SEX, DRUGS AND TATTOOING IN CORRECTIONAL FACILITIES AND THE RELATIONSHIP TO STIS, HIV AND AIDS

Karen Booyens[1] and Christiaan Bezuidenhout[2]

ABSTRACT

One of the biggest challenges correctional centres face is to manage behaviour that could be life threatening and potentially dangerous to their inmate populations. Although assaults and stabbings occur quite frequently it is the behaviour where there are in some cases consent involved that challenge the safe governance of inmates. Although consensual sexual intercourse, rape, tattooing and injecting drug use occur in corrections, it is strictly prohibited by the Department of Correctional Services (DCS). Notwithstanding the outlawed status of these activities, it seems like it occurs unabated anyway. These activities are a high-risk for the exposure and transmission of Sexually Transmitted Infections (STIs), also known as Sexually Transmitted Diseases (STDs), human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) during an offender's period of incarceration. This study explores offender perspectives on the causes of STIs, HIV and AIDS in a South African correctional centre. Creswell's dominant-less-dominant mixed methodology strategy was followed. By using a structured interview schedule 100 face-to-face interviews were conducted with male offenders comprising of child, juvenile and adult remand detainees, as well as juvenile and adult sentenced offenders. The research participants identified sexual intercourse (consensual and coerced) as the major contributory risk factor to their exposure to and transmission of STIs, HIV and AIDS. This article also presents an overview of studies by other scholars on sex, tattooing and drug use in correctional settings.

***Keywords**: human immunodeficiency virus (HIV); acquired immunodeficiency syndrome (AIDS); correctional centres; offender; consensual sex; rape; tattooing; injecting drug users.*

INTRODUCTION

In South Africa the human immunodeficiency virus (HIV) remains one of the most notable communicable conditions amongst the general population. It is believed that the prevalence of HIV is even higher in the incarcerated population than in the general population, since correctional facilities are high risk environments for HIV exposure and transmission due to needle sharing during the imprinting of tattoos and during intravenous drug use. In a correctional enclosing, incidents of violence, consensual sex, sexual assault and rape also regularly takes place, which adds to the possible contracting of the disease (Bonnycastle, 2011:18; Jürgens, Ball & Verster, 2009:57; Jürgens, Nowak & Day, 2011:1; Krebs, 2006:113).

According to the Human Sciences Research Council's (HSRC) National HIV Prevalence, Incidence and Behaviour Survey (Simbayi, Shisana, Rehle, Onoya, Jooste, Zungu, Labadarios & Zuma, 2012:1) the proportion of South Africans infected with HIV has increased from 10.6 per cent in 2008 to 12.2 per cent in 2012. This implies that the infected number of South Africans were 6.4 million in 2012 making the HIV infection rate of the general South African population amongst the highest in the world (Tapscott, 2008:12).

1. Lecturer. Department of Social Work and Criminology, University of Pretoria. E-mail: karen.booyens@up.ac.za
2. Associate Professor. Department of Social Work and Criminology, University of Pretoria. E-mail: cb@up.ac.za

During 2006 Lim'uvune Consulting was instructed by the Department of Correctional Services (DCS) to investigate the HIV and syphilis infection rate of both correctional staff and offenders in the custody of the Department. The pilot study was conducted in Gauteng and 2 770 offenders participated in the study. The HIV prevalence rate of the offenders was found to be 19.8 per cent or 1 047 of the offenders tested HIV positive. This is higher than the national HIV population rate at the time of 16.25 per cent (Sakawuli, 2006:3). According to Krebs (2002:22): "it is the pre-prison characteristics, behaviours and experiences of an inmate that work together to determine whether these risky events will be practiced by a given inmate". Therefore, groups of inmates may engage in HIV high-risk behaviour before, during and after incarceration (Moseley & Tewksbury, 2006:133). A known risk precursor in acquiring HIV is to be infected with a curable sexually transmitted infection (STI). Many inmates enter corrections with a STI and then subsequently encounter risky activities that put them at risk risk of progressing to HIV status. The World Health Organisation (WHO) (2013) conservatively estimated that 499 million new cases of STIs, such as gonorrhoea, chlamydia and syphilis, occur worldwide every year. Having an STI increases the chances by three-fold or more of acquiring HIV infection.

Statistics provided by the DCS relating to the STI and HIV prevalence rate in its correctional centres are questionable. In 2009 it was reported that the Department experienced a three per cent HIV prevalence rate whereas the Institute for Security Studies (ISS) and the Judicial Inspectorate for Correctional Services (JICS) estimated a range of between 40 to 60 per cent of the South African incarcerated population being infected with HIV and the acquired immunodeficiency syndrome (AIDS) (Avert, 2014). Therefore, according to Spiegler (2012:10) one can safely conclude that the DCS does not know the actual prevalence rate amongst the offender population. AIDS-related deaths inside correctional centres are recorded as a natural death. During 2012/2013, the JICS received 652 natural death reports and in 2013/2014 there were 588 natural deaths recorded, showing a decrease in the number of reported natural deaths. Most natural deaths inside South African correctional centres are the cause of cancer, cardiac related, pneumonia, HIV-related and tuberculosis (TB)-related (Tshabalala, 2013:61; Tshabalala, 2014:71). HIV is therefore an infection associated with different serious diseases, high treatment costs and shortened life expectancy. It is important to note that HIV infection is the most important risk factor for the development of TB and TB is the main cause of death among people living with HIV. Various factors relating to the infrastructure and management of the correctional centre contribute indirectly to HIV transmission and other infections, namely: correctional overcrowding, gang activities, vulnerable and young first time offenders, corrupt correctional officials and poor health services (Jürgens et al, 2011:3, 5). This article explores offender perceptions about the exposure and transmission of STIs, HIV and AIDS in a South African correctional centre. Creswell's dominant-less-dominant methodology was followed. An interview schedule was used as the data collection instrument with face-to-face interviews being conducted with one hundred (100) male inmates.

