HARM AND RISK REDUCTION IN PRISONS

INTRODUCTION

Harm reduction originated as a framework for dealing with substance use and abuse (Riley 1993:1) and has gained impetus over the past decade because of the spread of AIDS. Although general belief has it that HIV is spread through sexual contact, injection drug use became one of the primary risk factors for HIV infection (Inciardi & Harrison 2000:2). The following examples amplify this:

- In the USA more than 20 percent of reported AIDS cases are directly associated with drug injection.
- Thirty percent of new HIV infections in the USA present injection drug users.
- In some European countries injection drug use accounts for as many as 60 percent of AIDS cases.
- From January to September 1988 HIV infection amongst injection drug users in Thailand rose from 1 to 40 percent (Rana 1996:4).
- In the United Kingdom between 60 and 100 percent of heterosexually acquired HIV is related to injection drug use.
- In Canada more than 10 percent of female AIDS cases are related to injection drug use.

Harm reduction, therefore, began as a strategy to intervene in injection drug use communities to allow drug users to adopt risk reduction practices that prevent the spread of HIV.

As a front-runner in terms of incarceration, America declared war on drugs during the late 1980s. This war is not over yet. Drug-related offences ignited an explosion in prison population growth. According to Schmalleger and Smykla (2001:325) the number of American inmates who needed substance abuse treatment rose from 688 000 in 1993 to 840 000 in 1996.

Lately, South Africa has become one of the lucrative new drug markets of the world. Drug use increased in public as well as in institutional settings. Organised crime is reported to be on the increase. Forming part of the organised crime scene, drug dealing is becoming a major concern for crime fighters. The number of people arrested in South Africa for dealing in hard drugs like cocaine rose from 15 in 1995 to 75 in 1997 (Volksblad 2001:1). According to the findings in a study by the University of Cape Town (Mans 2000:12) Grade 11 pupils spent more than 22 million rands on mandrax, dagga (marijuana), alcohol and cigarettes in 1999 alone.

Growing substance abuse is a major concern in the South African criminal justice system. In a recent study by Parry, Louw and Pluddemann (2001:5) 95 percent (N = 999) of arrestees in three metropolitan areas (Cape Town, Durban and Gauteng) agreed to provide urine samples for substance testing during their arrest. Forty-five percent of these arrestees tested positive for at least one substance, with 39 percent testing positive for dagga (cannabis), 19 percent testing positive for mandrax and 5 percent testing positive for cocaine (6 percent in the Durban area). Inmates also use substances out of...
boredom and to encourage themselves when gang-related violence is to be performed. The substances mostly consumed for the purpose of engaging in violence are dagga and mandrax (Luyt 1996:161).

The scale of drug use in prisons became a course for concern. Nelles and Fuhrer (1997:14) report that more than half the inmates in many prisons use illegal drugs. More disturbing, however, is the deadly link between drug use and the transmission of infectious diseases such as HIV and viral hepatitis. For this reason harm and risk reduction in prisons has to be applied in a wider context than the original application with regard to injection drug use.

THE PREVALENCE OF HIV/AIDS IN PRISONS

Inmates are at exceptional risk for infection with the human immuno deficiency virus (HIV). This is, in the view of Kantor (1998:1), because of the connection between injection drug use and imprisonment. Additionally, other exposures inside prisons contribute to the risk of being infected. These include sexual practices, severe violence that is more often than not associated with spilled blood and open wounds and gang-related rituals such as tattooing. In many cases, a lack of exposure also contributes to HIV infection, like insufficient educational exposure and prevention practices, as well as an unbalanced emphasis on prison policies and practices to the detriment of inmates who are at risk to malpractices where HIV infection could take place.

Until recently very little research was done and very little data was available to establish if HIV is indeed transmitted to people while inside prison. Hammett et al (1994:6), for example, held the view that available data suggested that transmission of HIV inside prisons occurs at a very low rate. Therefore, the need for increased prevention efforts is not that high. In addition, prisons systems seem not to be keen on systematic collection of HIV and AIDS information or to investigate prevalence. Many systems rely on testing at the request of the inmate for data that are reported as official figures.

However, as Hammett et al (1994:7) pointed out, regardless of the infection rate documented in studies, it is clear that sex and drug use continue to occur inside prisons, and that they represent high-risk activities for the transmission of HIV. The following two examples are applicable to the above statement. Firstly, an inmate in Louisiana indicated that he was infected with HIV through sexual intercourse and needle sharing during an eight-months-prison term when a cellmate and himself “did every unsafe thing you can do.” Secondly, in Germany a survey by Deutsche Aids-Hilfe showed that about 17 percent of HIV positive participants believed they had acquired HIV infection while in prison (Jurgens 1996:9). Recently, growing statistical evidence of HIV infection inside prisons made the issue one of greater concern, as will transpire from the discussion to follow.

Australia

Norberry et al (1991:66) underpinned the statement that data collection about HIV in Australian prisons is suspect and that it is not even possible to compare the six states and two territories with each other. The Australian Government made a similar observation in 1989 and stated that information is inadequate to monitor the HIV epidemic in Australia (Heilpern & Egger 1989). Even today it is very difficult to obtain statistics in official documentation such as annual reports of the different states in Australia. For example, the 2001 inmate census of New South Wales does not mention HIV infection rates, although it mentions that the number of drug offences among males is the second highest type of crime at 11.6 percent, while it is the highest type of crime amongst females at 12.2 percent.
(Corben 2002:24). The latter, however, is only an indication of a high-risk crime in terms of potential HIV infection.

Importantly though, as pointed out by Kerr (1992:3), even with full compulsory testing the prevalence of HIV could not be accurate enough without regular re-testing every three months. Although Australian figures are reported to show lower infection than expected, there is ample evidence that high-risk behaviour that occur in prisons will certainly contribute to the likelihood that HIV infection will be spread within prisons (Kerr, 1992:4). In a study involving 108 inmates in New South Wales, 40 percent of respondents reported involvement in at least one of three HIV high-risk behaviours while imprisoned, including injection (25%), sharing tattoo equipment (17%) and oral or anal sex (8.5%) (Dolan et al 1994:6).

