

# Mapping the Legal Framework to Prevent Sexual Violence & HIV in South Africa's Correctional Facilities

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# Executive Summary

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Sexual violence and HIV and AIDS are key areas of concern within the South African correctional system, as inmates experience both at heightened proportions. External estimates from the Institute for Security Studies and the Inspecting Judge claim the range of HIV and AIDS to be from 40-60%. The detention environment is highly conducive to the spread of HIV, swift development of AIDS, and perpetration of sexual violence through the systems already in place within detention facilities (i.e. the lock-up system; overcrowding; insufficient sexual education; etc.). These issues (and others) play a role in the rape, assault, and spread of HIV and AIDS to men, women, and children outside of prison upon inmate release. Sexual abuse of inmates also constitutes gross violations of their human rights. As the state is curtailing inmates' rights while under its custody, the state is under a heightened duty to protect their rights. Improved policies and practices that effectively prevent HIV and sexual abuse of inmates will improve the well being of not only inmates, but also the wider population.

Domestic and international law and standards call for comprehensive policies, programs, and laws addressing inmate health, namely HIV and AIDS prevention and treatment. The updated National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016, has strong, clear language that identifies inmates as a highly vulnerable population, and underscores the need for the Department of Correctional Services (DCS) to enforce laws and policies to prevent sexual violence in correctional centres as a key strategy for addressing HIV in South Africa. Yet, the correctional system is still in dire need of a comprehensive policy aimed at combating prison rape and addressing HIV and AIDS. A framework that is gender sensitive, upholds the human rights of inmates, that aims at preventing, detecting and responding to sexual abuse, and that includes precautionary measures to mitigate the impact of HIV and AIDS is needed.

While activist organizations such as the Treatment Action Campaign (TAC) and SECTION 27, and leaders in the field like the Civil Society Prison Reform Initiative, have forged ahead in the fight for inmate rights, more interventions are needed in the areas of sexual health, education and safety, and violence prevention in correctional centres. Proper tools (beyond the HIV education and provision of condoms) need to be provided for inmates to protect themselves from HIV and AIDS (and STIs). Department of Correctional Services (DCS) members must be capacitated to address sexual abuse. The Department of Health must ensure its health care professionals are sensitized to the needs of male survivors of sexual assault in correctional facilities (98% of inmates are male), and lubricants must be provided along with condoms to better facilitate safe sex amongst inmates. DCS must also work more closely with the South African Police Service to prosecute incidents of assault. The South African Police Service (SAPS) must also ensure that sexual abuse does not occur in its holding cells or during transport of offenders to correctional facilities. The Judicial Inspectorate of Correctional Services – tasked with inspecting and reporting on treatment of inmates and prison conditions – must develop a stronger human rights ethos and prioritize prison rape and HIV prevention. High-level

management at provincial and national levels must be committed to address these twin issues. Lastly, civil society must be galvanized and consider stronger advocacy approaches that bore fruit in the past, and tackle the issues of prison rape and the spread of HIV with the urgency they are due.

## Introduction

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This paper seeks to outline the policies and laws in place that are focused on the prevention and treatment of HIV and AIDS and the prevention of sexual violence in South African detention centres. Each year, 360,000 people circulate through the correctional system. The mistreatment, trauma, and illnesses that inmates are exposed to violates their human rights and has an impact on the public health of the communities to which they return. Violations of prisoners' rights to health and physical integrity are not only a failure to inmates, it is also a violation of the government's responsibility to aid in the promotion of the public's health as contained in the Bill of Rights, international agreements, and domestic legislation and policy. Key policies to address prison sexual abuse and HIV are lacking, leaving South African correctional facilities without a framework to guide their approach to these issues.

## Background

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### The Department of Correctional Services

The political changes that took place in South Africa in the early 1990s also impacted the prison system. The beginning of the demilitarisation of prisons started in 1991, when the Prisons Services was separated from the Department of Justice and given the new title "Department of Correctional Services" (DCS).

With the passage of the new South African Constitution in 1996, an overall framework for governance in the country was outlined. All governmental agencies were thus obliged to align their core practices with the Constitution [1]. The Constitution of the Republic of South Africa provides for a National Department of Correctional Services, with its accountability being vested in the Commissioner who is answerable to the Minister of Correctional Services [1]. The Commissioner is assisted by Chief Deputy Commissioner. The implementation of policy is then under the responsibility of Provincial Commissioners in each province. Each province is divided into Areas of Command with a Commander leading each region [1].



Perhaps contrary to common belief, inmates retain all rights except those curtailed to implement the imposed sentence. South African jurisprudence has supported this view on numerous occasions [2]. The state thus has a duty to care for inmates in a manner that does not violate their rights. The practice and threat of being raped in correctional centres impinges on these rights. The Bill of Rights states that: 'Everyone who is detained, including every sentenced inmate, has the right to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment.' [3].

The governance of the correctional system is very closely aligned with the treatment of inmates [4]. On paper, this is well developed and the DCS is accountable by means of its "internal auditing and control procedures, the departmental investigative unit (aimed at investigating corruption), the Auditor-General, Public Service Commission (PSC), the Department of Public Service and Administration (DPSA), the Standing Committee on Public Accounts (Scopa), and the Parliamentary Portfolio Committee on Correctional Services", which processes legislation and supervises DCS [4]. In addition, the Judicial Inspectorate of Correctional Services (JICS) occupies a special position in the current oversight architecture, and is mandated "to facilitate the inspection of correctional centres in order that the inspecting judge can report on the treatment of inmates and conditions in correctional centres" (section 85(2))[5]. The Inspecting Judge "inspects or arranges for the inspection of correctional centres in order to report on the treatment of inmates in correctional centres (Section 90)[5]. These various structures are in place to hold DCS accountable in respect to budget, strategic direction, management, and governance.