THE TRANSMISSION OF STIs, HIV AND AIDS IN CORRECTIONS

Concerns about STIs, HIV and AIDS in correctional centres are twofold: first there is the risk of transmission during incarceration and then there is spread thereof in society once the offender is released from the correctional centre. Minnie, Prins and Van Niekerk (2002:51) affirmed that the first offender in South Africa was diagnosed with AIDS in 1987 and he died soon afterward. The transmission of STIs, HIV and AIDS within correctional centres can occur through sexual intercourse (either consensual or coerced), injecting drugs caused by intravenous shared needle use and tattooing. In South African corrections there is not a high prevalence of injecting drug users (IDUs), however, tattooing is commonplace. Regarding

forced sexual activities in South African correctional centres, the Jali Commission of Inquiry into corruption, maladministration, nepotism, intimidation and other improper conduct in the main Management Areas of the DCS concluded that sexual violence and the transmission of HIV and AIDS were widespread in all correctional centres in South Africa. The Commission also found evidence of the sale of young offenders for sex with older offenders and that a "sodomy ring" (an organised sex pact) involving juvenile offenders existed among various correctional officials (Jali Commission of Inquiry, 2002). Furthermore, the JICS found that half of all inmates surveyed confirmed that sexual abuse occurs regularly (Tshabalala, 2013:75).

Sex and rape in correctional centres

Unprotected sexual activity during incarceration in correctional centres in Malawi, Nigeria and South Africa is the most common cause of HIV infection (Gear, 2001). This may be due to the damage that is done to the epithelial lining (lining in the inside of the rectum) during anal penetration, making it easier for the semen of the host to enter the bloodstream of the partner. Furthermore, the likelihood of HIV transmission is higher for the receptive partner during anal sex than for the inserting partner. The reason for this is that the semen in cases of ejaculation and or natural discharge of lubrication fluids of the inserter is exposed to prolonged contact with mucous membranes in the rectum (Goyer, Saloojee, Richter & Hardy, 2004:13; Krebs, 2006:114). Despite the known high risk of HIV transmission during sexual penetration without the use of a condom, the majority of offenders (78%) that participated in the research study conducted by Booyens (2008) at Kgosi Mampuru II Remand Detention Centre (previously known as Pretoria Local Correctional Centre) indicated that anal penetration is the most common sexual activity between men. In Malawi, homosexuality or "unnatural offences", as it is referred to in that country's penal code, is illegal and punishable with a period of imprisonment of at least 14 years. Males who are incarcerated as a result of homosexuality are usually not deterred by the prison sentence as their punishment. Therefore, despite this sanction consensual sex still continues in Malawian corrections. In addition, male on male rape also occur frequently in Malawi prisons. Moreover, a study conducted from 2000 to 2001 in two rural Malawian prisons set out to determine the prevalence rate of STIs amongst male inmates and found that out of 4 229 inmates involved in the study 4.2 per cent had STIs and about one-third of these infections were acquired during the period of incarceration (Zachariah, Harries, Chantulo, Yadidi, Nkhoma & Maganga, 2002:617-618).

Although sexual activities are common among male inmates it is strongly prohibited by the DCS. Booyens and Bezuidenhout (2014:386-387) found that South African male inmates engage in different types of sex ranging from consensual 'marriage' sex to forced sex. The first is consensual sex that entails a relationship developing between two inmates and a 'domestic' life is shaped inside the correctional centre. This type of sexual relationship serves an emotional and affective purpose for offenders since incarceration deprives a person of 'normal' emotional and sexual relations. The second type of sex is known as 'exchange sex', whereby offenders sell their bodies in exchange for commodities needed inside a correctional centre to survive, such as cigarettes, an extra set of clothing or prepaid phone cards. Sex becomes a way of acquiring luxuries in order to survive. It is usually the inmates who are not visited by friends or family that will turn to this type of sex. Sexual intercourse between the men occurs after an agreement, and therefore consent given (consensual), has been reached by both parties. Thirdly, there is the sexual trading by corrupt correctional officials and the subsequent sexual behaviour between offenders. However, this type of sexual transaction cannot be described as consensual as the potential victim did not have a say in this transaction and is compelled to participate in a sexual act with another inmate. The sex transaction is facilitated by a third party, who abuses his power and authority in order to generate proceeds. Forced sex (rape) is perpetrated mainly by prison gangs. First time

uninformed inmates are approached by gang members and persuaded to get the tattoo of the gang. The meaning of this tattoo and the activities in which a particular gang participate, is never clearly explained to this inexperienced first time inmate. Only after the tattoo has been applied, it is then explained to them that they must engage in sexual acts since true membership to the gang demands this – it is the code of the gang. The unsuspecting victim is thus threatened, forced and intimidated through violence and threats of violence into a sexual relationship with another man.

Spiegler (2012:15) postulates that addressing sexual violence in corrections are in its infancy stages in South Africa. This sentiment was already stated by Booyens in 2008. The DCS is currently developing initiatives to address the link between prison rape, gangsterism and HIV and AIDS in the form of the enactment of the Correctional Matters Amendment Act 5 of 2011, which places a responsibility on correctional officials to assess remand detainees during their admission for their vulnerability to sexual violence. Strategies have also been outlined in the Draft Policy Framework to Address Sexual Abuse of Inmates that includes:

i) the training of officials to recognise signs of sexual abuse;
ii) inmate classification with the goal to separate vulnerable inmates from other inmates; and
iii) maintaining the safety of inmates through increased supervision (Spiegler, 2012:16).

The DCS is also now recording cases of sexual assault and rape in their facilities separate from general assault cases (Spiegler, 2012:16).

Injecting drug users (IDUs) inside corrections

Many inmates go to a correctional facility with a drug problem. Some scholars and organisations even postulate that more than halve of the correctional populations in the world had a history of substance use before they entered into the correctional system. Others enter the system with severe substance dependency and corrections usually do not address these substance dependency problems that are often sustained within the correctional walls (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2003). Many first-time users also join the substance use fraternity in a correctional facility enabling them to deal with the psychological shock and loneliness of incarceration. In these situations many that did not enter the correctional setting with a disease or infection easily contract HIV, TB or hepatitis as a result of intravenous drug use and needle sharing. Strathdee, Hallett, Bobrova, Booth, Abdool and Hankins (2010:268) postulate that the number of injecting drug users (IDUs) worldwide were 15 million in 2007 of whom around three million were infected with HIV. The high HIV prevalence rate and dependency on drugs among offenders, coupled with the sharing of injecting drug equipment make corrections a particularly high risk environment for the transmission of HIV and other related substance use diseases. In more recent studies the abovementioned postulation about the substance use population in correctional centres has been supported. Researchers in this study also concluded that a substantial number of offenders are drug dependent, with estimates ranging between ten per cent to 48 per cent in male offenders' and between 30 per cent to 60 per cent among female offenders (Jürgens et al, 2009:57). Regarding substance use and needle sharing, it is postulated that it is difficult for IDUs to get clean needles or bleach to clean equipment. The reason for this is that the possession of a needle or any drug use equipment is regarded as contraband and is a punishable offence within a correctional centre. IDUs are also prone to share needles that have not been sterilised between uses since needles are often hard to come by and cleaning materials are not readily available (Avert, 2014; Jürgens et al, 2011:4). During a general life skills session with a group of sentenced male offenders in a South African correctional centre, the group spontaneously answered a question regarding substance use in correctional centres and stated that it was rife. They also elaborated on a