In some Australian states, like South Australia, Queensland, Northern Territory and Tasmania compulsory testing programmes were in operation during the nineties. New South Wales has been making use of mass compulsory screening since November 1990, while in Victoria inmates are encouraged to do HIV testing voluntarily as part of a reception programme. In Western Australia testing was also voluntary, but in comparison to Victoria (99%), very few inmates seek testing. Currently, Australian policy regarding HIV testing is in line with the guidelines on HIV infection issued by the World Health Organisation, which states (International Centre for Criminal Law Reform and Criminal Justice Policy and the ICPA 2001:16): “Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited. Voluntary testing for HIV infection should be available in prisons when available in the community. Voluntary testing should only be carried out with the informed consent of the prisoner.”

Queensland was the only state that addressed seroconversion during incarceration. Inmates were tested at admission, with a retest after three months. Queensland went further by testing inmates every twelve months and also again prior to release (Egger 1991:66). The policy also made room for placement of HIV positive male inmates at two different prisons, namely Moreton B or Numinbah. There were no placement limitations on females (Queensland Corrective Services 1998: 34).

In October 1997 the Queensland Anti Discrimination Tribunal determined that the policy of compulsory testing discriminated against HIV positive inmates and had to be stopped. After deciding against challenging the decision legally, an extension time for implementation was obtained to 1 August 1998 (Queensland Corrective Services 1998: 34). Governed by the Queensland Corrective Services Act of 2000 and the Health Act of 1937, testing for HIV became voluntary and needs to be offered to inmates at the same time that blood is taken for syphilis and Hepatitis B. The latter two are communicable diseases. Persons who decline a HIV test on admission have to be informed that they can request such a test at any time during incarceration (Queensland Government 2001:2).

**Brazil**

Prisons in Brazil are not different from those in other parts of the world. Human Rights Watch (1998:7) reported various incidents of sexual abuse, particularly on weaker inmates. Violence is a general occurrence, particularly to control drug trade. One inmate reported: “In three years I’ve seen six people die violently; most of them owed money. One guy, in 1996, they injected ten grams of cocaine in him; when he didn't die quickly of that they hanged him.” Tattooing is reported as the official way to show gang affiliation and fights are violent and bloody due to the use of homemade...
Serious contagious diseases such as tuberculosis and HIV/AIDS have reached epidemic levels in the Brazilian inmate population. By denying inmates proper treatment, the prison system not only endangers inmates' lives, it facilitates the transmission of such illnesses to the general population through conjugal visits and upon prisoners' release. Since prisoners are not entirely cut off from the world outside, the unchecked spread of disease among inmates represents a serious public health risk. As the 1996 São Paulo parliamentary report on prisons stated, the existing state of affairs can be described in a single word: "Calamity."

Inmate populations everywhere tend to have greater medical needs than the population at large. Not only do prisons hold a higher proportion of persons at risk of illness, such as injection drug users, but also the prison environment is in itself conducive to the contracting and spreading of disease. Among the factors favouring a high incidence of health problems among inmates are the stresses of imprisonment, unhygienic conditions, overcrowded cells that place inmates in close and continuous physical contact with each other, and physical abuse.

**Canada**

Studies into risk behaviours among Canadian male and female inmates in a provincial prison in Montreal indicated that 73.3 percent of all men and 15 percent of all women injected drugs. Having sex in prison has been reported by 6.1 of the male and 6.8 percent of the female inmates. From the research, Hankins et al (1995:59) called for aggressive policies to prevent intramural spread of HIV.

In the Canadian Federal Correctional system, the prevalence of high-risk behaviour is even higher. In British Columbia, Nichol (Jurgens 1996:7) found that 63 percent of inmates reported tattooing or body piercing while in prison, 67 percent reported drug injection either inside or outside prison (17% reported drug injection only while in prison), and 18 percent reported that they had shared a needle with someone who was HIV positive. Ploem (Jurgens 1996:7) also reported high-risk behaviour in the Federal system in new Brunswick, of which tattooing was very high, but all statistics were lower than in British Columbia.

Management of inmates with HIV infection in Canada includes the policy objective of effective institutional and medical management while ensuring that all appropriate and necessary precautions are taken to prevent virus transmission. There is no difference between placement of inmates with HIV/AIDS and those who have no indications of the disease. Housing of inmates is done according to the following guidelines:

- If the inmate has HIV antibodies, placement is in the general population
- In cases where the above is not feasible, attempts shall be made to place the inmate in protective custody
- Once protective custody is not feasible, it is followed by placement in administrative segregation
- When the inmate develops AIDS, he or she shall be placed in the health care center of the prison (Correctional Services of Canada 1996:2).

All inmates are managed similarly. Upon entrance into the prison, inmates are not routinely screened for presence of HIV antibodies. Testing could only occur with valid consent and inmates may lodge requests with the institutional physicians to be tested. Discretion for testing lies with the institutional physician, but all testing has to be preceded by a period of counselling from...
health service staff regarding the possible outcome of the test results. HIV positive inmates may only be managed differently from the general inmate population when this is medically indicated (Correctional Services of Canada 1996:2).

France
In 1994, Rotily et al (1996:2) conducted a study of HIV prevalence in prisons in the southeast of France. The researcher was not allowed to collect information about risk behaviours inside prisons. Of the participants, 20 percent were intravenous drug users, of whom 51 percent reported needle sharing prior to incarceration. Rotily et al (1996:6) arrived at the disturbing result that HIV prevalence was significantly higher among inmates who have been incarcerated previously (19.9% versus 4.4% of people incarcerated for the first time). The researchers claimed that the likelihood of infection increases with the frequency and duration of incarceration. Together with the low levels of preventative strategies in French prisons, they claim that imprisonment *per se* is a high-risk situation for HIV infection.