In recent years, it has been recognized that both the JICS and the Inspecting Judge had rather limited mandates and lacked powers to follow up on inspections. It was stressed that the JICS also had no disciplinary powers, and rather had only powers of investigation[6]. Activists throughout the country argue that the JICS does not act sufficiently on their mandate to hold DCS accountable for human rights violations. Furthermore, the JICS' independence has been called into question – it receives its funding directly from DCS, has to consult with the DCS Commissioner when appointing staff and in certain cases determining their salary, and JICS staff (except for Independent Correctional Centre Visitors) are administratively considered DCS employees, subject to the same internal evaluation procedures as DCS members [7, 8]. To date, JICS has not been sufficiently focused on human rights violations, lacking the ethos of a strong watchdog body, and thus has not tackled the issues of prison rape and spread of HIV.

Looking at accountability in practice, the history of the DCS post-1996 is a troubled one that led to the establishment of the Jali Commission of Inquiry in 2001. The commission was set up by President Thabo Mbeki in 2001 to probe corruption in the public service, especially departments such as the DCS [9]. In 2006, the Jali Commission released a report on corruption and maladministration within the correctional system. In the report, the Commission concluded that sexual violence and the spread of HIV and AIDS were issues plaguing South African correctional centres. Key recommendations included training staff to deal with issues of violence, rehabilitation of perpetrators, and it was strongly suggested that the means for the separation of

people who were vulnerable to sexual violence be put in place [2]. Significantly, the report stated that if DCS did not address these key issues, it was effectively imposing a death sentence on vulnerable inmates [10].

## Sexual Abuse in DCS Facilities

In 2007 JICS released data from a survey that found that 7% of offenders it surveyed had been subjected to unwanted sexual attention during their incarceration. Nearly half of all offenders surveyed reported that abuse happens either “sometimes,” “often” or “very often” [11]. Other researchers have documented how sexual abuse is rife in adult and juvenile correctional centres, such as the Centre for the Study of Violence and Reconciliation’s report on Boksburg Youth Centre from 2006, and an article published by Ghanotakis et al, based on interviews with DCS officials, health officials and JICS’ independent correctional services visitors in 2004 and 2005 [12, 13]. In the Ghanotakis piece, Wardens described how quickly someone can get raped once they enter a correctional facility, often on the first night spent in a communal cell. Through this process, an offender is “*branded a perpetrator coming to prison, but he can arrive at court or at home as the victim*” [13].

Research on sex and sexual violence in detention indicates that sexual violence, which is largely unrecorded, is ritualised and fundamental to establishing offender identities and hierarchies [14]. These identities and hierarchies mirror the most rigid and oppressive iterations of unequal gender norms in the general population. Through coercion, a portion of the male offender population is positioned as “women” – to be treated as the property of other offenders who get to maintain their identity as “men” [14]. For male survivors, rape robs them of their manhood. The humiliation of being labelled as a “woman” reflects the lower status that women are accorded in the wider society.

The sexual abuse that occurs in correctional facilities reflects and reinforces men’s understanding of sex as an expression of male dominance. CSVr’s research at Boksburg Youth Centre indicates that offenders’ understanding of sex, sexuality, and masculinity is drawn largely from their prison experience [15]. Thus, many inmates, particularly youth, adopt a range of negative attitudes and behaviours while incarcerated, which they bring back to the partners, families, and communities to which they return. Thus, while sexual violence is clearly linked to gang violence and its culture of domination, sexual violence and rigid gender roles that are enforced inside detention centres contribute to the abuse of women, men, and children, and the spread of HIV outside of detention, when inmates are released. As one offender described:

*“It is like your manhood is taken away from you. At the end of the day, you feel justified by raping the next person...it feels like retaining your manhood” [13].*

Understanding the macho culture and its resulting violence is an important aspect of understanding the context in which prison rape occurs. The link between violence and hyper-masculinity is critical to the



question of sexual abuse. The International Men and Gender Equality Survey, conducted in 2009-2010 by the International Centre for Research on Women and Instituto Promundo found that in South Africa, 68% of surveyed men with significantly gender inequitable attitudes had committed rape [16]. These men who had raped were more prone to other forms of violence, such as fighting with knives, illegal gun-possession and gang membership. Clearly, sexual abuse and masculinities that promote violence inside correctional centres fuel future violence inside and beyond the detention setting.

The links to gang culture and resulting intimidation make it difficult for survivors of sexual abuse to report or lay charges. As a former independent correctional centre visitor stated, very few trials result from prison rape. The visitor said:

*“What we often find at the inspectorate is that the person would have lodged a complaint and then withdraw the complaint or come forward and say ‘we’ve solved it’. But we also know that it being linked to gangster activity in prisons, there is a lot of pressure on that victim coming forward and going through with the charges.”*

Overcrowding in DCS facilities also means there’s a lack of places of safety for young or first time offenders, forcing them into the correctional centres where they are vulnerable to sexual violence. As one inmate said:

*“So that is the thing concerning by the wardens also that is working on the sex and what to do...they don’t know because every day they come with new inmates...so they must accommodate the people” [13].*

The trauma and ongoing humiliation and degradation that offenders experience through prison rape, or when offenders are forced to join gangs for safety and survival, all add to the likelihood that they are more likely to contribute to a range of health problems that impact the general population. This may be from contracting HIV, STIs and TB and not adhering to treatment, or to engaging in criminal activities including, violence against women and children. It also compounds the difficulties of re-entry into society. As one former inmate said about friends’ reactions after he returned home:

*“They expected me to be the same...they ask lots of questions about what happens in prison, they ask if people have sex with each other and this happens. All these questions are really mental torture” [17].*

The psycho-social needs of survivors during re-entry is an important consideration given South Africa’s high recidivism rate, which is estimated to be 80% [18].