follow up question regarding needles and other drug use paraphernalia. They were adamant that they either steal needles from the hospital clinic or bribe corrupt officials to smuggle needles and other equipment they need for substance use to the housing sections in the facility (Booyens, 2015).

One way of curbing HIV transmission among incarcerated IDUs is the so-called needle and syringe programme (NSP). A programme of this nature was introduced in Switzerland in 1992 and since then NSPs have been introduced to over 60 correctional facilities in 11 countries (Jürgens et al, 2009:59; Jürgens et al, 2011:7l; Rutter, Dolan, Wodak & Heilpern, 2001:1). Most of these programmes are introduced in small correctional facilities with fewer than 200 offenders. The distribution of the needles and syringes can be carried out by health professionals such as doctors or counselling staff working in a correctional centre, as well as offenders trained as peer educators. Another method of distribution is through automatic vending machines where sterile injecting equipment is exchanged for used needles and syringes. Studies conducted on NSPs concluded that the availability of sterile injecting equipment has not resulted in an increased number of offenders injecting substances, an increase in overall substance use or an increase in the amount of substances in the correctional facility but has reduced HIV figures in general (Jürgens et al, 2011:7-8; Rutter et al, 2001:1).

Prison tattoos

Tattooing, although prohibited worldwide in many correctional facilities, is commonplace – especially amongst gang members. Prison tattoos can be self-applied or applied by other offenders using self-built improvised equipment or equipment that gets smuggled into a correctional centre. Strang, Heuston, Whiteley, Bacchus, Maden, Gossop and Green (2000:61-63) conducted interviews with 1 009 adult male detainees in prisons in England and Wales during 1994. A total of 111 men had been tattooed while in prison, with 38 receiving their first tattoo inside prison. Of the 111 offenders, 60 indicated that they had applied the tattoo themselves, 40 received a tattoo from a cellmate and 35 had been tattooed by another offender (not sharing the same cell). The majority of the offenders used a sewing needle and ink from a pen or dyes to apply the tattoo, but other instruments used included sterile hypodermic needles, safety pins, bedsprings and guitar strings. Twenty-six of the 111 men that received a tattoo in a correctional facility, indicated that they had been tattooed at the same time as another inmate, and for 12 of these offenders a previously used needle was used without being sterilised. However, seven of the 12 reported that the needle was usually cleaned (washed) before applying the tattoo.

Tattooing in corrections involves multiple skin punctures with sharpened and altered implements, including needles and plastic ink tubes found inside ballpoint pens. In many instances the tattooing equipment has not been sterilised, increasing the risk of HIV transmission (Avert, 2014; Bonnycastle, 2011:21). If tattooing needles are cleaned, the most reported method is heating the needle in a flame above a match, followed by immersion in boiling water. South African sentenced male offenders stated that needles and other equipment are cleaned with spirits, usually smuggled from the correctional centre clinic (Booyens, 2015; Strang et al, 2000:64). Offenders that receive tattoos in correctional centres also increase their infection risk by covering the freshly applied and possibly bleeding tattoo with (dirty) clothing or a piece of cloth to conceal it from correctional staff (Bonnycastle, 2011:23).

From the aforesaid it is clear that unprotected sex in correctional centres, substance use by means of irresponsible intravenous consumption and tattooing with unsterilised homemade or professional equipment, are all factors in becoming HIV/AIDS infected in a South African correctional facility.

OVERVIEW OF THE DEPARTMENT OF CORRECTIONAL SERVICES'S POLICIES ON HIV AND AIDS

In 1992 the first policy referring to HIV and AIDS in the South African correctional system was formulated and from 1995 onwards was implemented. With this policy the DCS aimed to segregate HIV positive inmates from the general prison population. During this period the procedure was to interview new inmates to determine whether they engaged in high risk behaviour, test those who were considered high risk and if tested HIV positive to segregate and house them in a separate correctional facility. Inmates were considered high risk if they were illegal immigrants, convicted of a sexual crime, intravenous drug users or had had sexual relations in a country where "HIV infection is present in ten per cent or more of the population" (Goyer et al, 2004:29, Spiegler, 2012:13). In 1994 it was clearly stated in the DCS White Paper on Corrections that sexual relations in whatever form will not be permitted or tolerated and that condoms will not be distributed to inmates (Spiegler, 2012:14). A former South African inmate sued the DCS and claimed to have contracted HIV through sex while incarcerated form 1993 to 1994. According to him the DCS did not warn inmates about the risks of unprotected sex and did not supply condoms (Dolan, Lowe & Shearer, 2004:124). This policy, which promoted the segregation of HIV positive inmates, was criticised by the World Health Organisation, and as a result was amended in 1996. The outcome was the end of segregating HIV positive inmates and inmates were only to be tested if they requested it or on demand by the district surgeon. Inmates had to consent to this in writing before the test could be administered. This amended policy also made provision for the introduction of various projects. These projects included STI clinics at all correctional hospitals where offenders can be tested, treated, counselled and given information about STIs. The condition of offenders with HIV or AIDS was also to be monitored and special supplements issued to them (Goyer et al, 2004:29-30). In a separate policy document the issue of condom distribution to inmates was set out "to be provided to the prison population on the same basis as condoms [are] provided in the community" (Goyer et al, 2004:31). In 1996 the first condoms were introduced in South African corrections (Spiegler, 2012:14). However, inmates were not issued with condoms before they had received education and/or counselling regarding HIV and AIDS, the use of condoms and the consequences of high risk sexual behaviour. Furthermore, condoms would only be issued on request by the inmate and then only issued by a nurse trained as an AIDS counsellor (Goyer et al, 2004:31).