Germany
Deutsche AIDS-Hilfe (1993:11-17) investigated the prevalence of HIV in German prisons on a national basis. The control group comprised 117 inmates who were HIV positive and who were all in prison during the investigation. Regarding aspects of high risk, 86.3 percent of the control group indicated that they had used drugs while imprisoned, while 70.1 percent indicated they had contracted HIV through injection drug use. Stuhlmann (in Jacob, Keppler & Stover 1997:31) reports that one third of all inmates in Germany consume drugs. In terms of sexual activities, 23.1 percent indicated that they had had sex while imprisoned and 23.9 percent were of the opinion that they had contracted HIV through sexual contact. In terms of HIV infection, 17.1 percent indicated that they were infected while in prison, 65.8 percent indicated that they were infected outside prison, while 15.4 percent did not know.

According to Deutsche AIDS-Hilfe (1993:17), the number of infections and sexual contact inside prison is very high. One could also not expect help from authorities. One inmate told the story that he had to face segregation if he did not stop taking drugs. This happened after he asked for help voluntarily. Two months after asking for help, nothing had happened. He was later transferred to a prison where drug use was even worse. Part of the problem was the high level of idleness he experienced in German prisons (Deutsch AIDS-Hilfe 1993:23-24). Germany is one of the countries supporting the European Prison Rules. Member states are expected to devise and implement a policy of combating HIV/AIDS in prisons in line with national, European and world-wide strategies. In German prisons the directive for dealing with HIV/AIDS is based on the right to health care, which is a fundamental right for all people. However, the fight against HIV/AIDS has focused attention on the inadequacies in prison medical services, also in many parts of Europe (Council of Europe 1995:16).

Results of a study undertaken using the health records of 1032 female inmates in Lower Saxony, showed that for 41 inmates seroconversion had occurred during uninterrupted imprisonment between 1992 and 1994. Of these, nearly 50 percent had definitely also been infected with hepatitis while incarcerated. HIV prevalence was 4.9 percent among injection drug users, while it was only 0.5 percent among non-injection drug users (Keppler, Nolte & Stover 1996:18-19).

South Africa
In South Africa the HIV/AIDS policy in prisons has been reviewed during 2001 to align it with the strategies
of UNAIDS, the World Health Organisation and the HIV/AIDS and STD Strategic Plan for South Africa for the period 2000-2005. Striking information gleaned from the Annual Report of the Department of Correctional Services (2001:82-83) is the participation in high-ranking bodies, where the Minister serves on the South African National AIDS Council. In addition, there are full-time representatives on the Inter-Departmental Committee on HIV/AIDS to facilitate the establishment of HIV/AIDS programmes in the workplace and the South African Military Alliance in order to combat the spread of HIV within uniformed forces and between uniformed forces and the community. HIV-related workshops were reported to involve health officials, while a total of 464 inmates have been trained as peer-educators during 2000 to increase access to HIV/AIDS information by inmates.

During July 2002 the South African Constitutional Court ruled that government has to make HIV medicine available to infected pregnant women to prevent transmission of the virus to their babies as an integral part of public health care (News 24 2002b:3). In its ruling the Constitutional Court spelled out that government should devise and implement, within available resources, a comprehensive and coordinated programme to realise the rights of pregnant women and their babies to health services aimed at combatting mother-to-child-transmission of HIV. The programme must also include counselling and testing (News 24 2002b, 4). As inmates are normally treated in line with public health care regulations, the outcome should be that pregnant inmates would be able to receive treatment, while other inmates will not have the same access.

In his budget vote speech, the Minister of Correctional Services (Ministry of Correctional Services 2002:7) indicated that the HIV/AIDS policy of the South African Department of Correctional Services includes health awareness and health education, condom provision, voluntary testing, screening for early treatment, management of opportunistic diseases and sexually transmitted infections, discharge of terminally ill inmates and management of information and reporting systems. The need for research and ongoing policy development was also mentioned. In addition, the Department of Correctional Services (2002:1) implemented peer education among offenders.

As far as the prevalence of HIV infection inside prisons is concerned, no survey has been conducted inside South African prisons. In 2000, the South African Department of Health conducted an antenatal survey and established a 24.5 percent prevalence of HIV for South Africa in general. However, the Ministry (2002:7) reports that inmates tend to come from a high-risk sector of the population and current conditions inside prisons can result in HIV transmission. The number of known HIV/AIDS cases inside South African prisons increased from 1 865 during 1998 to 3 397 at the end of 2000 (Department of Correctional Services, 2001:83).

With regard to the main theme of this article, namely harm and risk reduction, the South African approach to HIV education in prisons is cause for grave concern. Involvement is reported to be at the level of senior officials on inter-departmental forums, health care workers and some inmates who are trained as peer-educators. On 31 March 2001, the Department employed 567 nursing and support personnel out of a total of 32 572 staff members. The number of correctional and support personnel amounted to 30 505 (Department of Correctional Services 2001:19), and majority of these staff members have more daily contact with inmates than the 567 medical staff members.

With HIV infection numbers growing, there is no
evidence that ordinary correctional staff members have been exposed to HIV education in the year under review. Similarly, with 464 inmates trained for peer education in the same period (Department of Correctional Services 2001:83), the impact of utilising them to distribute the message regarding HIV has not been reported. Statistics unveil that less than one inmate for each medical staff member employed in the system has been educated regarding HIV. For a system managing 238 prisons and detaining 170 959 inmates at the end of March 2001, the efforts to reduce the harm that HIV infection can cause is just not enough to even remotely avoid the risk of potential HIV infection during imprisonment. The number of inmates increased to 178 998 at the end of March 2002, with a capacity of 109 106 inmates (Ministry of Correctional Services 2002:3).

In South African prisons most inmates are involved in gangsterism as one of the ways to survive is to belong to a gang. Prison gangs are known to have specific entry requirements and gang members are expected to wear insignia according to which they can be recognised. These insignia are in the form of tattoos. The same equipment is used over and over again. Needles used in tattooing are described as contraband and tattooing is also prohibited in terms of prison policy. Although inmates claim to sterilise needles used for tattooing through heating them with matches and cigarette lighters, they use normal ballpoint pens for colour. These instruments are not cleaned in the same way (Luyt 1994; 1996) and could be contributing to the spread of HIV.