## HIV in DCS Facilities

The DCS lacks critical data about HIV prevalence in detention facilities, despite it being a key area of concern. The DCS reported a HIV prevalence rate at 3% in 2009, though it is unclear how the department arrived at this figure. However, external estimates from the Institute for Security Studies and the Inspecting Judge of Correctional Services range from 40-60% [19, 20]. With such conflicting figures, DCS does not know the actual HIV prevalence in its prisons. The annual report does not disclose how this estimate was determined, even though the Department acknowledges this estimate as ‘unrealistically low.’

A 2007 study on HIV prevalence by Lim’uvune Consulting, commissioned by the DCS, reached over 10,000 inmates nationwide and found an HIV prevalence of 19.8 percent. The national prevalence is roughly 10.5% percent, and for adults aged 15-49, the estimated average is 17% [21]. Ninety-four percent of the infections were among male inmates, who constitute 98% of all incarcerated persons [19]. These results are considered to be lower than the actual prevalence due to limitations of the study (low participation among inmates, etc.). Despite these results, only 22 correctional centres are accredited to provide anti-retroviral drugs [22]. Today, there are 162,162 men and women in correctional centres with an overcrowding rate of approximately 137.25 percent [19]. The number of total inmates has increased by nearly 3,000 since 2007 and the overcrowding rate has remained relatively stagnant [19, 23-25].<sup>1</sup>

The HIV rate and overcrowding is particularly problematic when viewed in relation to the HIV pandemic. The detention environment is highly conducive to the spread of HIV, swift development of AIDS, and perpetration of sexual violence. As most inmates will be released, improved policies and practices that effectively prevent HIV and sexual abuse of inmates will improve the well being of not only inmates, but also that of the wider population.

## International Principles and Laws on Prison Health and HIV and AIDS

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Various international treaties and standards documents serve as a reference point for measuring the current state of South Africa’s correctional centres in terms of sexual violence and HIV prevention. Section 39 of the Constitution states that courts and other legal bodies must consider international law and may consider foreign law when interpreting the Bill of Rights [26]. Furthermore, section 231 of the Constitution says that a treaty binds South Africa after approval by a resolution of the National Assembly and the National Council of Provinces [26]. Consequently, in South Africa, there are numerous links between developing and

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<sup>1</sup> Level of overcrowding was approximately 144% in 2008; 140% in 2009; and 143% in 2010 (DCS Annual Report 2008; 2009; 2010).

implementing health law and international law.

A human rights-based approach to inmate health has a longstanding history in terms of HIV and AIDS prevention in correctional centres. According to Jonathan Mann, a key figure in developing the health and human rights approach to addressing HIV and AIDS, some of the major determinants of health are societal in nature [27, 28]. In other words, social determinants of vulnerability and health (i.e. poverty, discriminations, lack of access to information/treatment) make individuals especially vulnerable to negative health outcomes. Therefore, it is necessary to design a framework with values expressed in societal terms that aims to address the aforementioned social determinants. Mann stressed, “the human rights framework offers public health a more coherent, comprehensive, and practical framework of analysis and action on the societal root causes of vulnerability to HIV/AIDS...” [27, 28]. In turn, law and policy makers have utilized this approach in addressing root inequities in relation to HIV and AIDS. This approach is grounded in the rights enshrined in international human rights treaties and U.N. documents.

International agreements and standards documents recognize that any inmate living with HIV or AIDS should not be denied access to adequate care and treatment equivalent to that available in the community without discrimination on the grounds of their legal status [29, 30].

One of the first documents surrounding HIV and AIDS in prisons was created by the World Health Organisation (WHO) in its 1993 “WHO guidelines on HIV infection and AIDS in prisons.” The document recognizes a rights-based approach to HIV prevention and AIDS treatment as a best practice. More specifically, the document states that officials should not discriminate against inmates with HIV and AIDS; should not breach confidentiality; should adopt the general principles put into place by National AIDS programs; should put into place specific policies for the prevention of HIV and AIDS and for the care of HIV infected inmates; should implement policies to make prisons a safer place and to reduce risk for transmission of HIV and AIDS, and lastly, should make HIV and AIDS prevention a priority [31]. The WHO also recognised that prisons throughout South Africa represent “key points of contact with millions of individuals living with or at high risk of HIV infection” [32].

Going further, the WHO recognises the high prevalence of injection drug usage in the inmate population – though there is not a high population of users in South Africa’s correctional facilities, tattooing is pervasive. The WHO also states that as part of an overall HIV education programme, inmates should be informed of the dangers of drug use, provided with treatment for drug dependency while in prison, and provided with information on and tools for safe drug use (in states where such programs are made available) [31]. Thus, clean needles and bleach are necessary components to international best practices for HIV prevention in correctional centres. Although the WHO is clear in their guidelines, states are not necessarily obligated to abide by them. WHO guidelines are considered ‘soft law’, meaning they are ‘sources of non-binding international law that can provide guidance on the interpretation of international treaties’ and guidance on national policy [26].

In the UN General Assembly Declaration of Commitment, the UN General Assembly on HIV/AIDS states, “respecting the rights of those at risk of or living with HIV/AIDS is good public health policy and good human rights practice” [33]. The international community has generally accepted that inmates retain all rights that are not withheld as a part of their incarceration. The “loss of liberty alone is the punishment, not the deprivation of fundamental human rights,” and like all persons, inmates too have a right to the highest available standard of health care [29]. This right is guaranteed under international law in Article 12 of the International Covenant on Economic, Social, and Cultural Rights, in Article 25 of the UN Universal Declaration of Human Rights and in particular, General Comment No. 14 on the Right to the Highest Attainable Standard of Health which was adopted by the UN Committee on Economic Social and Cultural Rights [29]. In South Africa, this right is reflected in Section 27 of the Bill of Rights, which expounds, “the state must take reasonable legislative and other measures, within its available resources...” to achieve this right [3].