In the case of *W and Others v Minister of Correctional Services* (Cape Town Supreme Court, Case no: 2434/96) the judge in this case ordered the Minister of Correctional Services, the Commissioner of Correctional Services, the Commander of Pollsmoor Correctional Centre and the Provincial Minister of Health that corrections management to abide by the following guidelines:

- Keep the status of HIV and AIDS offenders confidential;
- Protect offenders from stigmatisation based on their sexual orientation or HIV status;
- Ensure that condoms are made available to all offenders;
- Provide treatment for offenders with HIV and AIDS;
- Test offenders for HIV only once they have given informed consent;
- Not to deny offenders the opportunity to work, based on their HIV status;
- Not to discriminate against a HIV positive offender regarding accommodation and ablution facilities; and
- Provide HIV and AIDS education to all offenders and correctional officials (Barrett-Grant, Fine, Heywood & Strode, 2001:358; Goyer et al, 2004:32).

In October 2002 the DCS again amended their HIV/Aids policy and a Management Strategy on HIV/Aids in Prisons was developed. This policy highlighted the handling of HIV positive offenders and is based on human rights principles and the fundamental rights as set out in the Bill of Rights in the South African Constitution, as well as those contained in the World Health Organisation (WHO) guidelines on the treatment of prisoners (Barrett-Grant et al, 2001:351; Goyer et al, 2004:32; Spiegler, 2012:14). In March 1993 the WHO had formulated general principles on HIV infection and Aids in corrections. These have subsequently been adapted by local authorities worldwide to meet their specific needs. The principles are as follows:

- "All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.
- The national Aids programmes should apply equally to prisoners and to the community.
- In each country, specific policies for the prevention of HIV/Aids in prisons and for the care of HIV-infected prisoners should be defined. These policies and the strategies applied in prisons should be developed through close collaboration among national health authorities, prison administrations and relevant community representatives, including nongovernmental organisations. These strategies should be incorporated into, a wider programme of promoting health among prisoners.
- Preventive measures for HIV/Aids in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release.
- The needs of prisoners and others in the prison environment should be taken into account in the planning of national Aids programmes and community health and primary health care services, and in the distribution of resources, especially in developing countries.
- The active involvement of nongovernmental organisations, the involvement of prisoners, and the non-discriminatory and humane care of HIV-infected prisoners and of prisoners with Aids are prerequisites for achieving a credible strategy for preventing HIV transmission.
- It is important to recognise that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should therefore participate actively in developing and applying effective preventive measures, in disseminating relevant information, and in avoiding discrimination.
- Prison administrations have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike.
- Independent research in the field of HIV/Aids among prison populations should be encouraged to shed light on – among other things – successful interventions in prisons…" (World Health Organisation (WHO), 1993:4).

Considering the above principles, the current DCS policy on HIV and AIDS includes the following:

- Non-discrimination based on a South African Supreme Court ruling that inmates with HIV and AIDS have the right not to be discriminated against (Refer to *W and Others v Minister of Correctional Services*) (Barrett-Grant et al, 2001:358).
- Offenders have the right to confidentiality regarding their HIV and AIDS status (Barrett-Grant et al, 2001:355).

The WHO guidelines on HIV infection and Aids in prisons regarding the confidentiality of HIV positive prisoners states the following:

> "Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents. Information regarding the HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff. Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoner's files, cells or papers to indicate their HIV status" (WHO, 1993:7).

Voluntary testing for HIV should be available in prisons, in conjunction with pre- and post-test counselling for two reasons: as part of an HIV prevention programme and as a way to diagnose those living with HIV and offer them treatment, care and support. Testing should only be carried out with the informed consent of the offender. Informed consent in this regard means that the offender understands the purpose of the test and how the results may impact on his life (Barrett-Grant et al, 2001:355; Jürgens et al, 2011:6; WHO, 1993:5). In *C v Minister of Correctional Services* (1995) a prisoner accused the DCS for testing his HIV status without him giving informed consent. The judge ruled in favour of the offender stipulating that: "Generally speaking, it is axiomatic that there can only be consent if the person appreciates and understands what the purpose of the test is, what an HIV positive result entails and what the probability of Aids occurring thereafter is" (Barrett-Grant et al, 2001:355).

In South Africa the process of voluntary HIV testing of inmates is as follows: The offender is referred to a member of the nursing staff to receive pre-test counselling. If, after this, the offender agrees to have the test, he must sign an informed consent form. Hereafter a blood sample is taken and the results are usually available after two weeks. The nurse will submit a list to the relevant correctional officials of all the inmates whose results are back from the laboratory, regardless whether positive or negative, for post-test counselling. The premise is that post-test counselling to all inmates will ensure the confidentiality of those who are HIV positive will be offered. Only the nurse and the offender know the HIV status and this information is recorded in his medical file (Goyer, 2003:55).

According to the DCS a total of 107 415 inmates had been tested for HIV in 2013/2014 with 6.35 per cent of those testing positive. This is an increase as only 76 202 inmates were tested in 2012/2013. However, in this test period 8.76 per cent of the subjects tested positive for HIV (Africa Check, 2014).

According to the WHO guidelines on HIV infection and Aids in prisons, all prisoners and correctional staff should be informed about HIV and AIDS and the prevention thereof.

Information made available to the general community should also be available to offenders, but appropriate to the educational level of the offenders. Furthermore, it is proposed that offenders receive HIV and AIDS education on entry, during their prison term and during the pre-release stage (WHO, 1993:5).

South Africa is the only African country where condoms can be accessed by inmates, and the current DCS policy provides that condoms be freely available from dispensers in common areas. Condoms can also be acquired on request from a medical officer or social worker (Barrett-Grant et al, 2001:357; Senok & Botta, 2006:481; Spiegler, 2012:15). Although this policy principle is indicative of making condoms available to inmates "on the same basis as condoms [are] provided in the community", there are certain implications. The condoms distributed in correctional centres are not made for anal penetration and may break during intercourse. Also, the dispensing of condoms in common areas implies that the inmate will be observed by correctional officials, as well as by fellow inmates, thus diminishing the objective of anonymity (Goyer et al, 2004:32). Although condoms are now currently made freely available to inmates, lubricant is not. Without proper lubrication a condom can easily tear and result in unsafe sex (Spiegler, 2012:21). Currently offenders use saliva, Vaseline, body lotion or yogurt as lubricant (Booyens, 2008: 136).