Against the backgroung of the looming HIV/AIDS epidemic, South African prisons are not excluded from the growing concerns. More than 90 percent of all natural deaths in South African prisons are assumed to be HIV related (Luyt 2002:22). Between 1995 and 2000 the number of natural deaths confirmed through post mortem reports increased by 584 percent, rising from 186 to 1 087.

Sex in prison is not limited to inmates only. In 1996 a former political prisoner acknowledged having sex at least twice with correctional officials while serving his sentence (CNN World News 1996:1). A judge, for example, recently received a video recording of correctional officials involved in sex scandals with youth inmates inside the Grootvlei Prison near Bloemfontein (News24 2002a:1). In more recent years, evidence of HIV infection in prisons suggests that the disease is spreading fast within prison populations comparable to the increase in Scotland, Spain, the United States, Australia, Canada and Brazil (Jurgens 1996:40; Norberry, Gaughwin and Gerull 1991).

As for South Africa the reported HIV/AIDS cases amongst inmates grew from 1 262 (HIV) and 53 (AIDS) in January 1998 to 2 600 (HIV) and 136 (AIDS) in December 1999 (Department of Correctional Services 1999:19). At the end of December 2000 the combined number of inmates who were infected by HIV and who had already developed AIDS rose to 3 397 (Department of Correctional Services 2001:83). This represents a rise of 661 confirmed cases, or 19.4 percent in one year. According to Group 4 (2000:16), a new role-player in imprisonment in South Africa, HIV/AIDS will pose enormous challenges, as normal education campaigns would be ineffective due to high illiteracy rates. From 1995 to 2000 AIDS-related deaths increased tenfold and is still on the rise.

**The United States of America**

No discussion of HIV/AIDS inside prisons could be complete without some background on one of the largest correctional systems in the world. Of the three detaining more than one million people, the United States is discussed mainly because of the availability of
information regarding the USA in comparison to Russia and China. In the federal, state and jail systems of the United States, official HIV census figures are recorded. At the end of 1999, 2.3 percent (24,607) of all State inmates, 0.9 percent (1,150) of Federal inmates and 1.7 percent (8,615) of the inmates in local jails were reported to be HIV positive. Between 1995 and 1997 the number of HIV positive inmates increased at a rate of 6 percent, while the overall inmate population grew by 19 percent in the same period. At year-end 1999, 3.4 percent of all female inmates and 2.1 percent of all male inmates were reported to be HIV positive. The State of New York, at 9.7 percent (7000 inmates) had the highest number HIV positive inmates. It represents more than one quarter of all inmates known to be HIV positive in the United States. New York, Florida and Texas housed nearly half of all HIV positive inmates in state prisons. The rate of confirmed AIDS cases in US prisons is five times higher than that of the general population.

Between July 1998 and June 1999, one in every 12 deaths among prison inmates was due to AIDS-related causes, while the infection rate is the highest in large jails (US Department of Justice 2001:1). Infection rates among males have remained relatively stable and increased by 1.2 percent annually. The estimated increase among female inmate infections, however, stands at 1.9 percent annually. The rate of HIV infection was higher among incarcerated females than among incarcerated males in all regions and most American States (US Department of Justice 2001:4). In state prisons, the percentage of deaths relating to AIDS is twice as high as those in the general population aged between 15 and 54. In 1998 about one in every eight inmate deaths was AIDS-related compared to 1 in 20 deaths in the general population (US Department of Justice 2001:7).

In a study done by Mahon (in Jurgens 1996:5), all forms of sex inside New York prisons were reported. It was reported that male correctional officials were having sex with female staff and inmates, while female staff were having sex with female inmates, and male and female inmates were having sex with the same and the opposite gender inmates. In terms of drug injection, inmates reported that drugs were plentiful, but that syringes were relatively difficult to find, and therefore shared almost always. Several of the 50 inmates in the focus group, as well as former inmates, indicated that they believed they became HIV infected through needle sharing inside prison.

Mutter (in Mahon 1995:24) identified 556 inmates in the Florida State prison system on the grounds of continuous incarceration since 1977. After reviewing their medical records for HIV testing during incarceration, a group of 87 were identified as having undergone testing for HIV infection. Of these, 21 percent (18 people) were found to be HIV positive. In the view of Mutter (in Mahon 1995:25), this provides strong evidence in favour of transmission of HIV inside prison.

According to Krebs (2002:21), tattooing is a high-risk HIV transmission activity that occurs on a regular basis inside American prisons. As is the case in South Africa, the equipment used for tattooing is considered to be contraband and is very difficult to obtain. For this reason the equipment is shared. This practice is reported to accelerate the risk of contracting HIV infection (Doll 1988; Mahon 1996; Krebs 2002).

HARM AND RISK FACTORS IN PRISONS THAT CONTRIBUTE TO HIV INFECTION ON A GLOBAL SCALE

The above discussion on various countries confirmed a global trend in terms of specific forms of harm inmates
are exposed to. Even in countries that were not discussed prisons show the same tendency. To include all continents (except Antarctica) Thailand and Russia could be mentioned as two examples where the need for harm and risk reduction in prisons is very high.

Initial indications were that HIV transmission in prisons occurs at a low rate. The problem with this statement is indeed the availability of data. Correctional systems have to rely heavily on voluntary testing of inmates. However, even with the limited data available, one could clearly determine a pattern of alarming increases in the number of inmates who are HIV positive. Certain high-risk behaviours inside and outside prisons are noticeable. These are sexual acts, drug use through needle sharing and tattooing.

**Tattooing**

The two most talked about viruses in the tattooing community are HIV and Hepatitis (B). The word tattoo was derived from the Tahitian word “tattau”, which means, “to mark” (Slabbert & Van Rooyen 1978:1). Tattooing is a permanent mark or design made on the body by the introduction of pigment through ruptures in the skin (Encyclopædia Britannica 2001:1). Tattoos in prison are used to mark one’s body as an identifier, mostly indicating membership in a particular gang. Each gang has its unique graffiti, signs and colours. Hand signs are used to communicate within the gang and as a challenge to rival gangs. The signs are made by forming letters and/or numbers with fingers. Most gangs have particular colours that they use to identify themselves.