International law is clear in its prohibition on inflicting inhuman or degrading treatment on prisoners (African Charter on Human and Peoples’ Rights, 1981 Article 5; Universal Declaration of Human Rights, 1948 Article 5). The law specifically “compels the authorities not only to refrain from provoking such treatment, but also to take the practical preventive measures necessary to protect the physical integrity and the health of persons who have been deprived of their liberty” [34]. Going further, it has been made clear that when health care services are lacking, situations of “inhumane and degrading treatment” are sure to follow. South Africa also signed and ratified the International Covenant on Civil and Political Rights (ICCPR) and its Optional Protocol, which commits its parties to respect prisoner rights to liberty and security of the person, and to be treated with dignity and humanity (ICCPS Article 10).

In line with the aforementioned, South Africa has ratified the United Nations Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (CAT), which obligates the state to address the issue of sexual violence in prisons under international law. The CAT aims to prevent torture throughout the world and requires states to take effective measures to prevent torture within their borders. Under CAT, torture is defined as: “[a]ny act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person... It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.” (Convention Against Torture, Article 1.1) [35]. The sexual abuse of inmates falls within this definition. However, while South Africa has become a signatory to the Optional Protocol to the Convention against Torture, which seeks to establish a system of regular visits undertaken by independent international and national bodies in order to prevent torture and ill treatment, it has failed to ratify the protocol. Further, torture is not defined under South Africa’s criminal law; acts that constitute torture have to be prosecuted as assault or another offense.

As demonstrated, international law and standards clearly outline a country’s obligation to develop and implement legislation, policies, and programs to protect the health and physical integrity of inmates. These interventions must be aligned with international human rights obligations that reduce the spread of HIV infection (as well as other diseases) and prevent the sexual abuse of inmate populations. In light of the

aforementioned, it is essential to look at South Africa's correctional system in the context of international human rights standards. Examining the origins of current laws and policies can provide insight for future policy actions.

## History of South African Correctional Services Policies on HIV and AIDS and Violence Prevention

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In South Africa, the law and policy debate regarding HIV and AIDS in the correctional system stems back to the early 1990s. The first policy to address HIV and AIDS in the South African correctional system was formulated in 1992 and "has been described as based on fear, lack of knowledge, and prejudice" [36]. The DCS approach was to segregate HIV-positive inmates, with the policy officially implemented from 1995. Upon entry, new inmates would be interviewed to determine if they were partaking in high-risk behaviors and then tested if they were deemed to be at a high risk for HIV. A separate facility was utilized for those inmates who were positive, keeping them isolated from the general inmate population.

In the 1993 case, *Minister of Justice v Hofmeyr*, the Supreme Court stated: "[t]he prisoner retains all his personal rights save those abridged or prescribed by law... the extent and content of a prisoners rights are to be determined by reference not only to the relevant legislation, but also by reference to his inviolable common-law rights." Following this case, South Africa enacted a new Constitution, with inmate rights being protected within it.

Relevant provisions are the following:

- Section 10 in the Bill of rights states: "everyone has inherent dignity and the right to have their dignity respected and protected";
- Section 11 states: "everyone has the right to life";
- Section 12 guarantees the "freedom and security of the person";
- Section 27 guarantees the right to have access to health care services;
- Section 35 guarantees every person who is detained, including every sentenced prisoner, the right "to conditions of detention that are consistent with human dignity, including at least... adequate accommodation, nutrition... and medical treatment."

Although the Bill of Rights articulated inmates' right to health care services, DCS officials continued to segregate HIV positive inmates and did not provide adequate safeguards for inmates who were at risk for acquiring HIV.

In 1994, the DCS produced a White Paper that declared, “[s]ex, in whatever form, cannot be condoned and authorized for prisoners in South Africa.” The paper went on to dismiss anything related to condom distribution within the prison, citing that sexual activity in prisons is neither permitted nor tolerated [37]. The DCS policy to distribute condoms was the result of a battle waged by several advocacy groups. Moreover, the negligence displayed by correctional authorities that did not make condoms available was brought to the forefront by an out of court settlement achieved by a South African former inmate [38]. Condoms were only introduced in South African correctional facilities in 1996. DCS again updated its policies for HIV and AIDS in correctional centres in October 2002. This change was made to ensure “that condoms... be easily accessible and available at all times” [36]. Previously, inmates had to obtain condoms from a member of the health staff and request condoms in person, one at a time. This marked policy development made condoms available from dispensers in common areas. The DCS has since committed itself to a policy of non-discrimination in handling inmates with HIV. This however, has not always been true in practice.

In 1996 a policy amendment paper was distributed to correctional services officials, ending the practice of segregating HIV positive inmates, as it would be a disclosure of information and a violation of the constitutional right to dignity and privacy. Inmates were only to be tested on a voluntary basis or upon recommendation by the district surgeon. The policy also stipulated that inmates’ written consent was required before a test could be administered [39]. This amendment still failed to address the root causes of the HIV epidemic plaguing inmates. In the years following, new legislative developments attempted to improve prisoner rights to HIV services.

## The Correctional Services Act of 2004 and the Current State of Correctional Facilities in South Africa

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In 1998, the Correctional Services Act (CSA) was enacted, creating a rights based framework for the South African correctional system. The rights outlined in the CSA apply to all inmates and outline the minimum standards for the treatment of inmates under South African law [40]. In it, there are numerous regulations (including those promulgated in 2004) outlining the rights of inmates, with some focusing on health care quite generally. The overarching purpose of the policy relating to health care in correctional facilities was to ensure that inmates are able to lead healthy lives. However, while the CSA does broach the subject, it fails to address the HIV and AIDS epidemic directly. Inmate rights to health care within the CSA include adequate access to medical care based on the principles of primary health care. This means that at least the same level of health care must be available to inmates as to members of the general population. Within the CSA, the right to medical care is to be supplied “within available resources.”