Offenders with HIV or AIDS may not be segregated from other inmates on the basis of their health status. An offender may only be segregated if he has a contagious disease such as TB or hepatitis, or acts aggressively towards other inmates (Barrett-Grant et al, 2001:256; WHO, 1993:6).

During 1997 in the case of *Van Biljon and Others v Minister of Correctional Services*, offenders challenged the DCS policy regarding the treatment of HIV positive prisoners. The result of the case was the High Court order that the DCS must provide ARV treatment to HIV positive prisoners, and the ruling is set out below:

> "Even if it is accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the State for patients outside, this principle can, in my view, not apply to HIV infected prisoners. Since the State is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the State must provide them must be treatment which is better able to improve their immune systems than that which the State provides for HIV patients outside" (Barrett-Grant et al, 2001:354).

The court decided that an inmate's right to medical treatment depends on an examination of circumstances, such as conditions inside the correctional facility, to decide what is adequate and that this decision does not mean that all HIV positive inmates should receive expensive medical treatment (Barrett-Grant et al, 2001:354). Although this case appears to have been a major victory for HIV positive inmates in South African correctional centres, De Vos (2003:32-33) is of the opinion that it can, at best, be described as a pyrrhic victory. While some of the applicants in this case did receive ARV treatment, they did not receive all the drugs prescribed to them.

In 2005 the availability of ARV treatment to offenders again came to the legal forefront when fifteen inmates from the Westville Correctional Centre in KwaZulu-Natal complained to the Aids Law Project (now known as SECTION 27) that they are denied access to ARVs. According to the DCS there were two reasons why these inmates at Westville Correctional Centre could not get access to ARV treatment: Firstly the Department of Health requires that all applicants for ARVs have to be in possession of a valid South African Identity Document (ID), including all offenders and detainees who want to apply for treatment. However, the majority of South African offenders and detainees are not in

possession of an ID book and are too poor to afford to pay for it. Secondly, that Westville Correctional Centre had difficulty accessing public health facilities to dispense the medicine, since the centre is not accredited to provide ARV treatment. However, on 22 June 2006 Judge Pillay ruled that **all** inmates at Westville Correctional Centre who need ARVs are to be assessed for treatment. The government applied for leave to appeal against this judgement and the execution of Judge Pillay's order was suspended until the final determination of the appeal. On 28 August 2006 Judge Nicolson ordered the government to immediately start with ARV treatment to sick inmates at Westville Correctional Centre and stated that the government was in contempt of court for ignoring the previous order by Judge Pillay (Aids Law Project and Treatment Action Campaign, [sa(a)]; Aids Law Project and Treatment Action Campaign [sa(b)]; Aids Law Project and Treatment Action Campaign [sa(c)]). Again this judgement seemed to be a victory for inmates' rights, but the judgement is not directly binding on other offenders in the same correctional centre or to offenders in other provinces. Therefore it seems the only way for inmates to get the necessary HIV treatment would be to apply for legal intervention.

Currently the DCS has 23 ARV sites in the Department, of which seven are in Gauteng. Correctional centres with health care services are able to provide ARV services to HIV positive inmates and those centres that are not equipped can refer inmates to the nearest Department of Health. Furthermore all offenders co-infected with HIV and TB should be on ARV treatment irrespective of their CD4 count[1] (Department of Correctional Services (DCS) 2012.). It is indicated in the DCS Annual Report (DCS, 2012b:75) that 65 per cent of HIV positive inmates eligible for treatment were placed on ARV – an increase from the 43 per cent as reported in the 2011/2012 DCS annual report. Despite these improvements inmates at Boksburg Correctional Centre in 2013 complained that access to ARVs was disrupted for weeks. Similar complaints of disrupted ARV treatment were also received from inmates at Modderbee Correctional Centre where the disruption is attributed to inmates being transferred between correctional centres and detainees spending short periods of incarceration that impacted on proper treatment programmes (Africa Check, 2014).

During 2012 the DCS, in collaboration with the National Department of Health, established Guidelines for the Management of TB, HIV and STIs in correctional facilities. Accordingly the HIV and AIDS programmes and services offered to inmates includes HIV counselling, testing and treatment; HIV education and information sessions; screening HIV positive inmates for TB; providing Isoniazid Preventive Treatment (IPT) to HIV positive inmates to prevent the likelihood of developing TB; providing HIV post exposure prophylaxis (PEP) to victims of male rape; distribution of condoms and ensuring access to voluntary medical male circumcision. During 2012 to 2013 a total of 1 511 084 condoms were distributed to inmates countrywide and 2 991 male medical circumcisions were carried out. Furthermore, ensuring that all HIV positive inmates repeat CD4 testing every six months, monthly TB symptom screening and regular STI screening (DCS, 2013).

The motivation for this paper was spawned out of the existing challenges regarding HIV and AIDS in correctional facilities, as well as a study that was undertaken in a correctional centre where specific questions were posed to participants regarding their perceptions and awareness of STIs, HIV and AIDS in the correctional facility.

RESEARCH STUDY METHODOLOGY

The research was conducted at THE Kgosi Mampuru II Remand Detention Centre SITUATED IN Pretoria, Gauteng. This correctional centre serves as a remand centre for juvenile and adult male detainees and a small number of sentenced adult male offenders. At the time of the research this centre also housed children (aged 13-18 years) who, as a result of the nature of their crimes (sexual and aggressive), could not be released under the supervision

of parents or guardians (Booyens, Beukman & Bezuidenhout, 2008:50), as well as sentenced juvenile offenders, who have since been moved to Youth Care Centres. The sample of research participants included five categories: child, juvenile (juveniles and youth were classified as one category for the purpose of the research) and adult detainees, as well as juvenile and adult sentenced offenders (Booyens, 2008:118). As per ethical protocol the researchers gained access to the correctional facility after obtaining permission from the Ethics Committees of the Faculty of Humanities (University of Pretoria) and the DCS. One hundred (100) face-to-face interviews were conducted – 20 interviews per inmate category. Approximately 2.2 per cent of the offender population incarcerated in this correctional centre were interviewed. The main aim of the study was exploratory in nature and focused on the nature and extent of sexual practices between male offenders in this correctional centre. However, participants' perceptions and awareness of contracting and transmission of STIs, HIV and AIDS inside the correctional centre were also explored.