**Drugs, syringes and needle sharing**

Many prison systems, particularly in more conservative jurisdictions, may find it disturbing that inmates should be educated on how to use drugs in a safe way while imprisoned. The fact remains, drugs are part of the daily life inside prisons, even in the countries where authorities deny it. Bothma (2002:1-4) recently described the integrated network of drug dealing inside South African prisons. At the same time various authorities across the country claim that drugs inside their prisons are limited to the occasional smoking of marijuana. The American war against drugs resulted in the biggest concentration of drug dealers behind America prison bars. In Switzerland, inmates addicted to heroine receive the substance under controlled conditions to ensure harm reduction (Nelles & Fuhrer 1997).

The spread of HIV/AIDS inside prisons is also linked to drugs. Therefore, by using education programmes inmates should be sensitised around the safe use of drugs, which includes the following:

- Never reuse syringes, needles and other drug preparation equipment
- Even when reusing drug preparation equipment, it should never be shared with other inmates
- Always sterilise injection equipment. A common and inexpensive practice is to use bleach for this purpose
- Obtain sterile syringes from reliable sources
- Only use clean water to prepare any form of drug
- Disinfect the skin before injection takes place
- Dispose of syringes safely after one use.

**Sexual acts**

In the prison community, opportunities for traditional heterosexual activities seldom present themselves, although it is not completely absent (Luyt 1999a; Bruyns, Luyt & Jonker 2000:185). Once imprisoned, attitudes are explicitly shaped in a single-sex fraternity. This is not a new phenomenon. According to Dwight (1978:42), the earliest recorded observance of sexual victimisation in a penal setting is recorded in a letter
dated 12 April 1826. In prison, constant challenges ensure that inmates (eventually) subscribe to a normative system where the toughest becomes heroic figures and role models to emulate. According to Toch (1997:178), achievements in physical combat and sexual conquest leads to status, esteem and collective admiration.

In general terms people in free society have respect and admiration for those they love, or even those they only make love to. In prisons, sex has nothing to do with love. Whereas sexual and physical relationships are condoned within almost every prison code, emotional or affectional attachments are seen as a sign of weakness (Wooden & Parker 1982:73). In 1974, Weis and Friar (1974:61) predicted that at least ten million of the 46 million Americans who are arrested at some point in their lives would be raped in prison.

Rape of predominantly male persons is not an occasional event. Instead, it is deeply rooted, systematic problem. After three years of research, and having received more than one thousand letters from inmates in American prisons, Human Rights Watch (2001a:xvii) points out that inmate-on-inmate rape is, indeed, a very serious problem.

Bondeson (1989:151) points out that although homosexuality is a relatively common phenomenon in the United States, it is a rarity in Swedish prisons. The major explanation for this difference, according to Bondeson (1989:151), is probably the longer sentences served by American inmates and the more closed world in which they live. In Sweden inmates generally serve shorter sentences, have furloughs and enjoy good visiting conditions. Only 2 percent of Swedish inmates claimed to have engaged in homosexuality in prison, while three times as many claimed to have experimented with it on the outside.

EXISTING HIV DETECTION AND PREVENTION STRATEGIES INSIDE PRISONS

Without a cure, education appears to be the best preventative measure in response to HIV infection both inside and outside prisons. Comprehensive programming should embody instructor and peer programmes, pre- and posttest counselling, and multi-session prevention counselling. According to Collica (2002:103), only 10 percent of American prisons offer programmes of the above extent. Today, most HIV prevention programmes in prisons are offered by outside community-based agencies (Collica 2002:103). This is not the ideal situation and one can honestly say that correctional regimes are not doing enough. Stevens (1993:381) reported that outside agencies experience a range of difficulties in implementing their programmes. These include aspects like the constraints resulting from prison activities, access to inmates, insufficient prison budgets and many others.

For HIV prevention programmes to be more effective, they need to do the following (Cotton-Oldenberg et al 1999; Keeton & Swanson 1998):

• Address the inmate population in a clear and concise manner
• Use language familiar to inmates
• Present relevant information
• Be specific on routes of virus transmission
• Be sensitive on cultural and environmental factors
• Tailor risk-reduction techniques to specific types of drug users
• Address issues of homosexuality
• Uncover ingrained attitudes and belief systems pertaining sex
• Provide exposure to information over multiple sessions, and even include a repetitive approach.
There is a school of thought (Des Jarlais and Friedman 1988; Baxter 1991; Martin et al 1995; Long 1998; Collica 2002) stating that **risky behaviour will only change when education is accompanied by the availability of resources supporting the educational efforts.** Unfortunately, resources like condoms, dental dams, bleach, clean needles and syringes and tattooing equipment are considered to be contraband in most prison systems. In addition, correctional authorities maintain the view that the provision of these items is perceived as condoning such behaviour. Also, one could not expect people to change their behaviour after one or two presentations about the risks and harm related to HIV infection.

Although - in my opinion and from research already discussed - efforts to prevent HIV infection inside prisons are by far not sufficient, prison systems have implemented some programmes to address the issue. An international survey revealed the following measures aimed at addressing HIV transmission prevention and suppression of HIV in prisons (International Centre for Criminal Law Reform and Criminal Justice Policy and the ICPA 2001:43-56):

**Testing of inmates**
The majority of tests for HIV detect the presence of antibodies to HIV, and not the virus itself. Testing for HIV antibodies should be done more than once, as there is a window period of about three weeks after infection (for the most sensitive tests) during which the virus could not be detected. The window period could be longer if tests are less sensitive (World Health Organization 2002:5).

The aim of testing inmates should be to inform all inmates on an individual and confidential basis about their results to enable them to adopt safer modes of behaviour while in prison. Segregation of positive inmates should never be the goal, as these people are not segregated in free society and such action could lead to human rights infringements. Compulsory testing was already highlighted as unethical and ineffective, hence the best approach will be one that positively encourages testing.