Legislation on sexual violence within correctional centres is sparse. In the CSA, inmate rights relating to violence in correctional facilities include the following:

Separation of certain categories of inmates:

- “Sentenced offenders must be kept separate from persons awaiting trial or sentence” (CSA, S7(2)(b)) [41].
- “Male inmates must be kept separate from female inmates... children must be kept separate from adults...” (CSA, S7(2)(b)(c)) [41].
- “Inmates may be separated based on their age, health or security risk” (CSA, S7(2)(d)) [41].
- Discipline:
- “The disciplinary system in a correctional centre is there to protect the safety of both staff and inmates. For this reason good order and security must be maintained” (CSPRI, 2010) [41].

Although the CSA attempts to address issues related to inmate safety, it does not adequately address the issues of prisoner rape, sexual violence, and inmate rights to safety within correctional facilities.

Since the promulgation of the CSA in 2004, new regulations relating to inmate health and safety have been enumerated. Although the right to access medical services is still intact, there is little to no direct mention of the HIV epidemic within correctional facilities, even though “HIV and AIDS have brought a new dimension to the correctional health care debate” [40]. Further, within the Act, inmates are guaranteed the right to a safe environment that is not harmful to their health or well-being with systems in place in attempts to regulate instances of violence among the inmate population. However, even though this is expounded upon, the CSA does not place obligation on inmates to report corruption, nor does it provide inmates who have reported corruption with any special protection [40].

Moving forward, DCS officials acknowledge that current policies (including the 1994 White Paper) do not provide appropriate framework for the areas of key service delivery such as: comprehensive health care, primary health care, HIV and AIDS policy, and the role of policy personnel, administrative personnel, professionals, and other correctional officials within the Department [42].

Efforts to address inmate violence and rape are in the early stages in South Africa. The DCS is trying to develop initiatives focused on the link between inmate rape, gangs, and HIV and AIDS. With the passage of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (SOA), the South African Parliament adopted a gender-neutral definition of rape, recognizing male victims of rape. Previously, this was treated as the lesser offence of indecent assault. Following this, in 2008 DCS officials convened a day long “seminar on offender rape in correctional centres,” bringing together senior corrections officials, non-governmental organizations, oversight officials, and academics to analyze the problem and develop possible responses [10].

Promisingly, the Correctional Matters Amendment Act (CMMA), passed in May 2011, places responsibility on the DCS to assess awaiting trial inmates upon admission for their vulnerability to sexual violence [43]. With its recent passage, regulations will be drafted in terms of its implementation, and a screening tool will need to be developed to assess inmates.

Going further, a number of related strategies have been outlined in the Draft Policy Framework to Address Sexual Abuse of Inmates in DCS Facilities, including: staff screening and training on identifying common signs of sexual abuse; inmate classification (as in the Correctional Matters Amendment Act), which proposes that “remand inmates are assessed for vulnerability to sexual violence and separated from other inmates”; and maintaining inmate safety through adequate staffing and supervision [44]. This draft framework was the product of a two-year collaborative effort by committed DCS members and advocates from CSVr and Just Detention International. Though completed and circulated within the department, the Policy Framework has yet to be signed and adopted by DCS. Together, the CMMA and the Policy Framework mark the first direct acknowledgement by DCS officials of the problem regarding sexual abuse in correctional centres. More recently, DCS has begun to track sexual assault cases separately from general assault cases for its statistics, showing further commitment by DCS leadership in acknowledging the issue.

Other pertinent policy pertains to the Department of Health (DoH). In 2005, the DoH published its National Sexual Assault Policy. The document recognizes that public health responses to victims of sexual assault have been inadequate and that the process of seeking health care often exposes victims to further trauma [45]. The three key strategies in the policy are to establish: an integrated institutional framework with the DoH to guide internal collaboration and cooperation; “designated, specialized, accessible, 24-hour health care services for the holistic management of patients to improve health status after sexual assault”; and links with both the community and other government stakeholders [45, 46].

Although National Sexual Assault Policy serves as a starting point for further addressing the issue of sexual abuse in correctional facilities, the policy (and DoH policy in general) fails to include medico-legal protocols for male rape victims, further excluding the male inmate population from strategies aimed at prevention. Medico-legal protocols could prepare practitioners to understand the medical needs of male victims better, and can be used to sensitize them to the type of confusion and trauma that male victims can experience. For example, male victims may have autoerotic responses when being sexually assaulted, and often feel like their masculinity and sexual orientation has been called into question. Medical practitioners must be prepared to interact with sensitivity and compassion when dealing with all rape victims, and likewise must understand what male victims specifically may experience.

Recent research indicates that many medical professionals are unfamiliar with sexual offences policy, impeding provision of appropriate services. For example, many medical officials mistakenly believe that rape victims must lay a charge in order to access free post-exposure prophylaxis [47]. Victims are not required to lay charges for this life-saving service [48]. Anecdotal evidence indicates that medical officials make incorrect

conclusions about prison rape cases, for example, by incorrectly concluding that no rape took place because the victims presents no scars or bruising. Under the Sexual Offences Act, violent force is not an element of rape – the legal definition hinges on lack of consent [49]. This misinformation prevents victims from obtaining life saving services and accessing justice.

In May 2006, the DoH was mandated by the South African National Aids Council (SANAC) to lead the process of developing a new five-year (2007-2011) National Strategic Plan for HIV and AIDS and STIs (NSP). The implementation of NSP 2007 – 2011, with its very ambitious targets to mitigate the impact of HIV and AIDS on South African society, is the responsibility of all sectors [50]. The targets within the NSP include: prevention; treatment, care and support; monitoring, research and surveillance; and human rights and access to justice [50]. Specifically for inmates, incarceration is recognized as a risk factor for HIV and AIDS and is correlated with “unprotected sex and injecting drug use in correctional facilities, but may also include risk of blood exposure as a product of violence and other factors” [50]. The NSP calls for interventions including: providing voluntary testing and counselling, condom provision, addressing inmate rape, and addressing intravenous drug use [50].