The age group of the participants ranged between younger than 18 years to older than 60 years. Participants identified themselves as heterosexual (85%), bisexual (10%) and homosexual (5%). The bulk of the participants (86%) were single at the time of the interviews. African offenders made up the majority (76%) of the participants followed by Whites (15%) and Coloured (9%). No Indian/Asian offenders participated in the study. Most of the participants were incarcerated for less than two years, with the majority for aggressive offences (64%), followed by economic offences (27%) and sexual crimes (11%). Note that some of the participants in this study were incarcerated for more than one offence (Booyens, 2008:121-133).

Creswell's dominant-less-dominant mixed methodology strategy was followed and the dominant qualitative data were supported by means of a descriptive quantitative analysis of findings. The structured interview method was used in this study since many of the participants were either unschooled or did not complete their education. Face-to-face interviews were conducted and in this technique the interviewer becomes part of the instrument along with the interview schedule in order to obtain high quality data. This also allows the researcher to ask additional questions for clarification when needed and allows probing when necessary, thus allowing the maximum response rate from the interviewees (Booyens & Bezuidenhout, 2014:383-384). The high noise levels inside the correctional facility prohibited the use of an audio recorder and responses were written down verbatim on the interview schedule. Once rapport was established with the participants the aim of the proposed research was explained to the offenders and those willing to participate in the study signed an informed consent form. The actual interviews were carried out in an allocated office within different sections (communal cells, single cells, reception area and the hospital section) of the correctional centre, and lasted between 40 minutes to an hour. The interview schedule comprised of the following sections: the biographical information of the participant, offence and sentence, general views regarding prison sex and rape while incarcerated and gang involvement (Booyens, 2008:131). Specific questions relating to sex and rape included offenders' perceptions and awareness of STIs, HIV and AIDS were posed to the participants – the focus of this article. Since the mixed methodology strategy guided the research, two different methods of data analysis were used – content analysis was used for the qualitative methodology and regarding the quantitative analysis the researchers made use of the services offered by the Statistics Department of the University of Pretoria.

FINDINGS

The findings of the research will be discussed according to the participants' perceptions of STIs, HIV and AIDS and the transmission thereof in the correctional centre.

Offender perceptions of STIs and the transmission thereof in the correctional centre

With regard to the quantitative data, we wanted to explore offenders' awareness of STIs in the correctional centre. Fifty seven per cent (57%) of the participants responded that they were aware of inmates with STIs in the correctional centre, forty one per cent (41%) reported that they were not aware of any inmates with STIs and only two per cent did not know what STIs were. In contrast with the majority of research participants who reported that they were aware of inmates with STIs, the nursing staff at this correctional centre during the same period reported that *"STIs is skaars"* (STIs are uncommon). This discrepancy could be due to the fact that inmates are not likely to report to correctional staff if they have a STI, possibly due to the stigma that one is engaging in sexual activities and could therefore be either homosexual or a rapist.

The 57 research participants who answered that they were aware of inmates with STIs in the correctional centre were asked a follow-up question, namely: What do you think are the causes of STIs in the correctional centre? Twenty-nine per cent of the fifty-seven per cent research participants who were aware of STIs, believed that the cause of STIs in the correctional centre was sex that takes place between inmates. The research participants believed that all types of sex could cause STIs, namely: anal sex, inter-femoral sex (between the upper thighs) and oral sex. Two of the participants described the transmission of STIs as follows: *"Mense wat seks het is vuil"* [people that have sex are dirty] and *"Sleep with another man on his ass it is dirty there, more dirty than the legs"*. The second significant group is those (14%) who were of the opinion that people do not get STIs in the correctional centre, but that they already have the infections when they are arrested. The following two responses support this finding: *"Others come from outside with that disease and then transmit it when they have sex"* and *"Can't get it in prison come from the outside and 'steamfood'* [this is how the inmates refer to the food in the correctional centre] *brings out the sickness"*. Thirdly, eight per cent (8%) respectively, are those who are of the opinion that STIs are transmitted in the correctional centre by those who do not use condoms during sex and those who do not know how STIs are transmitted. They said: *"No condoms, the only way they can do it is straight"* and *"Seksuele transaksie sonder kondome"* (sexual transaction without condoms). Lastly five per cent (5%) of the participants believe that inmates who contracted STIs did not wash after having sex. One participant expressed it as follows *"Sex with someone don't wash then next morning have sex with someone else".*

Offender perceptions of HIV and AIDS and their transmission in correctional centres

Eighty six per cent (86%) of the participants were of the opinion that HIV and AIDS is a problem in the correctional centre, with only eleven per cent who did not think it was a problem and three per cent who did not know whether it was a problem or not. A follow-up question to the above information relates to the causes of HIV and AIDS in the correctional centre. The respondents were asked the following question: What do you think are the causes of HIV/Aids in the correctional centre?

Similar to the major cause of STIs the majority of participants, namely: 61 per cent, believe that the cause of HIV and AIDS in the correctional centre is due to sex between inmates. Research participants commented as follows in this regard: *"People practicing anal sex"*; *"Jump op daai man"* [Jump on that man]; *"Sleep with another man and to make oral sex"*; *"Those who have intercourse and know they have Aids, know they are going to be sentenced so don't care about others. This can be compared to murder outside"* and *"Sleep with him from the ass, [be]cause there you find the blood, no blood on the legs".*

This is followed by 15 per cent that believe that HIV and AIDS is contracted when inmates fight and an inmate who is not infected with the disease, comes into contact with an infected person's blood. One inmate made the following comment in this regard *"When you are fighting with big guy blood of another person mix with own blood".* Thirteen per cent believe that inmates with HIV and AIDS had already had the disease before their incarceration. Some participants responded in the following way: *"Get Aids from outside but because of sex HIV is going all over the place"*; *"Got it from the outside, 'steamfood' shows the disease"*. Some research participants believe that inmates are already HIV positive or have full blown Aids when they enter the correctional centre, but their status remains unknown until they eat the prison food ('steamfood'). The participants noted that the steamfood (prison slang for the food they receive in the correctional centre) makes the disease 'visible' since the person will lose weight, and suffer hair loss and skin rashes. *"Kom van buite vat ander man naai hom, vat hom by die been"* [Come from the outside take another man and have sex with him, take him at the leg]. Eleven per cent (11%) believe that one can get HIV by using the same hair clipper or razor blade. The following responses highlight their concerns: *"Cut our hairs, pimple on head or blood and if you have pimples the blood mix"* and *"Cut hair with one razor and cut hair of all the prisoners. If one have pimples he will bleed and then they cut your hair you will get that blood".*