Many countries run voluntary HIV testing programmes or testing on request, including Australia, Canada, Czech Republic, Finland, Japan, Poland, Sweden and various states in America. The American state of Nebraska reported mandatory testing for all inmates, while countries like Botswana, Brunei, Fiji, Mauritius and some American states like Georgia and Oklahoma reported testing on admission without stating the nature (voluntary or mandatory) of it. South Carolina reported testing on admission and yearly mandatory testing, while Lithuania indicated testing on admission and two additional tests annually. Brazil reported the identification of new cases, but did not elaborate on how this is done. Some jurisdictions, like the Canadian Northwest Territories reported that they encouraged testing upon admission, but have not elaborated on subsequent actions to determine the HIV status of inmates. Tennessee makes provision for testing based on informed consent.

**Counselling**
Counselling is a very important prerequisite for HIV testing of inmates and, indeed, all other persons. According to Yeats (2002:7), many clinics and doctors now insist on pre- and post-test counselling to help patients deal with the psychological stress and anxiety likely to be experienced while waiting for test results. In the case of positive results, post-test counselling becomes even more important.

Personally I had to undergo a HIV test for life insurance
purposes a few years ago. The insurance company gave me the address of the clinic and on arrival the nurse filled a few tubes with blood and off I went. Fortunately for me I had no fear of a result other than negative. Irrespective of that, I awaited the day the results would be available anxiously and experienced a feeling of relief when they were confirmed to be negative. Yet, there was no counselling service involved in this whole process and hindsight tells me that an insurance company should not have overlooked the importance of such counselling. Similarly, for inmates who are exposed to more risks with greater chances of a positive HIV test result, counseling is a requisite. In addition, many inmates enter the system with the knowledge that they are HIV positive and they too should receive counselling.

Many correctional jurisdictions make use of counselling. Portugal, for example, have established a private specialised programme, while Switzerland makes use of an entire range of counselling services, information meetings and consultations led by a team of external experts. The American state of Wisconsin encouraged the development of a peer facilitators network and utilised inmates for the “sense of brotherhood” amongst them to ensure positive counselling results. “Positive living” counselling for HIV positive inmates is widely implemented in Zambian prisons. Correctional officials in the United Kingdom provide pre- and post-test counselling and other psychological services. Australia runs therapeutic units in the prisons of New South Wales, while Brunei also reported individual and family counselling. Other countries that reported the availability of counselling services include Germany, Ireland, the Philippines, Romania and Georgia, USA.

**Screening of inmates**

Screening is one of the most important strategies to ensure better inmate and staff health and to prevent transmission of infectious diseases. Infection surveillance and identification are two cornerstones of the screening process. Screening programmes enables staff to clearly identify the symptoms, trends, treatment, and isolation criteria of infectious diseases. The screening process should not be limited to medical staff members only, but the wider involvement of staff could make it more efficient.

Hungary follows a general approach in dealing with HIV, and female inmates are subjected to oncological screening, while designated personnel do voluntary screening of all inmates. New Zealand reported full health assessment on admission and the Philippines makes use of medical examinations during admission. Countries like Singapore and the American states of Alaska, Illinois and Massachusetts, for example, use screening on admission. Other American states such as California, Colorado and North Dakota report mandatory screening. South Carolina reported symptomatic screening on admission.

**Availability of antiseptics and disinfectants**

Antiseptics and disinfectants are sometimes provided to enable drug users to sterilise needles and injection equipment. The most popular item is bleach. Although bleach is not totally effective in eliminating HIV and does not kill the pathogen that causes hepatitis, the likelihood of infection is reduced (Inciardi & Harrison 2000:10). In addition, good hygiene practices such as the use of soap and other antiseptics play an important role in preventing and limiting the spread of infectious diseases as they destroy or inactivate the vegetative cells of infectious microorganisms.

Some Australian and Canadian jurisdictions as well as New Zealand distribute bleach, while Denmark reported the availability of disinfectants and Norway also makes chlorine available. In England disinfecting tablets are...
distributed. Other countries like Australia, Lithuania and the Slovak Republic report practices like the availability of disinfectants and environmental precautions.

**Education**

Education seems to be a common denominator in the fight against HIV infection. Preventative educational programmes take a variety of forms, ranging from distribution of literature, lectures, educational sessions by experts, staff training, the use of inmates as peer educators to multi-level educational programmes. One such programme was implemented in Minnesota, USA and entails four steps:

- Basic educational course upon admission
- One-hour briefing session on HIV and other STDs when placed in the general population inside the prison
- An intensive eight-week programme for inmates with chemical dependency
- A pre-release refresher prevention course.

Approaches to education could include compulsory education for all inmates, comprehensive information distribution (such as booklets), special needs programmes (like people with disabilities or from a foreign origin), voluntary group and individual sessions, and presentations from outside the prison. However, harm and risk reduction is reported to be a social process. It is also reported that developed countries follow harm reduction approaches in HIV prevention, both inside and outside prisons, but it is still not applied with the same effect in developing countries and to the rich and poor alike (Inciardi & Harrison 2000:22). This means that educational efforts should also have a social approach, rather than a punitive approach. Put differently, the focus should be on personal risk rather than occupational exposure. To realise the maximum value of the education, the educators themselves have to understand and support the underlying principles of what they educate.

A powerful educational tool is to allow people living with HIV/AIDS to make a contribution during educational sessions. These people turn out to be true advocates and even activists for behavioural change. A message is often just more powerful if it is a personal story based on fact. Using people living with HIV/AIDS, additionally ensures that the message could be relevant and meaningful to different population groups. Educational programmes should be of an ongoing nature, even if it means that the same inmates are exposed to the same educational programme more than once. Apart from repetition being an accepted method of teaching, the prison environment is of such a nature that many inmates may not attend important sessions of a specific HIV educational programme. Collica (2002:119) reported that female inmates in a research group were pulled from HIV/AIDS education sessions for a variety of reasons (commissary duty, visits, medical appointments and disciplinary hearings) irrespective of the fact that HIV/AIDS education was mandatory.