The new NSP for 2012-2016 was launched on World AIDS Day of 2011. The new document has strengthened language to address inmate HIV and sexual abuse. The NSP identifies inmates as a particularly vulnerable population to HIV transmission that must, therefore, be a focus of efforts to stem the pandemic. Recognizing that sexual violence and HIV are inherently linked, especially in South Africa’s correctional facilities, the Plan calls on the DCS to ensure the provision of appropriate prevention and treatment services, and to enforce laws and policies to prevent sexual violence in prison settings. The yet to be adopted Policy Framework to Address Sexual Abuse and the regulations that must be promulgated to implement the CMMA are crucial tools in fulfilling the aspirations of the NSP.

While still under the 2007-2011 NSP, the DCS commenced with the process to review its own implementation strategies for comprehensive HIV and AIDS programs and services to align them with the objectives of the NSP 2007-2011 [51]. Hence, the Department drafted their own policy, the “Framework for the Implementation of Comprehensive HIV and AIDS Programs and Services for Offenders and Personnel-2007-2011” [51]. The overall objectives in the document include: communicating HIV and AIDS programs and services to all offenders and personnel; implementing comprehensive HIV and AIDS programs and services to offenders and personnel; reviewing and developing new policies; capacitating offenders and personnel; monitoring the implementation of HIV and AIDS programs and services; evaluating the impact of HIV and AIDS programs and services among offenders and personnel; and facilitating and initiating research on activities relevant to HIV and AIDS [51]. This document recognizes that the DCS must implement HIV and AIDS programs and services for both offenders and personnel.

While the DCS HIV and AIDS Framework itself focuses on inmates, the department has yet to create or implement systematic measures to manage the disease among staff members. In addition, the framework is

noticeably silent on the “impact which HIV and AIDS might have on the governance of correctional centres, and on the measures which might be introduced to mitigate the negative impacts of the disease” [52]. In spite of this, the HIV and AIDS Framework received approval from the National Commissioner on October 29, 2007. However, it is unclear as to how much progress has been made, as the official documents are not available for public consumption. More recently, DCS officials have begun to re-formulate and make alterations to their management strategy, identifying key challenges within the correctional system.

Following the dissemination of the CSA, the DCS created a new White Paper on Corrections in South Africa. The 2005 document (an update of the 1994 document) outlined the new strategic direction of the Department for the 20 years following its dissemination and represented “the final fundamental break with a past archaic penal system...” and “the development of a new corrections-focused correctional system for South Africa” [53]. This White Paper made rehabilitation core to DCS’ mission, stating it is “a fundamental contribution to societal corrections.” [53].

DCS regards overcrowding as its most important challenge, stating “overcrowding does not only have significant negative implications on the ability of the Department to deliver... but constitutional provisions also oblige Government to act urgently on the matter” [53]. Further, the 2005 White Paper outlines numerous other challenges including:

- The state of the DCS facilities;
- Institutional prison culture;
- Corruption and mal-administration
- Training and re-training of members for the “new paradigm”;
- The needs of special categories of offenders – women, children, youth, the disabled, the aged, the mentally ill, long-term offenders, offenders with life sentences, first offenders, and foreign nationals; and
- Dealing with HIV and AIDS, and the effective management of communicable diseases [53].

When management is poor, corruption ensues and inmates are forced to live with poor health outcomes (i.e. HIV and AIDS) and rampant violence. DCS’s acknowledgement of corruption and strengthening management are key in their attempt to provide improved medical care and service delivery in correctional facilities.

While the White Paper outlines HIV as a challenge, little focus is placed on addressing HIV and AIDS, and there is no mention of sexual violence. In the document, HIV and AIDS is only mentioned twice:

- On page 20, DCS acknowledges the lack of focus on HIV and AIDS policy in the 1994 White Paper; and
- On page 77. DCS states “HIV/AIDS... will be addressed as integral to provision of comprehensive health care services and health care education to inmates. The department should focus on programs to reduce the impact of HIV/AIDS... to allow people under correction to leave the system as healthy as possible” [53].

This lack of acknowledgement on the impact of HIV and AIDS and violence within the correctional system illustrates negligence on the part of DCS officials to take the health and physical integrity of inmates seriously.

What is essential in furthering the humane treatment of inmates with HIV and AIDS, preventing its spread, and putting an end to sexual abuse are approaches taken to address mal-administration. South Africa's approach to correctional management "... is based on the principles of restoration or corrections, unit management, and secure, safe and humane custody and supervision" [53]. Part of the model addresses dealing effectively with corruption and maladministration.

DCS' approach is ideal in theory, articulating a strategy that is "in line with international human rights standards" [53]. However, implementation of the aforementioned policies has yet to be fully realized. Much work is needed to align South Africa with international standards in terms of the treatment and prevention of HIV and AIDS, and addressing sexual violence within the prison system.

## Mechanisms Furthering the Deteriorating Health of Inmates

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Under current South African legislation, inmates are guaranteed rights that provide for medical services, education, and equal treatment. However, current practices within the correctional system impede these rights.

Many inmates that go through the correctional system are not properly classified, and those who are most vulnerable to sexual violence are commonly housed with predatory inmates, gang members, and violent offenders in large communal cells. Furthermore, "perhaps the most problematic practice in prisons throughout South Africa is the system of 'lock-up'" [10]. Each night, inmates are sent to their cells, at which point they are locked up in communal spaces until the next morning [9]. During these times, prisons operate with minimal guards, creating prime opportunities for sexual predators to commit assaults. It is during this time that a vast majority of sexual crimes occur in South African correctional facilities. The vast overcrowding in detention centres exacerbates the abuse and victimization that occurs due to the lock-up system.