Eight per cent of those interviewed were of the opinion that HIV is transmitted in the correctional centre when those who have sex do not use condoms. One respondent said the following in this regard *"Have sex without a condom because we don't have".* Prison tattoos were mentioned by seven per cent of the participants. One respondent thought that the needle that they used for tattoos should be regarded as a cause of HIV/Aids. He made the following comment: *"Gebruik naalde om mekaar te tattoeër"* [Use needles to tattoo each other]. Lastly the use of drugs (3%), lack of education (2%) and hygiene (2%) were also mentioned as causes of HIV/Aids. Only two per cent of the research participants did not know the causes of HIV/Aids in the correctional centre.

CONCLUSION AND RECOMMENDATIONS

This contribution explored offenders' perceptions of STIs, HIV and AIDS in a South African correctional centre. From the findings, although from a relatively small sample, the majority of the research participants indicated that sexual intercourse, whether consensual or the result of rape, was the major contributing risk behaviour for the transmission of STIs, HIV and AIDS. Although IDUs in corrections and the tattooing in prison have been researched extensively in other countries, this has not been adequately or in-depth addressed by South African researchers. The inmates that participated in this study also did not consider IDU use as a major contributing factor. The authors acknowledge the following limitations of the current study:

- it was conducted in only one correctional facility;
- face-to-face interviews can result in underreporting especially with regard to such a sensitive topic theme as sexual victimisation; and
- the majority of the participants were incarcerated for aggressive (violent) offences and therefore the results cannot be generalised to other offence categories.

Recommendations to address the exposure to and transmission of STIs, HIV and AIDS in correctional centres are as follows:

1. Although IDUs are believed not to be as common in South African correctional facilities, the high risk their use poses while incarcerated should receive more vigorous attention by the DCS.

i) The possibility of introducing a pilot needle-and-syringe programme (NSP) should be explored by the Department.
ii) A cheaper and less controversial recommendation is that bleach and other disinfectants for sterilising needles (IDUs and tattoos) be made available. Currently offenders are making use of illegal means to obtain cleaning materials and if found in possession thereof may be sanctioned and face additional sentencing. Evaluations of correctional facilities that introduced bleach programmes shown that the distribution of bleach and other disinfectants is feasible and does not compromise security and do not increase substance use (Jürgens et al, 2011:8).

2. Tattooing, sex and substance use will not be prevented in Corrections and the DCS needs to develop a sustainable management programme of these challenges to address HIV and AIDS in the long run. The current substance abuse correctional programme presented by the DCS focuses amongst others on strategies to overcome alcohol and drug addiction, signs and symptoms of substance addiction, as well as relapse prevention. It is recommended that this correctional programme also emphasise safe substance use inside correctional centres aimed specifically at IDU and include HIV prevention as a further objective (DCS, [sa]:15).

3. Although condoms are available from common areas the authors recommend that the DCS consider condom vending machines in more accessible areas such as inside the housing sections. Currently the condoms being dispensed are not made (strong enough) for anal penetration and therefore good quality latex condoms are promoted as breakage or slippage is uncommon with these condoms. Furthermore lubricants should also be made available, as the practice of safe anal sexual intercourse is hindered as the current condoms tear easily during anal sex without it. Both authors visited several correctional facilities in South Africa and in many instances condom vending machines were always empty. The management of condom distribution in more private areas and the distribution thereof on a regular basis should also be governed with the necessary will to prevent HIV and AIDS, as well as other related diseases.

ENDNOTES

1. CD4 cells are white blood cells or lymphocytes and assist other cells to destroy infective organisms.

LIST OF REFERENCES

Africa Check. 2014. Do prisoners have access to better medical facilities than the public? 18 December. Available at: http://africacheck.org/reports/do-prisoners-have-access-to-better-medical (accessed on: 11 May 2015).

Aids Law Project and Treatment Action Campaign. [sa(a)]. *Access to treatment for prisoners*. Available at: http://www.alp.org.za/modules-php?op. (assessed on: 22 February 2008).

Aids Law Project and Treatment Action Campaign. [sa(b)]. *Prisoners denied access to treatment*. [Sa]. Available at: http://www.alp.org.za/print.php?sid=274 (accessed on: 22 February 2008).

Aids Law Project and Treatment Action Campaign. [sa(c)]. *Victory in Westville Prison case.* Available at: www.tac.org.za/community/westville (accessed on: 22 February 2008).

Avert. 2014. *Prisoners and HIV/AIDS.* Available at: http://www.avert.org/prisoners-hivaids.htm (accessed on: 12 May 2015).

Barrett-Grant, K., Fine, D., Heywood, M. & Strode, A. (Eds.) 2001. *HIV/AIDS and the Law: A resource manual* (2nd edition). The AIDS Law Project and The Aids Legal Network.

Booyens, K. 2008. *The sexual assault and rape of male offenders and awaiting-trial detainees.* Unpublished doctoral thesis, University of Pretoria, Pretoria.

Booyens, K. 2015. Sentenced male offenders incarcerated at Kgosi Mampuru II correctional centre. Personal interview, 14 May.

Booyens, K. & Bezuidenhout, C. 2014. An exploratory study of sex and rape behind bars in a South African prison. *International Criminal Justice Review*, 24(4): 377-391.

Booyens, K., Beukman, B. & Bezuidenhout, C. 2008. The nature and extent of child and youth misbehaviour in South Africa. In C. Bezuidenhout & S. Klopper (Eds.), *Child and youth misbehaviour in South Africa.* Pretoria: Van Schaik.

Bonnycastle, K.D. 2011. The social organization of penal tattooing in two Canadian federal male prisons: Locating sites of risk for empirically-based health care interventions. *The Howard Journal of Criminal Justice*, 50(1): 17-33.