In addition, Klein et al (2002:80) also reported that finding time in the prison schedule was identified as the most common barrier to offering HIV prevention education sessions and it should receive immediate consideration. This survey examined HIV prevention interventions available to approximately 70,000 inmates in 69 state correctional facilities in New York.

**Barrier methods**

The role that sex plays in HIV infection has already been discussed. Researchers even found infected people in a remote rural Indian village among entirely monogamous women who have scarcely left their villages (Brown 2002:1). As sex results in having contact with body
fluids, barrier methods are the most effective preventative intervention to limit the possibility of HIV and other STD infections. Barrier methods include the use of both male and female condoms. Special mouth condoms are also available for oral sex, but are not readily available and are rarely used (World Health Organization 2002:4).

Condoms have been reported to lower the risk of HIV transmission. Both the male and female condom is relatively effective in the prevention of HIV transmission. The male condom is more popular and also more readily available. The availability of condoms should be supported with education on how to use a condom. Condoms should also be easily accessible for both men and women, and are best distributed in places where a sense of privacy is increased and embarrassment is reduced.

In some prisons condoms are also made available. These include the systems of Australia, Canada, the Czech Republic, Denmark, Finland, Germany, Lithuania, New Zealand, Portugal, Romania, South Africa and England. In the survey done by the International Centre for Criminal Law Reform and Criminal Justice Policy and the ICPA (2001:51-56) twenty-nine American states responded on the question of HIV prevention inside their prisons and only the state of Vermont reported the availability of condoms to inmates.

Klein et al (2002:69-83) also researched the availability of HIV prevention services in the New York state correctional system. Although it is reported that specific HIV prevention interventions were selected for the survey, the distribution of condoms did not feature as a prevention strategy. Yet, the researchers claim that significant progress in meeting HIV prevention needs of New York inmates has been achieved and that the Criminal Justice System is a highly effective service delivery model for HIV prevention. Taking into account that Mahon (1996:1213) reported frequent and tragic instances of unprotected sex in the same correctional system, one could not but wonder if education in the absence of condom provision could be regarded as a highly effective service delivery to prevent HIV infection in any prison system. Krebs (2000:75) mentioned that preventative measures like condoms, bleach and clean needles are also denied to Florida inmates.

In South African prisons, condoms should be made available to inmates and condom dispensers strategically located in terms of policy guidelines (Luyt 2002:23). In practice, however, discussions with correctional staff revealed that inmates are sometimes forced to ask medical or other staff for condoms. This practice has a negative influence on the use of condoms. In one South African prison which was visited, the condom dispenser was placed behind a gate. Though it was strategically in the view of inmates, it could not be reached without asking the guard to open the gate, once again jeopardising confidentiality. During discussions an inmate mentioned that plastic bags are utilised as a barrier method. Although this practice is innovative it is not safe. Moreover, it could never be acceptable in a correctional system where the use of condoms is official policy and condoms are dispensed free of charge.

During the 5th CESCA conference (September 2001) in Windhoek, Namibia, the delegations of corrections in African countries like Botswana, Swaziland, Zimbabwe, Namibia and Lesotho entered into newspaper debates around condom provision in prisons with the South African Commissioner of Correctional Services at the conference. Criticism against South Africa and arguments for not providing condoms in these countries included no sexual activities in their prisons, and
providing permission for sex by providing condoms. Such an approach constitutes claiming that two wrongs result in one right.

From a harm reduction point of view, these arguments are unacceptable, particularly if one takes into consideration the small number of inmates detained in many of these systems, while the influence of HIV in these countries is devastating.

**Substance related prevention of HIV infection**

After HIV was first identified in 1981, substance abuse received new impetus in the early 1980s, when injection drug users and their partners became a focus point, as injection drug use was quickly associated with the transmission of HIV and other blood-borne and sexually transmitted infections such as HBV and HCV. While sharing of injection equipment became a primary route for HIV infection, the risk of contracting the virus increased beyond the circle of needle exchangers. People who had had sexual contact with injection drug users and the children born to HIV infected mothers also started to fall prey to a rapidly escalating virus infection. Other substances also contributed to the problem, as people using it are believed to engage in risky behaviour much easier than those who do not use any substance (National Institute of Health 2000:2).

Since the advent of HIV, injection drug use has directly or indirectly accounted for more than 36 percent of the AIDS cases in the United States. The trend is continuing. In 1998, nearly one third of all new cases of AIDS in the United States was associated with injection drug use. Acquisition of HBV and HCV can occur rapidly after injection drug use is started and co-infection with HIV in the United States is reported at 50 and 65 percent respectively for people who are injecting drugs for less than one year. In addition, it is estimated that 50 percent of Americans with HIV and tuberculosis in 1998 contracted HIV infection through injection drug use (National Institute of Health 2000:2).

**THE WAY FORWARD**

Many countries are already providing extensive services to prevent and address various infections inside prisons. The fact remains, however, that enough is not done. Developing countries, many of them in Africa, are still not confronting realities of living behind prison bars. First of all, harm reduction should be applied as wide as possible and should even include risks like suicide and self-mutilation.

From the discussion above it is evident that enough is not being done to protect people who are incarcerated from harm in the same way people in the free community could claim protection. For example, inmates are predominantly cut off from HIV treatment, where in many countries it is available to the public. Similarly, access to healthy food and exercise to cope better with HIV infection is not available. Many inmates are not allowed to engage in safe sex practices and are thereby under a constant threat of receiving a death penalty to be paid through instalments over ten years or even less.

We have learned that prisons are high-risk areas for the transfer of various contagious diseases. Apart from HIV, these also include various hepatitis infections, other sexually transmitted diseases and the all-important re-emerging tuberculosis. With inmate populations growing, correctional authorities world-wide have to address the situation.