Despite having 41,000 employees, the DCS often argues that it cannot change its lock-up policy because of staff shortages, though a change to this policy would greatly improve protection for inmates and prevent sexual abuse [54]. Contrary to these claims, JICS submitted that the DCS has a favorable staff ratio and identified improper implementation of a "two shift system and the manner of applying staff leave policies"

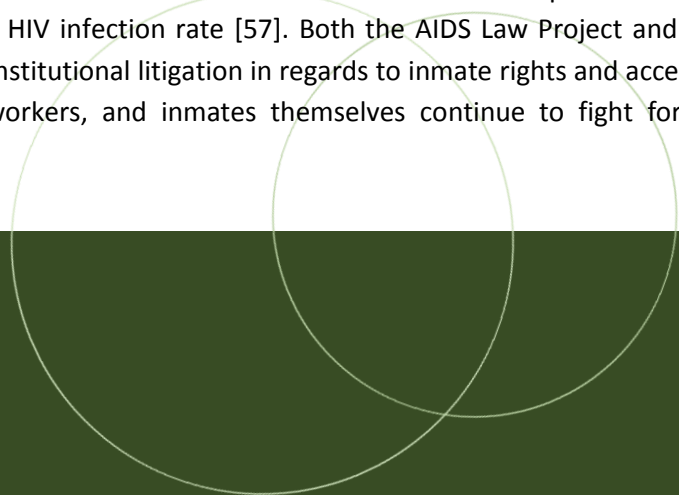
as sources for the problem [55]. JICS also went on to note that in some correctional facilities, senior officials were not present during inspection visits, and observed staff members disproportionately conducting administrative work instead of providing security. Research is needed to determine not only staffing levels, but also whether there is adequate custodial staff.

Conditions within correctional facilities put inmates at a higher risk of HIV infection while in detention. “The conditions inside prison can contribute, in varying degree, to the risk for HIV transmission, the progression of HIV, and the deterioration in health of a person with full-blown AIDS” [9]. The DCS has explicitly outlined its commitment to provide HIV education and condoms to inmates on the basis that condoms are provided in the community, however, the issue has not been adequately addressed, aiding in the higher numbers of HIV infection within the population. Anecdotal evidence suggests that DCS members are lacking basic information on HIV and are unfamiliar with sexual offences laws. As with many medical officials, DCS members seem to misunderstand the legal definition of rape (not requiring violent force, only lack of consent), and that a charge does not have to be laid for a victim to access PEP.

Going further, it is only in recent years that Anti-Retroviral treatment (ART) has been made available to all inmates in South Africa. This advance did not come easily and required protest, civil disobedience, and strategic litigation by inmates and civil society activists. It was in 2006 that AIDS Law Project (now called SECTION 27) and Treatment Action Campaign (TAC) organized a hunger strike by inmates, demanding that the government provide ARV treatment for HIV positive inmates. Concurrently, AIDS Law Project also represented 15 inmates at Westville Correctional Centre and was granted an order directing the government to provide ARV treatments to inmates. However, it took further action by civil society to ensure implementation of this order.

Director of the then AIDS Law Project, Mark Heywood, called for the resignation of the Minister of Health Manto Tshabalala-Msimang at the International AIDS Conference in Toronto. Timed to coincide with this event, hundreds of activists from TAC demonstrated for the rights of HIV positive inmates to access ARTs. During their protests, 45 members of the TAC were arrested after taking over government offices, including the South African Human Rights Commission. Shortly thereafter, the Department of Health announced that the Westville Correctional Centre had become accredited to provide ARV treatment and noted that three other correctional facilities had been accredited as well [56].

Following this, the South African Health Minister was hospitalized for a lung infection. In her absence, South Africa’s Deputy Health Minister (Nozizwe Madlala-Routledge) stated that the government had, in fact, been “in denial at the very highest level” over AIDS and commissioned a revised National Plan to triple the number of people receiving ART and to halve the new HIV infection rate [57]. Both the AIDS Law Project and TAC have undertaken substantive and successful constitutional litigation in regards to inmate rights and access to HIV medication. Today, advocates, health workers, and inmates themselves continue to fight for full compliance with the decree.





# The Future of South African Correctional Facilities

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South African authorities are failing to curb the spread of HIV and AIDS and to keep inmates safe from violence and sexual abuse. In doing so, they are going against international law and standards that protect inmate rights to health, dignity, and physical integrity. Inmates' rights are human rights, and in South Africa, as elsewhere, they are inextricably linked with community health. In moving forward, clear changes are required to realize the basic rights to health and physical integrity that inmates are guaranteed under law.

As previously mentioned, international law calls for comprehensive policies, programs, and laws addressing inmate health, namely HIV and AIDS prevention and treatment. South African DCS officials have also outlined their lack of appropriate policies in their 2005 White Paper. In order to address the issues of HIV and AIDS and violence within the prison system, South Africa needs a comprehensive policy and set of guidelines for the treatment and prevention of HIV and AIDS in prisons. The policy must be gender sensitive, addressing the specific needs of male and female inmates, must include precautionary measures to mitigate the impact of HIV and AIDS, and must focus on DCS staff as well.

In addition to the aforementioned, continuous and thorough sexual education programs need to be included within the South African prison context. Sexual education is necessary for the practice of safe sexual practices. Due to the heightened risk of HIV transmission in prison, and transmission once released from prison, "it is essential that inmates receive information about HIV... HIV education within prisons is one of the least controversial prevention methods" [38]. Some examples are the DoH funded peer education program conducted by Sonke Gender Justice Network and the recently initiated program by Health4Men. In pushing the inmate health agenda, more focus must be placed on providing these types of services to all inmates.

