedly tested negative for HIV. PW had been engaging in homosexual intercourse with another prisoner, and he asserts that the prison officials knew this, yet consistently denied him access to condoms. On or about 27 November 1994, the prisoner tested positive for HIV. The plaintiff alleges that during his incarceration:

- 7.1 it was common for prisoners generally, and for the inmates of the prison in particular, to engage in sexual intercourse;
- 7.2 a material proportion of prisoners generally, and of the inmates of the prison in particular, were HIV positive;
- 7.3 it was consequently inevitable that some of the prisoners who engaged in sexual intercourse with those who were HIV positive, would also become HIV infected.²⁰³

The response from DCS was to admit to the above assertions, with the exception that the prisoners referred to in 7.2 above were not necessarily the same as those referred to in 7.1. The plaintiff charges that the prison officials knew of both the existence and risk of homosexual activity in the prison and failed to take steps to prevent the activity or minimise the risk of infection. According to the plaintiff, the responsible authorities:

- 11.1 ignored and tolerated the practice; and
- 11.2 prohibited all prisoners from having access to condoms.
- 12 The above prohibition policy was not necessary for the achievement of any of the purposes for which the responsible authorities were vested with their powers of control and management of the prison. It was revoked in 1996 without any ill-effect.²⁰⁴

The Department's response to point 12 above was:

Save to admit that the aforesaid departmental policy was changed in 1996 that thereafter prisoners were provided with condoms by

Defendant, the remainder of the contents of this paragraph are denied and Plaintiff is put to the proof thereof.²⁰⁵

The plaintiff asserts that the conduct of the prison authorities violated his rights under the Correctional Services Act 8 of 1959, his common-law rights, and his rights under the Constitution, in particular:

23.1 His right in terms of Section 25(1)(b) to be detained under conditions consistent with human dignity, and to be provided with adequate medical treatment at State expense.

23.2 His right in terms of Section 11(1) to freedom and security of the person.

23.3 His right in terms of Section 11(2) not to be subjected to torture of any kind, whether physical, mental, or emotional, and not to be subjected to cruel, inhuman, or degrading treatment or punishment.

23.4 His right to life in terms of Section 9.

23.5 His right in terms of Section 10 to respect for and protection of his dignity.²⁰⁶

The plaintiff is claiming damages of R1,118,000 for future medical expenses, loss of earnings, and pain, suffering and risk of shortened life expectancy. The trial date is currently set for 10 February 2003.

Resources

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

- to advise Commanders and Heads of Prisons on the implementation of [HIV/AIDS] policy;
- to co-ordinate the practice of “Universal Precautions” in all prisons in the province;
- to monitor the efficiency of STI clinics in all the prisons in the province;
- to arrange information sessions in consultation with all the commanders at all prisons in order to inform the staff and the prison population of the policy amendment;
- all other duties as indicated in the directive on the provision of condoms.²⁰⁷

The province of KwaZulu-Natal contains 28,375 prisoners in 38 prisons from Ladysmith to Port Shepstone, Durban to Vryheid.²⁰⁸ The PHC for KwaZulu-Natal is responsible for programmes and education to reach each of these prisons, including both prisoners and staff, *in addition* to her regular duties as a full-time member of the nursing staff. She is not paid any additional salary for her role as PHC, nor is she provided transport or reimbursed for the use of her personal vehicle.²⁰⁹

From her experience, inmates have revealed a startling lack of knowledge about HIV and a keen, almost desperate, desire to learn more about HIV/AIDS. However, many do not even know that a provincial co-ordinator exists or that HIV/AIDS educational programmes are supposed to be available in the prison. While the DCS policy succeeded in identifying the need for a PHC position to address HIV/AIDS issues in the prisons, the policy is not able to achieve maximum effect because of the lack of any, let alone sufficient, resources to support the efforts of the PHC.

In spite of the lack of resources and absence any official instruction or support, the health and social workers at WMB have succeeded in implementing successful programmes for addressing HIV/AIDS. The positive results of these bottom-up approaches to HIV/AIDS attest to the benefits of incorporating local implementation structures in the policy development process. To illustrate, social workers and psychologists have organised a support group for HIV positive prisoners, although it is sometimes not possible for prisoners to attend due to staff shortages: there are not any guards available to escort them to the room where the support group meets.²¹⁰

One social worker described an exercise from the HIV support group where prisoners are asked to identify positives as well as negatives in their personal situation and encouraged to emphasise the positive as a coping strategy for their situation. The group has also learned beadwork skills and meets to make beaded AIDS awareness pins. This project does not receive any funding from the Department however and the prisoners must use their own money, usually provided by relatives, to buy the beads and other materials necessary to make the pins. When the prisoners finish making a batch of pins they are given to the relatives to try and sell outside the prison. This programme is entirely run by social workers who do not receive extra compensation or even their own budget for AIDS-related programmes.²¹¹

While the support group helps address the needs of HIV positive prisoners, peer education programmes have been organised to respond to the needs of

the general prison population. With the assistance of prisoners, guards, and other staff at WMB, certain peer leaders have been identified and engaged in an education programme aimed at disseminating HIV/AIDS information in a manner which will be best received by other prisoners. As with other social settings, prisoners are more likely to absorb information that is obtained from people with similar backgrounds and experiences, thus peer education programmes have become a common recommendation for effective HIV/AIDS intervention. The peer education programme at WMB consists of around 20 prisoners but faces many of the same limitations as the HIV support group due to the lack of resources.²¹²

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

Early release

No mention was made in either of the May 1996 policy documents of a programme of early release for prisoners dying of AIDS. WHO Guidelines on HIV Infection and AIDS in Prison eventually led South African policy makers to discontinue segregation practices, but did not seem to have an official impact regarding early release. In the WHO Guidelines, Section L.51 states:

If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom.²¹³

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

The official policy regarding early release at Westville Medium B consists of numerous bureaucratic levels, with the result that most prisoners die before

their release is approved. If the health staff believe that a prisoner should be released, the prisoner must be seen by the district surgeon as well as a specialist from the outside. This specialist only visits WMB once a week, and must see the patient twice: once to order additional tests and x-rays, and a second time to review the results. The specialist recommendation is then sent on to the parole board, and a social worker is notified who must determine if the prisoner will have adequate housing and care upon release.²¹⁴

This is no mean feat as many prisoners come from township areas where their families live in makeshift substandard housing and access to postal services or phone lines is considerably limited. Sometimes the family does not wish to care for the prisoner, either as a result of misguided fears associated with HIV or because they cannot afford the cost of burial services.²¹⁵

Assuming the social worker is able to surmount these difficulties, there is still the matter of the parole board which must visit the prisoner to make sure that the prisoner listed on the records submitted is the same prisoner that is sick and dying in the prison hospital. This entire process usually takes several weeks and can even stretch out for more than two months. According to one interviewee in the prison hospital, an application for early release was sent in for a prisoner in February 2000. The prisoner died in March of that year, and on April 16th, the approval for early release was granted.²¹⁶ For one social worker, who processes an average of five prisoners for early release each week, only one of her cases has lived long enough to go home to die.²¹⁷