**What correctional agencies have to do**

The AIDS research Institute at the University of California (2001:4) developed a prevention package that
could indicate the future direction of HIV prevention in the developing world. This was done with the cooperation of representatives from 37 countries heavily affected by the HIV epidemic. Harm reduction strategies inside prisons should become a priority on a wider front and could start off with the following measures:

- **Positive policy environments**

Public policies may inhibit or promote HIV prevention. In prisons the contribution policy makes is more in support of inhibiting HIV prevention. In dealing with HIV and AIDS, American correctional officials are able to justify virtually any policy or behaviour under the Turner Standard. In *Turner v. Safely* (1987), the court ruled that, “When a prison regulation impinges on inmates’ constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests” (Haas 1993:395). According to Krebs (2000:30) the vagueness of the Turner Standard has resulted in many legal victories for prison officials regarding HIV/AIDS issues. Essentially, the American courts have adopted an issue-specific hands-off approach to mediate disputes about HIV in prisons and correctional officials are allowed to implement nearly any policy regarding HIV/AIDS inside prisons.

Policy formulation needs to be addressed to accommodate harm reduction, like for example in Switzerland, where clean needles are provided to certain categories of drug injecting offenders. Normally, policy declares needles and syringes as contraband. With drugs in abundance scarcity of needles and syringes inside prisons increase the risk of HIV infection multifold. Correctional managers should think hard and long about a deviation from traditional penal approaches to manage drug use behind bars, as indications are that it could not be stopped or eliminated anyway.

- **Widespread public education about HIV**

Education regarding HIV and AIDS is one of the most widely applied prevention techniques inside prisons. However, education is lacking in many instances. For example, some educational material does not take account of the level of development of those who receive the education. In most cases correctional agencies rely on other government departments like health, volunteers or non-governmental organisations to present HIV education. Once the correctional agent takes responsibility, aspects like poorly equipped prison hospitals, the availability of treatment and properly prepared diets become part of the broader educational spin-offs. Of particular importance is that the mobilization of resources has to be coordinated with educational efforts.

Peer education has proven to be successful in many HIV education efforts. This is brought about because peer educators speak at the level of those who are being educated. In addition, inmates have no confidence in the medical staff. Education should not only cover aspects about HIV, but should also focus on safe needle practices, how to use condoms and the promotion of prevention strategies. Particular attention should be paid to sex education for youths, as statistics from developing countries indicate that HIV transmission occurs from an early age (AIDS Research Institute 2000:5).

- **Condom availability and social marketing**

Up to now condom use has been promoted as one of the most effective ways to prevent HIV transmission. Many communities have started initiatives to promote condom use. This is not the case in many prisons. If one considers the high-risk environment a prison represents, as well as the fact that so many inmates go through the revolving doors of criminal justice systems, it becomes difficult to understand why condoms are not dispensed
inside many of the prison systems. To argue that inmates do not engage in sexual activities and that condom distribution amounts to condoning sex inside prison is to ignore some fundamentals of the criminal justice system. Inmates go to prison as a criminal sanction, and not to receive the death penalty while they are there.

Condom distribution inside prisons is not enough. Correctional agencies should also take responsibility for education about condom use. This education should include the opportunity to practise how to use a condom, as knowledge should be followed up with skills, while attitudes on condom use should also be addressed. Even staff members should be sensitised regarding condom availability and how to use it. Free condom distribution is a priority in many countries as far as the free society is concerned, but these same countries neglect those who are imprisoned.

- **HIV counselling and testing**

Knowing that HIV infection is a modern time bomb, information about the prevalence and incidence of HIV infection becomes essential. Monitoring the epidemic is important in order to plan an adequate response. Monitoring would include testing. Testing is, however, limited due to the voluntary nature of it. As the inmate world is male dominated, there is little access to one of the largest sources of HIV data, namely antenatal clinics. Another source of information is blood donating agencies. In most countries inmates are not allowed to donate blood. The most reliable source for information thus becomes screening and the prevalence of sexually transmittable diseases.

Special measures should therefore be taken to enhance voluntary testing. This should include counselling. The latter could be done at different stages, including:
- Pre-testing counselling
- Post-testing counselling
- Counselling after incidents of rape, forced sex or consensual sex has been reported.

One of the major obstacles is the attitude of prison staff towards reported sexual incidents. Pro-active responses could result in a good opportunity to obtain valuable information regarding HIV prevalence. Instead, complaints are not dealt with properly.

- **Treatment of drug and alcohol abuse**

Drug and alcohol abuse are significant risk factors for HIV transmission (AIDS Research Institute 2001:6). Research revealed that inmates inject drugs inside prison, while many also injected drugs before imprisonment. This means that some inmates started drug injection inside prison. Despite the illegality of drug injection equipment inside prisons, drug users share equipment. Some literature (Jurgens 1996; Mahon 1996) reported needle sharing to be very high and the scarcity of needles means that the few available are shared by almost everyone.

In terms of harm reduction approaches one should consider alternatives to punishment of those who possess items that are declared contraband. Authorities should rather consider needle and syringe exchange and the provision of relatively inexpensive cleaning agents such as bleach. Some systems already implemented these uses with a large degree of success. Even primitive tattoo equipment could become safer after it has been sterilised.

**CONCLUSION**

Harm and risk reduction should not be seen as a soft approach to hard issues. The protection of human rights and, indeed, the lives of people is more important that
following punitive approaches. Harm reduction could have a positive influence on diseases like tuberculosis and hepatitis. Moreover, the international dilemma of HIV could be addressed positively at the very heart of our decaying societies, namely in prisons.

**BIBLIOGRAPHY**


Sydney: NSW Department of Corrective Services.


Haas, K C. 1993. Constitutional Challenges to the Compulsory HIV Testing of Prisoners and the


Riley, D. 1993. The Harm Reduction Model: Pragmatic Approaches to Drug Use from the Area between Intolerance and Neglect. Canadian Centre on Substance Abuse: http://www.ccson.ca/harmred


Volksblad. 2001. Georganiseerde Misdaad vier hoogty in Suid-Afrika. 09.04.01