While policy on the provision of safe sex tools (i.e. condoms) has improved over the years, more work is needed. While condoms are provided in prison common areas, lubricant is not, which hinders the practice of safe anal sex within the prison setting, even under consensual terms. The Centres for Disease Control and Prevention states: "[a] person should use generous amounts of water-based lubricant in addition to the condom to reduce the chances of the condom breaking" [58]. Lubricant is an essential prevention tool, as without it condoms can tear, resulting in unsafe sex, reducing the effectiveness of condom provision programs in correctional facilities.

Going further, attention must be paid to providing safer tools for tattooing intravenous drug users in correctional facilities. Wherever there are larger numbers of injecting drug users, there is a higher risk of HIV transmission, and this is true especially in prisons, where access to clean equipment is limited. A number of studies have found that Intravenous Drug Users (IDUs) are more likely to share injecting equipment within

correctional facilities than before imprisonment. In the Republic of Ireland, “70.5 percent of the IDUs surveyed reported sharing needles while imprisoned, compared to 45.7 percent in the month before incarceration” [59]. Although there is little injection drug use, the need for clean equipment is still a vital necessity because needle sharing occurs in large numbers through tattooing practices within correctional facilities. By simply providing bleach, efforts can prevent the spread of HIV amongst inmate populations.

Lastly, in order to help reduce the already heightened rate of recidivism among inmates, psychosocial services need to be in place and readily provided throughout South African correctional facilities. DCS needs to take responsibility for this and ensure that inmates’ mental health is treated as a priority. Offender reintegration networks, such as the National Institute for Crime Prevention and the Reintegration of Offenders (NICRO), offer programs that support this altogether essential element. Through increased collaboration, psychosocial needs of inmates can be more readily addressed and the rate of re-entry into the prison system can be lessened.

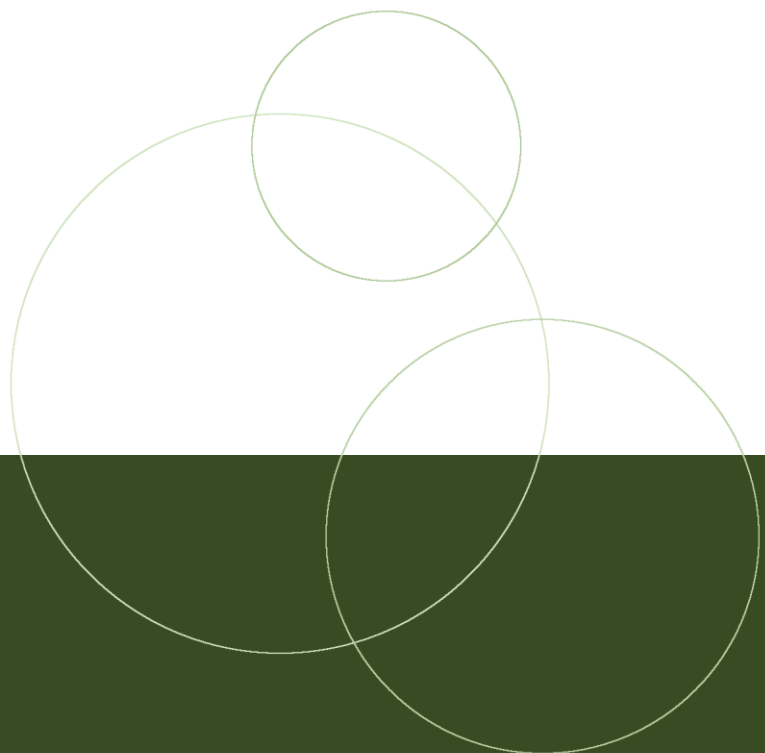
## Conclusion

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South Africa needs to make HIV and AIDS and sexual violence prevention a priority in the prisons context. Evidence suggests that prison rape fuels a cycle of victimization highlighting “the potential for male rape victims to themselves become violent in the future. So, in its bluntest form, a regularly stated argument is that unless we pay victims the attention they deserve, they will become rapists on the outside in attempt to regain their manhood” [60]. With high infection rates in prisons, the link between sexual violence and HIV cannot be ignored.

In moving forward, DCS needs to adopt and enforce more effective and comprehensive policies on the treatment and prevention of HIV and AIDS and sexual violence in the prison system. There is a strong road map for DCS to follow as the new NSP for 2012-2016 contains clear directives for the state to enforce laws and policies to prevent prison rape and sexual assault as part and parcel of its effort to prevent the spread of HIV. The NSP also unambiguously highlights inmates as a particularly vulnerable population for HIV transmission. Policies to implement this directive must create an enabling environment for DCS members to better protect the physical integrity of the inmates in their custody. DCS members must also receive support in order to be sensitized to the issues of sexual violence and HIV, and receive consistent training in order to have the technical knowledge to deliver on their mandate. Crucially, it should be incorporated into DCS training college curricula. Importantly, commitment to addressing these issues must come from DCS management, firstly by adopting the Draft Policy Framework to Address Sexual Abuse of Inmates in DCS Facilities, and drafting strong regulations to implement the Correctional Matters Amendment Act’s provision on screening inmates for vulnerability to sexual abuse.

Significantly, DCS does not stand alone in its mandate to protect the physical integrity and health of inmates in its facilities. The Department of Health is lacking medico-legal protocols for male victims of sexual offences, which speaks to the profound stigma attached to male rape. Medical practitioners must be prepared to deal with the specific needs of male victims. They must also be familiar with sexual offences policy to understand the legal definition of rape and rules surrounding victims' access to free PEP. Meanwhile, advocates for inmate rights must continue to push for higher levels of accountability for all DCS staff members, as well as the Parliamentary Portfolio Committee on Correctional Services, the Judicial Inspectorate of Correctional Services, the Department of Health, and the Department of Social Development in their respective roles managing, overseeing, and providing services for DCS.



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