Department of Correctional Services. [sa] *Correctional programmes targeting offending behaviour*. Available at: http://www.dcs.gov.za/Publications/Other%20Publications/Correctional%20Programmes%20Targeting%20Offending%20Behaviour.pdf

Department of Correctional Services (DCS) 2012a. *DCS commended for its 15 year struggle against HIV and AIDS spread*. National World AIDS Day at Baviaanspoort Management Area, Gauteng. 3 December. Available at: http://www.dcs.gov.za/docs/landing/DCS%20commended%20for%20its%2015-year%20struggle%20against%20HIV%20and%20AIDS%20spread.pdf).

Department of Correctional Services. 2012b. *Annual Report. 1 January 2012 to 31 March 2013.*

Department of Correctional Services, Joint Committee on HIV and Aids. 2013. *Department of Correctional Services' (DCS) HIV and AIDS programme for inmates*.

De Vos, P. 2003. Prisoner's rights litigation in South Africa since 1994, a critical evaluation. *Civil Society Prison Reform Initiative,* 3: 31-33.

Dolan, K., Lowe, D. & Shearer, J. 2004. Evaluation of the condom distribution program in New South Wales Prison, Australia. *Journal of Law, Medicine & Ethics,* 32(2004): 124-128.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2003. *Treating drug users in prison: A critical Area for Health Promotion and Crime Reduction Policy.* January-February. Drugs in focus. Bimonthly briefing of the European Monitoring Centre for Drugs and Drug Addiction. Available at: http://www.emcdda.europa.eu (accessed on: 20 May 2015).

Gear, S. 2001. *Sex, sexual violence and coercion in men's prisons.* Braamfontein: Centre for the Study of Violence and reconciliation. Available at: http://www.csvr.org.za/papers/papgear1.htm (accessed on: 14 November 2002).

Goyer, K.C. 2003. *HIV/AIDS in prison: Problems, policies and potential*. ISS Monograph Series. Pretoria: Institute for Security Studies. 97: 18-19, 29-33.

Goyer, K.C., Saloojee, Y., Richter, M. & Hardy, C. 2004. *HIV/AIDS in prison: Treatment, intervention and reform. A submission to the Jali Commission.* AIDS Law Project and Treatment Action Campaign.

Jali Commission of Inquiry. 2002. *Report presented to the Parliamentary Portfolio Committee*. Available at: http://pmg.org.za/docs/2002/appendices/020820jali.htm (accessed on: 15 September 2004).

Jürgens, R., Ball, A. & Verster, A. 2009. Interventions to reduce HIV transmission related to injecting drug use in prison. *The Lancet*, 9: 57-66.

Jürgens, R., Nowak, M. & Day, M. 2011. HIV and incarceration: Prisons and detention. *Journal of the International AIDS Society*, 14(26): 1-17.

Krebs, C.P. 2002. High-risk HIV transmission behavior in prison and the prison subculture. *The prison journal,* 82(1): 19-49.

Krebs, C.P. 2006. Inmate factors associated with HIV transmission in prison. *Criminology and public policy,* 5(1): 113-136.

Minnie, M., Prins, A. & Van Niekerk, E. 2002. The role of prison gangs as precipitating agent in the spread of HIV/AIDS in South African prisons with special emphasis on socio-cultural factors. *Acta Criminologica: Southern African Journal of Criminology,* 15(1): 51.

Moseley, K. & Tewksbury, R. 2006. Prevalence and predictors of HIV risk behaviors among male prison inmates. *Journal of Correctional Health Care,* 12(2): 132-144.

Rutter, S., Dolan, K., Wodak, A. & Heilpern, H. 2001. Prison-based syringe exchange programs: A review of international research and program development. *National Drug and Alcohol Research Centre Technical Report,* 112. University of New South Wales. Sydney: Australia.

Sakawuli, K. 2006. *DCS HIV prevalence survey 2006: Executive summary.* Lim'Uvune Consulting.

Senok, A.C. & Botta, G.A. 2006. Human immunodeficiency virus and hepatitis virus infection in correctional institutions in Africa: is this the neglected source of an epidemic? *Journal of Medical Microbiology,* 55(5):481-482.

Simbayi, L.C., Shisana, O., Rehle, T., Onoya, D., Jooste, S., Zungu, N., Labadarios, D. & Zuma, K. 2012. *National HIV Prevalence, Incidence and Behaviour Survey.* Pretoria: Human Sciences Research Council.

Spiegler, S. 2012. *Mapping the legal framework to prevent sexual violence & HIV in South Africa's correctional facilities.* Sonke Gender Justice Network. Braamfontein: Johannesburg.

Strang, J., Heuston, J., Whiteley, C., Bacchus, L., Maden, T., Gossop, M. & Green, J. 2000. Is prison tattooing a risk behaviour for HIV and other viruses? Results from a national survey of prisoners in England and Wales. *Criminal Behaviour and Mental Health,* 10: 60-66.

Strathdee, S.A., Hallett, T.B., Bobrova, N., Booth, R., Abdool, R. & Hankins, C.A. 2010. HIV and risk environment for injecting drug users: the past, present, and future. *The Lancet,* 376:268.

Tapscott, C. 2008. *An assessment of the impact of HIV/AIDS on correctional system governance with special emphasis on correctional services staff.* Civil Society Prison Reform Initiative (CSPRI). University of the Western Cape.

Tshabalala, V.E.M. 2013. *Annual Report for the period 1 April 2012 - 31 March 2013.* Judicial Inspectorate for Correctional Services.

Tshabalala, V.E.M. 2014. *Annual Report for the period 1 April 2013-31 March 2014.* Judicial Inspectorate for Correctional Services.

World Health Organisation (WHO). 1993. *WHO guidelines on HIV infection and AIDS in prison*. United Nations Programme on HIV/AIDS. Geneva: UNAIDS.

World Health Organisation (WHO). 2013. *Sexually transmitted infections (STIs)*. Geneva: UNAIDS.

Zachariah, R., Harries, A.D., Chantulo, A.S., Yadidi, A.E., Nkhoma, W. & Maganga, O. 2002. Sexually transmitted infections among prison inmates in a rural district of Malawi. *Transactions of the Royal Society of Tropical Medicine and Hygiene,* 96: 617-619.